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THE EXPERIENCE AND IMPACT OF GRIEF AND LOSS RESULTING FROM THE DEATH OF A LOVED ONE

by

Student M. Name

A dissertation submitted in partial fulfillment

of the requirements for the degree of

Doctor of Philosophy in Clinical Psychology

Name of Institute

June 2023

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Table of Contents

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Chapter 1

Introduction

Purpose Statement

The purpose of this study was to understand individuals' experiences of grief and loss related to the death of a loved one, as well as the psychological, spiritual, and physical impacts of this grief. Employing a phenomenological approach, I investigated participants' experiences by conducting in-depth interviews. I analyzed the recorded interviews and developed underlying themes that reflected common meanings related to the experience and impacts of death and loss. In addition, I maintained a focus on the neurobiology of loss over the course of the study. This investigation was based upon a depth psychological approach and theoretical models including psychoanalytic, attachment, and thanatology to further amplify and clarify this topic.

More specifically, I explored how the experiences of grief and loss affect individuals' perceptions of life and life experiences. Through a holistic approach that allowed for, and honored, participants' internal and external experiences, I aimed to investigate and understand the wide-reaching impact of grief and loss related to the death of a loved one. The goal of this study was to conceptualize, understand, and unify the various components underlying the participants' experiences surrounding grief and loss. My aim was to clarify each individual's unique experience, while also revealing significant and fundamental commonalities that would advance the understanding of grief and loss within the field of psychology.

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Relevance of the Topic for Clinical Psychology

In undertaking this research study, I reviewed a wealth of literature related to grief following the death of a loved one. As a Marriage and Family Therapist licensed in California, it has been my privilege to assist individuals and families with their losses and grieving processes. In working with those affected by death's debilitating grip, I have witnessed great pain and sorrow, as well as incredible rejuvenation and healing. Further, prior coursework at [Institute Name] offered me the opportunity to engage in phenomenological research. One particularly impactful research project allowed me to tentatively explore my own experience surrounding the death of my mother and its effects on certain family members. Through these processes and experiences, I have come to further appreciate and honor the incredible power of death, and I both respect and regret death's capacity to devastate—and even destroy—the living.

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Individuals face the death of loved ones in unique ways. For some, grief becomes persistent depression, while others discover acceptance, often expressing a sense of continued connection to the love one. Others mourn briefly, yet deeply, and then move on with minimal outward expressions. Some come to terms with death slowly and cautiously, accepting it as a necessary process of living. Still others suppress their pain through subconscious coping mechanisms, including self-medication with substances or other addictions. Death is a universal experience, yet it is most often encountered first through the loss of another. It is the individual's experience following an unenviable meeting with death that often affects their outlook on life. If the experience impacts the individual deeply and significantly, it can alter their perception of life on emotional, psychic, spiritual, and physical levels. The depth and breadth of this impact is specific to each individual, yet commonalities exist.

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Many clinicians are well-versed in theories surrounding the grieving processes associated with death and loss. Professionals in the field of psychology have generally acknowledged grief and loss as a critical area in need of ongoing research and attention. These topics continue to be researched through many lenses; through the current study, I employed a perspective that honored the individual's unique, holistic experience of and reaction to the impact of death. I explored the participants' grief and loss through phenomenological interviews that addressed the wide-ranging psychological, spiritual, and physical components of their experiences. Through this process, I derived a deeper understanding of both the commonalities and differences of such experiences.

This qualitative research effort was both warranted and necessary in order to understand and thoroughly appreciate death's impact upon the living. The field of psychology would benefit from novel insights to foster a healthy relationship with death, as well as additional means to effectively cope effectively with the processes involved in loss and grief. By more thoroughly understanding death, grief, and loss, it may be possible to address and remediate the unhealthy and destructive experiences associated therewith. In general, the field of psychotherapy may benefit from the results of this study through (a) a deeper understanding of the interrelated impact of grief and loss on individuals' psychological, spiritual, and physical processes; (b) an informed appreciation for the uniqueness of individual experiences of grief and loss; (c) an awareness of the commonalities between the individuals' experiences of grief and loss; (d) an appreciation of the wide-reaching effects of the human experience of grief and loss; and (e) a consideration of the manner in which the shared expression of the experience of grief and loss might, in its own way, offer therapeutic quality.

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Autobiographical Origins of the Researcher's Interest in Topic

As a young child, I faced terrifying circumstances that resulted in my family's flight from my birthplace of Iran. At barely 4 years old, the loss of my homeland and the fragmentation of my family were overwhelming and difficult to comprehend. Although we ultimately settled safely in the United States, the gripping, fearful experiences, as well as the immensity of my losses, never quite left my mind, body, and soul. Filled with a deep sense of grief and loss from such a tender age, my view of life was colored by my experiences of early bereavement. I felt fortunate to have my mother and father, brothers, and extended family as anchors to support this transition, and I faced my new homeland with the open, willing eyes of a child.

At the age of 7 years old, a far greater, more devastating loss took hold of me against my will. My mother—the most exquisite, gracious woman I had ever known—fell ill with mysterious and debilitating stomach conditions. Despite excellent medical care, her health worsened as I watched, confused and powerless to aid her. Cancer began to consume her body, while her mind and spirit relentlessly fought against its force. I vividly recall watching her brush her long waves of dark brown hair, laughing even as clumps of her silken locks fell into her lap. It was as though her soul and spirit remained above the physical changes and losses that she was experiencing. A turning point came when my father returned to Iran to finalize his personal and business affairs. In his absence, while under my elder stepsister's watch, my mother deteriorated rapidly. As her illness progressed, it seemed to devour her. I watched with fearful eyes as her spirit, too, ultimately moved away from me. No longer was she the generous, abundantly giving mother that I had known; in her place was a pale, sickly woman who had no time or energy for her youngest child. Too soon, my mother was moved to the hospital, away

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from all that was familiar to us both. Deprived from her sacred presence, I moved into a surreal, otherworldly space where I quietly anticipated her return to health, believing with a child's naïve perspective that all I needed to do was to wait with loving patience.

Placing my faith in her recovery, I spent hour after hour making her colorful drawings, childlike crafts, and an array of handmade cards. Even my schooldays were filled with ongoing art projects that were to make their way into the hands of any would-be visitor to my mother's bedside; I was told early on that she was in intensive care, where children my age were not allowed. I still clearly recall a classmate chiding me for wasting mounds of paper in my effort to get an art project "just right" for my beloved mother. A fight ensued, causing me to tearfully cry out, "I don't want to live without my mother!" Terrified and unable to comfort me, the principal called my stoic father for assistance. Faced with the incomprehensible, continued absence of my mother, I felt an incessant drive to connect with her. I believed that my handiworks, the sweet evidence of my love for her, would unify our spirits, infuse my mother with my love, and bring her safely back to me where she was needed, where she belonged.

It was only 2 years after my mother's actual death that I learned of her passing. Hoping to protect me, my family had not told me that she had died; instead, they had perpetuated the myth that she was still alive and recovering in the hospital, that she would soon be on her way home to me. Their attempt to shield me, however well-meaning, was a misguided effort that affected me profoundly. Only after a family conference of sorts determined that I should be informed had a friend's aunt gently and dutifully explained the circumstances surrounding the death of my mother. Without ceremony, I was taken to the cemetery, where an ordinary tombstone marked the grave of my extraordinary

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mother. Soft green grass had overgrown the mound under which her body had been put to rest 2 years prior. The grass's growth visibly marked the passage of the 24 months since her death, yet, at the young age of 11 years, I vividly recall my utter disbelief and the shocking sense of being transported above ordinary space and time.

Having been denied any sort of closure, or the opportunity to attend a funeral or engage in any form of parting ritual, I could not accept my loss. I could not grieve, but secretly maintained a wild hope that my mother would come back to me. My childish imagination wove stories and thick plots of mysterious kidnappings and secretive dealings to explain her absence—possibly due to the early trauma that I had witnessed escaping my country of origin. My hopeful, private tales provided for her homecoming; each imagining kept her spirit alive and in this world. She was my mother, my other half, my spirit, and my soul. On a visceral level, I felt that no man or God could take her away from me. With the persistence and courage only a child can muster, I yearned, pled, ached, and hoped for her return.

Writing of this now, some 30 years later, I still experience that same ache as permeate my mind, body, and soul. At times, I actually feel the pain as it comes to rest and take hold in my spiritual body and in my physical body. I can often physically sense the pernicious unrest in my core, my abdomen, where my mourning has its seed. "Ah," I think and feel, "I am so much like my mother, and I so much continue to suffer and grieve my loss of her, that I carry my grief with me as she carried her cancer." My grief is so alive and pervasive that it continues to cause me both physical and psychic pain.

I have engaged in years of psychotherapy to address the internal pain related to my unresolved grief issues. I have undergone countless medical treatments to address

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unrelenting abdominal and uterine conditions, while fearing death and the possibility of fertility loss. None of these treatments have eased the manifestations of the loss that I have never fully accepted and resolved. As another indication of my unresolved grief and the pain that I continue to carry, my doctor discovered a benign, grapefruit-sized tumor in my uterus that was recently removed. I believe to my core that this is one more of the long line of my internal pain manifesting itself through bodily conditions. I wonder if this tumor was also symbolic of my unfulfilled yearning to have a child of my own. I do not lose faith, for I realize that some internal healing occurs with each step I take in my journey to understand and address the loss of my mother. As I continue to mourn her, to feel and express my sorrow, I slowly move toward greater acceptance and a sense of freedom from the pervasive pain.

Despite my mourning of the physical loss of my mother, my emotional connection to her persists. I feel her spirit at every turn; I sense her aliveness and glorious presence through each butterfly that descends in my path. At the most unexpected times, I feel her heavenly presence by my side; she was an angelic figure in my childhood, and she remains as a guardian angel in my adult imagination. Despite my aching for her and my persistent grief, a unifying relationship with my mother continues to guide me on a spiritual level. I cannot touch her body, climb up and cry upon her lap, nor feel the sweet softness of her golden skin. I can, however, look skyward and sense that she is with me. I can close my eyes and imagine her long, sweeping skirts and wide, flashing smile. I can seek and find her in my deepest dreams, bringing her presence, the warmth of her loving embrace into the darkness of the night. I am not alone, and I am not without her; I am quite steadfast in my belief that she is eternally with me, and I with her. A mother such as

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mine never truly leaves her child, and the time will come when we are together once again, hand in hand.

The Researcher's Predisposition to the Topic

As a result of my personal experience with immense loss and grief, I have been compelled to further explore this often ruthless topic. I have side-stepped and danced around my sorrow for years; my fears and sadness have anchored me in pain. I want to find release, to move beyond the moorings that bind me. I have chosen to move forward, to look death in eye. I have dared to begin an open conversation with death, to allow the light of life to heal my own loss and grief by sharing the private journey of my own battle openly, and to honor this process along with those that have had the courage to do the same for the purpose of this research. In doing so, I find that the psychological, physical, and spiritual manifestations of my sorrow come and go with more ease, much like the gentle, cleansing waves of the ocean. In undertaking this process of healing, I can only become more empathetic, understanding, and desirous of aiding others on their own journeys with grief and loss. In bringing myself into a deeper awareness of my experiences with death, I am more present for others. My predisposition to this topic has not only led me to a investigate grief and loss on a psychological level, but to explore the cognitive, intellectual manifestations and understandings of these particularly fundamental human processes.

Statement of Research Problem and Questions

Research Problem

In conducting the current study, I was interested in exploring and further understanding the individual's unique responses of grief and loss following the death of a loved one. Specifically, I investigated the impact of the grief and loss as related to the

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individual's psychological, spiritual, and physical experiences. By approaching this topic through a holistic perspective, I hoped to further understand the overarching effects of grief and loss as it affects the individual's life and life perspective. It has been noted that phenomenological research is lacking on this specific topic. Beneficial, yet disparate information on the effects of grief and loss exists; yet, descriptions and interpretations on the holistic effects on the complex interrelationship between the emotions, mind, body, and spirit from grief and loss following the death of a loved one are limited. As such, it is necessary to offer a systematic, qualitative investigation of the individual's experiences of grief and loss following the death of a loved one. Moreover, valuable insights and understanding can be uncovered by interpreting data through a depth psychological lens, which adds to the body of literature and informs the clinical approaches with those affected by death, grief, and loss.

Research Question

The research question for this study was: Following the death of a loved one, how do the experiences of grief and loss impact individuals on emotional, psychological, spiritual, and physical levels? The subquestion was: From a holistic perspective, in what ways do the experiences of grief and loss affect the individual's perception of life and life experiences?

Definition of Terms

In this section, I provide contextual definitions of several concepts and terms that were central to the development of this study.

Aggregate essential description: The qualitative data analysis portion of the phenomenological research process requires careful review of the verbatim interview transcriptions for each research participant. Over the course of this review, a researcher

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notes recurring themes common to all transcriptions, then summarizes these common themes to form the aggregate essential description. According to Creswell (1998), "These transformations are tired together to make a general description of the experience, the textural description of what was experienced" (p. 55).

Archetype: The concept of the archetype is core to the understanding of universal themes and images that may arise over the course of researching fundamental issues such as grief and loss. A succinct definition of the term is as follows:

> A hypothetical construct posited by Jung to explain the manifestation of "archetypal images," i.e., all images that appear in dreams and fantasies that bear a striking similarity to universal motifs found in religions, myths, legends, etc… Archetypes are universal because human emotions are universal. (Young-Eisendrath & Dawson, 2006, p. 315)

Aspects: When using the phenomenological approach to qualitative data analysis, the themes and common meanings upon which the natural meaning units (NMUs) converge are known as *aspects*. As Creswell (1998) described, "The units are transformed into clusters of meanings expressed in psychological and phenomenological concepts" (p. 55). These aspects form the second foundational stage for understanding the qualitative phenomenological data.

Association: When working with psychological material, certain thoughts or images naturally arise as processing occurs. The associations made by individuals are united via common, shared emotional motifs. According to Young-Eisendrath and Dawson (2006), an association is "an idea or image spontaneously suggested by a trigger word or image" (p. 315).

Bracketing: When conducting interviews with study participants, it is necessary for the researcher to set aside any personal judgments or preconceived notions; this process is known as bracketing. Creswell (1998) indicated, "The researcher also sets

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aside prejudgments, bracketing…his or her experiences" (p. 52). Bracketing is an essential component of phenomenological qualitative data analysis, as it allows for a greater degree of researcher objectivity.

Collective unconscious: Certain shared cultural patterns and motifs appear throughout the history of mankind. Depth psychologists have concluded that this common, shared aspect of the psyche is held and manifested in the collective unconscious. Jung (2002) noted that the collective unconscious "is the preconscious aspect of things on the 'animal' or instinctive level of the psyche. Everything that is stated or manifested by the psyche is an expression of the nature of things, whereof man is a part" (p. 82).

Common aspects: Common aspects are the themes and meanings that are collectively shared in the data that arise from all participants. The common aspects arising from the participants' information yield the aggregate data that provide an overarching, cohesive understanding of the participants' collective experiences.

Complexes: In depth psychology, the complexes that form during psychological development are considered the foundation of the human psyche. Every individual's psyche is structured into various unique complexes. Samuels (1999) offered an integrated view of complexes:

> Outer experiences in infancy and throughout life cluster round an archetypal core. Events in childhood, and particularly internal conflicts, provide this personal aspect. A complex is not just the clothing for one particular archetype…but an agglomerate of the actions of several archetypal patterns, imbued with personal experience and affect. (p. 47)

Consciousness: In addressing the importance of being aware of individual issues and interrelated patterns, consciousness is a relevant concept. A general definition of consciousness is that which is known to the individual and that psychological material of

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which the individual is aware. According to Jung (2002), "Psychic reality still exists in its original oneness, and awaits man's advance to a level of consciousness where he no longer believes in the one part and denies the other but recognizes both as constituent elements of one psyche" (p. 197).

Ego: Multiple definitions of this term exist in the field of psychology. Operating from a depth psychological stance, Young-Eisendrath and Dawson (2006) offered an encompassing explanation of the ego in the following definition:

> Jung used the word "ego" to describe two significantly different phenomena: (1) to define that complex to which the sense of "I' is attached, at whose core is the archetype of the self; and (2) as the center of consciousness. Jung inferred a dialectical relationship between the ego and other complexes of the unconscious. This relationship, while depicted in dreams, is unconscious. (p. 316).

The ego, then, can be considered as the individual's conscious sense of personhood or self. When viewed as the core aspect of the individual's consciousness, the ego may be considered a force between the ego and the unconscious complexes.

Essential description: The essence of each participant's personal experience as revealed in the interview process is known as the essential description. Compared to the actual interview text, this essential description offers a more succinct, coalesced outline of the individual's unique experience. As Creswell (1998) stated, "Researchers search for the essential, invariant structure (or essence**)** or the central underlying meaning of the experience" (p. 52).

Images: In depth psychology, images are viewed as an integral aspect of the psyche that allow material to arise into consciousness in a form that can be understood. As uniquely individual material, images provide a method of communication within the individual; yet, as archetypally shared psychic structures, the images also allow for shared communication with others. Kugler (2005) noted that "Jung opted. . .to approach

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imaging as a primary phenomenon, an *autonomous activity of the psyche*, capable of both production and reproduction" (p. 80).

Natural meaning units: NMUs are critical elements of speech that are extracted from original texts or interviews. These units of speech form independent, discrete meanings related to the subject material. Creswell (1998) cited the position of Moustakas that "From the individual descriptions, general or universal meanings are derived, in other words, the essences of the structures of the experiences" (pp. 52–54).

Personal unconscious: The personal unconscious is the aspect of the individual's psyche which is unknown to the individual. The elements of the psyche of which the individual is personally unaware are contained within the personal unconscious. Jacobi (1973) defined this term as "an accumulation of contents that have been repressed during the life of the individual and is continuously being refilled with new materials" (p. 35).

Phenomenological data analysis: Central to the current research study was the particular method of qualitative data examination termed phenomenological data analysis. Creswell (1998) noted that this unique method of data analysis "proceeds through the methodology of reduction, the analysis of specific statements and themes, and the search for all possible meanings" (p. 52).

Phenomenology: The qualitative tradition of inquiry known as phenomenology can be described as the process of exploring the frameworks of consciousness in global human experiences. As Creswell (1998) indicated, a phenomenological study involves the investigation of "the meaning of the lived experiences for several individuals about a concept or the phenomenon" (p. 51).

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Second-order profile: The data analysis process involves carefully reviewing the original interview transcription for each participant. The noted NMUs, once compared, are condensed into aspects. The aspects are then listed and result in the formation of the second-order profile. Creswell (1998) stated, "All experiences have an underlying 'structure'" (p. 55), and the purpose of the second-order profile is to further clarify and coalesce this structure.

Themes: When reviewing interview text, the researcher determines commonalities and differences in the material provided by various research participants. In comparing data within and between participants' interview texts, common themes (i.e., ideas, motifs, or concepts) that arise are noted. These shared themes reveal the archetypal components inherent within the data.

Verbatim description supporting themes: Using each individual's unique interview transcript, specific verbatim quotes are selected for the purpose of supporting the developed themes.

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Chapter 2

Literature Review

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Voluminous writings and wide-ranging research exist on to the topics of grief and loss. To date, however, no studies have been undertaken using a qualitative, phenomenological approach to explore individuals' holistic experience of grief and loss resulting from the death of a loved one. In undertaking a review of the current body of literature, I found a substantial amount of highly relevant and supportive information. The relevant findings and conclusions are discussed in this chapter to justify the need for the present study.

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Several studies have been conducted in relation to grief as it relates to the individual, interpersonal, and cultural components of grief. As death is universally experienced, grief related to death has been explored since the first human mourned the passing of another. In clarifying the terms used in this research, *loss* is generally considered to be the experience of the death, while *grief* is the emotional response to loss. Grief is often described in regard to the individual's internal processes, whereas mourning is considered the expression of the emotions experienced while the individual grieves.

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Considerable research has been dedicated to understanding and enriching the human experience of grief. Researchers in the field of psychology has developed wide-ranging, highly significant theories to explain and understand the emotional, psychological, and spiritual foundations of human grief. Grief has also been thoroughly explored through various religious and spiritual paradigms. The physiological effects of grief have been investigated and explored by a broad array of researchers and writers.

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including Jung (1989, 2002), Moore (1994), and Romanyshyn (2002, 2007). Due to the extensive writings and research on the subject of grief, only the most fundamentally important theories and authors are addressed in this review, and the significance of this research study is highlighted in the process.

Grief and Loss

Grief is a natural response to loss, which is multilayered with physical, behavioral, and spiritual components. In the early work of Wolfelt (1983), this author defined grief as "an emotional suffering caused by death or bereavement" (p. 26). Wolfelt added that grief is a progression involving a chain of thoughts and feelings as an outcome of fear and sadness. For Wolfelt, grief is "an internal meaning given to an external event" (p. 26).

Grief is exemplified by a multifaceted set of cognitive, emotional, and social changes as a result of the death of a loved one. Individuals differ in the type of grief that they experience, particularly in terms of its intensity, duration, and expression (Christ et al., 2003). The emotions that accompany grief may often be overwhelming and difficult, and there is no "right way" for individuals to experience and expresses grief (Corr, 2000). Most individuals demonstrate related arrangements of intense anguish, anxiety, longing, sadness, and fixation, of which these symptoms eventually clear up over time. Scholars have shown that most people demonstrate the ability to deal successfully with grief-related challenges and do not experience serious grief-related health issues (Allumbaugh & Hoyt, 1999; Bonanno et al., 2004).

Grief is a universal experience of humankind. The loss of individuals, animals, possessions, family structures, and other important aspects of one's life can result in grief. First, it is important to define the terms commonly associated with loss, such as

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bereavement, grief, and mourning. Bereavement is viewed as having lost a close person including parents, partners, and friends, among others (Stroebe et al., 2008). Bereavement is defined as "a state caused by loss such as death" (Wolfelt, 1983, p. 26). In this framework, bereavement is the experience of losing someone in your life and grief refers to the feelings and emotions that go together with the loss.

Grief is viewed as the personal response to bereavement. The individual response involves an immense range of indicators, including emotional, cognitive, behavioral, and physiological reactions. Mourning, although often confused with grief, refers to the social demonstrations of grief that are influenced by the culture in which the mourner lives. Mourning is an "affective state that follows the loss of a dear one through death or permanent separation; it may also be the product of a more abstract bereavement, such as the loss of an ideal or mode of relationship with another person" (Porter, 1994, p. 240).

Grief is considered a normal part of the adjustment to the realism of a meaningful loss. Normal grief is described as an emotional reaction to bereavement, which conforms within expected norms, as provided with conditions and implications of the death, with respect to time course and/or intensity of symptoms (Stroebe et al., 2008). The difficulty lies in defining those expected norms. Nonetheless, it is understood that extremes in the intensity, circumstances of the loss, and the amount of time devoted to grieving may lead to seriously impaired functioning. As individuals express a broad range of emotional reactions following a loss, researchers have begun to define levels of normal to extreme grief that proposed criteria for a new diagnosis of complicated grief disorder (Horowitz et al., 1997). These criteria would include a period of bereavement of at least 14 months,

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intrusive symptoms related to the deceased, symptoms of avoidance, and maladaptive behavior.

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* describes *uncomplicated bereavement* as the distinctive grieving process that children and adults go through to adapt to the death of a loved one (American Psychiatric Association [APA], 2000). It is normal for individuals to experience mental health symptomatology such as depression when adjusting to the death of a loved one. In extreme cases, diagnoses of complicated bereavement or major depressive disorder are not provided unless the person is still experiencing mental health symptomatology 2 months after the loss. Some individuals may experience complicated grief, which describes when a person is overwhelmed with grief and his ability to fully function is hindered (Tonkins & Lambert, 1996). Complicated grief is a term that has mainly been applied to adults, and it is considered to include intrusive thoughts of the deceased, loss of security, and consistent searching for the deceased individual (Tonkins & Lambert, 1996).

The topic of grief is handled in diverse ways within households, pop culture, peer groups, and religious backgrounds. Strong feelings and emotions arise for most grieving individuals; these reactions include feelings of anger, sadness, confusion, and guilt, which are often misunderstood (Kastenbaum, 1998). Many theories of grief have been proposed to explain the phenomenon. Freud (1917/1957) developed the first systematic theory of grief, stressing the need for grief work on the part of bereaved individuals to cope with the loss. The concept of grief work has been quite influential up to the present. Kübler-Ross (1969) proposed the first stage theory of grief, in which an individual progresses through expected and orderly stages: shock, yearning, anger, despair, and

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acceptance. This theory gained popularity throughout the years and had a strong influence over the current beliefs of grieving; however, Kübler-Ross's stage theory has never been studied empirically (Zhang et al., 2006). Bowlby (1980) asserted a stage theory of grief, claiming that individuals pass through subsequent stages in the grief process.

Recently, stage theories of grief have come under criticism. Wortman et al. (1993) stated that stage theories underestimate the range of emotional responses that people experience following loss. These authors also stressed the lack of empirical support for stages in the process of grief.

Disenfranchised Grief and Ambiguous Loss

Several specialized concepts of grief and loss with relevance to the current discussion have emerged. Ambiguous loss and disenfranchised grief have been identified by separate theorists but are very similar in their characteristics. Loss is often not as clearly identifiable as death. Individuals experience various types of losses that involve people, experiences, relationships, or objects. Many of these losses are not acknowledged by society as legitimate sources of grief (Betz & Thorngren, 2006).

Unrecognized losses may include the end of a relationship, the loss of a job, physical or sexual abuse, physical disability, miscarriage, or chronic illness. According to Boss (1999), ambiguous loss refers to the incomplete or uncertain loss. This scholar identified two types of ambiguous loss. In the first, an individual may be perceived as psychologically present when an individual is physically absent; examples include a divorced mother who does not live with her children or soldiers who are missing in action. The second type of ambiguous loss occurs when an individual is perceived as psychologically absent, but they are bodily present. Examples of this situation include

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diagnoses of alcoholism, chronic mental illness, or terminal illness such as Huntington's disease. Ambiguous loss presents families with a confusing situation (Boss, 1999). Because the loss is incomplete, , there is uncertainty about who is still part of the family; thus, the family's system of belief is threatened (Sobel & Cowan, 2003) and the family finds it difficult to make sense of the loss in the face of the ambiguity.

According to Doka (1989), individuals face disenfranchised grief when they obtain a loss that cannot be explicitly recognized, mourned openly, or supported by others. This author identified three broad types of disenfranchised grief: (a) the relationship between the deceased and the griever is not renowned socially, (b) the loss in not recognized and acknowledged as important, and (c) the specific griever is excluded due to some specific characteristic of the individual. Social support and cultural rituals are acknowledged as important for the successful alleviation of grief symptoms (Doka & Aber, 2002). Therefore, when social support is not provided, one of the most powerful means of helping the griever is taken away. The griever may become isolated, and the grief may become chronic and unresolved.

The concept of loss that is not socially recognized and acknowledged as significant is quite relevant to the present research. Doka (1989) offered several examples of losses that can be very profound for individuals but, nonetheless, are often dismissed by the social network of the person as relatively unimportant: perinatal death, abortion, giving up a child for adoption, and loss of a pet. All of these losses are actual physical losses; however, certain types of losses are not socially recognized—or even considered real. There are many occasions when individuals experience a significant sense of grief and loss while the person is still alive.

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Doka and Aber (2002) referred to psychosocial death as "those cases in which the psychological essence, individual personality, or self is perceived as dead, though the person remains alive" (p. 224). Because of the significant change in the individual, others may perceive the individual as dramatically different from the person they knew prior to the changes. For example, the spouse of an individual affected by Alzheimer's disease or severe mental illness may grieve the loss of the identity and personality of their loved one, even when the individual is still alive.

The theoretical concepts of disenfranchised grief and ambiguous loss hold great appeal to the present research; however, limited researchers have investigated the validity of either concept. Families who have had children diagnosed with Long QT Syndrome, a form of irregular heartbeat, have lost something of the child that they knew, but this loss is incomplete. Therefore, ambiguity may be present in the family system. Likewise, the losses the family experiences may not be recognized by their social support system as valid. The family may feel isolated and left to attempt to cope with the loss without their support network. Sobel and Cowan (2003) studied the experiences of disenfranchised grief and ambiguous loss in families who received predictive DNA testing to identify the presence of Huntington's disease. The investigators in this qualitative study used grounded theory methods to identify themes related to disenfranchised grief and ambiguous loss through semistructured interviews. The findings indicated that the families' responses were consistent with Boss's (1999) definition of ambiguous loss, which was developed through semistructured interviews.

Empirical research related specifically to the concept of disenfranchised grief includes the Thornton et al. (1991) study of disenfranchised grievers and the levels of

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social support that they receive from others. In this study, college students read six descriptions of an individual's experience of grief. The situation was the result either of a traditional loss or disenfranchised death (e.g., miscarriage versus abortion). The students reported less sympathy and greater social distance from the disenfranchised griever. In a contemporary qualitative study of a pet-loss support group, Weisman (1991) reported that those whose pet had died were hesitant to discuss the loss with others for fear of criticism, condescending statements, and harmful suggestions. An element of disenfranchised grief was indicated by the individuals' fear of requesting social support.

Psychological Theories Pertaining to Grief

Psychoanalytic Theory

Sigmund Freud, generally accepted as the founder of psychoanalytic psychology, investigated the ramifications of the human experience of grief. Freud (1966) outlined the mourning process in the following terms:

> A perfect model of an affective fixation to something that is past is provided by mourning, which actually involves the most complete alienation from the present and the future. But even the judgment of a layman will distinguish sharply between mourning and neurosis. There are, on the other hand, neuroses which may be described as a pathological form of mourning. (p. 342)

In an attempt to elucidate the psychoanalytic perspective on grief in *Motherless Daughter*, Edelman (2006) maintained that the true mourning, according to Freud, involves a gradual and entire extrasensory disconnection from the loved object, with the purpose of later reattachment to another person. Edelman also noted that Freud's theory, while providing a foundation for research on grief, has been questioned by recent scholars. Specifically, the individual's ability to fully detach from the loved object, and the benefit of such detachment, is now thought to confound the bereavement process.

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Jungian and Depth Psychology Theory

Carl G. Jung, viewing grief through theories emanating from his work in depth psychology, described the paradoxical aspect of the human experience of death. Jung's theory on grief was beautifully addressed in a description of one of his own dreams on death, in which he had been tossed back and forth between two disparate fields of emotions. One part of him felt warm and delightful, yet the other side of him was fearful and grieving. As Jung (1989) noted,

> This paradox can be explained if we suppose that at one moment death was being represented from the point of view of the ego, and at the next from that of the psyche. In the first case it appeared as a catastrophe; that is how it so often strikes us. (p. 314)

Such a description offers a portal into a view of grief as the ego's response to death; the ego mourns and grieves what it perceives to be a terrible and devastating event. According to Jung, the psyche, however, would view the same death as a joyous event, not an occurrence to be grieved.

Memrie Gaddis (2002) offered substantial insight into the impact of the early loss of a father upon the individual's intimate relationships later in life. In interviews with five women aged 32 to 64 years old, Gaddis delved into the phenomenology of these women's early father loss, uncovering deep and painful wounding that had been largely unexplored. Gaddis noted coalesced themes surrounding issues such as relationship difficulties, depression, motherhood concerns, lack of attachment to stepfathers, fear of a partner's death, and difficulties in relationships with their own mothers. Although this phenomenological study was similar in approach to the current undertaking, Gaddis's work is unique in respect to theoretical orientation and its specific focus on the early loss

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of a father. This researcher's study was focused on the effects of the loss on later intimate relationships, and the sample included both male and female participants.

Giuliana Zlatar's (2009) study entitled "Discovering Mother: Embracing the Feminine: An Imaginal/Archetypal Approach to the Loss of the Mother at an Early Age" focused on the individual's experience of the loss of a mother at an early age. Zlatar explored various women's ability to appreciate and understand the archetypal patterns surrounding the early loss of a mother. This author found that a type of "scaffolding" ultimately acted as an ameliorative buffer between the archetype and the child who has experienced the loss. While making use of a depth psychological approach, Zlatar's study is important in its use of an alchemical-hermeneutic approach. Similar to the Gaddis (2002) study, Zlatar's (2009) work centered on the early loss of one particular parent. Zlatar also focused on the imaginal and archetypal psychological components of the loss.

In his phenomenological work entitled *The Soul in Grief,* Robert Romanyshyn (1999) further expanded the literature on human experience of grief. Noting the impact of grief upon his own life, Romanyshyn recognized the overwhelming significance of the grieving process. It was through his personal encounter with grief that his world changed and he realized that his sense of meaning had shifted:

> Grief blew apart my familiar world and forced me to recognize that I am not as much the author of meaning as I had believed myself to be. Rather, I am more like an agent of meaning, the means by which the dusty dreams of the things of the world are realized. (p. 47)

As Romanyshyn highlighted, it is through life-changing encounters with grief that the individual's psyche is forever altered; the emotional, spiritual, bodily, and psychic lenses through which the world is viewed are far different from those in place prior to the grief

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experience. It was this author's intention to extend knowledge in this area by offering further insight into the holistic experience of grief and loss through a depth-oriented lens.

Archetypal Theory

From an archetypal perspective, Thomas Moore (1994) discussed the importance of the grieving experience in furthering the overall human life experience:

> Hades may pull us under by means of an experience of death, either a close call for ourselves, or the death of someone close. It takes a profound maternal affirmation of life to allow such deaths to affect us, to acquaint us with the mysteries of the underworld, and then to send us back into life, never to be the same again. (p. 48)

From this perspective, the process of grief is an important part in the individual's journey. It is through the experience of grief that one is more fully able to explore and understand deeper facets of the self. Adding yet more depth to this paradigm, James Hillman (1991) detailed the effects of death upon the psyche, emphasizing the importance of grief on the individual's personal journey:

> Psyche must "die" herself in order to experience the reality of this beauty, a death different from her suicidal attempts. This would be the ultimate task of soul-making and its beauty: the incorporation of destruction into the flesh and skin…anointing the psyche by the killing experience of its personal mortality. (pp. 292–293)

Attachment Theory

In the *Handbook of Attachment,* Cassidy and Shaver (1999) stated that attachment theory is the most evident and empirically grounded conceptual framework in the fields of social and emotional development. This theory rests upon the importance of childhood attachment patterns as they affect short-term and long-range behavioral orientations. The death of a loved one may trigger immense feelings of grief, regardless of attachment history. Even secure and well-adjusted persons may experience severe stress and trauma as a result of intense grief. Attachment theorists have asserted that an appropriate bond

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between a caregiver and a child allows the child to form a secure relationship with the caregiver (e.g., mother).

According to Edelman (2006), attachment theorists have categorized individuals who experienced a death of a loved one into three groups. The first group includes those individuals who form "secure" attachments with other adults. The second group includes people who are fearful or hesitant about their social and romantic relationships. The third group consists of individuals who avoid being attached to other people (Edelman, 2006). While attachment patterns are thought to be formed in early infancy, severe disruptions at any stage in life (e.g., abuse, prolonged illness, or death of a loved one) can deeply influence a person's sense of attachment, resulting in the label of "insecure" attachment. This is supported in Edelman's note that "Even when an infant is raised by a loving mother and develops a secure bond with her…specific life events can disrupt his sense of security" (p. 181). Throughout all stages of life, the theory of attachment explicates the manner in which many individuals uniquely approach and process the experience of grief. In the current research study, I reflected upon the validity of this theory through the lived experience of participants who have lost a loved one early in life.

Thanatology: Stage Theory

Elisabeth Kübler-Ross (1969) described the five stages of grief as they related to individuals facing terminal illness. These stages were later found to be pertinent to other critical personal life events, including the death of a loved one, ending of a marriage, loss or change of a job, persistent illness, or other events perceived as being catastrophic in nature. The stages are denial, anger, bargaining, depression, and acceptance, with not all individuals passing through all five stages; further, there, is often a fluctuation between the stages. This theory, which is critical to a more fundamental understanding of loss, has

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had a substantial impact on the manner in which clinicians and the general public have come to understand and approach the process of grieving. In the book *Living With Death and Dying,* Kübler-Ross (1981) beautifully acknowledged the paradoxical aspect of grief: "Both birth and death involve great changes and adjustment, even inconveniences and pain, but also joy, reunion, and a new beginning" (p. ix). In the context of the current study, I anticipated that these stages would be reflected in the participants' holistic stories.

Psychological Theories Pertaining to Loss

Psychoanalytic Theory

People experience loss on a continuum that ranges from relatively minor permanent effects to enduring psychiatric conditions. Noting that early parental loss is strongly associated with the development of bipolar disorder, Gabbard (2005) further offered, "From a Kleinian perspective, the fundamental psychotherapeutic task with the bipolar patient may be to facilitate the work of mourning" (p. 228). While acknowledging the debilitating aspects of loss, Freud generally theorized that loss, when appropriately channeled, could be used as a force in generating psychic growth and creativity. As Edelman (2006) noted, "Ever since Freud described creativity as an attempt to compensate for childhood dissatisfaction and lack of fulfillment, psychologists and artists have been theorizing about connections between early loss, creativity, and achievement" (p. 292).

Jungian and Depth Psychology Theory

As with grief, loss was viewed by Jung as a necessary component of life that could be used to further comprehend the self and explore undiscovered aspects of the self. The resulting sense of loss could be used by individuals to further understand the

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psyche. Jung theorized that the self, as the internal regulator of the psyche, strives to use life experiences in order to find greater balance and a sense of wholeness. In "The Classical Jungian School," Hart (2006) posited,

> The conscious care which is always needed in the work of individuation: not reactive but steadily and persistently active in its attention to whatever goes on in the unconscious life. That kind of regular attention can turn apparent inner chaos into a sense of order and inner relatedness. (p. 98)

In the area of depth psychology, the experience of loss is one of the key life experiences that may be used to explore and expand the self more deeply and powerfully. Intense changes within the psyche might even be noted as affecting the individual externally. As Romanyshyn (2002) stated succinctly, "Loss can lead to a transformation, which is so profound that the bereaved one appears to those who have known him as another being" (p. 58).

Archetypal Theory

Archetypal theorists have viewed loss from the perspective of the images and archetypes contained within the loss experience. Under this paradigm, the individual who has suffered the loss of a loved may find healing through allowing the psyche to reveal the unconscious meanings and previously hidden internal dynamics and yearnings. The life of the individual's spirit—the soul—is paramount in the field of archetypal psychology, and the loss experience is viewed as an opportunity to further explore the depths of the soul. As Moore (1994) considered, "Renaissance philosophers often said that it is the soul that makes us human. We can turn that idea around and note that it is when we are most human that we have greatest access to soul" (p. 9). Even through the debilitating loss of a loved one, archetypal psychology asks the individual to make use of the experience to further delve into the self and, thus, foster the expansion of the soul.

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"Care of the soul asks us to observe its needs continually, to give them our wholehearted attention" (Moore, 1994, p. 210).

Attachment and Object Relations Theories

In their article, "Hidden Meaning of an Early Loss. The Common Ground of Attachment and Social Character Assessments and Their Clinical Applications," Millán and Millán (2004) detailed the psychological importance of loss:

> Bowlby's theory is based on clinical accounts of cases of important loss experiences. A transcendental role is given in Bowlby's theory to the experiences of loss. It stresses that the construction of mourning processes can be seen as a manifestation of search and as a general gradual mental reorientation. (p. 157)

The impact of loss upon the individual is seen as having far-reaching implications. Millán and Millán noted that the effects of loss are particularly noticeable when the loss occurs at an early stage in life, when the attachment bond is not secure, or when the loss is perceived of as devastating, regardless of the age of the individual. As underscored by theorists such as Bowlby, when a loved one dies, the individual may be profoundly affected by the loss, causing the individual to suffer from various psychiatric symptoms, interpersonal difficulties, and intrapsychic difficulties related to the severing of the attachment with the loved one. In such cases, the individual's intrapersonal and interpersonal relationships are affected through disruptions in attachment patterns.

In moving through the grieving process, the individual's attachment patterns serve an important role in the ability to integrate the necessary elements of the process. Citing Bowlby, Horner (1979) noted in *Object Relations and the Developing Ego in Therapy* that "whether a child or adult is in a state of insecurity, anxiety or distress is determined in large part by the *accessibility and responsiveness* of his principal attachment figure" (p. 48). The effect of a caregiver's repeated failure to connect or physical absence,

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whether through death or other separation, has a profound impact on the individual's formative patterns. The child perceives such situations as emotional or physical abandonments, and the resulting effects often endure through the individual's lifetime. Horner contended, "A gross deficiency in object relations leads to an arrest in the development of all sectors of the personality" (p. 51). Accordingly, one's ability to effectively manage loss and grief as an adult is related to foundational early childhood experiences.

Kohut (1987) described the importance of being able to appropriately hold the memory of the loved one:

> To elaborate the concept of an imago: if any one of us, as an adult, has to be absent from somebody he cherishes, needs or wants, or to whom we are very close, the memory image of this person remains in us. It becomes an object of longing, and we will think about this person. In the mourning process, by the way, this is also true. The memory process is there also. As a matter of fact, thinking about the dead individual and gradually withdrawing from the representation of that individual is one of the counterforces against identification. The individual becomes an internal object of affection, a memory from which one gradually withdraws. Therefore, one does not have to set the individual up in oneself as part of oneself. (p. 101)

The ability to successfully hold a memory (i.e., to be able to view and embrace an internal image of the person who is not available) is one indicator of an individual's ability to let go of the deceased loved one in a healthy fashion. A sense of feeling securely attached to a loved one is often considered a prerequisite in being able to effectively manage various life challenges, and the individual who has a secure attachment is often able to function more successfully and autonomously in times of stress and difficulty. In the case of the loss of a loved one, the ability to internalize a sense of the loved one and to gradually process the loss while maintaining a sense of the

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self as being whole may allow the grieving person to move through the loss in a more fully integrative fashion.

The Nature of Grief

The process of grief is similar to a rollercoaster ride. It often begins with a big drop, similar to the beginning response to a major loss. During the ride, the ups and downs occur with a variation of different emotions and degrees. The ride should eventually come to an end, but the memory of the experience still linger. A resurfacing of these memories may, in turn, bring up the emotions associated with grief once again.

There are several ways to consider the progression of grief. Theorists have proposed the idea that grieving comes to an end eventually through diathesis (Horacek, 1995). According to Freud (1917/1957), diathesis is a process that requires the grieved person reduce their relationship with the deceased prior to developing new relationships. Bowlby (1980) outlined a four-stage process of grief:

1. Phase I: Extreme emotions such as numbness and disbelief.
2. Phase II: Restlessness and anxiety, with episodes suggesting the return of the deceased.
3. Phase III: Feelings of ineffectiveness and despair, and realizations that life will potentially not be similar to how it was previously.
4. Phase IV: Restructuring of life as a result of accepting necessary change.

Ward (1993) proposed four phases of grief which are aligned to Bowlby's four-stage process; shock and disbelief, denial, growing awareness, and acceptance. According to Ward, mourners move back and forth between the stages, rather than exhibiting a consistent and expected pattern. Various behaviors may be demonstrated throughout the process of grief (Freeman & Ward, 1998).

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Horacek (1995) described and categorized grief responses into physical, psychological, and cognitive responses. These responses can last from days to years. They include (a) physical responses like tiredness, lack of appetite, and sleep problems; (b) psychological responses such as guilt, fear, and depression; and (c) cognitive responses like sense of uncertainty, low drive, and fixated thoughts of the deceased. Additionally, Freeman and Ward (1998) described 10 shared experiences of grief: (a) shock, (b) physical symptoms of distress, (c) depression expressed through feelings of helplessness and hopelessness, (e) emotional release demonstrated by strong instant emotions after the reality of the loss sets in, (f) fears that are many and varied, (g) anxiety and worry internalized through intense dreams or insomnia, (h) resentment towards others regardless of association, (i) guilt associated with alternative actions that could have been taken to change outcome, (j) healing using positive and negative memories, and (k) releasing, acceptance, and pain reduction not through the process of forgetting.

The tasks of mourning are performed at a personal pace, not prescribed in sequential order, and can repeatedly be readdressed (Wolfelt, 1983; Worden, 1991). Researchers have identified common tasks during the grief process. The first task involves coming to terms with the loss and realizing that the person will not be returning. The second task consists of feeling emotions including anger, depression, and guilt. The third task includes reviewing the previous relationship while current relationships are changed to support moving forward. In the fourth task, focus shifts to developing new connections (Charkow, 1998; Doka & Martin, 1998; Freeman & Ward, 1998; Horacek, 1995).

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In addition, Doka and Martin (1998) added a fifth task in which belief systems are restored due to loss. Being able to operate on a normal basis is most commonly achieved after an individual completes the tasks of grief effectively. Horacek (1995) clarified that continued grief is acceptable and not a devastating factor. In defining this concept, Horacek compared grief as to that feeling of loss or removal of a limb and the associated feeling of something substantial missing. Continuing grief may also be experienced during significant occasions like anniversaries or birthdays. Dysfunctional or complicated grief can arise as a result of these tasks and hamper one's ability to function successfully (Horacek, 1995). Socially unacceptable losses such as suicide or abortions can complicate the grieving process due to the lack of support (Freeman & Ward, 1998). Disenfranchised grief refers to the experience of grief that involves sickness, or friends and lovers not overtly mourned or consoled (Doka, 1987).

There are four factors that influence whether an expression of grief is considered complicated (Freeman & Ward, 1998). These include (a) the type of relationship (e.g., dependent, possessive), (b) the circumstances surrounding the loss (e.g., murder, accident), (c) challenges due to mental health, and (d) and personality characteristics with respect to how they adapt. Grief can occur in response to common life events (Lenhardt, 1997). These occurrences can include marital separation, loss of employment, relocation (Charkow, 1998), retirement, passing of a loved animal, illness, and other unexpected life changes (Rando, 1984). Grieving is an illogical complex process that can take the bereaved though various phases at different points of time (Freeman & Ward, 1998). Due to this, there is an understanding that the grief experience is unique to each person (Freeman & Ward, 1998). The consideration of the factors, including the length and

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magnitude of the experience, supports in identifying typical from atypical grieving (Freeman & Ward, 1998).

Types of Grief

There have been multiple scholarly proposals regarding typical reactions to grief (Bonanno & Kaltman, 2001; Jacobs, 1993). In multiple studies, researchers have investigated standard and complex grief and also clarified other types (Stroebe et al., 2008) and available empirical support (Stroebe et al., 2008) focusing on the characteristics of the types of dysfunction (Bonanno & Kaltman, 2001). The findings of such researchers indicated a lack of consensus whether grief progresses in chronological stages (i.e., stage theories; Bonanno, 2004; Maciejewski et al., 2007). In the current body of literature, scholars have categorized different types of complicated grief separately from normal grief such as prolonged grief or postponed grief (Bonanno & Kaltman, 2001; Stroebe et al., 2008). There is evidence and empirical support for these variations of grief (Bonanno & Kaltman, 2001), as well as confirmation that these grief reactions are exclusive, rather than variations of other mental illness (Bonanno et al., 2007).

Anticipatory Grief

Anticipatory grief has been described as an individual's experience of the affective, physical, and cognitive responses associated with the expectation of the death of a loved one (Corr & Corr, 2000; Rando, 1986). The concept of anticipatory grief introduced by Erich Lindemann (1944) was central to the current study of persons' reactions to normal death. Lindemann focused on the process of grief work that a person engages in when anticipating a significant loss. Since the introduction of the concept, research on anticipatory grief has largely centered on the experience of women dealing with the death of their husbands (Parkes, 1970; Parkes & Weiss, 1983) and parents

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dealing with children who are terminally ill (Bozeman et al., 1955; Richmond & Waisman, 1955).

There have been inconsistent research results concerning whether anticipatory grief is an adaptive or a maladaptive response (Rando, 1986). Lindemann (1944) suggested that negative reactions to anticipatory grief may lead to early affective estrangement from the person who is dying. Fulton and Fulton (1971) found that the experience of anticipatory grief has the potential to minimize the normal grief response after the person dies. This may lead to social disapproval or ostracism by those who might otherwise have provided support.

There are also significant positive effects of anticipatory grief. The ability to anticipate the death of a loved one may allow families the opportunities to "say goodbye" to the dying individual and enable the completion of relational tasks (Byock, 1997; Corr, 1992). Therefore, anticipatory grief has the potential to result in a healthier process of grief for the family following the person's death.

Rando (1986) provided a thorough analysis of anticipatory grief in *Loss and Anticipatory Grief*. In defining anticipatory grief, Rando emphasized the multidimensional nature of the concept. As the significant loss has yet to occur, the grief is normally experienced from two different perspectives: the dying individual and those who hold a significant relationship with that person. The term *anticipatory* implies that a future loss is being grieved; in fact, grief is experienced by losses that have happened in the past, those that are presently occurring, and those that have yet to happen. Finally, the experience of anticipatory grief is influenced in complicated ways by psychological, social, and physiological factors. Rando defined this type of grief as consisting of

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processes of mourning, coping, interacting, planning, and psychosocial reorganization. These processes are initiated in response to the awareness of the impending death of a significant individual. The process of anticipatory grief entails balancing the difficult needs of remaining attached and letting go of the dying person.

Cultural and developmental factors can affect the ability of individuals and families to process the news concerning a future loss—and, thus, shape the overall trajectory of grief (Die-Trill & Holland, 1993; Rando, 1986). The ages and developmental levels of the persons affected by the impending loss can interact with the specific types of illness in determining the experiences of those involved (Rolland, 1994). For example, the experiences of grief in a family of a young adult who is dying versus the family of a young child who is dying are likely to be very distinct. The level of communication and active involvement is likely to be higher for the family of the young adult because of the overall perceived level of maturity. Futterman et al. (1972) found that for parents of a terminally ill child, the process of anticipatory grief has the potential to lead to moderate amounts of detachment from the child. Separately, parents were able to maintain the overall care and nurture of their child.

Anticipatory grief occurs while expecting an impending loss (Casarett et al., 2001). This type of grief is the topic of debate and disagreement (Corr et al., 1997). The label of anticipatory grief is often utilized when referring to the patient and their family who are about to die. It encompasses similar symptoms of grief after a loss and represents the social, cultural, affective, and cognitive responses of the patient and relatives when expecting death (Knott & Wild, 1986). Anticipatory grief can be a means of relief for caregivers and families. In contrast, the person who is dying can potentially be flooded

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with grief and overwhelmed, resulting in introverted and isolative tendencies. For instance, scholars have found that dying husbands' surviving wives stay with them until they pass on (Silverman, 1986), suggesting that it would be abnormal if the widows began to experience and display grief prior to the death of their husbands because they could not give the same level of assistance. In this case, it is clear that mourning should only occur following death.

There are several misconceptions of anticipatory grief. One significant misunderstanding has been found to be confusion between anticipatory and predictable grief. Theoretical discussion implies that there is a limited amount of grief that can be experienced, which signifies that the expectation of the loss will lessen the outstanding grief suffered after the death (Corr et al., 1997). As a result, anticipatory grief should not be experienced solely due to the understanding that terminal illness exists or a sufficient period to forget has passed from the beginning of the sickness until the death.

Some scholars have noted that anticipatory grief seldom occurs. For example, Corr et al. (1997) found that acknowledgement and healing occurred relatively early in the process of grieving—in some cases, even prior to the death. Grief indicates that there has been a loss. As such, it would be beneficial for the bereaved individual to accept that death will inevitably occur. If not, the bereaved individual may blame themselves for not being fully present or available to the dying person. Research findings have demonstrated that the expectation of loss often builds attachment to the dying person (Corr et al., 1997).

Normal Grief

Normal grief often encompasses some disbelief, shock, denial, and/or emotional numbness shortly following death, especially if the death is sudden. Standard grief responses are apparent by continued advancement in the direction of acknowledgement

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of the loss. Emotional suffering is centered on the anxiety of detachment from the deceased, which often promotes longing, seeking, and fixation with the deceased and disturbing thoughts of death (Stroebe et al., 2008).

Some bereaved people feel anger, reject the fact that the loss has occurred, and experience considerable periods of sadness, despair, insomnia, change in appetite, fatigue, guilt, and loss of interest, all of which have negative effects. Grief reactions may also involve hallucinations of the loved one and searching for items or locations related to the person (Stroebe et al., 2008). High-intensity, time-limited periods of distress that last up to a half an hour, called *grief bursts* or *pangs*, can also be experienced. This type of feeling is a response to things that remind the individual of their loved one and usually is unpredictable (Stroebe et al., 2008). Given a long enough time, the majority of the bereaved experience reduced symptoms, symptoms with less force, and shorter period of being symptomatic. While recovery is not time-specific, the typical period for experiencing lower-level grief ranges from 6 months to 2 years following the death (National Cancer Institute, 2011).

Theorists have proposed a variety of models of normal grief (Bowlby, 1980). A majority of these models categorize the normal grief process as being different from the number of different forms of complicated grief. Of those, some utilize phases indicating that there are stages of grief with stage-specific characteristics. Kübler-Ross (1969) first theorized the stages of denial, anger, bargaining, depression, and acceptance in those aware of their impending death.

Jacobs (1993) developed a stage model of normal grief that organizes psychological responses into four phases: numbness disbelief, separation distress,

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depression-mourning, and recovery (Maciejewski et al., 2007). Jacobs (1993) noted that "it is important to emphasize that the idea that grief unfolds inexorably in regular phases is an oversimplification of the highly complex personal waxing and waning of the emotional process" (p. 18). Although other researchers have questioned these findings (Bonanno & Boerner, 2007; Silver & Wortman, 2007), there is statistical evidence of their validity (Maciejewski et al., 2007).

According to Shear and Shair (2005), normal grief happens when people "are deeply saddened by the death of an attachment figure during a period of weeks or months of acute grief" (p. 253). These authors recognized that the personality of grief and the grief reactions differ. The individual characterizes normal grief experiences "an intense yearning, intrusive thoughts and images, and/or a range of dysphoric emotions" (Shear & Shair, 2005, p. 253). The attention and commitment in everyday behavior is transformed, and the death of the loved one is incorporated into the bereaved individual's day-to-day life as the initial reaction subsides (Shear & Shair, 2005). While this integration occurs, "painful feelings lessen and thoughts of the loved one cease to dominate the mind of the bereaved" (Shear & Shair, 2005, p. 253). For a minority of people, however, normal grief adjustment does not occur, leading to complicated grief.

Complicated Grief

Several researchers have found that complexities exist with respect to grief, and the terms utilized to explain complicated grief (CG) are reliable (Prigerson & Maciejewski, 2005). Approximately 10–20% of people find coping to be exceptionally painful and difficult (Byrne & Raphael, 1994; Middleton et al., 1996; Prigerson & Jacobs, 2001). Shear and Shair (2005) noted that "integration of the loss does not occur and acute grief is prolonged in the form of CG" (p. 253). For the last 20 years, the

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complications that arise from grief or abnormal expressions of grief have been defined with a large number of terms. Some of these are *absent*, *abnormal*, *complicated*, *distorted*, *morbid*, *maladaptive*, *atypical*, *intensified and prolonged*, *unresolved*, *neurotic*, *dysfunctional*, *chronic*, *delayed*, and *inhibited* (Parkes & Weiss, 1983); however, other modifications were implicit and could be found in studies using such words as *delayed or absent grief*, *inhibited or distorted grief*, and *chronic grief* (Parkes & Weiss, 1983; Raphael, 1983).

Individuals who suffered from the complicated grief experience have a sense of "persistent and disturbing disbelief regarding the death" (Shear & Shair, 2005, p. 253). In complicated grief, there are emotions of bitterness, anger, and resistance to accepting reality, in addition to longing for the person who has died (Shear & Shair, 2005). For those suffering from complicated grief, "Thoughts of the loved one remain preoccupying often including distressing intrusive thoughts related to the death, and there is avoidance of a range of situations and activities that serve as a reminder of the painful loss" (Shear & Shair, 2005, p. 253).

Several authors have proposed various examples of complicated grief (Bonanno & Kaltman, 2001; Jacobs, 1993), including patterns from extensive clinical observation (Bonanno & Boerner, 2007) such as psychodynamic defense responses and characteristics connected with patterns of attachment (Prigerson et al., 2000). Such findings have shown that the occurrence of a small grief reaction, with the possibility for inhibited, absent, or delayed grief, depends on the degree of an individual's hardiness and flexibility (Bonanno et al., 2004). This pattern entails experiences such as distress or a cease in ability to function. This experience was found to occur in 15–50% of participants

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throughout the first 2 years following a death (Bonanno et al., 2004). The descriptions of these patterns are as follows:

1. Inhibited or absent grief: Displaying few characteristics of normal grief.
2. Delayed grief: Symptomatic feelings occur later than is most common.
3. Chronic grief: Elongated period of being symptomatic of experiencing grief.
4. Distorted grief: Presence of strong and unusual symptoms.

Support exists on a pattern of for chronic grief, which describes an experience of common grief for periods significantly longer than is standard. This type of grief has been shown to exist in approximately 15% of the target population of bereaved people (Bonanno et al., 2004), which is similar to the rates of significant mental illnesses symptoms such as anxiety, posttraumatic stress disorder (PTSD), and depression. Further, significant emphasis was put on separating normal and complicated grief (National Cancer Institute, 2011).

Prigerson et al. (2008) previously used the term *traumatic grief* to explain the essence of the first edition of the Inventory of Complicated Grief developed in 1995. The importance of recognizing the difference between PTSD and grief was most recently indicated in a widespread fashion following the terrorist attacks of September 11, 2001 (Prigerson et al., 2008). Consequently, *complicated grief* was used as the appropriate terminology to reduce the uncertainty between the grief response and PTSD.

An essential difference between complicated grief emanated in interpersonal attachment issues and PTSD was grounded in the occurrence of imminent hazardous events feared to hurt oneself or others. The choice to regress back to the term *complicated grief* noted the difference among these two disorders (Prigerson et al., 2008). Differences

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of belief about complicated grief focus on the "specifics of the diagnostic criteria and their categorization, determination of the boundaries between normality and pathology, concerns about social coercion and issues of stigmatization" (Prigerson & Vanderwerker, 2016, p. 91).

Scholars have speculated that complicated grief is a form of depression brought on by loss (Kim & Jacobs, 1991). Symptoms of grief comingle with depressive symptoms, along with other *DSM*-recognized illnesses like PTSD and anxiety. Complicated grief reactions exhibit adequate distinctive inconsistency to affirm separate consideration (Horowitz et al., 1997; Kim & Jacobs, 1991; Marwit, 1991, 1997; Prigerson et al., 1996).

Several studies have established a description of complicated grief that goes farther than the typical clinical notation, allowing for better statistical validity (Horowitz et al., 1997; Prigerson et al., 1996, 2000; Raphael, 1983). A majority of researchers have identified complicated grief using the classification of Prigerson and Jacobs (2001), which is based on the existing disorders listed in the DSM (Prigerson & Jacobs, 2001). According to Prigerson and Jacobs, it would be appropriate to label complicated grief as a different diagnosis if there is the propensity for a distinct illness.

Prigerson and Jacobs (2001) classified the symptoms and diagnostic criteria for complicated grief. These authors listed the symptoms as including feelings of distress, which include pangs of longing, and thoughts of the deceased, and feelings of traumatizing distress, which include shock, anger, detachment from others, and disbelief. This representation allows the identification of CG through the CG – Revised, which was

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altered to accurately measure and take these symptoms into account (Prigerson & Jacobs, 2001).

In addition, Prigerson and Jacobs (2001) proposed diagnostic criteria for complicated grief. These criteria were not adopted, however, and formal diagnoses of grief disorders remained absent from the *DSM*. Despite this, the criteria assisted in identifying symptoms, indicating the severity of those symptoms and separating complicated grief from normal grief.

In Criterion A, an individual has experienced the experience of a loss of a partner and their reactions encompass 75% of the following symptoms that can be felt on a day-to-day basis or to a significant degree; disturbing thoughts about the individual who passed on, yearning for that person, looking for that person, and extreme sense of loneliness since the death. In Criterion B, 50% of the following eight symptoms are required to be experienced on day-to-day basis: loss of purpose, sense of lack of being in the moment or being detached, disbelief, a feeling that there is no more meaning in life, a feeling that the individual has lost a portion of themself, a breaking of their view of the world (e.g., a loss of control or trust), engaging in negative behavior, and demonstrating irritability. Criterion C dictates that the symptoms should last half a year. Finally, in Criterion D, there is a loss of social functioning, ability to work, and loss of the ability to function in other areas. There is disagreement, however, that the length of time of half of year is the most appropriate measurement, with some indicating that a period of 2 years would be more suitable (Gibson, 2003).

General Experiences of Grief and Loss

The unexpected and untimely death of a loved one can influence the complexity of a person's reasoning and mental capabilities (Lifshitz, 1976). This may be related to

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more pronounced problematic actions, including poor life choices (Bowser et al., 2003; Lifshitz, 1976; Thompson et al., 1998). A variety of psychological struggles are associated with the death of a loved one. These feelings include guilt, anxiety, fear, anger, helplessness, scores reminiscent of depression and distress, as well as other psychological issues and symptoms (Holland et al., 2006). These experiences can indicate alterations in one's view of self.

The death of a loved one can influence people's expression of emotions towards others, in addition to the regularity and style of their social behavior (Martinson & Campos, 1991; Meshot & Leitner, 1993). Although the instant grieving phase separates "the bereft from previous social networks" (Handsley, 2001, p. 4), individuals are ultimately required to reinstate relational patterns with others. According to Handsley (2001), there is evidence that people who experience the death of a loved one go through a period of reorganization of their concepts connected to self-identity (Aron et al., 1991; Handsley, 2001; Meshot & Leitner, 1993). This finding is especially true in the case of familial losses (Handsley, 2001; Krause, 2007). The ensuing reevaluation affects the person's social abilities in how the person relate to others. Sometimes, however, there was a negative outcome socially, with some researchers finding that such traumatic experiences were related to an increased probability of isolating oneself from social interactions (Hammen & Peters, 1978; Hawthorne, 2008). This loss can result in detachment from others.

In addition, people who feel depressed after a significant loss can experience more negative social impact than individuals who are not depressed. Depressed people can experience more frequent rejections by and reduced enjoyment from interactions with

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peers (Connolly et al., 1992). Young individuals who experienced the loss of a parental figure moved towards such relationships with feelings of insufficiency (Cait, 2005). Grieving nursing students showed reduced emotional directness, and widows and other females who recently lost a close relation changed their friendships to a style that was likely to be one-way and involved a lack of closeness (Cait, 2005).

In some research conducted on the elderly and the widowed, scholars have identified a noteworthy reduction in both social involvement and interaction after the loss of a significant person (Bennett, 1997; d'Epinay et al., 2003). Females who experienced a loss of their maternal figures in their youth had the propensity of responding to loss by "seek[ing] out stronger bonds with peers, family members, and older women who [could] act as maternal substitutes" (Schultz, 2007, p. 36). Similarly, for teens, "bereavement can serve as a catalyst for the development of richer meanings, more satisfying relationships, and greater individual maturity and personal growth" (Schultz, 2007, p. 20). Others have found that teens that lost a brother or sister to cancer 7 to 9 years prior were unlikely to view death experiences as having a long-term negative effect; most were able to form deep and lasting relationships, especially with their family (Martinson & Campos, 1991).

Some researchers have concentrated on the importance of a supportive social structure in assisting people who experienced loss to get past the potentially debilitating effects, mitigate their symptomatic feelings, enhance their self-esteem, and improve scholastic performance (Chapman, 2004; Gray, 1987; Martinson & Campos, 1991). Social connections are crucial, and individuals who can acknowledge and fulfill this need may experience genuine feelings that are more pronounced than prior to the experience of loss. In addition, the need for support increases during the ensuing year after the death.

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Some exhibit a more pronounced need for connection following loss, including adolescents, which may indicate a yearning for recovery; this desire can also reflect a need to fill the void caused by their loss (Schultz, 2007).

The development of isolating behavior is influenced by factors such as age, ethnicity, sex, employment status, and income (Hawthorne, 2008). Those who have experienced the loss of a loved one may express a variety of symptoms and behaviors that may depend on their sex, race, religion, age, relationship with surviving parental figures, and ability to accept the experience of loss (Holland et al., 2006; Lifshitz, 1976; Park & Cohen, 1993; Raveis et al., 1999; Thompson et al., 1998).

Those who have experienced and recovered from significant loss may be better able to deal and assist with the needs of other people. Rask et al. (2002) concluded that "the adaptive recovery from the death of a loved one improves social and cognitive resources" (p. 138). These individuals are more likely to be in touch with the need for social engagement, as well as to benefit from these experiences. Thus, it is important to recognize that the impacts of grief and loss vary based on many factors.

Spiritual Components

Grief has been addressed through a spiritual lens throughout the history of mankind. As emotional, psychologically-minded beings, humans seek to understand death. The deep grieving process leads many individuals to search for spiritual meaning and understanding. While there is often a religious component to spirituality, many individuals maintain a spiritual connection that is devoid of a specific religious affiliation. In this sense, spirituality is often viewed as a sense of being connected to the self and/or to a greater reality. Viewing the experiences of grief and loss through a spiritual lens may offer the opportunity for a profound sense of interconnectedness.

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In *Psyche and the Sacred: Spirituality Beyond Religion*, Lionel Corbett (2007) described a man named Lewis and his individual foray into a spiritual investigation of grief:

> It suddenly comes home … that the worst spiritual crisis that can result from such suffering and grief is not the loss of faith but the realization that this is what God is really like—a torturer. In struggling with these feelings, Lewis achieves a new perspective on his situation as he comes to realize the element of selfishness in his grief. In the end, he arrives at the position that lived and embraced suffering is what raises humans above animals and makes them divine. (p. 170)

It is through such spiritual experiences that individuals may come to further understand the grieving process and its overarching impact on the psyche. With a greater appreciation for the importance of the sacred during times of suffering, the individual's spiritual experience of grief might serve as the catalyst for personal transformation. As Moore (1994) summarized, "The Christian doctrine of original sin and the Buddhist Four Noble Truths teach that human life is wounded in its essence, and suffering is in the nature of things" (p. 166).

In the context of the current research, I defined a soul as the essence of an individual that is connected to others on a timeless and universal level. As such, when viewed in concert with the individual's unique spirit, the soul is an important aspect of the spiritual component of the grief and loss experience. Individuals who have lost a loved one can feel their loss on a profoundly soulful level, including a continued "soul-connection" to the deceased. When the experience of loss promotes connectedness to the self and the greater web of life, the result can be a profoundly moving and vitally significant event of the soul. For a variety of reasons, some psychosocial in nature, many individuals are unable or unwilling to explore loss on a spiritual or soul-based level. Yet, for those who are ultimately able to embrace the loss and the grieving process as a

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natural, life-developing journey, the impact of the loss can be transformative. In *The Wounded Researcher*, Romanyshyn (2007) offered

> Mourning, then, is not just the experience we have after loss. On the contrary, mourning is natural to soul. It is the way of the soul, the soul's way of knowing and being, the activity of the soul that challenges the ego-mind to hold onto what it possesses by letting go of it. (p. 14)

It is through such deeply spiritual and soul-filled approaches to loss that the individual is often able to release and yet remain connected to the loved one who has passed.

Emotional Components

For many individuals, the grieving process includes intense emotions. Emotional components are part of the psychological reaction that is strongly constellated in grief. Kübler-Ross's (1969) five-stage theory of grief outlines the oft-seen progression of denial, anger, bargaining, depression, and acceptance. The individual who has lost a loved one may experience emotional responses such as rage, anger, depression, sadness, anxiety, and melancholy. Noting that those in the process of grieving often appear unemotional and detached, Edelman (2006) posited that such behavior may indicate an underlying sense of overwhelming grief and anxiety, offering, "The more composed a teen appears, however, the greater her risk of experiencing long-term, unresolved grief, and researchers now know that unresolved grief in turn places individuals at risk for depression, physical illness, and drug and alcohol abuse" (p. 57). While Edelman's comment relates to adolescents, such emotional experiences are common reactions to grief and loss among individuals of all ages.

One's ability to cope with loss and grief on an emotional level is largely based upon learned behaviors. While emotional patterns formed in childhood can be adjusted through conscientious attention and concerted effort (e.g., through personal

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psychotherapy efforts), many individuals are unaware of the dynamic power of historical patterns. When looking at family systems, the multigenerational role of emotional processes, which can be formed through family relationships, becomes evident. Individuals who become aware of dysfunctional patterns and move toward differentiation from familiar, historical modes tend to function more adaptively in general. Particularly in situations of high stress or significant life changes such as the death of a loved one, emotional patterns learned in childhood may unconsciously move to the forefront. In *Family Evaluation,* Kerr and Bowen (1988) stated,

> When multi-generational emotional process results in individuals and family branches high on the scale of differentiation, the excellent adaptiveness of those individuals and families results in their having a low incidence of clinical symptoms and other problems (stable in most aspects of functioning). (p. 236)

When addressing issues of grief and loss, a deep awareness of the highly significant importance of familial patterns is essential. Whether the deceased person is from the family of origin or is unrelated by birth, the emotional experience of the loss is contextualized by intergenerational patterns. By maintaining an awareness of the often unspoken and unconscious historical family patterns and messages surrounding emotions in general, unique emotional experiences surrounding loss and grief can be more fully understood and acknowledged.

As previously noted, emotional reactions due to the loss of a loved one vary considerably in depth and nature. Depending upon the individual's emotional and relational connections to the loved one, as well as a plethora of other psychosocial and neurobiological factors, the loss of a loved one might result in a deep, yet curative, progression through the grieving process. In *New Passages: Mapping Your Life Across Time*, Sheehy (1995) noted, "Involuntary losses can become the catalyst for voluntary

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changes in the practice of our lives, altering the efforts we make to connect with others, the values we choose to make congruent with our actions, the habits we change…" (p. 142). Such an attitude is indicative of emotional groundedness and a healthy willingness to embrace even deeply difficult losses with an attitude of awareness and acceptance.

In cases where the loss is faced with a profound sense of openness, a willingness to embrace the often intensely devastating and life-altering manifestations of the loss, the deeply emotional aspects of the grieving process can be viewed as markers of the journey. Romanyshyn (2002) investigated the importance of restoring emotional connections during the course of grieving the loss of a loved one, offering the following personal perspective on the process:

> The journey home through the pathetic heart awakened by grief is a journey of remembrance…The heart awakens to its imprisonment within a world that has lost its vision of the visible order of things…Because the heart cannot bear this absence of the invisible world…its journey becomes one of grieving the broken connections between itself and nature, a grieving which in its remembrance of those connections begins the process of restoring them. (p. 172)

The emotional sensations and connections that are initially anesthetized as a result of the loss must be attended to, given space, and allowed to unfold through the process of remembrance. In undertaking such a journey, the connections with the loved one are restored in a new way, and the impact of the loss may naturally and more beautifully resolve. Individuals who are able to explore the emotional components of a loss, rather than avoiding or cutting off the surrounding emotions, can ultimately metabolize the profound effects of the loss more fully.

It is the emotional and spiritual lessons to be discovered within the grieving process that allow for a more fully realized understanding of one's own humanity and interconnectedness to the greater whole of life. As Sheehy (1995) stated,

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> Oedipus, blind and bedeviled on all sides by vengeful gods, has one of the most triumphant Aha! Moments in all literature: "Despite so many ordeals, my advanced age and the nobility of my soul makes me conclude that all is well." He recognizes that he would not have discovered his full humanity without his mistakes and suffering. (p. 173)

Significant suffering occurs upon the loss of a loved one. It is through such losses and the resulting painful emotions, such as anger, sorrow, and depression, that individuals learn more fully who they are and what it means to be human.

Physical Components

The physical body, as an extension of the psychic and emotional body, may carry the experience of loss and grief. It is common for the grieving individual to sense physical changes. Experiences of sleeplessness, lethargy, anxiety, and an overall deadening may overtake the grieving individual. In *Freeing the Soul from Fear*, Robert Sardello (1999) said, "Body and soul are more like two sides of a leaf than like two discrete entities. The body is the soul's expression in the world…if the body becomes dulled the soul has limited means of engaging the world" (p. 66). To the extent that the psyche is not allowed to express the pain and sorrow carried so deeply within, the manifestation of pain and increasingly appear in the increasingly appear in the individual's body. As Moore (1994) noted, "Illness offers us a path into the kind of religion that rises directly from participation in the deepest levels of fate and existence" (p. 167). The body, whether expressing the soul's grief and loss through physical symptoms such as anxiety, depression, soreness and aching, or insomnia, seeks to express that which it carries within. The culture in the United States allows little room for the soulful expression of a wide range of reactions to the most difficult human experiences. With such repression in mind, Sardello (1999) described

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> We not only become filled with anxieties but also find ourselves more uncomfortable in our body. . . We may feel tired for no reason an ongoing sense of exhaustion. A dim but pervading sense of depression accompanies us. . . unlocatable pains, stirrings of hunger. We may find ourselves eating to try to restore comfort, taking medication, sleeping too little or too much. Such measures may alleviate discomfort, but they do not restore a sense of well-being to the body; they merely obscure discomfort and allow us to perform our duties, but our body is not enthusiastic about being in the world. (pp. 44-45)

The psychosomatic manifestations of grief are often undetected or misdiagnosed. Unresolved grief may be commonly labeled as depression or anxiety, and prescription medications become a readily accessible and inexpensive tool to temporarily ease distress; however, the underlying causal factors often remain ignored and untreated. As Moore (1994) outlined,

> The human body is an immense source of imagination, a field on which imagination plays wantonly. The body is the soul presented in its richest and most expressive form. In the body, we see the soul articulated in gesture, dress, movement, shape, physiognomy, temperature, skin eruptions, tics, diseases—in countless expressive forms. (p. 155)

Society might be far better served by approaching experiences such as grief from a whole-body perspective. Noting that modern medicine often fails to include the emotional and psychic body in its diagnosis and treatment of disturbances in the physical body, Moore (1994) suggested, "Imagine a medical approach more in tune with art, one that is interested in the symbolic and poetic suggestiveness of a disease or malfunctioning organ" (p. 155). When working with the emotional and psychological components of grief, it is important for those within the mental health community to include an understanding of—and appreciation for—the physical effects of grief.

The Neurobiology of Grief and Loss

Researchers have clearly indicated that grief and loss also affect the individual on a physiological level. It is no surprise, then, that the loss of a loved one triggers myriad

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complex neurobiological processes. The individual is often not conscious of the innumerable physiological changes that result from experiences such as loss; it is the basic emotional manifestations (e.g., sorrow, anger, and sadness) that are often at the fore of the individual's conscious experience of loss and grief. In reviewing the underlying neurobiological changes that occur during such life-altering events, several core aspects are deserving of particular attention. In this section of the literature review, I discuss the impact of loss and grief on attachment, emotions, coping mechanisms, memory, integration, guilt, and trauma from a neurobiological perspective.

Attachment

Naturally, the loss of a loved one results in a deep sense of being abandoned or cut off from a significant source of attachment and connection. A multitude of factors affect the level and nature of this feeling of disconnection. When the loss is sudden or unexpected, the inability to gain a sense of closure often makes the loss more deeply felt. When the attachment bond was originally secure, however, such a loss can often be better managed due to the historical bond of intimate connection. In such cases where the attachment history was dysfunctional, the actual loss can initiate an unfolding of issues that were repressed. According to Cozolino (2002) in *The Neuroscience of Psychotherapy*:

> *Attachment schemas* are implicit procedural memories of caretaking experiences. These memory networks become evoked in subsequent interpersonal experiences throughout life. Attachment schemas serve to direct our attention toward or away from others by providing us with ongoing and unconscious input about approach/avoidance decisions. (p. 183)

Therefore, in cases where an original attachment pattern was insecure, the individual experiencing the loss may find that childhood patterns are evoked, and physiological changes can occur as older memories are triggered unconsciously. Memories held within

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the social brain may be activated by current events such as loss, and these experiential changes may parallel neural network shifts that are generated by the activation of memories. An upwelling of emotions and bodily sensations can result as historical patterns are reactivated and experienced in the current situation. In discussing the impact of environs that negatively impact the growth of the individual in *Affect Dysregulation and Disorders of the Self*, Allan Schore (2003) asserted that such environments

> …negatively influence the ontogency of homeostatic self-regulatory and attachment systems. Social environments that provide less than optimal psychobiological attunement histories retard the experience-dependent development of frontolimbic regions, areas of the cortex that are influenced by the attachment experiences and prospectively involved in homeostatic functions. (pp. 32–33)

Clearly, a disruption in early attachment systems impacts the individual on a multitude of neurobiological levels. As a result, the individual may struggle with self-regulation and basic homeostatic functions in general; when faced with stressful situations such as the death of a loved one, such difficulties can be exacerbated and result in significant disturbances.

Individuals with secure attachment histories also face substantial personal and psychosocial issues following a loss and through the course of the grieving process. Those who experienced a lack of appropriate attunement and positive attachment-based interactions in childhood often face a greater degree and variety of difficulties due to underlying patterns of dysregulation (Cassidy & Shaver, 1999). In cases where a death results in the child being left motherless, there is evidence of significant neurobiological effects (Cozolino, 2002). When a child is separated from the mother at any early age, whether through death or other intervening events, such events are extraordinarily stressful for the child. Increased hypothalamic-pituitary-adrenal activation results, and the

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child's developing brain may be severely impacted. As Cozolino (2002) maintained, "In unavoidable situations such as illness or death, the ability to lessen the impact of stress hormones via interpersonal and chemical interventions may create the possibility of avoiding yet more difficulty and stress later in life" (p. 312). Many children do not receive appropriate interventions following the loss of a loved one. In such cases, a physical separation from the mother affects the child's attachment experience with concomitant, pervasive changes on a neurobiological level (Cozolino, 2002). The impact of such events is often profoundly persistent; even when the experiences are generally repressed, subsequent losses often unconsciously trigger the unresolved and emotionally-laden formative attachment experiences.

Emotions

As the ability to regulate emotions is a critical aspect of basic human interactions, an understanding of the basic neurobiological factors involved in emotional regulation is of vital concern when exploring loss and grief. For most individuals, the loss of a loved one can generally be managed with levels and ranges of emotion that do not interfere considerably with their ability to function. Those who have been negatively impacted by dysfunctional childhood environments and relationship patterns, however, may experience significant difficulties accessing, experiencing, and expressing appropriate emotions.

Schore (2003) offered, "Early failures in dyadic regulation therefore skew the developmental trajectory of the corticolimbic systems that mediate the social and emotional functioning of the individual for the rest of the lifespan" (p. 33). If an individual experiences appropriate early affective communication, the organization of the related control systems in the child's developing right brain is affected positively. In

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cases where the individual receives an insufficient or inappropriate level of such interplay, the ability to successfully regulate affective communications is hampered. As the right brain plays the key role in processing somatic and psychosocial information, situations that negatively affect the development of the right brain affect the ability to appropriately regulation emotions.

In times of crisis or stress, any resulting dysfunctions may be particularly evident. For example, an individual who has learned to suppress feelings of sadness may laugh uncontrollably during a funeral. On the opposite—but related—end of the spectrum, another individual who is unable to sense and exhibit appropriate affective regulation may be unable to shed tears, even at the loss of a loved parent or child. The ability to access and display appropriate emotions can be a critical manifestation of a lived experience. When an individual is unable to regulate emotional states, particularly during times of significant disturbances, it is possible that the underlying psychosocial causes (e.g., grieving the death of a parent) will not be fully acknowledged and processed (Schore, 2003).

Avoidance and Repression as Coping Mechanisms

For a variety of reasons, whether situational or psychological, individuals are often unable to cope with loss fully or effectively. Avoidance is commonly used to defend against experiencing the depth of the loss, and these patterns will intensify in order to control the increase in intensity of the emotion related to the loss. Particularly in cases where the individual historically defended against certain emotional states, a strong tendency exists to continue those same patterns when a loss is experienced. Cozolino (2002) stated, "The neural networks that organize emotions are shaped by early experiences to guide us away from thoughts and feelings for which we…are made

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uncomfortable, or led to neglect by others…leading us to remain on tried-and-true paths and avoid situations that trigger our unremembered past" (pp. 49–50). As such, the individual may repress their memories, emotions, current thoughts, experiences, and bodily sensations related to the loss.

When the individual is unable to make appropriate sense of emotions, whether due to patterns learned in childhood or other events, coping strategies and defense mechanisms are developed by the brain. These strategies are affected on an unconscious level within the brain's circuits of unconscious memory, the circuitry that controls fear, alleviating the anxiety and allowing the individual to function. As a result, a degree of distortion in reality occurs when defense and coping mechanism are employed. Depending upon the nature of the individual, the stressor, and the type of defensive mechanism or coping strategy employed, distortion of reality may be experienced to a lesser or greater degree. The patterns are then perpetuated by the cortex, that area of the brain that engages in higher-level functioning; it is the cortex that rationalizes both thoughts and resulting behaviors. Such processes persist on an unconscious level. The defense mechanisms and coping strategies to which the individual becomes accustomed are precisely those measures that are characteristically employed by the individual during anxiety-inducing and stress-provoking events, such as the death of a loved one.

Memory

In times of anxiety and stress, the brain's neurochemistry reflects an increase in stress-related hormones such as adrenaline and cortisol (Schore, 2003). A substantial increase in these hormones affects the memory due to the impact upon the hippocampus, as well as other regulatory areas of the brain. In certain situations, the brain—operating protectively to afford homeostasis—ultimately blocks out memories through dissociation.

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Referencing current information, Schore noted that current "early emotionally negative childhood events and prolonged stress lead to a dissociative (functional) amnesia" (p. 219). In such cases, pernicious brain dysfunction can be induced by subsequent sporadic environmental stressors. As such, individuals who are prone to dissociation may experience an even greater degree of memory loss and memory instability during times of acute stress and anxiety, such as is often experienced when facing the loss of a loved one.

Individuals who are facing high levels of stress and emotional overload may employ dissociation as a defense mechanism. During intensely difficult life challenges such as an unexpected, traumatic loss of a loved one, an individual may unconsciously dissociate as a coping strategy. Schore (2003), referencing a study by Powles (1992), discovered highly interesting connections that link dissociation, elevated emotional states (e.g., stress resulting from fear), and numbing induced by endogenous opioids:

> Recall traumatized infants are observed to be staring off into space with a glazed look, and the child's dissociation and vagal tone in the midst of terror result from elevated levels of cortisol and vagal tone, while opiates induce pain numbing and blunting. The state of conservation-withdrawal occurs in hopeless and helpless contexts, and is behaviorally manifest as feigning death. (Schore, 2003, p. 217)

It is interesting that the states of hopelessness and helplessness, both of which are common responses in the loss and grieving processes, result in a response that evidences a death-like posture. It appears that when faced with states of high stress or fear that are often intrinsic aspects of the separation, loss, and grief cycles, the individual may find temporary relief in adopting a numbed, lifeless posture similar to that of a corpse. While Schore referenced children, it is possible that many aspects of the research can be extrapolated to the experiences of individuals at other life stages.

During times of loss, the memory of historical events can be either soothing or traumatizing to the individual. Based upon personal experience, history of interactions

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with the deceased, memories, and individual neurobiology, the triggering of memories may be experienced as either curative or disruptive. From a neurobiological paradigm, Cozolino (2002) offered, "Given that the organization of memory is encoded among neurons and within neural networks, the malleability of memory is a behavioral manifestation of the plasticity of neural systems" (p. 100).

From this perspective, it is the brain's very plasticity that enables reworking and reframing of traumatizing memories to alleviate the suffering that stems from such memories. An individual's affective reactions to a historical experience can be modified by the introduction of information, which allows the memory to shift toward a positive or neutral status. By altering the nature of the memories and creating a beneficial narrative, the neurons and neural networks within which the memories are contained are changed. If such structural changes are made, particularly with the assistance of a trained psychotherapist or other intervention specialist, the individual is able to experience the loss and the grieving process without perpetuating a pattern of trauma through the reexperiencing or repression of negative or difficult memories. By capitalizing on the brain's unique malleability, memories that trigger suffering—and, thus, compound the grief process—can be reframed in a fashion that allows the individual to release negative associations.

Integration

A key aspect of the ability to move toward acceptance of the loss is the ability to integrate various aspects of the historical relationship with the loved one. As Romanyshyn (2002) noted,

> The rituals of psychotherapy are rituals of mourning, and language, which holds such a key place in the talking cure, is central to these rituals, to this practice of letting go…[W]e practice a way of speaking which holds onto the meanings and

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stories made by letting go of them. (p. 59)

Healing can be found in integrating the historical aspects of the relationship with the deceased into the grieving individual's sense of personal life history. Successful integration also affords a restructuring of one's outlook in order to cope effectively with loss. Acknowledging that acceptance is the final stage of Kübler-Ross's (1980) five-stage grieving process, the importance of integration is clearly significant.

From a neurobiological stance, Cozolino (2002) noted that when compared to those with insecure attachment schemas, adults who have more secure attachment histories can utilize and organize both emotional and cognitive memory to a greater degree. Historical incidents of trauma and general life experiences appear to be more readily and fully integrated by such persons. A high level of psychological integration is achieved through the successful processing and integration of childhood experiences— and, subsequently, general life experiences such as loss. As neurological integration is an intrinsic aspect of psychological integration, a higher level of neural integration between cognitive and emotional processing networks naturally results when appropriate integration occurs. In general, when compared to those who utilize primitive defense mechanisms to cope with difficult life experiences, individuals who can integrate emotional materials have a higher degree of affect regulation and emotional availability. Accordingly, integration serves an important role in more thoroughly understanding the effective processing of the loss and grief experiences.

Guilt

In many cases, the grieving process is worsened by an individual's sense of guilt for being responsible for some aspect of the death. Whether conscious or unconscious, self-blame can heighten and extend the grieving process considerably. Such guilt is often

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connected to the feeling that the individual did not act appropriately or sufficiently while the loved one was alive; this may be connected to historical circumstances, or to a feeling of being helpless or inept at staving off the actual death. In addition, the griever may feel a sense of guilt from letting go of the loved one. The individual may feel that releasing the deeply felt presence and memory of the loved one is a form of emotional abandonment or betrayal. Thus, a strong sense of guilt may often be unconsciously attached to the idea of releasing the loved one and moving forward with life. On a neurobiological level, the right hemisphere of the human brain has a laterality bias toward negative emotions and distrust (Cozolino, 2002). This right hemisphere bias may perpetuate a human tendency toward emotions such as guilt and shame. Shame, while related to grief, is considered as a primary socializing affect stemming from internalized aspects of early childhood experiences. Bradshaw found that individuals who operate from a base of shame may "find criticism, rejection, and abandonment in nearly every interaction" (Cozolino, 2002, p. 99). Due to an increased sensitivity determined by early learning history, individuals who are shame-based may then experience not only greater degrees of guilt, but also a heightened level of abandonment as the result of a loved one's death. Thus, the experience of loss and the grieving process may be more difficult and disruptive due to the destructive nature of the historical emotional and cognitive distortions that accompany the tendencies toward both guilt and shame.

Trauma

Although most individuals encounter substantial difficulties when facing the loss of a loved one, the experience of the loss as a traumatic event can be affected considerably by an individual's psychosocial history. There is a tendency for those who have a history of unresolved trauma to experience similar events as being more traumatic

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than those who have a history of no trauma or resolved trauma. Those with trauma histories tend to respond to stressful situations far differently from untraumatized persons. In an article entitled "The Body Keeps the Score: Memory and the Psychobiology of Post-Traumatic Stress," Bessel van der Kolk (1994) noted, "Under pressure, [traumatized individuals] may feel or act as if they were traumatized all over again. Thus, high states of arousal seem to selectively promote retrieval of traumatic memories" (p. 6). Under normal circumstances, such individuals normally are fairly well adjusted psychosocially; yet, traumatic events (e.g., the death of a loved one) can trigger historical trauma-based psychological and physiological response patterns. Referring to properties of early social trauma, the effects of which can be pernicious and experienced throughout life, Schore (2003) maintained,

> The resulting psychobiological disequilibrium is expressed in a dysregulated and potentially toxic brain chemistry. Indeed, this same interaction between high levels of catecholamines, excitatory transmitters, and corticosteroids is now thought to mediate programmed cell death, and to represent a primary etiological mechanism for the psychophysiology of neuropsychiatric disorders. (p. 253)

Clearly, whether an individual is traumatized as a child or as an adult, the effects of unresolved trauma—particularly trauma that is foundational to the person's core sense of self—will pose additional difficulties when life stressors arise. The impact of loss and the grieving process will often be much greater for individuals with a history of unresolved trauma. In such cases, the death of a loved one will often activate the individual on countless conscious and unconscious levels. Neurobiologically, such an individual is predisposed to a variety of psychological and biological issues based upon response patterns to trauma that were never properly resolved. The loss of the loved one triggers the previously unresolved psychological, cognitive, and behavioral patterns, and the original trauma is often reexperienced along with the current traumatic loss. In the

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midst of the psychosocial stressors that accompany the loss of a loved one, the traumatized individual is often entirely unconscious of the complex nature of their responses. Without appropriate intervention and support, the loved one's death becomes yet another layer on the mound of the historically unresolved traumas. Such individuals have substantial difficulty completing the grieving process appropriately and satisfactorily unless attention is given to the underlying issues.

Interventions Supporting Grieving

Regarding grief counseling, there have been some psychological articles that portray a pessimistic view of grief counseling which suggested that grief counseling may be more harmful than beneficial. For example, Neimeyer (2000) claimed that grief counseling is ineffective. Larson and Hoyt (2007) did an extensive review of Neimeyer's work and discovered that there was an understudied statistical analysis used to interpret the data, meaning that the empirical findings were doubtful. Larson and Hoyt (2007) suggested that a study by Allumbaugh and Hoyt (1999) has been one of the most thorough and expansive meta-analyses to date examining the outcomes of grief counseling; their results suggested that there are positive effects from this counseling. Grief is a difficult topic to study, however, and there remains a deficiency in the literature. According to Leighton (2008), there is no primary theory that will benefit all grieving individuals. As discussed, individuals perceive loss in a variety of ways depending on their culture, age, and background. It is important for practitioners to be aware of these factors prior to implementing therapeutic techniques, as an intervention may prove to be therapeutic for one but detrimental for another.

Not all individuals who are impacted by death are in need of psychotherapy and professional help, but all grieving individuals need support when coping with the loss of

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a loved one (Schuurman, 2000). Some individuals receive support from their family and community and do not need intervention from mental health providers. Nevertheless, it is important for individual to understand the concept of death and encourage any communication or questions about death and the process of grief (Willis, 2002).

Interventions for Children Depending on Developmental Stage

After the loss of a parent, caregivers should try to maintain a routine schedule and keep the infant in their own home (Johnson, 1999). The infant should have a consistent caregiver and should receive additional affection and human interaction. Caregivers for children in the preoperational stage (i.e., those between 2 and 7 years old) should be honest about death and communicate with children using age-appropriate language (Johnson, 1999). Caregivers should answer questions, explain what death is, and discuss the feelings that the child may be experiencing (Johnson, 1999). Children should be told that it is acceptable to cry and that they did not cause the death (Johnson, 1999). Hooyman and Kramer (2008) indicated that due to children's inability to express their feelings using language, they may best be able to express these emotions through nonverbal behaviors such as making art. As children in this stage partake in magical thinking, it is important to use concrete language when communicating about the death (Willis, 2002). Lastly, for children in the preoperational stage, the caregiver should prepare the child for the funeral and involve the child in the funeral planning.

In reference to children in the concrete operational stage (i.e., school-age children between the ages of 7 and 11 years), caregivers should answer any questions that child may have and let the child know that he did not cause the death (Johnson, 1999). In addition, children in this stage should be encouraged to talk about their fears and encouraged to use play as an emotional outlet. Moreover, children should be encouraged

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to assist with the deceased individual's memorial (Johnson, 1999).

Children in the formal-operational stage should also be encouraged to communicate their emotions. Caregivers should be honest and open and provide the child with a journal (Johnson, 1999). Children in this stage should be involved in the funeral planning or encouraged to be a part of the memorial (Johnson, 1999). There are many similar tasks regarding the developmental stage that caregivers may perform to help children cope with the loss of a loved one. No matter what developmental stage the child is in, the caregiver should provide the child with love, support, and encouragement throughout the bereavement process.

Client-Centered Interventions

Practitioners of client-centered therapy (CCT) view each patient as unique and diverse. According to Rogers's (2003) theory of personality, individuals are the center of their persistently changing world, and each individual experiences and perceives the world differently. The approach leads to the resolution of stress dues to the therapeutic alliance and the collaboratively created, unique, and healing human interaction (Joseph & Worsley, 2007). CCT incorporates some important models that Rogers posited must exist in order for effective transformation to occur. This approach focuses on the individual, rather than the intervention as the focus of efficient change (Rogers, 2003). These straightforward models include:

1. Unconditional positive regard: The therapist needs to perceive people as good and that without unconditional positive regard, the client will not feel safe to share private information, could feel undeserving, and may grasp onto undesirable aspects of the self (Rogers, 2003).

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2. Nonjudgmental attitude: Clients are viewed as being worthy and the therapist should not permit judgment (Rogers, 2003). People have the capability to see their faults and know what they need to alter, even if they may not acknowledge it at first.
3. Reflection. The emphasis of this concept is gaining insight self through reflection. Reflection enables one to understand one's thoughts and feelings (Rogers, 2003).

By following these ideas, therapy provides space for self-exploration, where the therapist is the guide instead of an instructor. Rogers indicated that when clients are troubled and are struggling with personal difficulties, the therapist must first create a relationship with the client and provide them with a safe place to share their difficulties. Secondly, Rogers suggested that in CCT, the therapist should try to understand the client's inner world and accept the client.

In the study of Goodman et al. (2004), the researchers reported that the use of CCT helps in restoring children's positive sense of self and helps to rebuild trust in themselves and others when coping with grief. Goodman et al. incorporated a treatment evaluation using questionnaires that were completed without informing the treating clinician, and a thorough posttreatment evaluation was conducted by an independent blind evaluator. This study focused on a single case study implementing CCT with a 15-year-old teenager who lost her father in the 9/11 terrorist attacks. The investigators implemented the Schedule for Affective Disorders and Schizophrenia for a thorough diagnostic interview, the Behavioral Assessment System for Children, the Child PTSD Symptom Scale, the Family Environment Scale, and the Global Assessment of Functioning Scale, which were completed by the clinician. The child's mother completed

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the Maternal Social Support Index, the Brief Symptom Inventory, and the Posttraumatic Symptom Scale Self-Report. Thorough pretreatment and posttreatment assessments were completed. The pretreatment assessment measures suggested that the girl endorsed feeling extremely distressed and exhibited several symptoms of PTSD, but did not meet the criteria for diagnosis. She reported frequent feelings of betrayal and powerlessness due to losing her father on 9/11. The mother also exhibited some symptoms of PTSD.

After implementing a brief midtreatment evaluation, the researchers found little decline in both the mother and daughter's PTSD symptomatology; however, they acknowledged that it was beneficial for them to have someone with whom they could share their feelings. By the end of the 4-month CCT treatment study, both the mother and daughter did not endorse nearly as many distressing and PTSD symptoms as at baseline. At the 1-month follow-up, both mother and daughter maintained more positive functioning and interpersonal interaction. The researchers concluded that CCT is an effective theoretical modality to implement with children who are experiencing grief, as well as traumatic grief, because it allows the child's story to unfold under the client's control (Goodman et al., 2004). These authors concluded that the child's overall grief symptomatology consisting of depression and trauma associated symptoms decreased throughout treatment.

More research should be undertaken to obtain additional information regarding CCT and grieving children. Larger sample sizes and case study designs should be implemented to continue to evaluate the treatment effects of CCT with grieving children. Moreover, the comparison among different theoretical modalities, developmental groups,

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and the treatment of childhood grief would provide clinicians with a more solid foundation for treating grieving children.

Cognitive, Behavioral, and Affective Interventions

Cognitive-behavioral therapy (CBT) is a treatment approach that may also be applied with grieving children. CBT integrates the cognitive restructuring approach in cognitive therapy with the behavioral modification technique of behavioral therapy (Heimberg et al., 2005). The goal of CBT is to correct faulty information processing in order to alter assumptions that perpetuate maladaptive emotions and behaviors (Heimberg et al., 2005). The CBT approach looks at how problematic beliefs and behaviors take part in the creation of psychological problems and the continuation of these problems over time (Heimberg et al., 2005). CBT also requires the essential formation of a therapeutic connection with the implementation of therapeutic homework techniques (Heimberg et al., 2005).

Dunning (2006) published an article identifying preventative interventions that may be used when an individual parent dies. This author presented cognitive, affective, and behavioral frameworks that make the grieving process less difficult and prevent the potential development of traumatic grief. Dunning suggested that the cognitive framework is the first framework to which clinicians and caregivers should tend and recommended the investigation of the individual's perception about the loss before giving accurate information to correct any false beliefs. According to Dunning, the affective framework is another important area that needs to be addressed with individual who are coping with the loss of a loved one. Children need more help with labeling and identifying their feelings, and the children should be approached in an indirect fashion; when approached directly, children may exhibit resistance (Dunning, 2006).

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Dunning (2006) suggested the use of art as an effective intervention with young children; one particular intervention introduced drawing six circles on paper and asking the child to fill in the circles with faces. The faces should be considered "feeling faces," which the child is asked to fill in, showing the kinds of feelings that one experiences when someone dies (Dunning, 2006). This activity can allow for the therapist to obtain a better grasp of the child's current emotional state. Lastly, the behavioral framework is another aspect that needs to be addressed with children who are coping with grief. Children may act out in a variety of ways due to the loss of a loved one, and Dunning indicated that caregivers should inform children that although they have strong feelings, it is important for them to not act out in harmful ways. Children should be provided with materials to express their behaviors such as a punching bag, heavy-duty markers, and Play-Doh (Dunning, 2006). Children should be encouraged to do activities such as picking out their "mad color" and using it to scribble on a piece of paper or draw a picture about what is making them angry. In summary, Dunning's article pertaining to appropriate cognitive, behavioral, and affective interventions provided readers with a variety of CBT methods that make it easier to express their emotions related to the death of a loved one and inform caregivers of the appropriate expectations for grieving children.

Interventions for Childhood Traumatic Grief

There is currently limited literature and research pertaining to childhood traumatic grief (CTG), as it is a relatively new construct introduced to the field of psychology. Layne et al. (2001) examined interventions for childhood traumatic grief among 55 15- to 19-year-old Bosnian youth who survived the civil war. These scholars recruited their sample from 17 secondary schools throughout Bosnia and Hercegovina. The sample

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reflected individuals with average to severe levels of grief or depression. These investigators implemented group psychotherapy that was trauma-focused and grief-focused, with no random assignment. The trauma focused and grief-focused intervention in this study was based on a treatment protocol developed by the researchers that spanned 20 sessions and was divided into four modules.

Module 1 consisted of six sessions targeted at decreasing distress, increasing group cohesion, psychoeducation, relaxation training, and grief-focused therapeutic work (Layne et al., 2001). The second module consisted of eight sessions dedicated to the therapeutic processing of traumatic experiences. The third module consisted of approximately three sessions that focused on adaptive grieving to loss, and the fourth module consisted of three sessions that focused on promoting developmental progression. Program evaluations were collected two times throughout the course of the school year. The pretreatment measure data were taken from a classroom survey measuring posttraumatic stress, depression, and grief. Regarding assessment measures, the Reaction Index – Revised was used to focus on posttraumatic stress experience within the past month. The Grief Screening Scale is a self-report inventory that these researchers used to assess grief symptoms. The Depression Self-Rating Scale is an 18-item self-report questionnaire used to assess for depressive symptoms, and the Child Self-Rating Scale is another self-report questionnaire used to examine social-emotional adjustment. The Self-Satisfaction Survey is a 10-item self-report questionnaire used to assess general satisfaction. An experienced Bosnian psychologist translated all measures. Layne et al. found that those who obtained both trauma-focused and grief-focused treatment made improvements in PTSD and childhood traumatic grief symptomatology. Posttraumatic

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stress scores showed a significant lessening in distress over time. These results suggested that the combination of trauma-focused and grief-focused treatment are effective in treating childhood traumatic grief. The results also indicated that decreases in posttraumatic stress were linked to classroom and school rule adherence, but adversely connected with school nervousness and withdrawal. The assignment of the treatment group was not randomized, however, and there was no control group. In addition, only pretreatment and posttreatment evaluations were implemented, and there were no further outcome studies. Furthermore, not all assessment measures implemented were culturally sensitive or normed for Bosnian youth.

Brown et al. (2004) suggested that CBT assists in treating children who are coping with childhood traumatic grief. Brown et al. completed a single case study that examined the effects of CBT on a child who lost his father in the 9/11 terrorist attacks. These authors employed CBT with the child and implemented a pretreatment, midtreatment, and posttreatment assessment with a 6-month follow-up. Brown et al. administered a variety of assessments ranging from the Behavioral Assessment Scale for Children, the Student Teacher Relationship Scale, a demographics form, the Brief Symptom Inventory, the PTSD Symptom Scale Self-Report, and the Family Environment Scale in order to assess the child's mental health symptomatology. Brown et al. then administered Grief Cognitive-Behavioral Therapy, a treatment modality developed by Judith Cohen and Anthony Mannarino. The treatment followed the Traumatic Grief CBT manual that provided a step-by-step movement of skills growth, cognitive and emotional handling of traumatic events, and participation in bereavement tasks (Brown et al., 2004). The treatment modality focused on any traumatic symptomatology initially in the first

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eight sessions, and the treatment involved psychoeducation about grief and the relationship between thoughts and behaviors, relaxation training, cognitive restructuring, and creating trauma narratives (Brown et al., 2004). The next part of treatment addressed grief symptoms and implemented memory making, social skill-building, and making meaning of the loss (Brown et al., 2004). Brown et al. found that the child became more symptomatic over time throughout treatment; initially, the child's grief symptoms were masked, but there was a reduction in the child's symptomatology following grief cognitive-behavioral therapy. The limitations of this study included its very small sample size, which did not allow generalizability of the treatment of cognitive-behavioral therapy to other children coping with CTG; however, this study is an ongoing empirical evaluation that will continue to work with other grieving children (Brown et al., 2004). In summary, the Brown et al. study opens the door for additional empirical studies examining treatment options for CTG, and the results suggested that CBT is a useful therapeutic modality for treating this target population.

Salloum and Overstreet (2008) explored the use of community-based grief and trauma intervention with children experiencing traumatic grief after Hurricane Katrina made landfall in August of 2005. Fifty-six children between the ages of 7 and 12 years with reported symptoms of traumatic grief in combination with PTSD symptomatology were assessed. These researchers employed the Loss and Survival Team (LAST) treatment program, a 10-week treatment community-based intervention established for elementary-age children experiencing grief and trauma due to the death of a loved one. The intervention incorporated specific methods and ecological perspectives. Techniques of cognitive-behavioral therapy and narrative therapy were also implemented to help

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trauma. Each LAST treatment session lasted 1 hour, and children were pulled out individually during the group to discuss any sensitive material one-on-one with a mental health counselor. In this experimental project, children were randomly allocated to two treatment groups: an individual treatment group and a group treatment group. Pretest, posttest, and 3-week outcome measures were administered. In treatment, clinicians registered responses to open-ended questions connected to coping, interest, and social systems. The clinicians who performed the assessments were not aware of the randomized treatment assignments. The researchers implemented assessments consisting of a traumatic event questionnaire with a yes-or-no format that determined the type of loss the child experienced during Hurricane Katrina; the UCLA Posttraumatic Stress Disorder Index, which gauged posttraumatic stress responses; the Mood and Feelings Questionnaire – Child Version, which measured symptoms of depression; the UCLA Grief Inventory – Revised, which was used to assess grief symptomatology; a one-item measure of distress, which was used to measure the child's insight of their overall level of distress; and a measure of treatment satisfaction that explored the child's view of the intervention.

Salloum and Overstreet (2008) found a noteworthy connection between posttraumatic stress scores and depression scores, traumatic grief scores, and overall distress scores. The sample of this study included 30 children who completed all assessment measures (15 individual therapy participants and 15 group therapy participants), and the results of a recurring-measures AVNOA revealed a significant reduction in the mean traumatic grief scores. Salloum and Overstreet did not find significant effects between individual and group treatment modality. The study had a

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reasonable sample size and valid and reliable assessments. In addition, the groups were randomized and assessment evaluators were blind. This study had limitations, however, in that there was no control group; thus, symptoms may have just declined over time. In addition, there was limited follow-up on the participants. Moreover, the treatment model's effectiveness was unclear.

Cohen and Mannarino (2004) extensively explored trauma-focused and grief-focused literature further with children experiencing childhood traumatic grief. These authors defined trauma-focused and grief-focused therapy as involving "affective expression skills, stress management skills, cognitive triangle, creating a child's trauma narrative, trauma processing and joint parent-child sessions (p. 824). Furthermore, as illustrated in Table 2, Cohen and Mannarino identified components of trauma-focused therapy and grief-focused therapy for grieving children.

Cohen and Mannarino (2004) expanded trauma-focused and grief-focused components necessary for treating CTG. Religious and cultural experiences are considered to impact childhood bereavement and it is significant for treating clinicians to explore and acquire each child's religious traditions and cultural beliefs because it may be used as tool in treating CTG. (Cohen & Mannarino, 2004). In addition, the therapist ought to explore what parents and children believe occurs after death (Cohen & Mannarino, 2004). Cohen and Mannarino encouraged children to talk about death in general because they may not have had a chance to ask question or explore the topic further. Moreover, Cohen and Mannarino indicated that children must also acknowledge what they have lost, and the therapist should support the child in experiencing the pain and facing the loss. Cohen and Mannarino recommended addressing ambivalent feelings

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the child may have towards the deceased, as well as reassuring the child that ambivalent feelings are normal. Furthermore, Cohen and Mannarino recommended maintaining positive recollections of the deceased and redefining the relationship with the deceased by accepting that the relationship has changed. Lastly, children should commit to current and new relationships and make sense of traumatic losses by integrating their personal experiences and acknowledging the strength required to get through the difficult event (Cohen & Mannarino, 2004). Upon completing treatment for children experiencing CTG, Cohen and Mannarino recommended joint parent-child grief sessions, which enable the whole family to share their feelings about loss, warmly remember the loved one, and acknowledge the love and support that each family member has for one another.

Overall, the current body of research examining grief-focused and trauma-focused approaches suggests that the combination of these two interventions is beneficial in treating CTG. There are limited findings revealing the efficacy of various treatment modalities for CTG. Future researchers should collect more data and explore treatment options for children experiencing traumatic grief.

Support Groups

Support groups appeared to be beneficial for grieving children. The Dougy Center for Grieving Children & Families, considered the first peer support group for children impacted by death, was founded in 1983 by Beverly Chappell (Schuurman, 2000). Chappell was a nurse who observed the positive impact of children helping children cope with death, and she also noticed that often siblings of dying children and children with critically ill parents were often not included in the process of death (Schuurman, 2000). After the development and success of the Dougy Center, grief support groups for children started to appear throughout the United States. In their study, Tonkins and Lambert

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(1996) reported that following the attendance of support groups, the children's grief symptomatology was significantly reduced and children who attended the groups experienced a greater relief in symptoms versus the children who were on the waiting list for the support group. Tonkins and Lambert employed discussions about the deceased and the unfairness of death. The groups completed art projects and play therapy that focused on the positive memories about the deceased. Overall, the grief group treatment researched by Tonkins and Lambert was found to be a positive intervention for grieving children and resulted in a significant decrease in a child's grief symptomatology.

Eppler (2008) promoted appropriately responding to children's feelings of loss and grief and encouraged support groups for grieving children. Support groups should focus on processing emotions of fear, anger, and sadness related to grief and highlight positive strengths such as social supports and a healthy self-concept (Eppler, 2008). Support groups help children to see that the emotions they are experiencing are normal, they are not alone, others are concerned about how they feel, and their feelings matter (Schuurman, 2000). Due to different developmental stages and cognitive frameworks grief support groups should be organized based on a child's age (Schuurman, 2000). In addition, most grief support groups are time-limited; however, children can attend a new group cycle if they so desire (Schuurman, 2000). Curriculum-driven groups tend to work better when they include activities like a memory box or memory drawing because they promote an outlet for discussion (Schuurman, 2000).

Grief Camps

Therapeutic summer grief camps seek to provide a positive experience through which children can process the recent loss of a loved one. The Camp Forget-Me-Not therapeutic summer weekend camp is one such program. Farber and Sabatino (2007)

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conducted a 2-year theory driven assessment of this therapeutic seasonal camp. In response to much feedback and data from the first summer camp, the scholars suggested clinical interventions that were implemented the following summer. According to Farber and Sabatino, the alterations in the clinical interventions for the second year of the summer camp resulted in empirical findings. This study centered on the camp model, children's participation in bereavement activities, and psychosocial response, with results revealing that Camp Forget-Me-Not delivers positive therapeutic experiences to grieving children (Farber & Sabatino, 2007). The limitations of this study involved the use of a nonexperimental group strategy, lack of pretest assessment measure for parental ratings of a child's grief symptomatology, absence of a randomized control group, and low instrument validity. Despite the limitations of the study, caregivers observed that Camp Forget-Me-Not showed some positive results in decreasing children's grief symptomatology. The many limitations of this study should be mitigated in future research. In many ways, the grief camp can be viewed as an intensive support group, and due to positive impacts of support groups on grieving children, it is likely that the grief camp produces similar positive results.

Play and Expressive Therapy

The use of play and expressive therapy is important when facilitating therapy sessions for grieving children because children lack the cognitive ability to express their emotions and experiences clearly (Webb, 2003). The goal of play therapy with bereaved children is to facilitate the child's processing and acceptance, as well as to clarify any cognitive confusion surrounding the death (Webb, 2000). In many cases, a child will attempt to maintain a "comfort zone" between their play content and real-life circumstances, and the therapist should respect this boundary (Webb, 2000). The play

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"disguise" permits the child to act out personal emotions like anger, sadness, fear, or jealousy (Webb, 2000). Webb indicated that play therapy is used with both children and adults and refers to nonverbal methods such as art, music, writing, and movement. Items such as games, puppets, books, and sand are all used for play therapy (Webb, 2003). Play therapy consists of an interaction of symbolic play between a child and a trained play therapist, who attempts to reduce the child's emotional distress (Webb, 2000). It is important that the professionals and specialists employing play therapy with grieving children are properly trained. The therapist should provide the child with a range of toys and not encourage or direct the child to any one particular toy (Willis, 2002). Specific toys that may be employed in play therapy include family-related nurturance toys, such as doll houses and dolls; aggression-related toys such as bop bags, dart guns, or small plastic soldiers; or expressive and construction toys such as coloring utensils, Play-Doh, blocks, and sand (O'Connor & Schaefer, 1997). Children use the toys in the playroom to express their emotions (O'Connor & Schaefer, 1997). Play therapy provides a safe environment for children that enhances the development of emotional and motor skills (Willis, 2002). Adults may often believe that children are too young to understand death, but according to Webb (2000), children reveal their understanding of death and loss through arts rather than verbal communication. Moreover, children should not be forced to share and discuss their artwork; activity should be considered to be fun for the child, and the simple act of playing is considered beneficial (Willis, 2002). On some occasions, the child will talk directly about the deceased person, and the therapist is encouraged to supportively listen; however, on other occasions, the child may begin to express their emotions, but become vulnerable and revert into the world of play (Webb, 2000).

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Music Therapy and Narrative Therapy

Music may also be an effective intervention for grieving children. Music therapists utilize the components of music to stimulate personal inspiration, promote awareness, and encourage communication and expression (McFerran & Hunt, 2008). Willis (2002) indicated that some children benefit from being able to spend time alone listening to personal song choices, creating a therapeutic response.

Narrative therapy is a collaborative approach that focuses on the stories of people's lives while separating the person from the problem. The use of narratives also may help children process grief and loss. According to Leighton (2008), narratives help children put their feelings into words, and the narrative therapist should try to facilitate the story-telling process. Eppler (2008) identified sadness as a dominant theme in many stories about grief and death; however, the themes and experiences expressed in the stories contained a range of emotions. Eppler (2008) encouraged narrative interventions because they foster resilience and positive growth. Corr (2004a) completed a study examining grief narratives in children's books. This author found that many children's books that focus on childhood loss and grief include themes of "meaningfulness, connectedness, and transcendence" (p. 337). Corr (2004b) also suggested that many of these narratives on childhood grief foster communication between the caregiver and the child and offer constructive ways to cope with grief. Carefully selected stories can open the lines of communication between the child and caregiver. Although there are many beneficial therapeutic narratives available for grieving children, some narratives may be confusing or upsetting. It is recommended that the caregiver or therapist review books prior to sharing them with the child, avoiding narratives that contradict the child's

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spiritual or personal beliefs (Heath et al., 2008). Moreover, the language and content of the book should be appropriate for the child's age.

Spirituality and Rituals

Spirituality is a coping mechanism that is beneficial to both adults and children. According to Leighton (2008), spirituality is the human pursuit for the meaning of life. Bereavement can provide individuals with an opportunity for spiritual growth and understanding (Leighton, 2008). Adams et al. (2008) reported that grieving children often reported having dreams about the deceased, citing that these dreams offered a sense of reassurance and a spiritual connection. Many children viewed dreams about the deceased as a message that the deceased person's soul lived on (Adams et al., 2008).

Kübler-Ross (1981) recommended that parents and caregivers do not exclude children from funeral and memorial services. If children are sent away during the memorial, they may believe that they have done something wrong (Kübler-Ross, 1981). Alternatively, children should be given the choice about whether they would like to be involved and participate in memorial services (Kübler-Ross, 1981).

Andrews and Marotta (2005) examined the connection between spirituality and children coping with loss. The study examined six children between the ages of 4 and 9 years old that had experienced a loss of a family member within the past 18 months. These scholars conducted initial semistructured interviews with children and their caregivers and then follow-up interviews 3 months later (Andrews & Marotta, 2005). Some of the questions that the interviewers asked the parents were "How has the child made meaning of the loss?" and "What objects bring your child comfort?" Sample questions asked to the children were "What things help you feel better?" and "Who makes you feel better?" (Andrews & Marotta, 2005). These researchers used NUD*IST

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software to analyze responses to interview questions and introduce common themes identified by children and their caregivers. The results were not considered to be empirical, but rather transcendental, due to the individualized responses and the spiritual components under examination.

Three instruments were used in this study; the first was a game called the imagination game, where the child was asked to imagine the deceased person, the funeral, and themselves; then, the child was asked to imagine a future time and God or a higher power (Andrews & Marotta, 2005). After completing the imagination technique, the child was asked to rate the intensity of their emotion and describe what they were feeling. Visual stimulus cards were the next assessment measure implemented. Each child was shown a series of cards that had pictures ranging from sunsets to rainbows, and the child was asked to share any thoughts or feelings while examining these cards. Lastly, the researcher maintained an investigator journal with notes and data in reference to each session and assessment. Andrews and Marotta found that primary attachment figures such as caregivers, friends, and pets served as a source of comfort for the grieving children; moreover, continuing family routines and maintaining a relationship with the deceased the challenges of the grieving process for the child. Additionally, Andrews and Marotta cited that linking objects were a beneficial way for the child to preserve their connection with the deceased. A linking object describes an object in which the grieving child places power to maintain the illusion of an external connection with the deceased individual. Toys, clothing, jewelry, items in nature, or pictures are examples of linking objects (Rando, 1993).

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Andrews and Marotta (2005) discovered that God or a higher power was a consistent theme throughout the children's responses. The children's emotions towards God ranged from happiness to sadness, but overall, spiritual connections evolved in relation to the death of a loved one. Lastly, Andrews and Marotta cited that through play and imagery, children identified that toys and playing often made them feel better. In summary, the study had limitations in terms of its small sample size and the researchers' subjective interpretation of children's responses to interview questions and assessment measures; however, the findings suggested that if children are encouraged to keep a connection with the deceased through spiritual constructs such as a linking objects, and if the child has an attachment figure that encourage communication and provides a safe and comforting environment for the child, the grieving process may be less difficult.

Another positive intervention or way of coping with the loss of a loved one is to implement rituals that remember the deceased person and provide those still living with a sense of comfort. Rituals preserve the memory of the deceased and serve as an outlet through which children can express their grief in a therapeutic and healing manner (Norris-Shortle et al., 1993). According to Doka (2000), a ritual is a "special activity that extends meaning to a set of actions" (p. 29). Examples of rituals include attending public gatherings, funerals, lighting a candle, eating a particular meal, or attending a spiritual service (Doka, 2000). Rituals may be spiritual in nature or based on something that the deceased person used to enjoy (Doka, 2000).

Nature can also be used with rituals. The use of nature may also be incorporated in helping children process and cope with grief. According to Willis (2002), the use of flowers, rain, and trees may have a therapeutic effect, as the task of planting a plant or

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starting a bird feeder allows a child to keep a living connection with the deceased individual. Rando (1993) suggested that rituals are very powerful because in the chaotic time of loss, a ritual provides a sense of structure and control. Rituals generate social support, spiritual soundness, and a sense of connection to the person who has passed away (Rando, 1993). Doka (2000) indicated that rituals date back to ancient times and have been used as a therapeutic tool for eons. Doka argued that it makes sense to continue to implement something that has proven to be therapeutic and meaningful for centuries. Rituals may be generalized to many other situations and events, not only death and loss.

The Need for Research on the Topic in Clinical Psychology

While research exists centering on the topics of grief and loss in relation to the death of a loved one, scholars have often ignored or discounted the full spectrum of effects experienced by the individual. To address this issue, I gathered data through individual interviews with participants in order to more richly and fully appreciate the unique grief and loss experiences of those who have lost a loved one. I delved into the individual's highly personal experiences by conducting semistructured face-to-face interviews with those who have faced the death of a loved one. A phenomenological approach, coupled with an interpretive theoretical lens that blending psychoanalytic, Jungian, archetypal, attachment, and stage theory modalities, offered a highly unique and beneficial perspective. By reviewing, deconstructing, and coalescing each participant's interview data, I revealed the common themes and dissimilarities in the interview data. The data from this study will help clinicians be able to approach bereaved clients with a greater depth of understanding regarding the holistic experience of grief and loss that includes thoughts, emotions, body, and spirit. As Moore (1994) succinctly stated, "The

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In general, the field of psychotherapy will benefit from this research study through (a) a more thorough understanding of the interrelated impact of grief and loss on the individual's emotional, psychological spiritual, and physical processes; (b) a strong appreciation for the uniqueness of each individual's experience of grief and loss; (c) insight into the commonalities between individuals' experiences of grief and loss; (d) the wide-reaching effects of the human experience of grief and loss; and (e) a fuller and deeper appreciation of the fashion in which the shared expression of the experience of grief and loss might, in its own way, act as a curative force.¶

ancient Greeks taught that the god who heals is the same god who brought the disease in the first place" (p. 167). I undertook the current research study with Moore's quote as a reminder of the importance of appreciating the lessons of the past, that which the collective unconscious might offer, and all that new research might illuminate. It is vitally important to unite and integrate ancient wisdom with current thoughts and experiences.

Summary

Despite the huge and wide-ranging research and writings on the topics of grief and loss, prior to this investigation, no studies had been undertaken regarding a qualitative, phenomenological approach to the individual's holistic experience of grief and loss as related to the death of a loved one. The purpose of this study was to understand individuals' experience of grief and loss related to the death of a loved one and its psychological-, spiritual-, and physical-level impacts. Psychological researchers have developed wide-ranging, highly significant theories to explain and understand the emotional, psychological, and spiritual foundations of human grief.

Grief has been thoroughly explored through various religious and spiritual paradigms. Majority of individuals experiencing grief show parallel forms of significant distress, anxiety, yearning, sadness, and focus on these symptoms reduce over time; however, individuals vary in the type, intensity, duration, and style of expressing their grief (Christ et al., 2003). Most people respond efficiently to bereavement-related distress (Allumbaugh & Hoyt, 1999; Bonanno, 2004). Several theories are discussed in the literature on psychological theories pertaining to grief, including psychoanalytic theory, Jungian and depth psychology theory, archetypal theory, attachment theory, and thanatology. In addition, the body of research reflects numerous psychological models

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pertaining to loss, including psychoanalytic, Jungian and depth psychology, archetypal, attachment, and object relations theories.

The death of a loved one can result in increased behavioral challenges, such as restlessness and dangerous life decisions (Bowser et al., 2003; Lifshitz, 1976; Thompson et al., 1998). The death of a significant person while one is at an early age can result in changes to one's cognitive and perceptual abilities (Lifshitz, 1976). Researchers have clearly indicated that such events also affect the individual on a physiological level. It is no surprise, then, that the loss of a loved one causes myriad complex neurobiological processes. The individual is often not conscious of the countless physiological changes that result from experiences such as loss; rather, it is the basic emotional manifestations (e.g., sorrow, anger, and sadness) that are often at the fore of the individual's conscious experience of loss and grief. In reviewing the underlying neurobiological changes that occur during such life altering events, several core aspects are deserving of particular attention. The impact of loss and grief on attachment, emotions, coping mechanisms, memory, integration, guilt, and trauma were discussed from a neurobiological perspective.

While a wealth of literature and research exists on the topics of grief and loss in relation to the death of a loved one, the findings thereof tend to discount the full spectrum of effects experienced by the individual. The results of the current study contributed to the field of psychotherapy through (a) a more thorough understanding of the interrelated impact of grief and loss on the individual's emotional, psychological spiritual, and physical processes; (b) a stronger appreciation for the uniqueness of each individual's experience of grief and loss; (c) further insight into the commonalities between

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individuals' experiences of grief and loss; (d) the wide-reaching effects of the human experience of grief and loss; and (e) a fuller and deeper appreciation of the fashion in which the shared expression of the experience of grief and loss might, in its own way, act as a curative force.

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Chapter 3

Methodology

Research Approach

I selected a qualitative phenomenological approach to guide this study. As a highly personal research approach, phenomenology enabled an investigation of the wide-reaching impact of grief and loss related to the death of a loved one through individual interviews. Qualitative studies, while not as empirically grounded as quantitative studies, have gained regard and acceptance for their unique benefits, including the significance of individual experiences and the resulting wealth of personally insightful data. According to Golafshani (2003), "If we see the idea of testing as a way of information elicitation, then the most important test of any qualitative study is its quality" (p. 601). A depth psychological approach was central to this research, and additional theoretical approaches (i.e., psychoanalytic, attachment, thanatology) were used to further interpret, amplify, and augment the selected investigative approach.

Research Methodology

Data Collection

I recruited nine individuals to participate in recorded face-to-face interviews. The interviews provided the participants an opportunity to explore the phenomenology of their lived experiences of grief and loss with a focus on spiritual, psychological, and bodily impacts. Below, I outline the processes of participant solicitation and selection.

Data Analysis

Following the personal interviews, I began the data analysis process to discover common themes and constructs. I first listened to each interview in order to gain a deep sense of the feeling, tempo, and content of each session. I then transcribed and analyzed

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the recordings to determine the underlying themes and coalesce meanings related to the emotional, psychological, spiritual, and physical impacts of death and loss. I also identified and noted noticeable dissimilarities in the data. The overarching purpose of this study was to richly brighten each individual's unique experience, while also revealing significant and fundamental commonalities. I further magnified the interviews by viewing the lived experience of the participants through a depth psychological perspective. The following additional theoretical lenses were utilized: psychoanalytic, attachment, and stage theory. This brought added insight and psychological understanding to the experience of grief and loss of a loved one.

Participants

Participant Solicitation and Selection

I recruited a total of nine male and female adult (i.e., over 18 years old) volunteers as the research participants. All participants had experienced the loss of a loved one. The inclusion criteria included that a minimum of 1 year had passed since the death of the loved one, giving the participants enough time to be able to initially process the grief, as well as the ability to reflect on the effects of the experience of the loss and the grief. I gathered prospective participants through referrals from practicing psychotherapists; however, no participants were the current or past client of a therapist. Respect was given to all participants who were in the grieving process; thus, I maintained a heightened sensitivity to this issue when presenting invitations to participate in the study. The participants' sensitivity was ascertained through asking questions as outlined (see Appendix E, "Grief Sensitivity Scale"). I distributed a letter of invitation describing the study to potential participants (see Appendix C, "Letter of Invitation"). The sample pool consisted of contacts and clinical associates who had recommended a person who might

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be both well-suited for the study and could potentially benefit from the research study processes. Such persons were invited to contact me if they were interested in participating and met the inclusion criteria.

During an initial phone contact, I screened potential interested participants for suitability via the Grief Sensitivity Scale. Qualified individuals received the informed consent form, which provided full details on the nature of the current project and the data collection process; a copy of this document is included in Appendix A. This form outlined the possible risks and benefits of the study, an assurance of the participants' confidentiality, and my contact information. Any questions that arose over the course of reviewing the informed consent were discussed beforehand. The participants signed the informed consent form and received a copy of the same for their records. Those interested in participating arranged a convenient date and a mutually agreed-upon location for the private, recorded interview.

General Selection Criteria

The general selection criteria (e.g., race, sex, marital status, ethnicity, education level, and socioeconomic status) were random, except for the following: (a) being aged 18 years or older and voluntarily participating in the study; (b) possessing the ability to speak, read, and comprehend English; (c) having experienced the loss of a loved one, with a minimum of 1 year having elapsed since the death; (d) being of appropriate mental health status and emotional stability to be assessed through the interview process and the related Grief Sensitivity Scale and Study Sensitivity Survey; and (e) indicating an interest and willingness in engaging in further personal exploration of the topics of grief and loss through preliminary discussions and voluntary participation in this study. In terms of exclusion criteria, those having received a *DSM* diagnosis such as an Axis II disorder,

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psychotic disorder, or compromised cognitive functioning were not included in this study.

Several additional factors were considered and monitored due to the sensitive nature of the research topic and the possibility of triggering reactions within the pool of interested participants. I ascertained these factors through personal discussion and completion of the Study Sensitivity Scale. These factors were as follows: (a) possible confusion or misunderstandings resulting from language issues in cases where the participant's English was rudimentary or English was the participant's the second language; (b) personal, spiritual, or religious factors that may have affected the individual's understanding of the topic and personal bias toward the topics; (c) level of understanding (i.e., sufficient emotional and intellectual ability); (d) concerns or barriers related to the ability to disclose and discuss personal data due to social, cultural, and personal issues such as race, ethnic background, or sexual preference; and (e) significant personal issues that might have caused participants distress or required additional support or psychotherapeutic services. Those who were still having a significant response to the grief and loss and experiencing anxiety, depression, or PTSD were screened for suitability and given the opportunity to decline participation.

I informed all potential participants that they could discontinue their participation in the study at any time and for any reason; I stressed that there would be no consequence involved for any such action. I informed all potential participants that they would be contacted following the actual interview in order to review transcriptions of the interviews, refine personal information and details, and offer appropriate support and follow-up communication. My contact information was supplied to all participants. No

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information regarding the participants was shared with therapists, referring persons, or any other entity. No participant was a current or prior client of any referring therapist.

Materials

To guide the semistructured interviews, I compiled a list of open-ended questions (see Appendix A). In order to ensure a natural and free-flowing interview, the participants were not shown this actual list. Not all of the questions were asked, and I had the opportunity to ask probing or follow-up questions as the interview progressed. Natural deviations from this list were welcomed and allowed. Although the focus remained on loss and the grieving processes, supplementary information was expected.

Procedures

Data Collection

Following the receipt of referrals for possible research interview candidates, I contacted the prospective participants via telephone. General details of the study and their prospective role as an interview subject were described. The discussion also included a brief review of the suitability criteria, as detailed in the Grief Sensitivity Scale and the Study Sensitivity Survey. With those individuals who were interested, willing, and suitable, I arranged a preliminary personal meeting in order to more thoroughly discuss the study. At this initial face-to-face meeting, I provided the prospective participants with a detailed letter and reviewed the parameters of the research study in greater depth. Details such as the audio-recording of the interviews, the nature of the interview questions, and the follow-up procedures were discussed. Due to the sensitive nature of the research topic, I conducted a more thorough, in-person evaluation of each prospective participant's actual suitability for the study by making use of the Grief Sensitivity Scale and the Study Sensitivity Survey. Once both myself and the prospective participant

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agreed that the individual was well-suited for the study, the informed consent form was reviewed and signed. In addition, I outlined the possible risks and benefits associated with participation in the study. Confidentiality issues were also discussed. I then provided an opportunity for the potential participant to raise any additional questions or concerns. I determined that due to the deeply sensitive nature of the research topic, the actual interview appointment should be conducted separately from the preliminary discussions and document review. Accordingly, prior to the conclusion of this meeting, a separate appointment for the actual interview was set.

On the day of each interview appointment, a brief reorienting discussion of the participant's role in the study occurred prior to the interview itself. All interviews took place in a secure, private, and comfortable setting. The participants were reminded that the interviews would be audio-recorded and that their private identifying information would remain confidential. General confidentiality concerns and general ethical issues were reviewed, and the participants were had another opportunity to raise any questions or concerns. The audio-recording of the interviews began after I facilitated a brief, relaxing introduction into the interview process. During the interviews, I used preset questions as a guideline for the interview (see Appendix A, "Interview Questions"). Although the unique nature of the semi-structured interview process allowed for deviations from this template, the participants were asked to provide details on general issues such as (a) their relationship to the deceased; (b) a description of the impact of the loss; (c) the physical details of the loss and surrounding situational factors; (d) the personal level of preparation following the loss; (e) the level of closure related to the loss; (f) the most difficult aspects of the loss; (g) any positive aspects of the loss; (h) the

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effects of the loss and grieving upon other relationships with loved ones, general relationship with the self, long-terms goals, and healthy living practices; (i) emotional, spiritual, physical, and cognitive changes that occurred as a result of the loss and grieving; (j) any particular spiritual or religious practices that aided with the loss and grieving; (k) any events or situations that prompt a resurgence in feelings related to the loss and grieving; (l) the manner in which deep feelings related to the loss or grieving were managed; and (m) any specific images or feelings that developed in connection with the loss and the grieving process. Any additional subjects that naturally developed as a result of the semistructured nature of the interview process were explored.

After completing each interview, I listened to the recording completely before beginning transcriptions. Following the initial review of each taped interview, I listened to each tape for verbatim transcription purposes. The tapes were reviewed at least two times to ensure proper transcription. To ensure confidentiality, I assigned each transcript a number (e.g., Participant 1, Participant 2, and Participant 3) in place of participants' actual names or initials.

Following the transcription of each taped interview, each participant received a complete transcription of the interview for review via email and mail in a confidential manner. Each participant had the opportunity to correct and comment upon the document. I remained available to the participant to answer questions, review and confirm document edits, and respond to any concerns before finalizing the document. This step concluded the data collection portion of the research process.

Data Analysis

Upon finalization of each interview transcription, I thoroughly analyzed each transcription to uncover coalesced meanings and themes. I personally reviewed the taped

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interviews and transcribed each interview. The specific detailed processes that I undertook for the phenomenological qualitative data analysis were as follows. NMUs were individually extracted from the text of each participant's interview transcript. Then, the NMUs that arose from each transcript were compared within that individual transcript and condensed into aspects. A second-order profile (i.e., a list of the aspects found in the original text) was developed from each participant's data, followed by an essential description (i.e., a summary of the experience and elaboration of the second-order profile) for each individual. An aggregate analysis was developed by comparing the second-order profiles for all participants to ascertain and illuminate commonly shared aspects. Then, the common aspects (i.e., distinct themes across all interviews) were uncovered as a result of the condensation of all collectively shared aspects, and an aggregate essential description were developed by summarizing all common aspects noted. Lastly, verbatim descriptions offering supportive themes from each individual transcript were compiled. Although phenomenological data analysis is intrinsically time-consuming and detail-oriented, the rich depth and intimate essence of the results are incomparable. This multistage research process provided the necessary data to afford a unified understanding of the collective nature of the experience being studied. As a result of this research, the experiences of grief and loss resulting from the death of a loved one can be more fully understood, particularly as they impact individuals psychologically, spiritually, and physically.

Limitations of the Research

Phenomenological research affords a unique opportunity to bring a greater depth of understanding to the topic being studied; yet, this approach carries its own challenges. The phenomenological approach afforded me a profound glimpse into the highly

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personal, subjective experiences of the participants. In doing so, a major limitation was the fact that the resulting foundational data were inherently subjective in nature. In analyzing this data, I strived to remain objective through bracketing my own preconceptions and judgments, yet I acknowledge that phenomenological data analysis cannot be entirely free of my own experiences and resulting personal conceptions.

Because the participants in this study were referred by practicing therapists, a high degree of similarity may exist among the research participants. Some of the participants may have previously engaged in some form of psychotherapy, which may have affected the results of the study. Further, persons involved in psychotherapy may appear to be more educated and aware of the psychological aspects of grief and loss. Such individuals, in general, may appear more psychologically-minded than the general population. In addition, certain segments of the population are underrepresented in psychotherapeutic populations because factors such as race, socioeconomic status, culture, and sex impact the likelihood of engaging in psychotherapy. Accordingly, a known limitation of this study was the fact that certain segments of the general population would be underrepresented.

Due to the time-intensive nature of the selected methodology, I was restricted to working with a relatively small number of research participants. While the data offered by the participants were incredibly rich and informative, the research population was limited to nine participants. Thus, the results of this study cannot be extrapolated to the general population due to its small sample size. While this research informs a greater understanding of the experience of grief and loss resulting from the death of a loved one

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in respect to the psychological, spiritual, and physical effects, the results cannot be generalized to the greater population or applied to those who have yet to lose a loved one.

In working with issues such as grief and loss, an important inherent limitation of a phenomenological qualitative study is the changes in memory experienced by the research participants. It is understood that individuals often recall a memory or event differently due to the passage of time. Cognitions and memories are often affected by intervening experiences, and the changeable nature of the human memory in general is a critical consideration. Further, due to the inclusion criterion that 1 year must have passed since the loss of the loved one, it was possible that some participants could have experienced a loss fairly recently, while others could have experienced the loss many years prior. The variation in the number of intervening years may have affected the study results, as it is generally accepted that loss and grief experiences diminish in intensity over time.

The interview process is associated with several limitations. Even allowing for natural variations and digressions in the nature and quality of questions and responses, the preset list of questions was relatively abbreviated. Further, as the actual interview process was restricted as to the timeframe, the content and flow of the interview could have been constrained, and a critique could be made that there were too many directed questions. As the rapport established between myself and participant was limited, the depth of the information provided may have been affected, as this topic may have been considered too personal and sacred to convey in detail. Given the highly sensitive and personal nature of the research topic, any such concerns are very understandable, yet the results of the study may have been impacted accordingly. Finally, I anticipated that the

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audio-recording of the personal data, even with the understanding of the confidential nature of the interviews, could have impact the participants' level of personal ease and ability to comfortably disclose sensitive material.

Ethical Considerations

I made a concerted effort to comply with all American Psychological Association standards regarding conducting research with human participants. In addition, I maintained full compliance with the criteria of this institute's Human Ethics Committee for Research. Each participant received an informed consent form and a letter outlining the nature of the study, copies of which are attached in the appendices. The informed consent also clarified and detailed the study's confidentiality issues. I identified participants using a number in all interviews and written transcriptions, and all identifying information that might cause the identity of the person to be recognized was removed or concealed. Confidentiality was protected to ensure that no harm came to the research participants. All research documents and files were kept in a secure location to ensure the protection of the participants' data and information. Other relevant considerations regarding general ethics in relation to potential participants and actual participants are noted in the aforementioned section.

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Chapter 4

Findings

The purpose of this study was to understand individuals' experience of grief and loss related to the death of a loved one and its psychological, spiritual, and physical impact. Using a qualitative phenomenological approach, one central research question was posed: Following the death of a loved one, how do the experiences of grief and loss impact individuals on emotional, psychological, spiritual, and physical levels? The following subquestion was also posed: From a holistic perspective, in what ways do the experiences of grief and loss affect the individual's perception of life and life experiences?

The focus of the study was on nine individuals who have experienced the death of loved one, who participated in face-to-face interviews. The recorded interviews were transcribed and analyzed to determine underlying themes and coalesced meanings related to the experience of the various emotional, psychological, spiritual, and physical impacts of death and loss. I analyzed these transcripts by viewing the lived experience of the participants with a focus on a depth psychological perspective. In Chapter 4, I present the results of the thematic analysis. It is important to note that the chief advantage of this study is that responses to interview questions touched on thematic characteristics of the research that were not specifically covered by any single research question or interview question, which allowed new information to emerge. This research characteristic was an advantage because it did not confine the interviewees to a narrow set of answers; instead, the participants were allowed to express their individual perceptions and beliefs more fully based on their experiences of the phenomenon.

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Organization and Interpretation of Data

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All interviews were audio-recorded. In accordance with standard ethical procedures, I informed all participants that the interviews would be recorded to ensure the consistency and reliability of data analysis. To promote the creditability of the data, I utilized the member checking during the transcription of individual interviews.

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Upon finalization of each interview transcription, I thoroughly analyzed each transcription to uncover coalesced meanings and themes. The specific detailed processes undertaken for the phenomenological qualitative data analysis were as follows. I extracted NMUs individually from the text of each participant's interview transcript. The NMUs that arose from each transcript were then compared within that individual transcript and then condensed into aspects. A second-order profile (i.e., a list of the aspects found in the original text) was developed for each participant, and an essential description (i.e., a summary of the experience and elaboration of the second order profile) was formulated for each individual. An aggregate analysis was developed by comparing the second-order profiles for all participants to ascertain and illuminate commonly shared aspects. Then, common aspects (i.e., distinct themes across all interviews) were uncovered as a result of the condensation of all collectively shared aspects. I developed an aggregate essential description by summarizing all common aspects noted. Lastly, I compiled verbatim descriptions offering supportive themes from each individual transcript. In the next section, I present essential individual and structural descriptions of NMUs culled from the interview transcripts.

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Essential Individual Description

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interviews. The summary presents the individual themes as perceived, felt, and experienced by the nine participants of the study.

Participant 1

Participant 1 is in her early 30s. She shared her personal and family experiences regarding the loss of her cousin. She described her grieving as a long, tormenting process. Unlike the loss of other persons important to her, this participant felt grief after the loss of her cousin because she was unable to show her cousin care towards the end of her life. Although she had visited and spend a short time with her cousin before her death, she expected that she would fully recover and had not thought her demise to be possible. Participant 1 shared that her cousin was close to her and that the only hindrance to a regular reunion was that her cousin's family lived far away from the rest of her family.

Participant 1 shared that she had a tendency to deny the death of a loved one. She said, "I don't want to remember anyone I love as a dead body lying in a casket ever. That is not what they were to me." For Participant 1, the essence of a person lies in their soul; thus, "Once the soul has left the body, there's no need to look at the body anymore."

In her grieving, Participant 1 experienced the feelings of isolation and felt the unnecessary indifference of people's action towards the death of her cousin. She recalled the burial ceremony of her cousin and considered it as an unloving act. She described the burial ceremony as empty and performed "by people we didn't even know… etched in my memory."

In her effort to recover from the loss, Participant 1 transferred her attachment and extended the loss times to the husband of her cousin. While grieving, she held her cousin's husband responsible for not taking effective care of her. She explained, "I just never felt that he gave her enough attention, and he's not a warm fuzzy person like my

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cousin was." Participant 1 believed that death is not relative to how an individual lived life. In the case of her cousin, she believed that the death of her cousin had less to do with health than with the inadequacy of care and attention.

After the death of her cousin, Participant 1 cited that she became more receptive to other individuals who are close to her. She explained that she needs to make the most out of the present, because "What if today were the last day?" Her experience has made her more fearful about death, particularly the feeling of losing someone. She felt that anger resides in her heart as a consequence of her experience. She recalled the feeling of anger towards others' existence in exchange of the life of her cousin. In her grieving, she resents the individuals who desire to end their grieving.

Although Participant 1 reported having accepted the loss of her cousin, she stated that she finds herself "vulnerable…if somebody mentions that somebody has died." She experienced reliving the emotions of loss when heard the grieving of others. As such, she experienced anxiety over several things, and this anxiety made her "look older." The effect of grieving made her recall instances that she refused to remember anything about anxious events. She admitted, "I feel that my short-term memory has been compromised." Furthermore, the loss of her cousin also affected her sense of invincibility. She implied that death is something that may come even before aging, and thus must be accepted. As time passes, Participant 1 said that clearing her mind through exercise can ease down her painful memories.

Participant 2

Participant 2 is in her early 70s. Her experiences with loss and grief are vast. She has experienced losing her parents and other individuals attached to her. The loss of the second husband was the most significant and difficult grieving process that she

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encountered in her life. She shared that her husband already had a "troubled heart," even before they were married. Although she and her husband were prepared for their eventual death, she considered herself unprepared for the early death of her husband. In fact, she recalled the words they always uttered: "If we had 10 good years, then it was worth it, and we would be happy." Participant 2 admitted, however, that although she "had quite a long time" recovering from the loss of her husband, she had decided to end the grieving process. Participant 2 is an independent woman who described her relationship with her husband as "two independent people actually being married." Thus, grieving is manageable for her, and she utilized more of her time in work. She said, "My salvation is that I have a job, and I still have a job which keeps me going, and I just could not be without something to do."

Participant 2 recalled that losing the companionship she had for years was the most difficult aspect of her husband's death. She described her husband as "a very personable guy," who was loved by everyone. She explained that death of her husband was sudden and was difficult to accept. Through this process, however, she learned to accept the loss. She said that the experience of her husband's death prepared her for her own.

In the case of Participant 2, her coping mechanism for the grieving process includes continuing her life and lifestyle that she had with her husband. She continues to travel and work for her employer, "who thinks that I'm worth keeping even though once in a while I take off for a couple of weeks." Her innate independence helped her in coping with this loss.

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When asked about the effect of death to her relationship with her living loved ones, Participant 2 denied the assumption. She stressed, "I think that the hardest thing was dealing with his children because . . they felt that I was the second wife." She recalled that grieving the death of her husband was affected due to his first family demanding the remains of her husband. The death of her husband changed her outlook in life. She said that she appreciated the life she had with her husband. She said, "I have really no desire to get married again or to have any kind of relationship other than men friends."

While she admitted that there were changes occurring as she lost her husband, she said that she had not withdrawn from the reality of his actual death. She said that she was not fearful of being alone because she keeps herself busy at work. In terms of the spiritual aspect, Participant 2 said that she had been spiritual within the Catholic religion, and her spiritual deeds did not end after the death of her husband. For example, she continued to help the needy. She also stressed that she is not certain where to associate her consciousness in health. She indicated, "As I get older, you know, I'm quite aware of my diet, and of my exercise, and—and I really try very hard to stay in good shape."

In the 11 years since her husband's death, Participant 2 has retained two drawers filled of his belongings that she felt she has the accountability of keeping. When asked about anything that brings her in touch with the loss, she said "Well, I'm getting over it. Now its 11 years, but I'm sure other people tell you this, but for maybe the first 5 years I kept a lot of his clothes." She stressed that keeping a regular communication with friends who both knew them helps her grieving process. She continued to recall many aspects of her husband, such as his interest in becoming a sailor.

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Participant 3

Participant 3 is in her late 20s. She was an adolescent when she experienced losing her mother due to lung cancer. Although she knew at the time that lung cancer patients seldom survive, she prayed to God and hoped that her mother could recover from her illness. As such, when her mother died, she stopped going to church, isolated herself from her family, and resented the spiritual power of God. She felt that her family could not understand her grief. She recalled that every time her family went to visit her mother's burial site, she just nodded and said "hi" to the grave.

Although she loved her father and her siblings, Participant 3 was more attached to her mother. She explained,

> I was always closer to her than to my Dad. Because when we were back home, she raised us when I was 4 until 12. That's when we moved here with my Dad. So I don't have the same relationship that I had with her compared to my Dad. I always had her to talk to when I had problems or when I was gonna do things. I couldn't do the same thing with my Dad.

The death of her mother meant the loss of her confidant and a friend. She said that the death of her mother affected her motivation to pursue the dreams that she aimed toward. She recalled,

> One of the promises I gave her was when I get in and start making money, I would take her out, go shopping, all that stuff—give her what she deserves. And now that she's gone, there's no point. I don't have the same motivation as I used to.

Participant 3 missed her mother so much that she thought that suicide was an option for her to reunite with her mother. Ultimately, she was deterred by thoughts of her father and siblings; therefore, suicide was no longer an option.

Participant 3 developed a sleep disorder following the loss of her mother. According to this participant, sleeping is difficult for her, especially when she hears her

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mother's favorite music. When this happens, she cited that she finds herself visiting the tomb of her mother. Participant 3 shared that she tries to live and relive the memories that she had with her mother. She said, "I see pictures, music that reminds me of her. . . every day I think about her, and I get very emotional." By experiencing the presence of her mother, Participant 3 tried to end the grieving by staying "strong."

Participant 4

Participant 4 is in his late 40s. He lost his father because of lung cancer. Although he said that he was aware of his father's illness, his father kept the illness a secret until he was dying. Participant 4 felt that the word "loss" was inappropriate to describe his case, instead proposing "transition." Participant 4 explained that the spirit of his father only transforms in another being and that his soul is not completely gone:

> I wouldn't actually use the word *loss* because even though my dad is no longer here, the transition wasn't a loss. It was a transition It didn't really affect my lifestyle change. The whole process was a really delightful transformation and experience before.

As such, the grieving process for Participant 4 in fact helped him in getting to know things about his brother. Participant 4 considered the changes as a deepening experience that aids him in knowing himself better.

Unlike the other participants in this study, Participant 4 believed that his loss is only a part of a transition. He believed that the spirits of his loved ones convey messages that help him in everything he does. Participant 4 had no resentful feelings, explaining,

> This thing that happened yesterday, almost losing him, I really got more connected with his spirit because I didn't think I was ever going to see him again, so my dad, I have this whole presence. I actually didn't see him that much in his later years. I talked to him on the phone, but I hadn't gotten up here in ages, so I didn't know how he'd aged. I just always had a connection with his spirit.

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Participant 5

Participant 5 is in her early 40s. She was 35 years old when she lost her father due to lung cancer when he was 60 years old. Participant 5 was slightly timid in sharing her experiences. She repeated several times that her family had issues with business, which made their grieving less important.

Although Participant 5 stated that she loved her father, grieving was not a difficult experience for her, and she did not consider the death of his father as a life-changing event. For her, "the death part of it doesn't mean an end to the relationship." Further, she noted that she was not "involved in his daily life at all." As such, when asked about the image she has of her father, Participant 5 described that she pictures him as healthy.

Participant 6

Participant 6 is in her mid-50s. She described the feeling of losing her mother and the resulting "realization that death is a part of the process" of being born, living life, and experiencing death. With the loss of her mother, Participant 6 said that experience gave her the "opportunity to have a perspective on my mortality." Her perspective about death is that it can be "orchestrated" or prepared. Participant 6 said that she maximized knowledge as a caregiver when preparing herself for the eventual death of her mother. Reflecting on losing a loved one, Participant 6 said that while she accepted that life has to end, "certain things needed to be addressed."

When asked about her experiences when her mother died of cancer, Participant 6 indicated that the "excruciating pain" that her mother experienced was the most difficult part. The living moment of her mother, however, gave her the "intimate experience" that her mother deserved to have. Even after the death, Participant 6 believed that her closeness with her mother remains as and "nonjudgmental support" of a mother in

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dealing with her own challenges and endeavors. She said that she feels the presence of her mother when a "beautiful bird flies over my head during a time of struggle," describing it as "a symbolic reminder from my mother that I am strong enough to overcome it."

Participant 6 recalled that losing a loved one changed her view about life. She learned to be "more forgiving" of herself and became calm in dealing with her life goals. She learned to include helping people as her "career goal" and not take "toxic" people seriously. With these new perspectives, she felt spiritually blessed and felt that she lived a "physically slower lifestyle." She also learned to appreciate the deeds of people around her by saying, "You're a good daughter/son."

While she felt that she had moved on, Participant 6 said that she still recalls the pain of losing a loved one when seeing a daughter taking care of her mother, walking slower, helping with choices, waiting, and caring. When confronted with this situation, she usually engages herself by talking to friends and "giving myself time to experience the memory."

Participant 7

Participant 7 is in his mid 30s. He lost his father when he was 26 years old. He recalled that the death of his father had changed his life because of the responsibility that he assumed in its wake. Participant 7 said that he was unprepared for the sudden death of his father. The cerebral aneurysm that caused the death of his father made him feel uncertain of reaching closure. He recalled, "His death was so sudden that it left a lot of things unsaid. So, I feel I will—for now—still work towards a closure." With the loss of his father, Participant 7 feels the anger and the anxiety the responsibilities of which he had to take charge. He said, "I felt tired and lacked energy and cognitively was in

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disbelief that he was gone." He questioned the existence of God while wondering where his father had gone. It was his faith in God that helped him recover from these "tough times." Participant 7 indicated that pictures and special events such as graduation and holidays remind him of his father. He said that when reminded by his loss, "I tend to exercise or just allow my thoughts to go where they want and deal with it as it goes."

When asked about the difficult aspect regarding the death, he indicated that he missed sharing his accomplishments and life changes with his father. Through this loss, he learned to value the presence of loved ones; thus, he recommended spending "more time with your siblings and your child." He explained, "I want to be around to help my family." Participant 7 also indicated that with the loss, he learned to value his health and to value his life goals: "I don't want life to pass by without doing what I want to do."

Participant 8

Participant 8 is in her late 60s. She described her mother as the source of strength in their family; therefore, losing her mother destroyed their "family structure." Although her mother's cancer diagnosis gave them an opportunity to prepare for her death, Participant 8 considered the loss as accidental. She explained, "I don't think anyone can have an ample time for such loss…especially since I always thought that I didn't have enough time with her." Participant 8 blamed herself for this regret: "Had I insisted for her to stay with me, I could probably have prevented the outcome which she certainly did not deserve." Participant 8 revealed that seeing her mother relieved of pain helped her to accept the death. She emphasized, however, that she cannot forget or "close the chapter." Participant 8 believed that her mother had unfinished business regarding uniting their family members: "She was the driving force, and she never completed the task that she started. Perhaps that is why the closure has taken so long, because she was not given the

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opportunity to complete her task."

The death of her mother provided this participant with appreciation for different aspects of life, such as family. She advised,

> Never take anything for granted and how important certain members of your family are to your foundation of life and its structure. How fragile life is, and we always take everything for granted and how fast a smile can turn to tears and sadness and how powerless we feel when reality takes over beyond our control. Basically, as unfortunate as it sounds, we cannot change destiny, no matter how good and/or how bad we are.

As a result of her experience, she realized the importance of living the life to the fullest. With the consideration that death cannot be stopped, this participant recommended,

> Enjoy the moment, live for now and don't think about what is up. Live life to the fullest and put everything out there, and remember, today is the tomorrow that we were anxiously awaiting for yesterday! Therefore, live for now and let the chips fall where they supposed to, and if you are not here tomorrow, make sure that you have done it all, and hopefully done enough good things that your legacy keeps your family proud.

She also revealed that the life of her mother did not end in her death; "Out of sight should not mean out of mind. [We will] keep her memory and legacy a live as long as we all live."

As such, Participant 8 is kept reminded of her mother on occasions such as holidays, "seeing other older ladies with their grandchildren," or "when someone close dies—especially if is a younger child or when someone is sick, it doesn't matter what kind of disease." In these situations, Participant 8 looks up at the ceiling because "I believe that she is watching us, so she can hear me. That is good enough for me."

Participant 9

Like Participant 8, Participant 9 is in her early 50s; she, too, lost a mother who was the source of strength for the unity of their family. Participant 9 described her mother as an independent woman who suffered cancer when the participant was 14 years old. At

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this young age, Participant 9 said she never thought that she would lose her mother; she was full of hope that her mother would soon recover. As such, when asked about whether she had achieved closure regarding the demise, she responded,

> [I] never had closure before the death and didn't have closure immediately after the death. I guess a few years after it became easier and easier to deal with. But to this day, certain times and moments when I look at her picture, I just think of her or a specific date brings all those pains back.

Participant 9 recalled that it was difficult to lose her mother as a teenager; however, she felt grateful that her father was still with her, as her experiences taught her that the presence of a loved one is valuable. With her experiences, her relationship with her father changed after seeing the sacrifices her father made after this loss. She indicated that these experience shaped her outlook in life: "I am here more for others that are alive than try to change my life because of losing a loved one that was so dear and close to me as my mother." The lesson that this participant learned was that time is valuable and that it should be spent wisely with loved ones:

> I want you to look at your life and loved ones and remember you don't know how much time that you have with them so tell them what you want them to know because you don't know what tomorrow brings. Tell them how you loved them and what you want them to know from your heart.

Participant 9 said that she eventually recovered from the loss. Her sense of sadness stemmed from her realization that she was unable to express her care and love. She revealed that she continues to talk to her mother; for example, she asked her mother "to keep an eye out for the family everyday, as she was the glue that held it together."

Essential Structural Descriptions

In this section, I present the aggregate analysis of the culled NMUs of the experiences of nine participants involved in the study. Essential structural descriptions are presented in a manner consistent with the research questions. Four thematic

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categories and one subthematic category emerged to answer the question: Following the death of a loved one, how do the experiences of grief and loss impact individuals on emotional, psychological, spiritual, and physical levels?

The first thematic category identified was the feeling of resentment encountered during the process of grieving. Five major categories were developed, constituting the first theme. Eight of the participants involved felt the feeling of anger as a result of the attachment that was lost along with their loved ones. Participant 2 cited that after the death of her cousin, she also lost her connection with her cousin's husband. Participant 3 lost the person who became her companion for 7 years. Although Participant 3 is an emotionally independent woman, she recognized that she had lost the person who accompanied her in every escapade. Participants 7, 8, and 9 felt resentment because their deceased parent was their family's source of strength; thus, losing them changed the family structure.

Eight of the participants also identified a feeling of anger because they were unprepared for the death of their loved ones. Although eight participants indicated that they were informed of the possibility of the death of their loved ones, they were emotionally unprepared to accept this fact. Although participants indicated that these deaths were significant for them, their levels of emotional responses varied. Participants 4, 5, and 6 had positive dispositions after the death of their parent, while Participant 3 considered committing suicide to feel the presence of her mother.

Four of the participants felt the bitterness as a result of unfulfilled hopes and aspirations. In addition, four participants cited that they were hopeful for the full health recovery of their loved ones prior to their demise. Resentment was also felt as a result of

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their unmet desire to see and feel the presence of their loved ones. Participant 1 dreamt of her cousin wearing red lipstick. Her imagination eased the hatred she felt after the death. Participant 3 described playing the music of Beatles to feel the presence of her mother. Participants 6, 7, 8, and 9 cited that they continue to speak aloud to their loved one with the belief that their words will be heard.

Finally, being unable to show care before the death of a loved one was identified as a factor that resulted in blaming oneself and/or others for the death of a loved one. Participant 1 blamed her cousin's husband for the inadequate care provided to her sister.

Table 1

Thematic Category 1: Resentment as Major Feeling Encountered During the Grieving Process

Thematic Categories/Constituents	# of Participants to Offer This Experience	% of Total Responses Given by Participants
Loss of attachment	8	25.81
Unprepared death	8	25.81
Missed/failed hopes of recovery/aspirations	5	16.13
Desire to see and feel the person/missing the loved one	8	25.1
Unable to care before death	2	6.45
Total	31	100.0

Through the analysis, I identified three negative effects associated with the individual who felt the resentment as a result of the death of their loved ones: (a) tendency to withdraw in painful situations, (b) felt symptoms of emotional disturbance, and (c) loss of faith in God waning of spiritual connection. Although these effects were in varying levels according to their unique experiences and attachment with the deceased individual, these negative effects were prevailing during the grieving process. Participant

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5 indicated that he was unaffected by the painful death of his father because he believed in the possibility of connecting with his father's spirit.

Table 2

Subthematic Category 1: Associated Negative Effects of Resentment

Thematic Categories/Constituents	# of Participants to Offer This Experience	% of Total Responses Given by Participants
Tendency to withdraw in painful situations	5	26.32
Felt the symptoms of emotional disturbance (sleep disorder, fatigue, anxiety)	7	36.84
Loss of faith in God/waning of spiritual connection	7	36.84
Total	19	100.00

When asked about the whether they had achieved closure over the death of their loved ones, four of the participants stated that they are still engaged in the grieving process and felt no closure about their loved one's death. Although the lives of their loved ones end many years ago, four of the participants continue to ruminate on their memories of their beloved person. For example, Participant 2 still possessed the personal belongings of her husband despite his passing 11 years prior. Closure concerning death is difficult to achieve, particularly when (a) the time spent with the loved one is considered short, (b) there is hope for recovery, (c) there is a loss of a companion/confidant, and (d) there are unresolved issues.

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Table 3

Thematic Category 2: Grieving Process is Not an Assurance of Acceptance and Closure of Death

Thematic Categories/Constituents	# of Participants to Offer This Experience	% of Total Responses Given by Participants
When time spent with loved one is considered short (e.g., living separately, absence)	7	30.43
When there is hope for recovery	4	17.39
Loss of companion, confidant	6	26.09
When there are unresolved issues (livelihood, ambitions, etc.)	6	26.09
Total	23	100.0

I identified four thematic categories reflecting the theme of learning about the value of life and the presence of loved ones. Participant 1 shared the loss of her sense of invincibility following the death of her cousin and the realization that death comes by surprise; "I just never thought I'd be burying a cousin before my parents." Thus, she realized that she needs to attend to the needs of the people important to her, because "What if today were the last day?" This mindset has been instrumental in dealing with other people. Participant 6 also shared the same sentiment, describing death as a process that every "mortal" must experience. Accordingly, one must experience being close to loved one before life ends.

Eight participants noted that instead of mourning the painful death of their beloved, they took strength by living their life with friends and family. Although Participant 3 considered committing suicide, she diverted this intention by spending her time with her father and siblings. Participant 1 focused on attending to the needs of her other family members. Participant 5 felt closer to his deceased father by learning about

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his interest in house electrical wiring. Other participants opted to spend time with their living family members. Seven of the participants implied that life has a short timeline. All participants who indicated cancer as the cause of death of their beloved revealed that the last hours of their loved ones were spent creating happy memories.

Finally, six of the participants indicated that grief and loss experiences deepened their viewpoint regarding life. As discussed earlier, their experiences taught them that no one is invincible and that life is short.

Table 4

Thematic Category 3: Learned the Value of Life and the Presence of Loved Ones as a Result of the Experiences in Grief and Loss

Thematic Categories/Constituents	# of Participants to Offer This Experience	% of Total Responses Given by Participants
Receptive in dealing with relationships	8	27.59
Taking the loss of loved ones positively	8	27.59
Making the most out of the present	7	24.14
Deepened outlook in life	6	20.69
Total	29	100.0

When asked about images of the deceased encountered in their dreams and imagination, nine of the participants indicated recalling the happy memories they had with their beloved. Their dreams and imaginations with their loved ones centered on (a) the loved one's interests, (b) happy conversations with someone close to the loved one, (c) an image of the living person, and (d) the routine works of the loved one when they were still alive.

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Table 5

Thematic Category 4: Death is Remembered as a Celebration of the Happy Memories With Loved Ones

Thematic Categories/Constituents	# of Participants to Offer This Experience	% of Total Responses Given by Participants
Remembering the loved one's interests (music, lipstick, aspirations)	7	33.33
Remembering conversations with loved one	5	23.81
Remembering the loved one as a living person	7	33.33
Remembering the routine works of a loved one	2	9.52
Total	21	100.0

Summary

In Chapter 4, I presented the findings of the study relative to the research question: Following the death of a loved one, how do the experiences of grief and loss impact individuals on emotional, psychological, spiritual, and physical levels? The findings of the study included four thematic categories: (a) resentment is a major feeling encountered during the grieving process, (b) grieving process is not an assurance of acceptance and closure of death, (c) learned the value of life and the presence of loved ones as a result of the experiences in grief and loss, and (d) death is remembered as a celebration of the happy memories with loved ones. These themes reflect the nine participants' experiences of grief and loss, which influence their emotional, psychological, spiritual, and physical states. These themes mirror the experience of the process and impact of grief and loss. Experiences are unique to the individual; however, commonalities exist. Grief and loss are inescapable aspects of life, and the experience thereof promotes resilience through learning, growth, and adaptation. In the subsequent

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chapter, I discuss the implications of the current findings. I also present recommendations for future researchers interested in this topic.

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Chapter 5

Summary, Conclusions, and Recommendation

The purpose of this qualitative phenomenological study was to better understand individuals' experience of grief and loss related to the death of a loved one and its psychological, spiritual, and physical impact. The main research question asked: Following the death of a loved one, how do the experiences of grief and loss impact individuals on emotional, psychological, spiritual, and physical levels? A subquestion was also posed: From a holistic perspective, in what ways do the experiences of grief and loss affect the individual's perception of life and life experiences?

The sample of the study included nine participants who had experienced the death of a loved one. The face-to face interviews were recorded, transcribed, and analyzed to determine the underlying themes that coalesced meaning related to the experience of the various emotional, psychological, spiritual, and physical impacts of death and loss. During the data analysis, I viewed the lived experience of the participants with a focus on a depth psychological perspective.

All interviews were audio-recorded. In accordance with established ethical procedures, all participants were informed that the interviews would be audio-recorded to ensure the consistency and reliability of data analysis. To improve the creditability of the data, I performed member checking after transcription by sending the transcripts to participants for their review and approval. Upon finalization, I thoroughly analyzed each transcription to uncover coalesced meanings and themes. Using the phenomenological process of data analysis, I formed essential descriptions of NMUs at the individual and structural levels.

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The findings of the study revealed four thematic categories, which answered the research questions. The themes were as follows: (a) resentment is a major feeling encountered during the grieving process, (b) grieving process is not an assurance of acceptance and closure of death, (c) learned the value of life and the presence of loved ones as a result of the experiences in grief and loss, and (d) death is remembered as a celebration of the happy memories with loved ones. These themes reflect the participants' experiences of grief and loss, as well as the impact on their emotional, psychological, spiritual, and physical states.

In Chapter 5, I discuss and interpret the results of the study in greater detail. I consolidate the findings of the present study relative to the available and known literature about grief and loss related to the death of a loved one and its impact on psychological, spiritual, and physical levels. This includes the implications of the research findings by theme, followed by recommendations for future research, which conclude the chapter and the study.

Implications

Grief is multidimensional, with physical, behavioral, and meaning/spiritual components. This normal response to death and/or loss is characterized by a set of cognitive, emotional, and social changes. Individuals differ in the type of grief that they experience, particularly in terms of intensity, duration, and expression (Christ et al., 2003). Scholars and authors have previously explored grief has through various religious and spiritual lenses. The majority of individuals experiencing grief show significant distress, anxiety, yearning, sadness, and focus; however, for most, these symptoms decrease over time.

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The findings of the study revealed four thematic categories, which answered the research question and subquestion. The themes were as follows: (a) resentment is a major feeling encountered during the grieving process, (b) grieving process is not an assurance of acceptance and closure of death, (c) learned the value of life and the presence of loved ones as a result of the experiences in grief and loss, and (d) death is remembered as a celebration of the happy memories with loved ones. These themes reflect the participants' experiences with grief and loss, including the impact on their emotional, psychological, spiritual, and physical states.

Several theories are predominant in the literature on psychological theories pertaining to grief, including psychoanalytic theory, Jungian and depth psychology theory, archetypal theory, attachment theory, and thanatology: stage theory. In addition, previous scholars have discussed psychological theories pertaining to loss, including psychoanalytic theory, Jungian and depth psychology theory, archetypal theory, attachment theory, and object relations theory. These theories can be used to explain the findings of the present study.

Resentment is a Major Feeling Encountered During the Grieving Process

Grief is considered a normal part of the adjustment to the reality of a significant loss. An individual's reaction to bereavement may include a vast array of manifestations, including emotional, cognitive, behavioral, and physiological reactions. Although it is often confused with grief, mourning refers to the social manifestations of grief that are influenced by the specific culture in which the mourner lives. Some of the current participants considered grieving as a long and tormenting process. Those who had a close attachment to their departed beloved had the tendency to deny the reality of their death. Some experienced feelings of isolation or perceived the indifference of others.

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Cassidy and Shaver (1999) presented similar ideas in their attachment theory. This theory reflects the importance of childhood attachment patterns, as they affect both short-term and long-range behavioral orientations. The death of a loved one may trigger immense feelings of grief, regardless of attachment history. Even the most secure and well-adjusted persons may experience severe stress and trauma as a result of intense grief. Attachment theorists have asserted that an appropriate bond between a caregiver and a child allows the child to form a secure relationship with the caregiver.

The death of a loved one may result in negative feelings of resentment or anger as a result of the lost attachment. Previous scholars have indicated that a variety of psychological struggles are associated with the death of a loved one, including fear, guilt, anxiety, helplessness, and anger; grieving individuals have higher scores on instruments evaluating depression and other psychological distress indicators (Holland et al., 2006; Jiang et al., 2006; Thompson et al., 1998). These individual challenges are frequently indicative of adjustments in self-concept. When a death results in a loss of companionship and a change of family structure, many individuals experienced anger because they were unprepared for their new reality. Although individuals may have been informed of the possibility of the death of their loved one, they remained emotionally unprepared.

According to Edelman (2006), attachment theorists have categorized individuals who experienced a death of a loved one into three groups. The first group includes those individuals who form secure attachments with other adults. The second group is people who are fearful or hesitant about their social and romantic relationships. The third group consists of individuals who avoid attaching themselves to other people (Edelman, 2006,

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pp. 180–181). While attachment patterns are thought to be formed in early infancy, severe disruptions at any stage in life (e.g., abuse, prolonged illness, or death of a loved one) can deeply influence a person's sense of attachment. This is supported by Edelman, who noted, "Even when an infant is raised by a loving mother and develops a secure bond with her…specific life events can disrupt his sense of security" (p. 181). Throughout all stages of life, the theory of attachment explicates the unique manner in which individuals approach and process the experience of grief.

Although the death of a loved one is always significant, the level of emotional response varies by individual. Some of the current participants maintained positive dispositions after the death of their loved one. For those who were not as attached to the person, grieving was not a difficult experience. Some people did not consider the death of their loved one as a life-changing event. Moreover, individuals often felt bitterness as a result of unfulfilled hopes and aspirations. They were hopeful for the full recovery of their loved ones. Resentment was also felt due to their unmet desire to see and feel the presence of their loved ones. Such resentment was also likely when the individual was incapable of showing care to their loved one before their death, resulting in blaming of others and themselves. Some participants blamed themselves and/or another person for delivering inadequate care or attention, leading to the loved one's death. Participants explained that death is not relative to how the deceased individual lived their life.

After experiencing the death of a loved one, some people become more receptive to relationships with others around them. Participants reported becoming more fearful about death, feeling hatred, and cursing other people's deaths. During the grieving

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Resentment was also felt as a result of …ue to their unmet desire to see and feel the presence of their loved ones. A person may also…uch resentment was also likely resentment …hen thean…individual wasis…incapable to show…f showing care to their loved one before their death of a loved one… which may result…esulting in blaming of others and themselves. f for the death of a loved one. This also happen when the person blames another …ome participants blamed themselves and/or another person for delivering the …nadequate care or attention, being provided that…eading to resulted to in …he loved one's death. of a loved one. …articipants explained thatSome people believed that…death is not relative to how thean…deceased individual lived his or her ... [106]

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process, resentment may be felt for others who desire to end their grieving. As such, the impact of loss has far-reaching implications for the individual.

In the work of Millán and Millán (2004), the authors cited that the effects of loss are particularly noticeable when the loss occurs at an early stage in life, when the attachment bond is not secure, or when the loss is perceived as devastating, regardless of the age of the individual. As theorists such as Bowlby (1980) have underscored, the profound effects of the loss of a loved one may cause individuals to suffer from various psychiatric symptoms, interpersonal challenges, and intrapsychic difficulties. In such cases, the individual's intrapersonal and interpersonal relationships are affected through disruptions in attachment patterns.

As individuals progress through the grieving process, their attachment patterns play an important role in the ability to integrate the necessary elements of the process. In *Object Relations and the Developing Ego in Therapy*, Horner (1979) cited Bowlby's assertion that "whether a child or adult is in a state of insecurity, anxiety or distress is determined in large part by the *accessibility and responsiveness* of his principal attachment figure" (p. 48). The effect of a caregiver's repeated failure to connect or physical absence, whether through death or other separation, has a profound impact on the child's formative pattern development. The child perceives such situations as emotional or physical abandonments, and the effects often persist through the individual's lifetime. Horner contended, "A gross deficiency in object relations leads to an arrest in the development of all sectors of the personality" (p. 51). Accordingly, an individual's ability to effectively manage loss and grief as an adult would be related to their foundational early childhood experiences.

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Grieving Process is Not an Assurance of Acceptance and Closure of Death

According to Edelman (2006) and Freud (1966), true mourning involves a gradual and entire extrasensory disconnection from the loved object, with the purpose of later reattachment to another person. Edelman stated that the individual's ability to fully detach from the loved object, as well as the benefit of such detachment, confound the bereavement process. Over time, most people achieve closure over the death of their loved ones; however, some remain engaged in the grieving process. Although the lives of their loved ones ended many years ago, they continue to hold on to the memories and personal belongings of their loved ones.

In the preeminent work of Kübler-Ross (1969), this theorist described the five stages of grief as they related to individuals facing terminal illness. These stages were later found to be pertinent in critical personal life events, including the death of a loved one, ending of a marriage, loss or change of a job, persistent illness, or other occurrences perceived as being catastrophic in nature. The stages of the Kübler-Ross model include denial, anger, bargaining, depression, and acceptance. Not all individuals pass through all five stages of grief; moreover, there is often fluctuation between the stages. This theory is critical to a more fundamental understanding of loss, and it has had a substantial impact on the manner in which clinicians—and many individuals in the general public—understand and approach the process of grieving. Kübler-Ross beautifully acknowledged the paradoxical aspect of grief as follows: "Both birth and death involve great changes and adjustment, even inconveniences and pain, but also joy, reunion, and a new beginning" (p. ix).

Even after accepting the loss of their beloved, some of the participants in the current study recalled reliving the emotions associated with their loss when faced with

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the grieving of others. This caused anxiety or repression of events. Such individuals had the tendency to withdraw from painful situations, exhibit symptoms of emotional disturbance, and experience a loss of faith in God or waning of spiritual connection. Although these effects varied based on the individual's unique experiences and attachment with their deceased loved one, the negative effects prevailed throughout the grieving process.

The death of a loved one may also cause a lost sense of invincibility. The unpredictability of death at any age was a difficult concept for many to accept. Such participants described themselves as unprepared for the early death of their own friends or family. Some perceived their loss as something manageable; after time, they could decide to end the grieving process. Others employed coping mechanisms such as continuing the lifestyle that they had shared with their loved ones.

Individuals Learned the Value of Life and the Presence of Loved Ones as a Result of the Experiences in Grief and Loss

Although it is difficult, many participants gradually learned to accept their loss. After this experience, their outlook in life often changed, becoming more forgiving of themselves and more driven to achieve their life goals. In their new perspective, they felt spiritually blessed and more appreciative of the deeds of others. Moreover, they gained a greater knowledge of the value of life and the presence of loved ones. In their effort to recover from the loss, individuals transferred their attachment and sought additional time with living family members. Romanyshyn (1999) highlighted that life-changing encounters with grief forever alter the individual's psyche; that is, the emotional, spiritual, bodily, and psychic lenses through which the individual views the world are far different from those in place prior to the grief experience.

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The current participants explained that their losses turned into strengths by inspiring them to reconnect with friends and family. They diverted their attention from grieving alone to spending time with their living family members. This aligned with the work of Moore (1994) from an archetypal perspective, in which the process of grief was described as an important part in the individual's journey. It is through the experience of grief that one is more fully able to explore and understand deeper facets of the self.

Although significant changes occur with the loss of a loved one, some participants described facing the reality of life and shifting their attention to work. One person, who had previously been an outcast in their religion, began to perform spiritual deeds following the death of their beloved. Others sought to help the needy. These participants considered the changes that they experienced as aiding them in knowing themselves more deeply.

According to Jung (1989), loss and grief are necessary components of life that could be used to further comprehend the self and explore undiscovered aspects thereof. A sense of loss can be used by individuals to further understand the psyche. Jung theorized the self as the internal regulator of the psyche, which strives to use life experiences in order to achieve balance and a sense of wholeness.

Death is Remembered as a Celebration of the Happy Memories With Loved Ones

Some participants cited that they continued to encounter their beloved in their dreams and imagination. Jung's (1989) theory on grief addressed this in a description of one of his own dreams on death, in which he had been tossed back and forth between two disparate fields of emotions. One part of him felt warm and delightful, while the other side of him was fearful and grieving.

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Some people continue to recall happy memories of their beloved. These memories may include their loved one's image, interests, conversations, or routine activities. These descriptions offer a portal into a view of grief as the ego's response to death, in which the ego mourns and grieves what it perceives to be a terrible and devastating event.

According to Jung (1989), the psyche would view the same death as a joyous event, not an occurrence to be grieved. Archetypal theorists have explained loss from the perspective of the images and archetypes contained within the loss experience. Under this paradigm, the grieving individual may find healing by allowing their psyche to reveal the unconscious meanings and previously hidden internal dynamics and yearnings. The life of the individual's spirit (i.e., the soul) is paramount in the field of archetypal psychology, and the loss experience is viewed as an opportunity to further explore the depths of the soul.

Some participants explained that they continue to talk to their loved ones, with the belief that their words will be heard. In the perspective of Kohut (1987), the ability to successfully hold a memory and embrace an internal image of the person who is not available serves as an indicator of individual's ability to let go of the deceased loved one in a healthy fashion. A sense of secure attachment to a loved one is often considered a prerequisite to effectively managing various life challenges, for such an individual is often able to function more successfully an autonomously in times of stress and difficulty. In the case of the loss of a loved one, the ability to internalize a sense of the loved one, as well as to gradually process the loss while maintaining a sense of the self as being whole, may allow the grieving person to move through the loss more fully integrative fashion.

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Recommendations

Despite the vast and wide-ranging body of research and writings on grief and loss, I determined that no studies had yet been conducted using a qualitative, phenomenological approach to explore individuals' holistic experience of grief and loss related to the death of a loved one. The purpose of the current study was to understand the individual's experience of grief and loss related to the death of a loved one and its psychological, spiritual, and physical impact. Theorists in the field of psychology have developed wide-ranging, highly significant models to explain the emotional, psychological, and spiritual foundations of human grief.

The results of the current study significantly answered the research questions posed; however, further qualitative research is both warranted and necessary in order to understand and thoroughly appreciate thoroughly the impact of death upon the living. The field of psychology would benefit from new insights that foster a healthy relationship with death, as well as a means to effectively cope effectively with the processes involved in loss and grief. Additional research should be conducted with the aim of thoroughly understanding death, grief, and loss following the death of a loved one, as well as the unhealthy and destructive experiences associated with the same. The results of this study cannot be extrapolated to the general population due to the small sample size and limited cultural awareness, as the participants did not reflect different multicultural perspectives on death and the grieving process. Therefore, I recommend future investigations to thoroughly explore the experience of grief and loss resulting from the death of a loved one in respect to the psychological, spiritual, and physical effects.

According to Freeman and Ward (1998), an awareness of the background theory, knowledge, considerations, and strategies associated with the grieving process prepares

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professionals to anticipate, understand, and respond to grieving individuals in an informed and appropriate manner. A comprehensive understanding of the impact of grief and loss for educational facilities is also important. School communities are advised to raise members' awareness of the grieving process before a personal loss or crisis occurs. It is my suggestion that tailored education on this subject be provided to the wide range of professionals delivering care to the bereaved.

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Appendix A

Research Participant Informed Consent

I, [Student Name], am in the dissertation phase of my PhD in Clinical Psychology program at [Institute Name]. This form offers important information related to your voluntary participation in my dissertation research project. If you have any questions or concerns about this process or your involvement, please ask me for clarification prior to signing this form. You may contact Dr. [Professor Name] at (XXX) XXX-XXXX.

The Purpose of this Research: I intend to study certain aspects of your experience of death (the loss of a loved one or family member) and how this experience has affected your life. The research study and the study results may be used in the dissertation itself, as well as in future publications, and oral presentations.

The Research Procedures: The interview of approximately 1 to 2 hours in length (which will be tape recorded) will provide the data used in this study. During the interview, I will ask a series of open-ended questions related to the experience of the loss of a loved one or family member. As the researcher, I will transcribe the interview transcript. From this transcript, I will formulate specific themes relating to the experience. I may find it valuable to contact you during this process to ask questions or obtain clarifications. Upon completion, you will receive a copy of the initial typed transcript and thematic analysis to add comments and/or to clarify any information.

The Potential Benefits and Risks for Participants: Participants may benefit from this study by having the opportunity to gain further understanding and awareness of experiences related to the death of a loved one or family member. In reading the results of interviews and my research process, you may gain additional understanding of your personal experiences related to this topic. Certain risks are involved in research participation; while this study is designed to be nonthreatening and nonintrusive, unexpected and/or undesirable emotions and feelings may arise as a result of exploring your experience. Concerted efforts will be made to decrease risks and undesirable effects, yet the process of remembering, reviewing, and discussing certain personal experiences may be disturbing. If you experience negative reactions at any time before, during, or after the interview, you may immediately discontinue the process without any penalty whatsoever contact me at # and I will offer referrals to therapists if necessary. No compensation (financial or otherwise) is offered for participation in this study.

Protection of Research Participants: All participants in this study may opt-out of their voluntary participation at any time. As well, all participants may, without penalty, decline to answer research questions. The participant's confidentiality will be protected by removing identifying information. A pseudonym will be given to all participants.

Participant Consent and Signature: The researcher, [Student Name], has explained to

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the participant all details outlined above. The participant has been given ample opportunity to ask questions; any questions and concerns have been satisfactorily addressed.

Researcher: Printed Name:_____
Signature:_____
Date:_____

By signing below, I acknowledge that I am a voluntary participant in this study, and that I am an informed, consenting participant. I also acknowledge that I have read this consent form in full. Any questions and concerns that have arisen have been addressed by the researcher noted above. I willingly desire and agree to participate in this study under the terms and conditions outlined above. As well, I hereby agree to the researcher's use of my personal interview and related data in accord with the terms and conditions noted and described above.

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Appendix B

Letter of Participation

I, [Student Name], am a graduate student at [Institute Name] in City, State. In pursuing my Ph.D. in Clinical Psychology, I have chosen to study certain human responses to death from a phenomenological approach. The dissertation requirement for my Ph.D. in Clinical Psychology offers me the opportunity to explore the individual's experience of death (specifically the death of a family member or loved one) in a deeply personal interview process. The interview process, which allows for a face-to-face exploration of your unique perceptions of death and your personal experiences related to death, will take approximately 60 minutes. All identifying information will be kept confidential. The research questions have been designed by me in order to allow you the opportunity to reflect upon, and then discuss, how the experience of a loved one's death has affected you. Such an experience influences and affects us on many levels; the impact often persists over years or even a lifetime. In exploring your experience related to death, I hope that the overall interview process proves helpful to you in further understanding your relationship to the subject matter. If you are referred by a therapist, rest assured that your information will remain confidential.

The interview process may bring forth certain emotions and thoughts; this is normal, and may occur during or after the interview process. Should you find any such thoughts upsetting or disturbing, please do not hesitate to contact me; I will discuss your concerns with you and, if necessary, provide you with a referral for therapy. Please refer to the attached "Informed Consent" for further details and specifics regarding my dissertation and your possible participation. The "Informed Consent" also provides important contact information in the event you have questions or concerns. Please feel free to contact me at # or via email at XXX@XXX.com.

Thank you so very much for your willingness to participate!

Sincerely,

[Student Name]

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Appendix C

Letter of Invitation

A doctoral graduate student at [Institute Name] in [City, State], I am pursuing my Ph.D. in Clinical Psychology. I would like to invite you to participate in my current research study. If you, or someone you know, may be interested in working with me to explore personal experiences related to the loss of a loved one and the resulting grieving process, please contact me. The grieving process can affect each person in a variety of ways and for different periods of time. I will be working with participants on a confidential basis to understand human responses to death from a phenomenological approach. Through the interview process, I will be exploring each individual's experience of death (specifically the death of a family member or loved one). The purpose of this study is to increase the understanding of such experiences, raise the general level of sensitivity to the grieving process, and contribute to the field of psychology.

The interview process will involve a 1- to 2-hour confidential, face-to-face exploration of each participant's unique perceptions of death and personal experiences related to death. In offering individuals the opportunity to further explore and understand their experiences related to death, greater understanding may result.

If this research study sounds interesting to you, please contact me at (XXX) XXX-XXXX or via email at XXX@XXX.com. Comprehensive details will be provided, and an informed consent will be agreed to prior to any actual participation in the study. Thank you so much for your interest!

Sincerely,

[Student Name]

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Appendix D

Dissertation Interview Questions

1. In exploring the death of a loved one or family member, how has the death of one particular person impacted you? What was their relationship to you?

2. Please provide the following details regarding your loss.

   a. Your age at the time of the loss.
   b. The age of your loved one.
   c. Cause of the loss (natural causes, accidental death, etc.)

3. Do you feel that you had ample time to prepare for the loss?

4. Did you feel as though you had closure before the death? If not, did you have closure after the death? How long did it take to obtain closure, and how did it occur?

5. In reflecting upon the loss, what remains the most difficult aspect? 5a. In reflecting upon the loss, what are the positive (if any) aspects of the experience of the loss?

6. In what ways has the loss affected your view of life? (In other words, after the loss occurred, in what ways did the meaning of life, or your own lifestyle, change?)

   a. Relationship to other loved ones
   b. Relationship to your own self
   c. Relationship to long-term goals
   d. Healthy living practices (exercise, eating, medical care)

7. Please offer just a few sentences or words (the first thoughts that come to mind without thinking or self-editing) related to the following changes you noted related to the loss:

   a. Emotional changes
   b. Spiritual changes
   c. Physical changes
   d. Cognitive (thought) changes

8. Do you have a spiritual practice or religious belief that has helped you with the loss?

9. Do you notice that anything in particular brings you more in touch with your loss or causes feelings of loss to be unexpectedly triggered?

10. When feelings related to the loss affect you deeply, how do you manage those

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emotions (activity, therapy, talking with friends, compartmentalizing, etc.)?

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11. Do you have a specific image or feeling related to the loss in general? (For example, sensing that the person is with you, dreams of the person, an image of Heaven, etc.)

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12. As we near the end of the interview, are there any other thoughts or feelings related to your loss that you wish to discuss or share with me?

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Appendix E

Grief Sensitivity Scale

Understanding that potential research participants may still be in a grieving process, it is important for the researcher to assess the potential participant's level of sensitivity. This assessment will aid the researcher in assessing a prospective participant's level of sensitivity as it relates to the loss experienced and the grieving process; in general, a greater number of "yes" responses will indicate a heightened sensitivity. If no responses are in the affirmative, the individual will be considered appropriately stable and suitable for the study. If up to two responses are in the affirmative, the individual will be deemed to have moderate heightened sensitivity as a result of the loss and associated grief. In such cases, issues of concern will be discussed with the potential participants. As well, supportive services, including grief counseling, will be recommended and appropriate referrals made. If three or more responses are in the affirmative, the potential participant will not be considered for the study due to a heightened possibility for negative effects that cannot be appropriately monitored and addressed in the research process. Such individuals will be referred for outside grief counseling and support services. The level of grief sensitivity will be ascertained through asking the following questions:

1. As a result of your loss and the grieving process, do you feel that you need more support from family and friends at this stage?
   Yes No
2. Have you had more than one significant loss in the last year?
   Yes No
3. Since the loss, does the intensity of your grief continue to become progressively worse?
   Yes No
4. In the time since your loss, have you noticed that you are dissatisfied with your level of energy to work, socialize, do household tasks, participate in hobbies, etc.?
   Yes No
5. Have you experienced any increased financial, health, work, or relationship problems as a result of your loss?
   Yes No

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Appendix F

Study Sensitivity Survey

In working with human research participants, each prospective participant's general sensitivities regarding the study parameters must be ascertained. It is critical to monitor and avoid potential impediments or difficulties that may negatively impact participants. This survey addresses the following factors: (a) potential difficulties that may result from language issues (e.g., where English skills are rudimentary); (b) personal, spiritual, or religious factors that may affect the individual's understanding of the topic and personal biases toward the topic; (c) level of understanding (emotional and intellectual abilities); (d) concerns or barriers related to the ability to disclose and discuss personal data due to social, cultural, and personal issues such as race, ethnic background, or sexual preference; and (e) personal issues that may create participant distress and may require additional support or psychotherapeutic services. Those responding in a fashion evidencing issue that may affect suitability for the study will, as necessary, be given referrals for outside support and will be excluded from this study. Prospective participant's suitability for the study will be ascertained by verbal discussion of the following questions:

1. Do you have difficulty understanding written or spoken English? If so, on a scale of 1 to 10, with a "1" being "no difficulty" and a "10" indicating "severe difficulty," how do you rate your ability to communicate in English? (Note: A score above "2" will indicate that the individual is not a suitable candidate. It is essential that participants possess strong English communication skills.)
2. As this study addresses the topics of grief and loss in depth, are there any personal, spiritual, or religious sensitivity that may affect your ability or desire to discuss these topics with me? If so, on a scale of 1 to 10, with a "1" being "no issues of concern" and a "10" indicating "substantial issues or feelings of concern," how do you rate your ability and desire to discuss these topics with me on an in-depth basis? (Note: Scores above "2" will indicate that the individual is not suitable for the study; participants must possess the desire and ability to comfortably discuss the topics.)
3. Do you have a high school diploma or equivalent? Do you have any learning disabilities or psychological concerns that may affect your desire or ability to understand my research study and your potential participation? If so, please describe them to me. (Note: If any items indicate a possible detriment to the prospective participant or the study, the candidate will not be considered a suitable participant.)
4. As the discussion of personal topics such as grief and loss can be difficult, do you have any concerns or barriers related to the ability to disclose and discuss personal data due to issues such as culture, race, ethnic background, social concerns, or sexual preference? (Note: If any items indicate a possible detriment to the individual, the candidate will not be considered a suitable participant.)
5. Are you concerned about any personal issues that may be worsened by discussing grief or loss? If yes, do you have the ability and desire to obtain

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psychotherapeutic services or support? (If “no,” the candidate is not suitable.) If yes, on a scale of 1 to 10, with a “1” being “slight concerns” and a “10” being “substantial concerns,” how do you rate the personal issues that may be worsened by discussion? (Note: Scores above “2” will indicate that a prospective participant is not a suitable candidate; to avoid harm, participants must possess sufficient psychological stability.)

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