

THESIS

THE IMPACT OF CLIENT DEATH ON CLINICAL GEROPSYCHOLOGISTS: A
QUALITATIVE ANALYSIS

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ABSTRACT

THE IMPACT OF CLIENT DEATH ON CLINICAL GEROPSYCHOLOGISTS: A QUALITATIVE ANALYSIS

Although clinical psychologists who work with older adults are expected to work competently in areas of death and dying, there has been little research that explores how client death impacts these professionals. Using Interpretative Phenomenological Analysis, interviews with 10 professional geropsychologists were transcribed and analyzed for common themes across participants. Identified themes included: development of a different mindset in geropsychology; circumstances of memorable client deaths; personal/professional boundaries; impact of client death on clinical work; and developing specific coping strategies. Results from the present study suggested that despite grief reactions, participants believed that experiencing client death led to both personal and professional growth that helped them to become better clinicians. They also identified immediate reactions to client death that ranged from a sense of joy and peace to feelings of loss and regret. Participants identified specific coping strategies they used to cope with this phenomenon.

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The Impact of Client Death on Clinical Geropsychologists

In 2010, the American Psychological Association (APA) officially recognized clinical geropsychology as specialty of professional psychology, defining clinical geropsychologists as clinical psychologists who have knowledge, skill, training, and experience related to the aging process and to the unique needs of the older adult population. One area of expertise outlined in geropsychology competencies is psychologists' involvement in end-of-life (EOL) care (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009; Karel, Knight, Duffy, Hinrichsen, & Zeiss, 2010). Although professional geropsychologists are expected to provide competent care for clients dealing with issues of death and dying, current research and clinical guidelines provide little insight into how this experience might affect geropsychologists. Given findings that clinicians' fear of death may interfere with their ability to empathize with clients who are dying (Kirchberg, Neimeyer, & James, 1998), this topic is relevant not only to geropsychologists' wellbeing, but also to their ability to provide competent care to clients.

Despite the relevance of this topic, a limited number of studies have directly addressed how psychologists are impacted by nonsuicidal client death (Kouriatis & Brown, 2011). Existing research has relied on case studies and clinical case reflections based largely on the experiences of generalist practitioners who experienced client death as a rare and unexpected event. Results of these studies identified some common issues therapists experience when a client dies: countertransference effects in which experiences from their personal histories complicated their reactions, struggle with the ambiguity of the therapeutic relationship, and feelings of guilt, denial, and avoidance (O'Brien, 2011; Veilleux, 2011; Rubel, 2004; Schwartz, 2004; Lardaro, 1988).

Theories of Health Professionals' Grief

Two major theories have been used to illuminate health professionals' experience of patient death. Doka (2002) identified the concept of "disenfranchised grief," grief reactions that are not socially recognized, acknowledged, or sanctioned by one's social groups. Preliminary findings on therapist reactions to client death have supported the disenfranchised grief model, with therapists and psychologists discussing a sense that their professional role precludes them from openly mourning for their clients (Kouriatis & Brown, 2011; O'Brien, 2011; Schwartz, 2004). One example of this dilemma would be the need for a therapist to balance respect for confidentiality with a desire to attend a funeral (O'Brien, 2011; Rubel, 2004). In this example, the clinician's grief is more likely to be experienced as disenfranchised due to a lack of social expectation that clinicians would have a grief reaction or that they would require space or support in mourning their clients.

Papdatou (2009) proposed a model of health professionals' grief emphasizing the importance of professionals' perception of the death, meaning assigned to death and caretaking, the potential for grief complications and the opportunity for personal growth. Further, this model posited that professionals' reactions to loss result from many interacting variables. Although existing findings seem consistent with this model, there have not yet been empirical studies that explored the relevance of this model to therapists' grief.

Client/Patient Death in Geriatric Populations

Specific to geriatric work, studies conducted in long-term care (LTC) and hospice institutions have identified ways that health professionals (e.g. physicians, occupational therapists, social workers) have been impacted by older adult patient death. These reactions included feelings of grief and sadness (Rickerson et al., 2005; Keidel, 2002; Allen & Miller,

1988) and a sense that certain deaths are particularly memorable, even in settings where patient death occurs regularly and becomes normalized (Munn et al., 2008; Moores, Castle, Shaw, Stockton, & Bennett, 2007; Kasket, 2006). Some (Strom-Gottfried & Mowbray, 2006; Keidel, 2002) have argued that repeated experiences of patient death may lead providers to experience more pervasive problems such as burnout or vicarious traumatization (Figley, 2002).

On the other hand, health professionals have also reported increased end-of-life knowledge and professional efficacy (Anderson, Williams, Bost, & Barnard, 2008; Bluck, Dirk, Mackay, & Hux, 2008), as well as a heightened appreciation for life and an increase in empathy for others (Cipriani et al., 2000; Allen & Miller, 1988) as consequences of patient death. Further, researchers identified finding meaning in the experience as an important part of the professionals' coping process (Hulbert & Morrison, 2006; Clark et al., 2007).

Purpose of the Present Study

Existing studies have demonstrated that therapists and other health professionals are impacted in various ways by their experiences with patient death. Based on the nature of professional psychologists' professional helping role as well as the higher likelihood of experiencing client death in geriatric populations, clinical geropsychologists seem uniquely positioned to experience client death more often and to have complex reactions that merit further investigation. The present study was designed to expand upon existing research by focusing specifically on the experiences of clinical geropsychologists who experienced at least one client death. Because intentional deaths (e.g. suicides or homicides) have numerous legal and ethical complications that were beyond the scope of this study, this study focused on deaths by disease process or unintended accident.

Prior publications have focused either broadly on various healthcare professionals in a given setting or very narrowly on a single practitioner's experience with a specific client or clients. Thus, the present study targeted geropsychologists who experience client deaths in order to fill a gap in the literature as well as to enhance the ability of practitioners to provide competent care to the aged populations. The research question investigated was: "How are geropsychologists impacted by nonsuicidal client death?" Through this investigation, the study explored the impact of client death on geropsychologists, both personally and professionally.

Method

Qualitative Methodology and Rationale

In the present study, an Interpretative Phenomenological Analysis (IPA) approach to qualitative research provided a framework for the researcher to investigate how geropsychologists perceived and made sense of the experience of client death (Smith & Osborn, 2003). The IPA approach acknowledges that researchers must interpret the data through their own worldviews and that reported experiences and can never be fully understood from the point of view of the participants (Willig, 2001).

Researcher-as-instrument Statement

The researcher is a 24-year old woman with African American and European American ethnic heritage who identifies as heterosexual and agnostic. The researcher is a student in a doctoral program in counseling psychology, and has seen adult clients in a university counseling center and in a department clinic that provides sliding scale services to community members. She has never experienced client death, but was motivated by an interest in existential issues as well as in clinical work within health settings.

Participants

Consistent with IPA, purposive sampling was used to find participants who met the requirements and made up a relatively homogenous sample (Smith & Osborn, 2003). Participants were recruited through professional organizations and listserv notices in geropsychology professional networks (see Appendix A), and were from various regions in the United States. In order to participate, individuals were required to be licensed psychologists who reported a majority (over 50%) of clients aged 65 and older. Participants were selected for information richness and a small sample size made it possible to capture subtle yet meaningful data in the analysis (Brocki & Wearden, 2006).

The sample for this study consisted of nine women and one man. Participants were 32 to 58 years old at the time of the interview. All 10 participants identified as European American/White and worked in the United States (see Table 1 for additional demographic information). Participants had worked with older adults in a variety of settings, with the majority having worked in long-term care facilities and hospital/medical settings. Additionally, participants reported that they had worked in primary care practice, group practice, independent practice, community mental health, and hospice.

Table 1
Selected Participant Demographics

Participant	Gender	Age	Region of U.S.	Religious Affiliation	# Client Deaths	# Years Licensed	# Years Geropsychologist
1	F	51	Midwest	Catholic	50+	16-20	16-20
2	F	42	West	Agnostic	15	1-5	1-5
3	F	46	Northeast	Jewish	800	16-20	11-15
4	F	38	Midwest	Christian	50	6-10	6-10
5	F	58	Midwest	Christian	25	30-35	20-25
6	F	54	West	Christian	5	6-10	1-5
7	F	49	Midwest	Agnostic	30	16-20	11-15
8	F	32	Midwest	Agnostic	50	1-5	1-5
9	F	35	South	Catholic	10-20	1-5	1-5
10	M	45	West	Christian	6	1-5	1-5

Note. M = male; F = female.

Procedure and Data Collection

Once qualified participants received a cover letter detailing the requirements of participation and agreed to participate in the study (see Appendix B), they were sent the demographic form that assessed age, gender, race/ethnicity, religious orientation, years of experience as a licensed psychologist, and years of experience as a geropsychologist. Each demographic form was assigned a numerical code to link the demographic information to the interview (see Appendix C).

Consistent with IPA methodology, data were collected using semi-structured interviews that took place by phone and lasted approximately 50 minutes. Participants were asked to define and describe their experiences with client death. Open-ended questions included: “Tell me about your experiences with client death;” “Tell me about a particular client death that affected you the most”; “To what extent, if at all, do you feel that your experiences with client death have affected your work as a geropsychologist.” Probes were used to gain more depth or additional information about participants’ responses. Although some probes were outlined in advance, the interview questions flowed from the participants’ responses.

Data Analysis

Smith, Jarman, and Osborn (1999) described the process of data analysis in IPA as a step-wise and recursive process of interpreting and coding the data. Interviews were audiotaped and were transcribed verbatim following the interviews. During and immediately after the interviews, notes and memos were written in order to document the researcher's thoughts and insights. Once interviews were transcribed, the researcher completed by hand a step-wise and recursive process of data analysis as described by Smith et al. (1999).

In the first step of data analysis, each transcription was checked in order to verify accuracy as well as for immersion in the data. At this stage, the researcher began making notes in the researcher's journal regarding preliminary interpretations, themes, and associations that arose when examining and analyzing the data. Second, the researcher began to identify theme titles that represented the "essential" nature of the transcribed interview data. Third, connections between emerging themes were identified, clustering themes together and identifying the hierarchical nature of themes. After the transcriptions were coded and theme lists from each case were compiled, the researcher created and ordered a master list of themes and recursively compared the master list with the original data.

Saturation

In qualitative research, data saturation occurs when each additional participant or interview generates no additional insight or themes, and the data becomes redundant (Bowen, 2008). Because the data analysis process occurred simultaneously with data collection, this measure was used to determine the sample size of the study. Saturation was identified by comparing new information to preliminary theme titles from data analysis. In the present study, it appeared that saturation was achieved after the eighth participant, at which point two additional

participants were added and their interview data confirmed that no additional themes were elicited.

Establishing Trustworthiness

Trustworthiness is the standard of methodological rigor and credibility used in qualitative research (Morrow, 2005). The present study used four methods of establishing trustworthiness. The first method was member checking, achieved by inviting participants to review their transcribed interviews and soliciting feedback to ensure that the interview data was accurately reflected in the transcript. Five of the ten participants responded to a request for feedback. Two individuals made minor revisions, and all participants who responded indicated that their transcripts accurately reflected their interview.

A second method of establishing trustworthiness was peer review (Creswell, 2007). The researcher sought feedback throughout the data collection and data analysis process from a research team of peers and a counseling psychology faculty member. All members of the team were trained in and knowledgeable about geropsychology and qualitative research.

A third method of establishing trustworthiness was the researcher's journal, in which reflections regarding the study procedure, questions, ideas, and hypotheses were recorded. These notes were used to identify issues to discuss with the research team as well as to formulate preliminary analyses and conclusions during both initial and final stages of analysis.

A fourth method of establishing trustworthiness was thick description, achieved by including anonymized demographic information, direct quotes, and thorough descriptions of interview data. Interviews were transcribed verbatim, making note of significant non-verbal utterances (e.g., sighs) to ensure that the content and meaning of the interview was reflected in the analysis (Creswell, 2007).

Results

A number of themes and subthemes emerged from the data with considerable overlap in participants' descriptions of their experiences with client death (see Table 2). The major themes identified were: development of a different mindset in geropsychology; circumstances of memorable client deaths; personal/professional boundaries; impact of client death on clinical work; and developing specific coping strategies.

Table 2

Common Themes and Subthemes in Participants' Experiences with Client Death in Geropsychology

Themes/subthemes
Development of a Different Mindset in Geropsychology
Perceiving older adult client death as normal, inevitable, and expected
Developing personal concept of “good death” and death as positive experience
Becoming more comfortable with death and with personal reactions to death over time
Recognizing personal reactions to client death that include joy, relief, or neutral emotions as well as sadness and grief
Circumstances of Memorable Client Deaths
Feeling connected to clients; feeling intimacy, closeness, genuine admiration and liking
Watching clients make progress and achieve goals; experiencing professional satisfaction
Sharing experience of good death with clients
Feeling helpless or powerless during traumatic or painful client deaths
Personal/Professional Boundaries
Personal experiences with illness, death, and dying impact reactions to client death
Experiences with client death lead to personal growth and reduced fear of death
Personal beliefs about death and meaning in life impacted by client death
Cognitive/emotional reactions to client death spill over into personal life
Impact of Client Death on Clinical Work
Immediate challenge of maintaining focus and managing emotional reactions
Long-term impact is overwhelmingly positive and improves quality of clinical work
Professional role expands to include end-of-life planning and advocacy, increased knowledge and competence
Developing Specific Coping Strategies
Giving oneself permission to be impacted and exploring reactions
Using cognitive and behavioral strategies to gain closure
Finding joy and meaning in clinical work with dying individuals
Seeking coworker and facility support when available

Note. $N = 10$. All themes and subthemes listed above were present in over 70% or more of participants' narratives.

Development of a Different Mindset in Geropsychology

Participants emphasized the uniqueness of geropsychology within the larger field of clinical practice, particularly in the focus on death and dying. The present study illustrated the mindset that geropsychologists developed: they viewed death as normal and as a natural and inevitable part of their work. Further, they developed concepts of “good death” and of death as a positive experience both for clients and for the geropsychologists themselves. Although there

was some variation in the concept of good death, common ideas included client acceptance, preparation, and dignity. One participant described her gradual realization that her clients were not always fearful of death and that death was not always a negative experience:

They're wanting to be released from pain. So, when that happens, I feel like that's – that's a good thing. You know, it's sad to lose them and we miss them, but they're ready to go. (Participant 1)

Participants also mentioned developmental processes, noting changes in their mindset with increased experience with patient death, additional training and self-awareness, and their own chronological age. Many participants described an initial hesitation to acknowledge the way that client death impacted them and their discovery over time that it was important to allow space for personal reactions. One participant described her process of acknowledging and making space for her personal reaction:

I gave myself permission, I guess, to really cry about him. And at first I thought, what am I doing? Like, shape up here, what's the matter with you and that's sort of the way I talked to myself at first. Then I thought, well no, I knew him on such a deep level that it's okay, it's kind of a normal reaction. (Participant 5)

Participants discussed experiencing a wide range of emotions based on the nature of the client's death and in some cases, their proximity to the death. For instance, participants described experiences ranging from working closely with clients who were actively dying to finding out about the death of a former client long after clinical work had terminated. One participant described feeling surprised by the death of a client with whom she conducted only one interview:

I mean, I just remember seeing her, sitting in the lobby not that long ago, it was just a little shocking because I didn't even realize she was sick, and then never mind sick, she was already dead. So just, I guess more of the shock of it, and the surprise for me, being out of the loop. (Participant 9)

Common reactions also included a sense of loss and a grief tempered by a perspective that included feeling closure, being at peace, and an appreciation for life. A participant described how this grief reaction seemed distinct from the grief she might feel in her personal life:

It feels like grief, but kind of in miniature, because they're not – they're not a central part of my life, but you know, you go – you go through all of the stages, just not as intensely and not as long. (Participant 7)

Further, when deaths were expected or when the therapeutic relationship was not strong, reactions were often more neutral, with participants hesitantly admitting to feelings of relief or to simply not having much of a reaction.

Characteristics of Memorable Client Deaths

Some client deaths appeared to be more memorable than others. The variables associated with memorable patient deaths were relationship factors in the therapeutic alliance, a sense of professional satisfaction, and the nature of the client's death.

With regard to the therapeutic relationship, participants described fondness and liking of their clients when asked to describe memorable client deaths. Further, they also referenced feeling that they had been effective as helpers in their work with their clients. Relationships in which participants felt particularly close to their clients often led to more feelings of loss with client death. The quote below illustrates the internal conflict that occurred for one interviewee when she felt she had more to offer her dying client:

I sort of felt like I got shut out of that process because these were clients that I'd had a very good relationship with and then they went off to a hospital somewhere and died in a place where I wasn't able to be there to be a resource for them – to talk about whatever it is they need to talk about. I think some of those were clients I just personally wasn't ready to let go of yet because we had such long-standing relationships. (Participant 3)

Often it was not just the client or the relationship that made a death memorable, but the nature of the death itself. When participants believed that clients' deaths were not "good deaths,"

the experience was often memorable and painful for the geropsychologist. One participant recounted the death of a likable patient who she felt died in a difficult and painful manner:

He died a very uncomfortable, from the perception of the staff and myself, a very uncomfortable, drawn-out death. And I think the reason that affected me so much is because that his death was not consistent with his life. (Participant 4)

Personal/Professional Boundaries

Another relevant factor that influenced how geropsychologists experienced client death was their subjective sense of the boundary between their personal life and their professional work. For most participants, personal issues impacted their clinical work, and their clinical work impacted their personal lives and belief systems.

Many participants indicated that personal experiences with death and mortality, such as family members' deaths and health crises, impacted their experience of client death both negatively and positively. On the negative end, these experiences reached the level of countertransference for some participants such that interacting with clients who had similar characteristics triggered feelings of personal loss or fears regarding their own health and mortality. However, some participants also felt that having prior experiences with bereavement helped them to better cope with and to feel less surprised by their reactions to client death.

Similarly, they found that their personal beliefs about death both impacted and were impacted by their experiences at work. Participants agreed that working in geropsychology, they spent more time thinking about their own death and believed they were therefore more proactive about their own end-of-life issues and less afraid of death. All participants discussed feeling that they faced their own mortality as a result of their work and they described this process as largely beneficial to their personal growth. One participant expressed appreciation for how her professional experiences with patient death helped her face the inevitability of death:

I think it, it helps because again, I don't have to be afraid to be close to [older relatives] just because they're going to die because I've had that experience of being close to people and they die and it's okay. (Participant 7)

Most participants felt that there was emotional spillover from their reactions to client death into their personal lives. Participants described their struggle to balance personal reactions to challenging deaths with their professional mandate of confidentiality, with most indicating that they modified client stories to remove identifying information so that they could share their reactions with partners and families. Other types of spillover included thinking about clients and having lingering feelings of sadness outside of the office.

Impact of Client Death on Clinical Work

In regard to the impact of client death on clinical work, geropsychologists found that there were some short-term negative effects such as difficulty focusing and a need to manage immediate emotional reactions. However, participants overwhelmingly agreed that the long-term impact of client death was that they became better clinicians. One participant described both those immediate challenges and the way she feels she has become better clinician in the long term:

There would be periods where it would be really challenging for me to be able to focus. I'd have to go and make sure there was time for me in between sessions to just catch my breath from that, and now, now I think what it does is it helps me become a better therapist. Every time I experience death I kind of integrate that into my professional identity as, you know, what was I able to do well with this person before they died? What did they do that enriched my life? (Participant 4)

Furthermore, many participants described becoming increasingly involved in clients' end-of-life planning, and even advocating for clients' wishes with families or multidisciplinary teams when necessary. One individual explained the complexity of his role as a geropsychologist working with older adults in the end of life:

Part of the work is facilitating conversations with their adult family members, and managing their psychological care, and you're balancing the need between respect for the patient and their confidentiality and respect for their needs, and the reality of the fact that they do need their family members involved. (Participant 10)

Developing Specific Coping Processes

Given that participants experienced multiple client deaths, were emotionally invested in their clients, and that some deaths were especially impactful, how did these professionals cope? Major strategies were noted, including: developing ways to find closure, giving oneself permission to be impacted by client death, and finding joy and meaning in doing work that encompasses death.

The concept of closure was recurrent in participants' discussions of their coping strategies, with some explicitly using the word closure, whereas others referred to "tying up loose ends," or used words such as "completeness." Participants' strategies for finding this subjective sense of closure included behavioral rituals such as reminiscing with coworkers, closing files, or visiting the patient's room. Cognitively, geropsychologists also reframed their experiences with client death to focus on positive aspects of the therapeutic relationship, such as the progress the client made in therapy.

Nearly all participants described the importance of finding joy and meaning in their clinical work with dying older adults. One participant compared this work to previous clinical work she had done with younger adults:

Just the feeling of helping another being come to a place of peace is a very powerful experience. When you work with younger clients, I think we can have a huge impact and help them through some major issues but then they continue on with their life. Whereas in geropsychology oftentimes, you are working with patients who are closer to the end of life, and so being able to help him find a peaceful place as he reviewed his life was very powerful. (Participant 2)

Coworker support was also identified as being helpful, and the availability of this support seemed to vary based upon the social norms of agencies in which participants worked. Some participants were able to discuss their thoughts or feelings about the loss of particular patients with other staff members, whereas others were conscious of a need to maintain their professional composure and limit their personal reactions at work. One participant described frustration with one LTC facility in which staff seemed to maintain a secretive stance toward death, using euphemisms for death (e.g., expired) and withholding information about patient death from other residents:

It's like they pretend it doesn't happen. It's like you're not supposed to talk about it. And the death of my own clients has been difficult enough, but death of people I don't even know has been difficult on my clients. (Participant 6)

Discussion

The current study addressed the personal and professional impact of nonsuicidal client death on geropsychologists. Using a qualitative design, five major themes were identified: development of a different mindset in geropsychology; circumstances of memorable client deaths; personal/professional boundaries; impact of client death on clinical work; and developing specific coping strategies. These results indicated that in the context of geropsychology, professional psychologists often perceived death as normal and natural, and were able to appreciate the possibility of a good death. Consistent with previous findings (Munn et al., 2008; Moores et al., 2007; Kasket, 2006), even when death was normalized, geropsychologists identified grief and sadness as common reactions. Additionally, participants recalled particular experiences with client death as memorable and moving, recounting detailed and emotionally-laden stories of loss that they had experienced anywhere from a few months to several years prior to the interview.

This study both supported and expanded upon the issues identified in prior case studies and clinical case reflections on therapist experiences with client death. The theme of professional/personal boundaries expanded upon Rubel's (2004) discussion of the paradox of intimacy and professional distance in the therapeutic relationship. Participants seemed to experience client death as an event that challenged their ability to separate their professional relationships from their personal lives. This challenge often spurred personal and professional growth for geropsychologists as they adapted and developed strategies to cope with their experiences. Thus, the present results supported prior findings that client death led to growth and professional development for clinicians (Veilleux, 2011; O'Brien, 2011; Lardaro, 1988). Further, specific coping strategies identified by this study such as cognitive reframing of client death and using rituals to gain a sense of closure demonstrate specific ways that professionals cope with this phenomenon.

The present study's results suggested that psychologists experience many of the same reactions as other health providers who experience client or patient death, including grief (Rickerson et al., 2005) and increased empathy (Allen & Miller, 1998). However, these findings contradicted previous findings that repeated experience with patient death is associated with increased symptoms of burnout and longstanding distress and fatigue (Figley, 2002; Keidel, 2002; Papadatou, 2000; Strom-Gottfried & Mowbray, 2006). In the present study, only one participant mentioned a sense of fatigue associated with client death. One potential explanation for this finding is that participants developed successful coping strategies that prevented burnout or fatigue. Another possible explanation is that individuals who experienced more longstanding distress were less likely to participate in the present study, or even to stay within the field of

geropsychology. Further, the exclusion of certain types of deaths (e.g. suicide, homicide) for the purposes of this study may have impacted this finding as well.

Additional themes identified in the present study were related to finding meaning and purpose in the experience of client death. Meaning-making processes are those in which individuals engage in cognitive restructuring in an effort to find meaning after experiencing a stressful life event that challenges global beliefs and goals (e.g., personal loss, trauma; Park, 2010). In contrast to the Clark et al. (2007) findings in which spirituality was a crucial part of meaning making, few geropsychologists in the present study discussed spirituality or religion as important to their coping with client death. Although it would be premature to draw any sweeping conclusions from this finding, geropsychologists in the present study seemed to conceptualize meaning-making through secular frameworks (e.g., psychological theories of lifespan development).

In the context of existing theories of professionals' grieving processes, these results were consistent with the theory of disenfranchised grief. Participants' responses indicated that the loss of an older adult patient is not socially recognized as a significant event for geropsychologists and that their grief is often unrecognized (Doka, 2002). This seemed particularly relevant when participants perceived facilities as unreceptive to open discussions of death and of staff reactions to death. Further, participants' descriptions of their own expectations, particularly in their early career experiences, seemed consistent with self-disenfranchisement, which occurs when individuals do not recognize their own grief reactions as valid (Neimeyer & Jordan, 2002). Whereas physicians, for instance, may be able to perform their professional duties while maintaining emotional distance, psychologists' efficacy often depends upon their ability to be empathic with patients, including those who are dying. Thus, part of geropsychologists'

developmental processes may involve recognizing their own disenfranchised grief and finding ways to recognize and express their reactions. The present study's results suggested that most participants felt they were eventually able to navigate this balance successfully, reporting that they were able to cope through private rituals or through seeking social contexts in which they could grieve openly (e.g., with trusted coworkers; in peer supervision groups; with loved ones).

Additionally, the present results provided preliminary support for Papadatou's (2000) model of health professionals' grief. Because this model was designed as a general model that encompasses multiple helping professions, and this study was specifically focused on professional psychologists, there were some differences in terminology and specificity. However, many of the overarching concepts seemed similar: for instance, the present study's subtheme of "countertransference and professional issues" is conceptually similar to Papadatou's (2009) hypothesis that patient death may trigger "past unresolved losses." Thus the findings of this study appear to warrant further investigation of this model with regard to geropsychologists' experience of client death.

In regard to the impact of client death on clinical geropsychologists' ability to perform clinical work competently, this research provided some support for the notion that additional training and awareness of the impact of client death would likely be beneficial. Although long-term competence did not seem to be compromised by client death, participants discussed difficulty focusing, managing emotions, and struggling with decisions about attending funerals, contacting family members, and talking to other residents. These results suggest that additional exploration of this phenomenon would likely benefit students or early career professionals.

In drawing conclusions from this study, it is important to note the impact of the interview process on empirical outcomes. Although care was taken to ensure that recruitment materials

contained neutral language, one common theme noted in the researcher's journal was that participants seemed to be arguing against an implicit hypothesis that client death would be traumatic. This tendency likely reflected a widespread cultural view of death as inherently negative, and participants' desire to provide a more balanced view of their work. Further, because the researcher was a graduate student in a professional psychology program, some of the interviews seemed to take on a dimension of novice-expert in addition to interviewer-interviewee. Due to this dynamic, participants' answers may have taken on an instructional and encouraging tone that would not have existed in a different context. However, again, this finding may be reflective of widespread ageism in the larger culture whereby geropsychologists feel motivated to defend their specialty and emphasize positive aspects of their work.

Limitations

As this was a qualitative study, the goal was to gain an in-depth understanding of a particular phenomenon rather than to generalize results to the entire population. Therefore, when interpreting these results, readers should be mindful of the characteristics of participants when making judgments about their applicability. The present sample was not representative of all psychologists who might work with older adults: all participants identified as European American/White; men were underrepresented in this sample; and most participants worked in long-term care facilities. Another important characteristic of the sample is that participants volunteered to participate and thus there may be important differences between those who chose to participate in a time-intensive interview process and the larger population of geropsychologists. Compared to those who did not volunteer, participants in the present study likely had much stronger feelings about client death.

Directions for Future Research

The present study has many implications for future research. Although one can reasonably deduce that geropsychologists are likely to experience client death, future research could quantify the prevalence of this phenomenon as well as identify predictive variables, such as clinical setting or specialty. Because many geropsychologists work in agency settings, future research should explore how facilities approach death and dying and which specific factors are most important in creating an environment in which professionals are able to process their reactions openly.

Additional research on the ethical and legal issues for psychologists in EOL care would also likely be beneficial. Geropsychologists seem to be in an ambiguous position regarding their ability to advocate for their patients' rights in multidisciplinary settings. There is also ambiguity in regard to clinicians' ability to attend funerals or have contact with deceased clients' families. Although these ethical quandaries are unlikely to yield simple resolution, future studies could explore how geropsychologists currently navigate these complex situations.

One surprising finding in this study was that all participants who had experienced older adult client death by suicide mentioned that experience during the interview. Although there has been substantial research concerning the impact of client suicide on psychologists, participants expressed a desire for more open dialogue about the phenomenon of client suicide specific to geropsychology.

Implications for Training and Practice

The present findings have important implications for clinical training and practice. Although formal geropsychology training sites are becoming more prevalent, many clinical psychologists have reported that they provide services to older adults without formal training

(Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002). These results suggest that clinical training programs, continuing education, and on-site geropsychology training should include discussion of the impact of client death on psychologists. A survey of clinical psychologist practitioners showed that 69% desired more training in death and dying (Norman, Ishler, Ashcraft, & Patterson, 2000), and these results suggest that a focus on personal reactions to death and dying may be particularly helpful.

With respect to practice, clinicians may benefit from the knowledge that client death is not always a negative experience for psychologists who work with older adults and that self-awareness and support may help them to develop specific coping strategies. In particular, clinicians who have unresolved personal loss or ongoing significant health concerns seem to be particularly vulnerable and thus may need additional support in managing personal reactions to client's EOL issues.

Conclusions

Clinical geropsychologists seem to develop a mindset in which death is expected and experiences with client death are incorporated into an improved sense of professional efficacy in dealing with older adult clients. Nonetheless, there are a number of factors that complicate this process, including the development of a unique connection with a client, unresolved personal issues surrounding death, and the challenge of coping with the immediate impact of the death.

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Appendix A

Recruitment E-mail

Dear Professionals,

My name is Amanda Foster and I am a graduate student in the Department of Psychology at Colorado State University. I would like to invite you to participate in my research study to assess how client death impacts clinical geropsychologists.

Requirements for participation are as follows:

- You must be a licensed psychologist
- At least 50% of your clinical caseload must be adults 65 and older
- You also must have experienced the death of an older adult client or patient as a result of disease or unintended accident (i.e. not homicide or suicide)

Participants will be asked to complete an interview with the researcher regarding your experiences. Your total time commitment will be approximately 50 minutes.

Although I will be asking for personal reactions and information, any identifying information will be concealed through pseudonyms in the final write-up of the study. The only potential risk is any emotional difficulty that may result from the discussion of difficult events with clients. However, I also believe that participants will likely benefit from talking about these difficult experiences.

If you would like to participate, or if you have any questions, please contact me directly at Amanda.foster@colostate.edu or 813-951-0691.

Thank you for your consideration,

Amanda Foster, B.S.

Appendix B

Cover Letter

Dear Professionals,

My name is Amanda Foster and I am a graduate student in the Department of Psychology at Colorado State University. We are conducting a research study examining how geropsychologists are affected by the death of their clients. The title of the project is “The Impact of Client Death on Clinical Geropsychologists: A Qualitative Analysis.” The Principal Investigator is Dr. Tammi Vacha-Haase and the Co-Principal Investigator is Amanda Foster, both from the Department of Psychology.

We would like to invite you to participate in an interview with the researcher about your experiences of client death. These interviews may take place either by phone, or in person if you are located within 50 miles of Fort Collins. A follow-up interview may be requested following preliminary data analysis. Participation will take approximately 50 minutes for each interview. Your participation in this research is voluntary. If you decide to participate in the study, you may withdraw your consent and stop participation at any time without penalty.

Because this is a qualitative research project, interview data may be published as part of the results of the study. In order to maintain anonymity, identifying information will be concealed through pseudonyms in the final write-up of the study. We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or from viewing unedited interview data. For example, your name will be kept separate from your research records and these two things will be stored in different places under lock and key. While there are no direct benefits to you, we hope to gain more knowledge about how geropsychologists manage the stressors associated with the death of clients.

The only potential risk is any emotional difficulty that may result from the discussion of difficult events with clients. Although it is not possible to identify all potential risks in research procedures, the researchers have taken reasonable safeguards to minimize any known and potential, but unknown, risks.

If you have any questions, please contact me directly at Amanda.Foster@colostate.edu or 813-951-0691. If you have any questions about your rights as a volunteer in this research, contact Janell Barker, Human Research Administrator, at 970-491-1655.

Sincerely,

Amanda Foster, B.S.
Graduate Student

Tammi Vacha Haase, Ph.D.
Counseling Psychology Faculty

Appendix C

Demographic Form

Thank you for your willingness to consider this study!

In order to participate in this study, you must meet the following criteria:

- You must be a licensed psychologist
- At least 50% of your clinical caseload must be adults 65 and older
- You also must have experienced the death of an older adult client or patient as a result of disease or unintended accident (e.g. not homicide or suicide)

Age:

Sex: Male Female

Race/Ethnic Group (check all that apply):

- European American/White Asian/Pacific Islander African American/Black
 Latino/Latina American Indian Alaskan Native
 Multiethnic Other (please specify): _____

Religious/Spiritual Affiliation (check one):

- Christian (Protestant) Catholic Jewish Hindu
 Muslim Agnostic Atheist

How long (in years) have you been practicing as a licensed psychologist?

- 1-5 years 6-10 years 11-15 years 16-20 years
 20 – 25 years 30-35 years

How long (in years) have you been practicing as a geropsychologist (i.e. with over 50% of your caseload including adults 65 and older)?

- 1-5 years 6-10 years 11-15 years 16-20 years
 20 – 25 years 30-35 years

What percentage (please estimate) of your clientele includes older adults?

In what settings have you worked with older adults (check all that apply):

- Independent practice Group Practice Long-term care facility
 Hospital/Medical Setting Primary Care Practice

In your work with older adults, how many times have you experienced the death of a client/patient (please estimate):