Addressing Disenfranchised Grief Among Mental Health Professionals

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Introduction

Disenfranchised grief, which can show up in a variety of ways, is described by Doka (1999) as "the grief experienced by those who incur a loss that is not, or cannot be, openly acknowledged, publicly mourned or socially supported" (p. 37). Since different individuals, families, communities, and cultures have their own ideas, customs, and subjective beliefs around grief—including who is entitled to grieve for whom, for how long, and under what conditions—the reality is that nearly anyone could end up in a scenario where one's personal loss goes unrecognized or is delegitimized by others.

Grief researchers and scholars have identified some of the more common manifestations of disenfranchised grief. This includes grief where the underlying relationship is not seen as a legitimate source of deep loss, such as relationships "between friends, colleagues, in-laws, ex-spouses, or former lovers" (Corr, 1999, p. 2). Corr also points to examples of the loss itself being disenfranchised, including perinatal loss, the death of a pet, or the loss of a child relinquished for adoption. In these cases, individuals are often expected to grieve privately or to move on quickly. Meanwhile, when grievers themselves are disenfranchised, society may deem a person or group incapable or less capable of grief; Brave Heart and DeBruyn (1998) note that American Indian communities have experienced this form of disenfranchised grief throughout U.S. history due to the characterization by settler society that Native people lacked the capacity and need to mourn.

One dimension of disenfranchised grief that warrants further attention is the unacknowledged or delegitimized grief of mental health professionals, who constantly grapple with trauma and loss in their work with clients. As Lipsky and Burk (2009) underscore, the impact of trauma exposure on those in the caring professions is well documented, with many practitioners displaying responses like hypervigilance, anger, fear, and an inability to empathize

with clients and their families. Beyond these common experiences of vicarious trauma, however, it is important to acknowledge that mental health professionals also experience direct and profound losses over the course of their work—particularly the sudden death of a client due to suicide or other causes. These losses are valid, but because they occur in a professional context and due to related issues of confidentiality and liability, the grief that results from them is sometimes at a higher risk of being minimized, ignored, or called into question.

This paper will explore the disenfranchised grief experienced by mental health professionals, its potential impact on those professionals, and recommendations for interventions and organizational practices that could help address disenfranchised grief in the workplace.

Examining Disenfranchised Grief Among Mental Health Professionals

Sudden Death of Client as Direct Source of Loss and Grief

A significant body of research confirms that mental health professionals experience direct loss and grief in response to the sudden death of a client. Ting et al. (2006) note that in a study with 25 clinical social workers who spoke about losing a client to suicide, participants reported a range of grief responses, including: deep sadness, uncontrollable crying, devastation, feeling ill physically, and a sense of personal loss. Linke et al. (2002) add that in questionnaires completed by 44 community mental health team members who had lost a client to suicide, 40% reported symptoms following the suicide that lasted for over a month, and the most commonly reported adverse effect was grief or sadness. Additionally, in her review of literature on therapists' responses to the death of a client, Veilleux (2011) finds that grief, sadness, and loss are among the most common reactions that clinicians have to a client's suicide; she also suggests that clinicians frequently experience feelings of pain and isolation in response to losing a client to other forms of unexpected client.

Disenfranchisement of Mental Health Professionals' Grief

Notably, across a variety of practice contexts, mental health professionals describe scenarios in which their grief over the death of a client has been disenfranchised by supervisors or colleagues. According to Ting et al. (2006), several of the clinical social workers they interviewed—whose work settings included community mental health clinics, private practice, nonprofit groups, hospital-based agencies, and government agencies—said their supervisor either did not acknowledge the client's death as a personal loss for the social worker or did not offer space for the social worker to grieve openly or process the loss. In their literature review on caregiver grief, Strom-Gottfried and Mowbray (2006) emphasize that in some cases, supervisors, coworkers, and agency leadership will respond to a client's unanticipated death by "minimizing the loss" or by failing to allow space "for mourning, for adjustments in workloads, or for processing the death, all of which are vital for appropriate acknowledgment of the loss" (p. 11).

It is also worth considering that, intentionally or not, the loved ones of a client who dies by suicide could further contribute to the disenfranchisement of mental health professionals' grief. Veilleux (2011) describes the fear that many clinicians have over being blamed or threatened with litigation by the deceased client's family members, who may try to frame the clinician as negligent or secretive. Ting et al. (2006) also highlight clinicians' fear regarding their deceased client's family, adding that some feel a sense of guilt over failing the family. Again, regardless of the family's actual intent in each individual case, one concerning impact is the potential marginalization of the mental health professional's own grief—sometimes coupled with the insinuation that this professional has no right or need to mourn the client's death.

Finally, there are scenarios where a mental health professional's own friends and family may disenfranchise grief over a client's death. Veilleux (2011) observes that emotional support

from loved ones is a critical resource for practitioners in processing the loss of a client. Linke et al. (2002) also stress that community mental health team members listed their own friends and family as a top source of support following the suicide of a client. By extension, if mental health professionals' friends and family members fail to acknowledge the loss of a client as a legitimate cause for mourning, or if they dismiss these types of losses as an expected part of the job, they could deeply complicate that professional's ability to move through the grieving process.

Impact of Mental Health Professionals' Disenfranchised Grief

Intrusion

Across the existing research, intrusive thoughts or feelings are among the most common responses that mental health professionals have to the sudden death of a client. Intrusion can come in the form of fear that another client will die, an inability to separate one's personal and professional lives, lingering reminders of the deceased client, or triggers that "set off unexpected intrusive memories" (Ting et al., 2006, p. 336). Chemtob et al. (1989) also state that in a study with more than 400 psychologists and psychiatrists in various practice settings, the loss of a client to suicide was linked to high rates of intrusion and disruption in clinicians' lives.

These intrusive responses have an intrinsic connection to disenfranchised grief. Intrusive memories and reactions to traumatic events overwhelm one's coping skills, and they are a powerful indicator that the trauma has not been successfully integrated (L. Okoloko, lecture and class discussion, October 2, 2019). In the immediate aftermath of a traumatic event, this type of response could be seen as natural or even expected, provided that it improves over time. To that point, Ting et al. (2006) and Linke et al. (2002) discuss numerous cases where mental health professionals' intrusive symptoms eased or dissipated within one month of a client's death. However, Ting et al. make a critical distinction: clinicians were more likely to accept and move

on from the loss when they received support and validation from others—especially their supervisors and colleagues. This makes sense in light of the observation by Doka (1999) that when individuals' grief is disenfranchised, "it can be much more difficult to mourn and reactions are often complicated" (p. 37). Consequently, in cases where the intrusion experienced by mental health professionals may be tied to their grief being ignored or delegitimized by others, workplace interventions or targeted organizational practices could make a vital difference.

Avoidance

Avoidance is another common response by mental health professionals to the sudden or unexpected death of a client. Ting et al. (2006) explain that avoidance can show up in a number of ways with clinicians who have lost a client to suicide, such as: avoiding or transferring clients who are suicidal, leaving their job to pursue a position with less direct exposure to suicidal clients, or even moving to another city or state. Linke et al. (2002) share similar findings among community mental health staff, with increased avoidance of clients they perceive to be at a higher risk of suicide, a greater sense of distance between themselves and their clients, and a stronger desire to leave their jobs. Meanwhile, Strom-Gottfried and Mowbray (2006) name a disturbing trend at the organizational level: out of fear over potential legal liability following the suicide of a client, mental health professionals are often told by supervisors or leadership staff not to discuss the loss with their colleagues or with family members of the deceased client.

Rather than looking at these avoidant thoughts and behaviors in isolation, it is crucial to understand their connection to disenfranchised grief. Herman (2015) frames avoidance as a constrictive response by trauma survivors to establish a feeling of safety and to protect themselves against overwhelming thoughts and feelings associated with the traumatic event. However, in doing so, they often miss opportunities to cope and recover. That risk is clearly at

play with mental health professionals who experience the death of a client, but it is especially high among those whose losses are delegitimized. Instead of being encouraged to accept and process their grief, they are steered away from "seeking the very support that will be crucial to successfully negotiating the grief process" (Strom-Gottfried & Mowbray, 2006, p. 11). Without the core grieving functions of making meaning of their loss and reconnecting with others around them, there is an added risk of their grief becoming unresolved or complicated (L. Okoloko, lecture and class discussion, October 23, 2019). Again, it may be particularly valuable to target these mental health professionals for workplace interventions or practices.

Workplace Interventions and Practices to Address Practitioners' Disenfranchised Grief

Given the powerful role that workplaces can play in either sanctioning or delegitimizing employees' loss and mourning, what follows is a series of recommended interventions and organizational practices that supervisors and leadership staff can utilize to address the disenfranchised grief of mental health professionals.

Recommendation #1: Increased Training on Death, Suicidal Behavior, and Grief

This first recommendation is providing mental health professionals with more "upstream" knowledge and skills so that they are better prepared for the realities of client death, suicidal behavior, and the grieving process. Existing research points to concerning gaps in knowledge and training among practitioners, with Ting et al. (2006) indicating that less than 50% of social workers went through formal suicide training in school. Even if these numbers have improved in recent years, it is reasonable to assume that gaps still exist and that there are currently mental health professionals in the workforce who lack adequate training around suicide—including prevention, intervention, and "postvention," a term referenced by Strom-Gottfried and Mowbray (2006) that entails processes for reviewing client deaths. Additionally, Linke et al. (2002) note

that the majority of community mental health staff they surveyed reported feeling "inadequately prepared for dealing with a suicide by their initial professional training" (p. 51).

Specifically, agencies and organizations that employ mental health professionals can partner with educational institutions to integrate content on death, suicide, and bereavement in both undergraduate and graduate coursework. For professionals who are already employed by these agencies and organizations, robust training on these issues should be required and regularly offered at no cost to employees to ensure that there are no barriers in terms of financial accessibility. At a minimum, Ting et al. (2006) suggest covering suicide prevention, intervention, and postvention training as well as common emotional responses by clinicians who experience the sudden death of a client. These trainings and any course content should also take a culturally responsive approach to death and bereavement that does not center dominant social identities.

In training current and prospective mental health professionals on common issues around death, suicide, and grief, the hope is that these individuals will feel better prepared for the significant challenges that accompany the loss of a client. Ideally, this would also help mitigate intrusive symptoms and avoidant thoughts and behaviors. At the same time, by providing these training opportunities, leadership staff and supervisors are acknowledging at the organizational level that preparing for the experience of loss and grief is a valid part of mental health work—and this is a key step in disrupting the perpetuation of disenfranchised grief in the workplace.

Recommendation #2: Workplace Postvention Protocols to Support Mental Health Professionals When a Client Suddenly Dies

As stated above, research indicates that mental health professionals are more likely to accept and process the death of a client when they receive support and validation from

supervisors and colleagues. There are clear postvention protocols that employers can implement to provide support to their staff following such a loss.

Strom-Gottfried and Mowbray (2006) detail multiple postventions that supervisors and leadership staff can utilize. The first, critical incident stress debriefing (CISD), is a brief group intervention designed to reduce feelings of isolation and to "alleviate the immediate stress employees experience after a traumatic event" (Strom-Gottfried & Mowbray, 2006, p. 13). Since CISD should take place within a few days of the traumatic event, Strom-Gottfried and Mowbray emphasize that employers must have trained CISD facilitators in place as part of their workplace protocols, and they should work closely with staff to ensure that everyone impacted by the event can participate. According to Mitchell et al. (2003), the core goals of CISD are to help participants verbalize their distress over the traumatic event, develop an understanding of their stress response, and return to relatively normal day-to-day functioning.

Mitchell and Everly (1997) state that CISD takes a few hours to complete and is facilitated by a minimum of two trained individuals: a mental health professional and a "peer support personnel" facilitator who is typically from the same profession as the participants. Mitchell and Everly also stress that CISD is not a substitute for psychotherapy, and it should always be offered within a broader set of crisis intervention procedures known collectively as Critical Incident Stress Management. During CISD, facilitators lead participants through multiple phases to transition the group from cognitive to emotional content and then back to cognitive content. Over the course of CISD, participants describe the facts of the traumatic event, share their thoughts and emotions around it, describe symptoms they may have experienced in response to the incident, have their symptoms normalized as a natural response to the incident, learn about stress management, and end with questions and discussion of what was learned.

In addition to CISD, Strom-Gottfried and Mowbray (2006) mention the psychological autopsy, a postvention typically used in response to client suicide that serves as an "an informal, in-depth study of the life and death of the client" and can help "make sense of the facts of the case" (p. 13). Isometsä (2001) describes the process used to conduct a psychological autopsy, with the first step being structured interviews with the deceased client's loved ones and health care personnel who had recently worked with the client. Information is then gathered from all available health records and other pertinent documents. Finally, the data collected from these two steps are synthesized for analysis—sometimes in the form of a case report.

In evaluating both CISD and the psychological autopsy as postventions, it is important to note that while CISD is widely used, multiple meta-analyses have yielded mixed results on its effectiveness (Mitchell et al., 2003). Still, Mitchell et al. point to significant clinical evidence that CISD helps individuals manage their stress following a traumatic incident. They also emphasize that CISD was never meant to be applied on its own and that it is most effective when combined with other Critical Incident Stress Management interventions like pre-crisis education, one-on-one follow-up, and referrals for additional care as needed. Meanwhile, Canter (2000) recognizes that there is limited comprehensive research to date on the validity of psychological autopsies, and he suggests that this postvention should be viewed primarily as a loosely structured technique for trying to capture the thoughts and feelings of clients prior to death.

Ultimately, there is demonstrated value to both CISD and the psychological autopsy, and Strom-Gottfried and Mowbray (2006) argue that the strongest postvention could actually be one that combines elements of both: a group review with impacted staff that examines the facts around a deceased client's case, while also offering space for those staff to discuss their feelings about the loss and to provide support to one another. Regardless of which postventions are

applied within a workplace, the key is to have consistent protocols in place to support mental health professionals in processing and accepting their grief—which could also help alleviate the intrusion and avoidance that so often accompany unacknowledged or unresolved trauma.

Recommendation #3: Organizational Practices That Allow Employees to Process Grief and Connect Over the Death of a Client

This recommendation is aimed at operationalizing a commitment to employees' healthy grieving and trauma processing following the sudden death of a client. One example of an organizational practice that demonstrates this commitment is having supervisors and leadership staff encourage their employees to attend the funeral of a deceased client. Employers could also consider providing staff with paid bereavement leave to do so, which validates the client's death as a legitimate loss for the employee. Additionally, Strom-Gottfried and Mowbray (2006) encourage supervisors, leadership staff, or colleagues to plan a memorial service or remembrance ritual at the office to honor the deceased client; this practice acknowledges employees' grief and also provides staff with an opportunity to support each other in the mourning process.

On a final note, employers can also engage in simple but powerful behavioral shifts that promote a culture of openly accepting and recognizing the grief that their employees experience when a client dies. For example, Linke et al. (2002) share that the community mental health staff they surveyed were appreciative of "comments from senior colleagues acknowledging the impact of a suicide" (p. 52). In check-ins and team meetings, supervisors can also make it clear to staff that they understand the significance of the loss, that they are open to discussing the client's case in whatever ways feel most supportive and appropriate, and that they encourage impacted employees to take time for self-care as they work to recover from the loss.

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