

2020

The Impact of Grief Work on Hospice Mental Health Providers Through a Bowen Family Systems Lens

Joshua Hernandez

Nova Southeastern University, jh2398@mynsu.nova.edu

Follow this and additional works at: https://nsuworks.nova.edu/shss_dft_etd



Part of the [Marriage and Family Therapy and Counseling Commons](#), [Psychiatry and Psychology Commons](#), [Rehabilitation and Therapy Commons](#), and the [Social and Behavioral Sciences Commons](#)

Share Feedback About This Item

NSUWorks Citation

Joshua Hernandez. 2020. *The Impact of Grief Work on Hospice Mental Health Providers Through a Bowen Family Systems Lens*. Doctoral dissertation. Nova Southeastern University. Retrieved from NSUWorks, College of Arts, Humanities and Social Sciences – Department of Family Therapy. (61) https://nsuworks.nova.edu/shss_dft_etd/61.

This Dissertation is brought to you by the CAHSS Theses, Dissertations, and Applied Clinical Projects at NSUWorks. It has been accepted for inclusion in Department of Family Therapy Dissertations and Applied Clinical Projects by an authorized administrator of NSUWorks. For more information, please contact nsuworks@nova.edu.

The Impact of Grief Work on Hospice Mental Health Providers
Through a Bowen Family Systems Lens

By

Joshua Hernandez

A Dissertation Presented to the
College of Arts, Humanities, and Social Sciences
In Partial Fulfillment of the Requirements for the Degree of
Doctor of Philosophy
Nova Southeastern University

2020

Copyright
by
Joshua Hernandez
May, 2020

Nova Southeastern University
College of Arts, Humanities, & Social Sciences

This dissertation was submitted by Joshua Hernandez under the direction of the chair of the dissertation committee listed below. It was submitted to the Graduate School of Humanities and Social Sciences and approved in partial fulfillment of the requirements for the degree of Philosophy in the Department of Family Therapy at Nova Southeastern University.

Approved:

03/16/2020

Date of Defense



Christopher Burnett, Psy.D.
Chair



Tommie V. Boyd, Ph.D.



Kara Erolin, Ph.D.

04/16/2020

Date of Final Approval



Christopher Burnett, Psy.D.
Chair

Acknowledgements

This journey would not have been made possible without the incomparable support within my life, helping me along the way. The help came in a plethora of forms, ranging from procrastination to letting me vent on the immense pressure to adequately perform on a daily basis. It would be a lie to say that this journey was done alone; therefore, I would like to divide up my gratitude into several parts:

- Thank you to the amazing friends and family members, who stuck by my side during this journey, and for letting me express myself during much needed times. Having each of you as a sounding board alleviated some of the tension I felt and helped place the focus back on the prize. A special thanks for the endless nights of memories, especially when you all knew I needed a break from the chaotic whirlwind of life.
- Thank you to the spectacular team of professionals that were a part of my dissertation team. You are all the real MVPs for the unfathomable support and guidance each of you have given me throughout my academic journey. Each of you has been able to challenge me in ways that have been able to give me a new perspective within my personal and professional life. My appreciation extends beyond the normal capacity.
- Thank you to the wonderful hospice organization that granted me permission to conduct my research at their facility. Without which, I would not have been able to have the space, and the needed participants to facilitate the study.
- Thank you to the remarkable team of mental health professionals who placed value in the study, taking time off their demanding schedules to participant in my

research. To talk to a stranger about your personal life and intimate thoughts is no easy task, and I am eternally honored that each of you placed trust in me.

- And lastly, to the mental health professionals around the world who come face-to-face with their own demons in-and-out of session, this is for you.

TABLE OF CONTENTS

	Pages
Acknowledgements	v
List of Tables	xi
List of Figures	xii
Abstract	xiii
CHAPTER I: INTRODUCTION	1
Hospice Care and Setting	1
Roles and Functions: The Interdisciplinary Team	2
Hospice Bereavement Coordinators	4
Grief and Loss	5
Death and Dying	6
Adapting and Transforming: My Process	7
Marriage and Family Therapy	9
Conceptual Framework for the Study	9
Statement of the Problem	11
Purpose of the Study	12
Significance of the Study	14
Summary	15
CHAPTER II: LITERATURE REVIEW	17
The Hospice Program	17
Bridging Systemic Theory and The Interdisciplinary Team	19
Bowens Family Systems Theory	21

Chronic Anxiety	24
The Emotional System	27
The Interdisciplinary Team: An Emotional System	29
Triangles and Interlocking Triangles	31
Differentiation of Self	34
Research on Differentiation	37
Defining Self	43
Self-Differentiation: The Therapeutic Significance	45
Differentiating Grief and Loss	48
Types of Grief and Loss	50
Sudden Loss	50
Anticipatory Grief	50
Complicated Grief	51
Traumatic Loss	51
Ambiguous Loss	52
Non-Death Loss	53
The Context of Death and Dying	53
Response to Death and Dying: A Bowenian Perspective	56
Summary of Literature	61
CHAPTER III: METHODOLOGY	64
Research Question	64
Qualitative Methodology	64
Interpretative Phenomenological Analysis	65

Data Collection	68
Recruitment	68
Inclusion Criteria	69
Interview Process	69
Location of Interviews	70
Data Analysis	71
Ethical and Legal Considerations	72
Research Validity	74
Epoché or Bracketing	76
Self of the Researcher	77
Challenges in Using a Bowen Framework in Research	79
Functional Levels vs. Basic Levels	80
Interlocking Concepts with Differentiations	81
Stress Management vs. Adapting from Stressors	82
Gathering Historical Data	83
Summary	83
CHAPTER IV: RESEARCH FINDINGS	86
Participants Demographics	86
Themes	87
Participant Representation	120
Summary	122
CHAPTER V: DISCUSSION AND IMPLICATIONS	124
The Relation Between Previous Literature and the Present Study	124

Expanding on Prior Literature	130
Research Implications	131
Managing Emotional Intensities in Hospice	131
MFTs and Managing Emotional Intensities Outside of Hospice	133
Personal Reflections	135
Strength and Limitations	137
Direction for Future Research	139
References	142
Appendices	155
Appendix A: Interview Questions	156
Appendix B: Letter of Intent to Hospice	160
Appendix C: Research Participant Inform Consent Form	161
Appendix D: Letter of Invite for Hospice	166
Biographical Sketch	167

List of Tables

	Pages
Table 1. Participant Demographics	87
Table 2. Superordinate and Subordinate Themes	88
Table 3. Participant Contributions to Theme	121

List of Figures

	Pages
Figure 1. Reciprocal Relationship Between Clients and Therapists	89
Figure 2. Example of a Triangle	111
Figure 3. Catalysts of the Time Traveller Effect	129

Abstract

Marriage and family therapists and other mental health professionals and clients can be thought of as their own, divine emotional unit, generating and distributing the anxiety of one to the other. In fact, Kerr and Bowen (1988) described anxiety as a driving force exchanged by every living organism, and the energy surrounded by every human relationship. Within a hospice setting, anxiety can be heightened due to catering to end-of-life care, which can potentially affect the emotional response and reactivity of the mental health professional, changing the course of treatment for the patient and their family. Emerging research within healthcare has focused on patients; however, research regarding the impact clients have on mental health professionals have been scarce. The present study seeks to explore how dealing with grief narratives on a daily basis impacts the functioning of mental health professionals in both their work and family system, informed by Bowen family systems theory. The study utilized interpretative phenomenological analysis to explore the lived experiences of mental health professionals impacted by the grief narratives of the patients and families each serve within hospice. The aim of the research was to expand mental health professionals' understanding on how clients may impact and potentially change the way therapists interpret the world from a Bowenian lens.

Keywords: hospice, Bowen family systems theory, systems theory, grief and loss, death and dying, mental health professionals

CHAPTER I: INTRODUCTION

Hospice Care and Setting

This dissertation study focuses on the experiences of mental health providers working in hospice care settings utilizing the Bowen family systems theory to understand their experiences. The term Hospice was introduced and applied to specialized care for dying patients in 1948 when a physician, Dame Cicely Sanders, began her research on terminally ill patients, creating the first hospice in London in 1967 called St. Christopher's Hospice (Richmond, 2005). Sanders introduced the concept of managing the pain patients had, and emphasized on the patient's dignity, compassion, and respect during their end-of-life care (Richmond, 2005). Eventually, the holistic notions hospice provided in incorporating the physical, emotional, and spiritual aspects of the patient were brought to the United States in the 1970s. A study conducted in 2016 by the National Hospice and Palliative Care Organization (2018) estimated 1.04 million Medicare beneficiaries are under the enrollment of hospice care. Based on the mortality experience in 2016, a total of 2,744,248 resident deaths were registered in the United States, resulting in death rates occurring in 849.3 per 100,000 population (Xu, Kochanek, Bastian, & Arias, 2018). However, the World Health Organization (2018) recorded 56.9 million deaths worldwide within the same year. Within a survey entitled Hospice Care Statistics (2012), which collected data on different hospices, an estimation of 1.65 million people with statistics indicating that around 44.6% of deaths occurred within the United States happened under the care of a hospice program. The utilization of hospice programs has grown exponentially throughout the years thanks to the philosophical notions held by Dame Cicely Sanders (Richmond, 2005).

According to a report by the National Hospice and Palliative Care Organization (NHPCO, 2018), hospice can be seen as the optimal quality care given to people who are in the process of facing end-of-life illnesses, with the prognosis of less than six-months to live. Hospice services were designed to provide expert medical psychosocial care, encompassing pain management, and emotional and spiritual support personalized for the patient and family's desires and wants within reasonable accommodation (NHPCO, 2018). Essentially, the goals of hospice are to deliver quality versus quantity of life, allowing for the patient to die in dignity, and giving the patient control over most (if not all) of the decision making processes within their hospice journey. For a better perspective, hospice concentrates on the compassionate care of the patient (quality), not the curing (quantity of life). Furthermore, services can be rendered in a variety of different settings, including independent living facilities, assisted living facilities, hospitals, patient homes, nursing homes, and other long-term care facilities.

Roles and Functions: The Interdisciplinary Team

The National Institute of Aging (NIH, 2017) postulated how hospice care allows for a team of professionals with certain skills to collaborate in providing optimal, end-of-life care to the patient and the family, including physicians, nurses, certified nursing assistants (CNAs), spiritual advisors (rabbis, chaplains, priest, etc.), mental health professionals (marriage and family Therapists, mental health counselors, and social workers), and volunteers. The interdisciplinary team collaborates with each other in order to develop a care plan tailored to the patient and the patient's family to meet their subjective needs in regards to pain management and symptom control (NHPCO, 2018).

Each of the professions serve an important role and function in delivering the optimal care for the patient and patient family in order to facilitate quality end-of-life care. Physicians and nurses provide the medical means to sustain the patient in the management of pain, allowing for nurses to supervise the progression of the chronic illness and the physicians to prescribe medications to ease the patient's discomfort due to the illness. The spiritual advisors (e.g., rabbis, chaplains, and priests) serve the function of allowing the patient and families to discuss potential apprehensions in relation to spirituality, providing religion-based support. Social workers offer different resources to the family in order to enhance social functioning and overall well-being for the patient and family members, assisting the family with services the patient may need prior to and after death occurs (i.e., funeral arrangements, facility placement, discharge plan, and any third-party sources). Bereavement coordinators are comprised of mental health professionals (marriage and family therapists, mental health counselors, and/or social workers) that cater to the emotional needs of the patient and family members prior to, during, and after the death of the family's loved one, providing therapeutic services in relation to grief and loss. Volunteers in hospice are imperative in the functioning role of providing a higher level of comfort and support for the patients and families: assisting in simple chores within the household, preparing meals, grocery shopping, and running a multitude of errands for the needs of the patient. Volunteers can also render administrative services.

The collaboration between each professional assist in the overall functioning of a hospice program in providing optimal patient centered care. The interdisciplinary team

allows for the construction of a care plan specifically designed, and tailored, for the patient and family in regards to their medical, spiritual, and emotional needs.

Hospice bereavement coordinators. Hospice bereavement coordinators can be referred to as mental health professionals that are trained in providing intensive, therapeutic services to families who are currently in the process of bereavement, or are grieving the loss of significant family member or loved one. According to the World Professional Organization (2001), a mental health professional can be defined as an individual that offers therapeutic services for the purpose of improving another individual's psychological well-being and/or implementing research within the field of mental health. Mental health professionals can include a variety of different professions: marriage and family therapists, mental health counselors, social workers, psychiatrists, and psychologists. For the purpose of this study, bereavement coordinators are persons from the disciplines of marriage and family therapy, mental health counseling, and social work.

Following the death of a hospice patient, bereavement support and therapeutic services can be accessed for about a year, allowing friends and family members an added layer of assistance in processing their grief symptoms. In 2014, after the death of each patient, an average of two family members received bereavement support from the hospice the patient was a part of (NHPCO, 2016). Bereavement support may include support groups, follow-up phone calls, bereavement visits, and mailings during the first-year anniversary of the death of the patient. Bereavement sessions can be done differently depending on the context: individual sessions (patient-to-therapist; family member-to-therapist; hospice employee-to-therapist), family sessions (family members-to-patient-to-

therapist), and/or group sessions (bereaved family members sharing experiences within a group setting).

The function and role of a hospice bereavement coordinator is to alleviate as much of the anxiety the family and/or patient is facing within the emotionally intense environment of hospice. Patients and families can be faced with a multitude of concerns, thoughts, angsts, fears, doubts, and other mixtures of emotions. Bereavement coordinators assist in the facilitation of the person's journey throughout hospice, creating a space for the patient and/or family members to think logically about the terminal illness.

Grief and Loss

Across the world, people are constantly being impacted by different losses. These losses may preclude a loss of a job, a divorce, an empty nest when a child leaves home, generational loss, loss of independence, loss of mobility, loss of a significant relationship, and so forth. For the purpose of this study, loss can be defined as “Deprivation, bereavement; failure to retain possession or control of something” (Medical Dictionary for the Health Professions and Nursing, 2012). Essentially, grief and loss within the current study is in relation to the dying process or death of a patient in regards to the family's emotional reaction. Additionally, grief and loss can be understood within a systemic lens due to the subjectivity of different contextual factors that may effect the process (Walsh & McGoldrick, 2004): religion, culture, gender, ethnicity, race, mourning beliefs, traditions and practices, and so forth. According to the Hospice Foundation of America (2018a), grief can be seen as a reaction to the loss persons have, or are currently, undergoing, and the experiences of both can be individualized among the members of the

family and friends facing said loss. People have different ways of grieving; therefore, there is no one correct way to grieve any of the losses any person may face. The person being affected by grief may also experience different emotional reactions and physical symptoms due to the loss (NHPCO). In addition, a hospice bereavement coordinator can be asked by any member of the interdisciplinary team to assist clients in processing a multitude of types of grief: (a) sudden loss, (b) anticipatory grief, (c) complicated grief, (d) traumatic loss, (e) ambiguous loss, and (f) non-death loss.

Death and Dying

The complexity involved with death and dying can be difficult for some people to handle, leaving patients, patient's family, friends of the patient, and even the interdisciplinary team in a state of quagmire. Death and dying are completely different constructs and processes that are separate, yet connected, to each other. The Farlex Medical Dictionary (2012) defines dying as "the last stage of life; a process that from a medical point of view begins when a person has a disorder that is untreatable and inevitably ends in death, or the final stages of a fatal disease," and defines death as "a cessation of integrated tissue and organ functions; in humans, manifested by the loss of heartbeat, by the absence of spontaneous breathing, and by cerebral death." In essence, dying can be viewed as a process, whereas death can be viewed as an event. Moreover, the construct of death and dying can be defined differently within each ecological level, ranging from the macrosystem (society) to the microsystem (the individual) (Walsh & McGoldrick, 2004).

In 2016, the National Center for Health Statistics (Kochanek, Murphy, Xu, & Arias, 2017) gathered data regarding the mortality rate within the United States, finding a

total of 2,744,248 recorded deaths. The same organization gathered data the previous year in 2015. Interestingly, there were significant differences found among specific variables when comparing the years. Between 2015 to 2016, there were 31,618 deaths more than in 2015; death rates increased for younger than the older generation; there were lesser death rates for non-Hispanic white females while non-Hispanic black males increased; the death rate increased from 733.1 deaths per 100,000 standard population to 849.3 per 100,000 standard population; and life expectancy decreased 0.1, resulting in 78.6 years for the average person. These statistics can suggest that the utilization of hospice programs have increased within the past year.

Adapting and Transforming: My Process

When I first began working in hospice as a bereavement coordinator, I did not know what I was getting myself into. The entire environment was foreign to me, and I did not know how to be a professional within an environment that catered to such high emotionally intense cases. Grief and loss are its own animal compared to dealing with other concerns one might see within the therapeutic environment, and I had to be mindful of such differences in the language I used, my expressions and mannerisms, my thinking in reflection to the generation I was serving at the moment, and my philosophy on life and death. Since starting within the field of hospice, I have undergone many changes within my personal life by reflecting, changing, and implementing the lessons my clients and patients have been able to bestow upon me. To survive within hospice, I had to adapt, changing the flow of my own currents, and transform into something that encompasses my newer meaning for life, asking myself, "When I am on my deathbed, what do I want to be proud of, and what would bring me peace?" These questions started a catalyst of

change that I began to execute, ranging from my love life, my family life, my school life, my relationships toward people, my expectations, and my way of thinking about my own mortality. Working with death is a privilege not many have; life is not the only teacher.

In the spirit of transparency, my paternal grandmother passed away due to pancreatic cancer back in 2009, my maternal grandfather passed away due to heart failure back in 2016, and my eight-year relationship has ended with my significant other in 2018. Dealing with my own significant grief and loss has been a bumpy road; however, these losses I have had tended to replay themselves in many of the settings I work in throughout hospice. Facing a patient who has chronic pain due to pancreatic cancer is not an easy pill for me to swallow because I was close to my grandmother. Conducting groups at the independent-living facility my grandfather used to reside in is another pill that is not easy to swallow. Hearing the experiences and life stories of those recently (or in the process of being) widowed is another difficult pill to swallow because I felt like my relationship died. Because of the circumstances that would arise within session, my anxiety would peak due to the personal and emotional involvement I had with each of those factors. The anxiety within myself would manifest as nervousness, unable to think coherently, replaying tapes pertaining to each scenario, and difficulty in remaining present with the patient and/or client(s). My own function and role as a therapist was being tempered with by the memories of my own lineage, my own anxiety, and my own losses—and experiences of those losses. Within hospice work, I am still adapting and transforming, working on these experiences, life lessons, and losses with hopes of mindfulness to such factors to help me thrive and survive within an emotional intense environment.

Marriage and Family Therapy

Marriage and family therapists (MFTs) are professionals trained to look at the relational context of the client within the therapeutic session, seeking to understand and remain curious of the relationships that are informing the situation and/or concerns the client is bringing to therapy. Similarly, Schooley and Boyd (2013) denoted that MFTs seek out relational patterns within the context of the individual, implementing systemic perspective into the world in which unfolds within the framework of therapy. People exist within a number of relationships that directly and indirectly affects their well being, influencing and fabricating their own individual experiences and reality (AAMFT, 2018). In essence, MFTs are rooted in systems theory, which simply can be described as understanding the interactions and functioning of the elementary parts to the whole of the situation (Mele, Pels, & Polese, 2010).

Additionally, Rambo, Boyd, and Marquez (2016) discussed how recent graduates from an accredited MFT program have a variety of options for careers, navigating readers throughout different avenues for occupations within distinct settings: agencies, residential, coaching, medical, legal, tribal, academic, corporate, faith-based, and private practice. The implementation of systems theory can help establish a stronger connection between its world and the world of hospice work, recognizing and analyzing the relational context within the medical field and end-of-life care pertaining to patients, families, physicians, nurses, nursing aides, and other mental health professionals.

Conceptual Framework for the Study

For this study, I utilized Bowen Family Systems Theory as my theoretical framework. Murray Bowen, M.D., founder of Natural Systems Theory, developed the

notion that the emotional symptoms of an individual are a representation of the emotional symptoms of the family, embedded within multi-generational patterns (Haefner, 2014; Kerr, 2003; Kerr & Bowen, 1988). In essence, Bowen noticed his trans-generational approach uncovering that current family patterns and problems tended to repeat themselves over generations (Haefner, 2014). Unresolved hiccups within the elder generation would trickle down to the present generation, manifesting its emotional symptomology within the affected individual and family members in the current generation. In order to better explain the interlocking forces that assist in shaping family functioning, eight concepts were established within the proposed theory (Bowen, 1978; Kerr & Bowen, 1988; Kerr, 2003): (a) triangles, (b) differentiation of self, (c) nuclear family emotional process, (d) family projection process, (e) multigenerational transmission process, (f) emotional cutoff, (g) sibling position, and (h) societal emotional process.

Survival within the world is an anxiety-provoking process because survival is not guaranteed for every living creature—from the level of a microorganism to the established human being and driving force of the universe. Bowen (1988) explained,

The concept of a natural system, in other words, assumes that systems exist in nature independently of man's creating them. The existence of natural systems does not even depend on the human's being aware of them. The principles that govern a natural system are written in nature and not created by the human brain. (p. 24)

Essentially, we do not create the system, the system, however, governs us. The manifestation of the energy generated by anxiety acts as a driving force of life, and

survival becomes primal. Due to the naturalistic conceptualization, the application of Bowen's Family Systems Theory can be practical to many facets in life beside the mental health field (Bregman & White, 2011).

Statement of the Problem

Presently, there is literature regarding the effectiveness of MFTs within healthcare; however, there are few empirical studies regarding the therapeutic efficacy of marriage and family therapists within healthcare systems (Tyndall, Hodgson, Lamson, White, & Knight, 2014). Research involving marriage and family therapists within the healthcare setting has become more prevalent over the years, yet not at the same pace as research pertaining to clinical work in other integrated settings (Pratt, Wittenborn, & Berge, 2019; McDaniel, Doherty, & Hepworth, 2014). Moreover, empirical research has been slow to focus on bereavement coordinators in hospice settings, and on the application of Bowen's Family Systems Theory in medical settings.

Bowen Family Systems Theory can be applied in a variety of different types of environments due to the similar emotional patterns contained within each system (Bregman & White, 2011). Bowen devoted his life to understanding the emotional process within a system while respecting the beliefs and practices of each individual within the system (Bregman & White, 2011). Even though the theory can be applied to a multitude of settings, there is little to no empirical research surrounding Bowenian Theory within the context of hospice, and there seems to be a gap in research regarding the concepts held within the theory (Nichols, 2014; Titelman, 2014). Moreover, there has been growth within the intersecting fields of marriage and family therapy and healthcare;

however, other research conducted within integrated settings have been growing at a more profound pace (McDaniel et al., 2014; Pratt et al., 2019).

Purpose of the Study

The aim of this research was to explore the relationship between how a bereavement coordinators' level of differentiation is affected by the clientele being serviced, and the specifics of the context in which such services are being provided. To address this, I utilized the qualitative research design of interpretative phenomenological analysis (IPA) with mental health professionals within a hospice in Florida to explore how dealing with grief on a daily basis impacts their emotional systems. I wanted to provide more information about how mental health professionals come to manage anxiety in a setting so completely enveloped by it. Emotional responses and reactivity often may manifest themselves for therapists during hospice sessions, which can change the direction and overall tone of therapy. When an increase of anxiety is present within session, the more likely a person's behavior will be driven by basic, primitive, and emotionally charged responses (Bowen, 1978; Kerr & Bowen, 1988; Papero, 2014).

Holland (1997) proposed a need for supplementary research on the impact on the therapist's level of differentiation and the therapeutic outcome (i.e., therapeutic efficacy). Regas (2011, 2013, 2014a, 2014b) stated that it is the therapist's duty to resolve underlying concerns within their life, and develop themselves in order to be most effective with clients. Similarly, Wampold (2001) argued that the therapist, independent of the model being utilized, contributes significantly to therapeutic change within sessions. In order to be an effective therapist, Bowen (1978) discussed the need for therapists to work on one's level of differentiation within their own lineage, which can

lessen the over-involvement of the therapist and minimize emotional responses.

Differentiation of self is important for the therapist. If the level of differentiation is lower than the person in front of you, then your acts of service may not be beneficial for them. Essentially, the greater the level of a therapist's undifferentiation, the more the therapist is susceptible to reacting to anxiety provoking situations, potentially impacting therapeutic sessions negatively.

Not many empirical studies have supported the idea that one's level of differentiation is correlated with a greater capacity in managing the emotional reactivity in interpersonal relationships (Wei, Vogel, Ju, & Zakalik, 2005). However, Titelman (2014) wrote about the difficulties in accurately capturing the phenomenon of differentiation due to the nature of it being on a continuum, fluctuating based on the context in which the person is present. According to Frost (2014), an important challenge in researching differentiation of self is to note the ways in which the other concepts and variables explained within Bowen's Family Systems Theory interlock with differentiation. In essence, from a Bowenian perspective, in order to be able to see differentiation, the researcher must capture a broad panoramic view of the participants' experiences by utilizing Bowenian concepts.

The emotionally intense environment of hospice is often stressful and anxiety-filled, resulting in probable complications in separating emotional functioning between the self, patient, and family of patients. Kerr and Bowen (1988) viewed emotional functioning between therapist and client as a system of interactions. These interactions can be viewed as a transfer of energy, of anxiety. The current study will seek to explore these interactions, with an eye toward how the grief narratives of the patients and family

members impact their hospice bereavement coordinators. Therefore, the research question will be, “How does dealing with grief on a daily basis affect the functioning of mental health professionals in both their work and family system?”

Significance of the Study

This research benefits members of the healthcare community and the field of marriage and family therapy. There is little to no research on how dealing with grief on a daily basis affects the functioning of a mental health professional in both his or her work and family system, adding to literature on Bowen’s Family Systems Theory. The emotional functioning of the mental health professional cannot be viewed separately from the emotional functioning of the client (Kerr & Bowen, 1988). In fact, one can view each functioning as a potential transfer of energy, or anxiety between each member of the therapeutic session. Anxiety can begin within one member of the family and infect the whole family in its wake (Kerr & Bowen, 1988). The current study explored these transfers of energy before, during, and after bereavement sessions and how the bereavement coordinators are affected throughout their lives by these interactions.

To further highlight the aim of this study, Bowen explained that every human behaves in symbiotic relationships, emotionally responding and reacting in a reciprocal relationship to one another (Haefner, 2014). Therefore, if family members can transfer and absorb each other’s energy (anxiety) then clients and therapists can also transfer and absorb each other’s energy. Additionally, when the therapist has higher levels of chronic anxiety (correlates to lower levels of differentiation) present within the therapeutic session, emotional responses and reactivity tend to manifest, resulting in more basic, primitive, and emotionally charged responses (Bowen, 1978; Kerr & Bowen, 1988;

Papuro, 2014). In addition, Regas (2011, 2013, 2014a, 2014b) explored throughout his studies the need for therapists to work on their levels of differentiation of self in order to become more effective with their clients, lessening the over involvement of the therapist and minimizing emotionally charged responses during sessions (Bowen, 1978).

The ability for an individual to be a *self* in the face of others within an emotional unit, distinguishing between their own emotions, feelings, and intellect and that of the group, contributes to a higher level of differentiation (Bowen, 1978; Haefner, 2014; Kerr & Bowen, 1988; Papero, 2014; Titelman, 2014). Thus, understanding ones emotional, feeling, and intellectual process can be helpful to the therapist in order to provide optimal and effective therapeutic services, becoming less susceptible to anxiety-provoking situations and potentially increasing emotional independence. This study highlighted not just how clients can be impacted by a therapist, but also how a therapist can be impacted by the client's grief symptomology on a daily basis. This study adds to the literature surrounding the healthcare community and the marriage and family therapy field; however, the application of this research can benefit those mental health professionals working within other clinical settings (e.g., LGBTQ, addictions, domestic violence, foster care). Therapists are human, and each mental health professional comes face-to-face with their own losses, whether death or non-death related.

Summary

In summary, this dissertation study explored the experiences of mental health providers working in hospice care settings utilizing Bowen family systems theory as the conceptual framework in understanding their experiences. The aim of the research was to explore the relationship between how a bereavement coordinators' level of differentiation

is affected by the clientele being serviced. Interpretative phenomenological analysis (IPA) was utilized in order to capture the experiences of mental health professionals in hospice. As stated before, due to the lack of empirical research, the healthcare community and the field of marriage and family therapy would benefit from the findings of the study. Within the subsequent chapter, I will be addressing the current academic literature on Bowen family systems theory, death and dying, and grief and loss, focusing on their interconnectedness.

CHAPTER II: LITERATURE REVIEW

The Hospice Program

Quantity of life changes to quality of life once a patient and their family decides to enter within a hospice program. Essentially, the norm within the medical setting is to pursue curative measures in order to prolong the life of an individual; however, during the care of hospice, the patients have a prognosis of less than six-months of life left as designated by a physician. In fact, The Hospice Foundation of American (HFA) (2018b) posit:

Hospice offers medical care toward a different goal: maintaining or improving quality of life for someone whose illness, disease or condition is unlikely to be cured. Each patient's individualized care plan is updated as needed to address the physical, emotional and spiritual pain that often accompanies terminal illness. Hospice care also offers practical support for the caregiver(s) during the illness and grief support after the death. Hospice is something more that is available to the patient and the entire family when curative measures have been exhausted and life prognosis is six months or less. (www.hospicefoundation.org/Hospice-Care/Hospice-Service)

Comparably, the National Hospice and Palliative Care Organization (NHPCO) (2018) defines hospice as the optimal quality care given to patients who are in the process of facing a terminal illness, providing psychosocial care, pain management, and emotional and spiritual support for the patient and entire family throughout the hospice journey.

In order to qualify for hospice, a physician would have to assess the patient and determine if “curative measures,” such as chemotherapy, radiation, surgeries, and/or multiple curative medication regimens, would not benefit (FHPCA, 2019). Once evaluation has been completed, the physician would create a referral for the patient to hospice if “curative measures” will not be of value. The Florida Hospice and Palliative Care Association (FHPCA, 2019) outlined the needed criteria to be considered for hospice services as follows:

- Your doctor and the hospice medical director certify that you are terminally ill and probably have less than six months to live.
- You sign a statement choosing hospice care instead of routine Medicare covered benefits for your terminal illness.

Furthermore, services can be rendered in a variety of different settings (NHPCO, 2018): independent living facilities, assisted living facilities, hospitals, patient homes, nursing homes, and other long-term care facilities.

For the patient and their family, hospice can be an anxiety-provoking environment. However, hospice can also be an anxiety relieving process where the patient has accepted the situation along with the members of the family. Not to say that there is no apprehension with waiting for the final hour to approach. For instance, hospice steps into the family system to assist in emotional, spiritual, and psychosocial support, helping to ease the weight of caregiving to the patient. Due to the emotionally intense environment, the hospice program may provide alleviation of anxiety that the family can face throughout the duration of the terminal illness. In order to keep the patient comfortable and pain-free, an interdisciplinary team member steps forward to create a care plan that

fits for the family and patient, measuring, assessing, and evaluating medication dosages, mental health therapy's effectiveness, and overall goal-oriented services being rendered in relieving physical and emotional symptomology within the patient and members of the family (NHPCO, 2018).

Bridging Systemic Theory and The Interdisciplinary Team

The interdisciplinary team seeks to assist by alleviating the anxiety within the family context. It seeks to provide optimal, end-of-life care for the patient and the members of their family. The interdisciplinary team is made up of physicians, nurses, certified nursing assistants (CNAs), spiritual advisors (rabbis, chaplains, priest, etc.), mental health professionals (marriage and family therapists, mental health counselors, and social workers), and volunteers (NIH, 2017). The interdisciplinary team collaborates with each other in order to develop a care plan tailored to the patient and the patient's family to meet their subjective needs in regards to pain management and symptom control (NHPCO, 2018).

Furthermore, Boyd, Watters, Canfield, and Nativ (2011) specified, "Each member of the team brings a particular understanding and provides a unique solution to address the patient's emotional and physical pain" (p. 28). Essentially, the individual aspects of the patient (spiritual, emotional, physical, cognition, and more) come together within the environment of hospice in order for the patient to be rendered with optimal, end-of-life care. In relation to systems thinking, the fundamental premise is shifting one's attention from the part to the whole (Checkland, 1997; Jackson, 2003; Weinberg, 2001), resulting in the indistinction of the individual properties to the overall construct. Hence, the interdisciplinary team within hospice, with each professional's expertise, is able to cater

to those individual aspects (parts) of the patient to make sense of the overall picture (whole). Likewise, Mele et al. (2010) elucidated that in order to comprehend a phenomenon, one has to turn from looking at the rudimentary components and turn to a global vision to underline the functioning. These systemic notions circle back to the central thoughts revolving von Bertalanffy's general systems theory (1968), which denotes that a system is a complex of interacting elements from part-to-whole and whole-to-part. Allowing for a holistic perspective to unfold for each patient and their family, offers the construction of a care plan specifically designed, and tailored, to the wants and needs of the patient in facets within their life (medical, spiritual, and emotional).

The act of collaboration transpires as a result of interdependence among the team members, operating as one unit and not working solely within the scope of their discipline's boundaries—again, part-to-whole. Wittenberg-Lyles, Oliver, Demir, and Regehr (2010) conducted a study, which found that having flexibility of a specific job function affords individual parts of the interdisciplinary team the opportunity to work together interdependently, allowing for the creation of novel professional activities that would not be possible without collaboration of the team members. Creation of novel activities can further allow for higher level of care during the emotional rollercoaster of hospice, providing further means to move more toward emotional neutrality of the anxiety being faced by the patient and family. Implementing a holistic perspective could allow for collaboration between each professional, drawing attention on the interconnectedness among the parts by reference to the whole.

Bowen Family Systems Theory

The development of Bowen Family Systems Theory did not occur until the early 1950s when Bowen discovered the emotional patterns within the members of families diagnosed with schizophrenia at the National Institute of Mental Health (Kerr & Bowen, 1988; Kerr, 2003; Titelman, 2014). Bowen's notions were able to switch the focus from the diagnosis being processed from a mother-patient orientation to processing schizophrenia as a manifestation of a distraught family, making strides within the field of Marriage and Family Therapy. In fact, Bowen postulated: "The family is a system in that a change in part of the system is followed by compensatory change in other parts of the system" (Bowen, 1978, pp. 154-155). Bowen's intergenerational perspective proposed that humans are a product of evolution, which suggests that similar forces that govern behavioral patterns within other living organisms contributes to the patterns seen and regulated in humans (Bowen, 1978; Kerr & Bowen, 1988). To elucidate, Kerr and Bowen (1988) posits,

The concept of a natural system, in other words, assumes that systems exist in nature independently of man's creating them. The existence of natural systems does not even depend on the human's being aware of them. The principles that govern a natural system are written in nature and not created by the human brain. (p. 24)

As stated within the prior chapter, we do not govern the system; the system (the natural system) governs us as it does within the ecological and biological systems. The emotional response and reactivity of an angry person cannot be understood in isolation without the consideration of the environmental context and intergenerational patterns

within the family. Comparably, a gazelle will not run in terror without a predator lurking in its midst due to its instinctual nature to survive. Principally, Bowen acknowledged that humans behaved in symbiotic relationships, emotionally responding and reacting in a reciprocal relationship to one another, identifying that patterns and unresolved problems within the family tended to repeat themselves over generations (Haefner, 2014). Bowen Family Systems Theory offers a framework for understanding natural human patterns of an individual in relation to its system (Bowen, 1978; Kerr, 2003; Kerr & Bowen, 1988;).

One of the pivotal components within Bowen Theory is anxiety, which can be defined as “the response of an organism to a threat, real, or imagined” (Kerr & Bowen, 1988, p. 112). Anxiety can be assumed to be a process in which all living organisms are in accordance with, and can be thought of as a force of nature that is constantly being exchanged and is the energy around all human relationships (Kerr & Bowen, 1988). Essentially, since the energy around all human relationships is anxiety, then there could be potential transfers of said energies between species. The manifestation of the energy generated by anxiety acts as the driving force of life, and survival becomes primal. Michael Kerr and Murray Bowen (1988) debated that anxiety and emotional reactivity have certain adaptive functions for an organism and is needed for its survival; too much and too little affects the survival of the species. Equally, Bateson, Brilot, and Nettle (2011) explained within a study that human anxiety responses prepares the individual to detect and deal with threats from an evolutionary standpoint. For instance, if the transfer of anxiety (of energy) from a herd of gazelles to a baby gazelle, a fawn, were absent, circumstances would look different when a predator was present during the adult years of the baby fawn.

From a Bowenian perspective, the emotional functioning of an individual can be rooted within the individual's family of origin along with the emotional reactivity and responses to certain stimuli (Comella, 2011). In essence, the natural forces within the system in which the individual is in attempts to shape the individual's emotional functioning, which can preclude one's way of thinking, behaviors, cultural values, spiritual notions, expectations within life, and so forth. Fundamentally, the emotional functioning of an individual that is shaped within the context of the family system serves as a foundational point as to how the individual will have interactions outside of their system (i.e., school, workplace, intimate/interpersonal relationships, and so forth) (Comella, 2011). Bowen (1978) understood that a change within one part of a system could send a shockwave of additional changes within other parts of the system. The energy, the anxiety, generated within one change can ripple and generate additional energy, anxiety, within the system, generation to generation. Comella (2011) best encapsulates Bowenian philosophies as a way for an individual to become conscious of the role and function of their emotional functioning in hopes for logical, not emotional, responses.

Furthermore, Bowen stated that the emotional symptoms of an individual are a representation of the emotional symptoms of the family, embedded within multi-generational patterns (Haefner, 2014; Kerr & Bowen, 1988; Kerr, 2003). To explain the interlocking forces that contribute in shaping family functioning, Bowen established eight concepts and four theoretical assumptions. The eight Bowenian concepts are as listed (Bowen, 1978; Kerr & Bowen, 1988): (a) triangles, (b) differentiation of self, (c) nuclear family emotional process, (d) family projection process, (e) multigenerational

transmission process, (f) emotional cutoff, (g) sibling position, and (h) societal emotional process. Contrarily, the four theoretical assumptions proposed by Bowen are as follows (Bowen, 1978; Kerr & Bowen, 1988): (a) chronic anxiety, (b) individuality and togetherness, (c) the emotional system, and (d) the emotional unit.

Chronic Anxiety

Anxiety can be described as the “response of an organism to a threat, real or imagined” (Kerr & Bowen, 1988, p. 112). Bowen proposed that the more anxiety was present within the individual, the more likely there would be an intense, emotional reactivity, discussing the subjective manifestations (i.e., sense of awareness and fear) and objective manifestations (i.e., bodily reactions to stimuli) of anxiety (Kerr & Bowen, 1988). Emotional reactivity, an uncontrolled reaction to a stimulus, can also be understood as manifesting within a continuum that “ranges from hyperactivity (the extreme behavioral frenzy) to hypoactivity (the extreme is behavioral paralysis)” (Kerr & Bowen, 1988, p. 112).

As stated in prior sections, anxiety can be seen as the driving force being exchanged by all of the living organisms, and is the energy around all human relationships (Kerr & Bowen, 1988). Bowen was able to distinguish between two anxieties that distinctly affect human relationships: acute anxiety and chronic anxiety. Kerr and Bowen (1988) defined acute anxiety as such,

Acute anxiety generally occurs in response to real threats and is experienced as time-limited. People usually adapt to acute anxiety fairly successfully. . . . Acute anxiety is fed by fear of what is. (p. 113)

In essence, acute anxiety is capable of being resolved after some time has past, and is considered to be situational. An example of acute anxiety would be a student presenting a project in front of the class. Anxiety may stir up feelings within the student, yielding to objective manifestations of anxiety, which may preclude nervousness and increased heart rate. The event is situational and time-limited due to the presentation being a one-time affair for a particular class. Anxiety may be self-correcting and may resolve once the event has been settled (or even during the event).

In contrast, chronic anxiety can be understood as being different from acute anxiety by where chronic anxiety makes it difficult to adapt to the energy being exerted by the manifestation. Kerr and Bowen (1988) explained chronic anxiety as such,

It is most accurately conceptualized as a system or process of actions and reactions that, once triggered, quickly provides its own momentum and becomes largely independent of the initial triggering stimuli. While specific events or issues are usually the principal generators of acute anxiety, the principal generators of chronic anxiety are people's reactions to a disturbance in the balance of a relationship system. (p. 113)

In other words, chronic anxiety can be thought of as a learned response manifested through one's lineage, conceptualizing a framework in which the person can survive the world based upon their family's genetic formula related to survival of their clan (Bowen, 1978; Kerr & Bowen, 1988). To help illustrate this concept, my family helped me understand that it is better to not be judged by those outside of our system, but by those within our system—appearance was everything within my emotional unit. Chronic anxiety was a living, breathing organism that travelled from my maternal

grandmother to her three children and then to her grandchildren. Everyone's expectations of a perfect family needed to be met in order for the survival of our system to be fulfilled. Anything that would threaten that survival would cater subjective manifestations of anxiety—a means to emotional stabilization. The anxiety is then not time-limited due to its manifestation within the family of origin.

Each of the proclaimed anxieties' have their own adaptive functions for an organism—too much and too little affects the survival of the species. Anxiety is necessary to prepare the species to detect and deal with threats from an evolutionary standpoint, allowing for the continued existence of the living organism (Bateson et al., 2011; Kerr & Bowen, 1988). Moreover, anxiety within the family context can be thought of as having its own, unique signature, defining its own boundaries according to the type of energy that system possesses. Every species and every person are not the same. Survival and adaptation to the environment surrounding the species can look differently within each emotional unit, which can further elucidate the inimitability each family possesses. As previously indicated, since the energy around all human relationships is anxiety, then there could be potential transfers of said energies between species, which explicates the notion that anxiety can begin within one member of the family and infect the whole family throughout its wake (Kerr & Bowen, 1988).

Similarly, Comella (2011) understood chronic anxiety as such: "People's flexibility to adapt is directly related to their level of chronic anxiety and the relationship system to which they belong" (p. 9). Each individual has their own comfortable level of potency in terms of their anxiety, fluctuating in relation to the system as an energy force that increases and decreases by duration, frequency, and intensity (Kerr & Bowen, 1988).

Additionally, in order to reduce one's level of chronic anxiety and emotional reactivity, one would have to distinguish between feeling and thinking responses within oneself and others, maintaining awareness by not blaming oneself and others, but by noticing the roles and function the self and others play within the relationship process (Bowen, 1978; Comella, 2011; Haefner, 2014; Kerr & Bowen, 1988), which further attests to Bowen's concept of The Emotional System.

The Emotional System

The concept of the emotional system is one of the most important ideas within Bowen's Family Systems Theory, providing a foundation for establishing a behavioral connection between humans and other animals (Kerr & Bowen, 1988). Essentially, the concept of the emotional system can be described as such,

Defined broadly, the concept postulates the existence of a naturally occurring system *in all forms of life* that enables an organism to receive information (from within itself and from the environment), to integrate that information, and to respond on the basis of it. (Kerr & Bowen, 1988, p. 27)

Bowen also posits,

Emotional functioning includes automatic forces that govern protoplasmic life. It includes the forces that biology defined as instinct, reproduction, the automatic activity controlled by the nervous system, subjective emotional and feeling states, and the forces that govern relationship systems. There are varying degrees of overlap between emotional and intellectual functioning. In broad terms, the emotional system governs the 'dance of life' in all living things. (Bowen, 1978, p. 356)

Every species and every person are not the same, which means that survival and adaptation within the environment surrounding the individual and species can look differently within each emotional unit. Each emotional system has a distinct comfort level in relation to their anxiety; every emotional system's dance of life will look different. Bowen would describe this as each family having their own genetic formula toward survival (Bowen, 1978; Kerr & Bowen, 1988). The notion behind the genetic formula can be in accordance with the unique energy each family possesses that assist in shaping the system. The energy, the anxiety, can be managed by being mindfully present within the scenario, thinking logically on how the roles and functions within an emotional unit interplays within the relationship process (Bowen, 1978; Comella, 2011; Haefner, 2014; Kerr & Bowen, 1988).

Bowen identified three major systems within the evolution of human brain development that assist in guiding human behaviors: the emotional system, the feeling system, and the intellectual system. The emotional system can be described as an automatic, hard-wired sensitivity and accompanying anxiety humans have to one another—from the level of our cells to our psychological and social reactions and interactions. The emotional system can be denoted as our innate need toward survival, safety, and reproduction. By contrast, the feeling system can be described as a more sophisticated form of the emotional system, concentrating on the superficial aspects of the emotional system (Kerr & Bowen, 1988). In essence, the feeling system is based on the feelings that are felt when situations occur (i.e., mutual interest, jealous, possessiveness, love, shame, guilt, loyalty, and so forth). The final system, the intellectual system, can be described as the ability for an individual to think logically,

comprehend, and understand the self within the context of a situation. Bowen would argue that man is distinct from other species due to their ability to convey their thoughts and understanding (Bowen, 1978; Kerr & Bowen, 1988). In essence, we shift from thinking individualistically to focusing on the interactions between the parts each person plays. Each system is interchangeable within certain given contexts depending on the type of anxiety the individual may be facing at that specific moment.

The level of anxiety present within an individual, in relation to their duration and intensity, can influence the system, making it difficult for individuals to distinguish between feeling and thinking responses (Bowen, 1978; Comella, 2011; Haefner, 2014; Kerr & Bowen, 1988). In other words, when more anxiety is present, the more likely an individual's behavior is driven by basic and primitive functions, yielding to emotionally charged responses. The individual's behavior, thus, becomes more driven by the emotional system, where the primal concern involves the fundamentals of survival and safety. However, the less anxiety an individual possesses, the more able a person would be able to think logically and understand the function and roles of each person including themselves within the intellectual system (Bowen, 1978; Bowen & Kerr, 1988; Comella, 2011). When anxiety escalates beyond the threshold, or limit, outside the range of the individual or of the emotional unit, triangles or interlocking triangles may form in order to provide emotional equilibrium (Comella, 2011).

The interdisciplinary team: An emotional system. As discussed in a prior section, the interdisciplinary team is made up of physicians, nurses, certified nursing assistants (CNAs), spiritual advisors (rabbis, chaplains, priest, etc.), mental health professionals (marriage and family therapists, mental health counselors, and social

workers), and volunteers (NIH, 2017), which all serve to collaborate and provide optimal, end-of-life care to terminally ill patients and patient families. Like an emotional unit, the interdisciplinary team can be seen as a family system due to the simplicity (predictability) and complexity (additional contextual factors) that are present within and outside of the unit (Bowen, 1978). Kerr and Bowen (1988) explained,

While the anatomical and physiological substrates of emotionality are contained within the physical boundaries of individual organisms, much of the emotional functioning of the organism is geared to its relationship with other organisms and with the environment. In fact, the functioning of the individual is often incomprehensible out of the context of the individual's relationship to the group. (p. 30)

In essence, the interdisciplinary team can be considered a family with each member of said system having their own function and role, culture, and means toward survival of the organization as a part and whole of the overarching organization. Again, survival is not guaranteed for every organism; however, from a Bowenian perspective in business, survival is absolutely necessary in order for the business to remain in good standing, and thrive within its environment in order to be more stable. Just like each member of a family, each member of the interdisciplinary team plays a function in keeping the unit as stable as it could be—allowing the energy of anxiety to be distributed and contained within the system (Bowen, 1978). Equally, stress and anxiety are a life force constantly being shifted, exchanged, and generated within different living organisms. Bregman and White (2011) elucidated on how decreasing stress and anxiety within the work environment can assist in increasing logical, coherent thinking within the

system. Correspondingly, Romig (2011) explicated on the hardship stress and increased anxiety within the workplace has on employees and the organization, yielding to the inability to seek out and think of solutions.

Thinking in these terms, one can consider the interdisciplinary team as an emotional system. Working within hospice, an emotionally intense environment, anxiety constantly is being distributed between and within each member of the team, depending on the case. The patient, the patient's family members, the team member's level of autonomy, the level of participation of directors and supervisors, the over-functioning and under-functioning of certain members, and so forth, all constitute a particular kind of emotional environment. Due to the different levels of intensity, duration, and sheer quantity of anxiety each case presents to the interdisciplinary team, the unit and its overall functioning can constantly be said to be fluctuating between the Emotional, Feeling, and the Intellectual Systems.

Survival and adapting within the environment looks different for every species, every person, and for every interdisciplinary team within a hospice, yielding to distinct comfort levels in relation to the generated anxiety (Bregman and White, 2011). Similar to any family, the team has its own genetic formula toward survival, sanctioning each member's energy in contributing to the overall shaping of the system (Bowen, 1978; Kerr & Bowen, 1988).

Triangles and Interlocking Triangles

When anxiety escalates beyond the threshold, or limit, outside the range of the individual or of the emotional unit, triangles or interlocking triangles may form in order to provide emotional equilibrium (Comella, 2011). Bowen elucidated, "The triangle is the

basic molecule of an emotional system. It is the smallest stable relationship unit” (Kerr & Bowen, 1988, p. 134). When there is an increase in pressure or emotional strain within a two-person relationship, a third person may be pulled into the two-person relationship in order to decrease the anxiety within the relationship (Bowen; 1978; Comella, 2011; Haefner, 2014; Kerr & Bowen, 1988). The triangle can be seen as a way to manage relational energy.

As stated previously, anxiety can be described as “the response of an organism to a threat, real, or imagined” (Kerr & Bowen, 1988, p. 112). Therefore, anxiety can be seen as being generated, exchanged, and surrounding each living organism that strive toward a means of survival, distancing and amplifying itself within the context of each dyad. Similarly, Bowen (1978) would agree that emotional forces within a triangle are constantly in motion, shifting back and forth in order to stabilize an emotional unit; however, the fluctuations toward emotional equilibrium within a triangle does not resolve the source of the anxiety.

The distribution of anxiety can sometimes not be contained within solely one triad; therefore, the anxiety within a dyad can shift and move into other triangles within an interlocking manner. Bowen (1988) would describe this process as being called interlocking triangles whereby anxiety is “unable to be contained within one triangle, overflows into one or more other triangles” (p. 140). In essence, when describing a family, the tension between a wife and her father can cause her husband to be pulled into the dyad; however, when the third person cannot assist in diffusing the said tension, then other members may be pulled in to contain the anxiety, generating multiple relational triangles to relieve the tension (i.e., wife-father-husband, wife-father-son, wife-father-

mother, and so forth). Again, due to the effervescent nature of anxiety and how there is a constant exchange of energy, patterns of triangulation can tend to repeat themselves across generations as learned patterns of behavior (Bowen, 1978).

Moreover, triangles may be understood as being neither a positive and negative concept; however, triangles and interlocking triangles could be understood as a generated energy. Each unit has its own quantity, duration, and intensity of the energy that gets exchanged, generated, and shifted back and forth within the triad. Due to these shifts, there may be a unit within the triad that does not receive as much energy as the other two, but the intensity, duration, and quantity of the energy is always shifting and distributing itself onto each of the members. According to Kerr and Bowen (1988),

To observe triangles, it is necessary to see “past” the symptoms to the underlying emotional process: the interplay of individuality and togetherness of anxiety on that interplay. To observe triangles, it is also necessary to recognize the influence on one’s perceptions of one’s own emotional reactivity to the system. (p. 151)

As previously stated, the manifestation of the energy generated by anxiety acts as the driving force of life, and survival becomes primal. Every person within a triad has his or her own means toward said survival, which means that triangles are ever-present. Kerr and Bowen (1988) would argue, “Nobody is immune from being triangled and nobody is immune from triangling others” (p. 161). When one triangle disappears, another forms soon after. In addition, triangles can even form through inanimate objects and belief systems (Bregman & White, 2011): medical settings, religion and pastoral care, music and art, organizations and different work environments, educational settings, and so forth.

Triangulation can even be seen in biology within cells, a person plagued by addiction, and more.

Furthermore, Kerr and Bowen (1988) explained, “If people can maintain, their emotional autonomy, triangling is minimal, and the system’s stability does not depend on it” (p. 139). When one is able to manage relational triangles efficiently in order to increase the functioning of the emotional unit and of the self, one has achieved a healthy level of differentiation of self, allowing one’s own quandaries to be contained and not contaminate others (Bowen, 1978; Comella, 2011; Kerr & Bowen, 1988; Titelman, 2014).

Differentiation of Self

Differentiation of self can be seen as one of the pivotal Bowenian concepts that assist in explaining the interlocking forces that help shape family functioning. Differentiation of self is viewed as an automatic, natural process within the human race, whereby defining self is an intentional process that can be modified by the individual lowering or raising of their level differentiation of self (Titelman, 2014). According to Kerr (1988), “differentiation can be defined as an ability for the individual to be an individual while being emotionally present and part of a group, a system” (footnote, p. 63). Essentially, the concept can be understood as a way for the individual to distinguish between emotions, feelings, and intellect within themselves and others part of their system. Comparably, Bowen (1978) argued: “The core of my theory had to do with the degree to which people are able to distinguish between the feeling process and the intellectual process” (p. 355).

When the individual maintains an emotional link in relation to the system while being able to define oneself within said system, a higher level of differentiation within the context has been achieved (Bowen, 1978; Haefner, 2014; Kerr & Bowen, 1988; Papero, 2014; Titelman, 2014). However, “a poorly differentiated person is trapped within a feeling world . . . and has a lifelong effort to get the emotional life into livable equilibrium’ (Bowen, 1976, p. 67). In other words, a poorly differentiated individual would be an emotional prisoner within the emotional system, struggling to distinguish between their own individual emotions, feelings, and thoughts and those of the system the individual is a part of, becoming more susceptible to anxiety-provoking situations, increasing emotional independence. Kerr and Bowen (1988) explained the levels of differentiation of self as such,

The higher the level of differentiation of people in a family or other social group, the more they can cooperate, look out for one another’s welfare, and stay in adequate contact during stressful as well as calm periods. The lower the level of differentiation, the more likely the family, when stressed, will regress to selfish, aggressive, and avoidance behaviors; cohesiveness, altruism, and cooperativeness will break down. (p. 93)

People having the ability to think coherently throughout situations, regardless of the intensity and duration of the anxiety that is being exerted, have the capability to think more logically rather than react emotionally, allowing the individual to recognize the role and function they play within the generated anxiety and how to respond to said anxiety. Moreover, when an individual is able to be mindful and aware of their own anxiety without the anxiety spilling over and contaminating others, the individual will be able to

enhance their own well-being, and develop an improved sense of self (Bowen, 1978; Comella, 2011; Kerr & Bowen, 1988; Titelman, 2014). As previously stated, “Family systems theory emphasizes the *function* an individual’s behavior has in the broader context of the relationship” (Kerr & Bowen, 1988, pp. 48-49). In essence, the individual is attentive and thoughtful of the role and function they have within the generated anxiety (i.e., highly differentiated), which allows for collectively thoughtful and rational responses to the anxiety within the relational system. Schnarch and Regas (2012) explained how individuals within the higher end of differentiation were able to not abide by the irresponsibility of others, whereas, those within the opposite end are able to balance emotional contact with other’s and not get absorbed within the anxiety other’s manifested or generated.

Additionally, Bowen proposed two primal forces that are constantly counterbalancing each other within the emotional system, describing them as the underpinning for the concept of differentiation of self (Titelman, 2014): individuality and togetherness. Bowen would conceptualize individuality as an instinct in which the individual “propels the individual to be separate, independent, and distinct entity, following his/her own directives” (Titelman, 2014, p. 25). Togetherness can be seen as the individual propelling himself or herself toward being “connected, dependent, and indistinct part of a couple, family, or nonfamily group” (Titelman, p. 25). Bowen theorized that these two primal forces are in constant tension within the Emotional System and the Feeling Systems. It is only through the functions of the Intellectual System that these forces are able to bring into any kind of working balance (Bowen, 1978; Kerr & Bowen, 1988). In essence, the lower the individual’s differentiation of self,

the more likely emotions and feelings governs the two forces. The higher the individual's differentiation of self, the more likely some kind of a balance of the two forces can be achieved.

Intriguingly, Bowen's concepts interplay with each other in a way that helps to further explain the theory of differentiation of self. With the concepts mentioned previously, each one bleeds into the next in order to better comprehend differentiation: chronic anxiety, the emotional system, and triangles (interlocking triangles). For example, lower levels of differentiation of self can be associated with higher levels of chronic anxiety, whereas higher levels of differentiation of self can be correlated to lower levels of chronic anxiety (Kerr & Bowen, 1988; Titelman, 2014). Furthermore, an individual with lower levels of differentiation of self can be more easily held emotionally captive within the emotional system due to not being able to separate self (personal thoughts, emotions, and beliefs) from the group. Conversely, individuals with higher levels of differentiation have better capacity to function within higher levels of thoughtfulness, allowing for the individual to be less emotionally reactive when chronic anxiety increases (Kerr & Bowen, 1988; Papero, 2014). Lastly, in regards to triangles, Bowen explained, "the lower the level of differentiation in a family, the more important the role of triangling for persevering emotional stability" (Kerr & Bowen, 1988, p. 139). Maintaining one's differentiation allows the individual to keep from infecting others from one's own problems in terms of triangles (Kerr & Bowen, 1988).

Research on differentiation. Researchers have been able to explore within studies how differentiation has been applied within different contexts and relational dynamics. Bowen's Family Systems Theory, as described before, can be applicable to

many facets within different disciplines, cultures, and contexts besides the mental health profession (Bregman & White, 2011); however, there is a gap within empirical research regarding the some of the propositions of Bowenian Theory (Nichols, 2014). Some researchers have attempted to quantify Bowen's concept on differentiation of self by developing certain scales: Haber's Level of Differentiation of Self Scale (1993), Skowron's Differentiation of Self Inventory (DSI; Skowron & Friedlander, 1998), DSI Emotional Reactivity and Emotional Cutoff (Wei, Vogel, Ku, & Zakalik, 2005), and Chabot's Emotional Differentiation (CED) Scale (Licht & Chabot, 2006).

Furthermore, research on the notion of differentiation has been conducted in order to achieve a higher understanding on the Bowenian concept in relation to lower chronic anxiety: trait anxiety (Griffin & Apostol, 1993; Haber, 1993; Peleg-Popko, 2002; Skowron & Friedlander, 1998), marital satisfaction (Haber, 1984; Richards, 1989; Skowron, 2000; Skowron & Friedlander, 1998), psychological and physical health problems (Bartle-Haring & Probst, 2004; Bohlander, 1995; Davis & Jones, 1992; Elieson & Rubin, 2001; Haber, 1993; Peleg-Popko, 2002; Skowron & Friedlander, 1998), greater psychological adjustment (Skowron & Friedlander, 1998), self-regulatory skills (Skowron & Dendy, 2004), lower relationship violence (Skowron & Platt, 2005), and substance abuse (Thorberg & Lyvers, 2006). Moreover, attempts to support the connection between cross-cultural validity and varying differentiation of self-inventories have developed over the years: persons of color have higher psychological adjustment and greater differentiation of self (Knauth & Skowron, 2004; Tuason & Friedlander, 2000), resolution skills, and having positive feelings and emotions toward one's ethnic group (Skowron, 2004). Skowron (2005) also conducted a study in which he found that

low-income mothers with higher differentiation of self is linked to greater academic achievement and fewer behavior problems in their children.

Again, Kerr and Bowen (1988) posits that less differentiated individuals with higher levels of chronic anxiety, become more dysfunctional under stress and were more prone to getting wrapped into the emotional orbit of others, which manifested more anxiety symptomology— bounded into physical, psychological, and social symptoms (Kerr, 2008). Individuals with higher levels of differentiation of self;

Have enough confidence in their ability to deal with relationships, even emotionally intense ones, so that they neither avoid them nor become highly anxious in encountering them. (Kerr & Bowen, 1988, p. 118)

Similarly, more recent studies have been conducted to build a bridge between differentiation of self and other subject matters, uncovering how the emotional and intellectual systems are distinguished at higher levels of differentiation of self (Bowen, 1978).

Research has been conducted on the impact of differentiation of self on behavior related to health. For instance, a study conducted by Peleg-Popko (2002) revealed significance in how lower levels of differentiation predicted somatic complaints and social anxiety within a sample of young adults from Israel. Moreover, another study investigated how higher levels of differentiation of self contributed to lower levels of intrusive thinking from the participants during genetic cancer screenings, which, in turn, led to predicting partner distress during genetic counseling (Bartle-Haring & Gregory, 2003). These findings, also, coincide with the notions proposed in Bowen Theory on how

physical symptoms can manifest within individuals with lower levels of differentiation (Bowen, 1978; Kerr, 2008; Kerr & Bowen, 1988).

Additionally, research has asserted that when an individual has lower levels of chronic anxiety, there is an increase of cognitive functioning. Knauth and Skowron (2004) conducted a study in which the researchers found that higher differentiation of self within adolescents correlated with lower levels of anxiety, and overall symptomology (physical, psychological, and social symptoms; Kerr, 2008). Moreover, adolescents' anxiety mediated the relationship between differentiation of self and problem solving, proposing that adolescents who are able to manage their anxiety have higher levels of differentiation, which allowed for higher problem-solving skills (Knauth, Skowron & Escobar, 2006). The presented studies suggest that adolescents with higher levels of differentiation can exhibit lower levels of anxiety and overall symptomology, which can assist in cognitive performance and emotional functioning.

Due to the emotionally intense environment of hospice, mental health professionals could likely respond and react emotionally during sessions due to the generated anxiety, which can influence the direction of therapy. Bowen postulated that an increase of anxiety might lead to basic, primitive, and emotionally charged responses (Bowen, 1978; Kerr & Bowen, 1988; Papuro, 2014). Regas (2011, 2013, 2014a, 2014b). He claimed that it is the therapist's duty to resolve underlying concerns within their life, and develop himself or herself in order to be most effective with clients. Similarly, Wampold (2001) explained how therapeutic change within session has more to do with the effectiveness of the therapist rather than the model being utilized, which connects to

Bowen's notion on the need for therapists to work on their own level of differentiation to decrease emotional responses within therapeutic sessions (Bowen, 1978).

Differentiation of self is imperative as a mental health professional. When the therapist's level of differentiation is lower than the client sitting in front of the clinician, then the mental health professional's act of service would not be as beneficial due to their susceptibility to reacting emotionally to anxiety-provoking situations, impacting the therapeutic session in a potentially negative manner. Moreover, a study found that the concept of differentiation of self is connected to a higher ability to manage one's emotional responses within interpersonal relationships, resulting in an increase of mature relational functioning (Wei et al., 2005). Furthermore, Aldea and Rice (2006) utilized Skowron's Differentiation of Self Inventory (DSI), finding that higher scores of emotional reactivity and emotional cutoff is correlated to increased levels of anxiety and distress within the research participants. These presented studies can suggest that lower levels of differentiation contribute to higher levels of psychological distress, which can conclude the importance of differentiation in psychological well-being.

Correspondingly, within Bowen's teachings and research, a phenomenon by the name of symbiotic relationships came to light, where Bowen spoke about the premise of relationships acting in terms of another. The emotionally intense environment of hospice can be stressful and anxiety –provoking, which could lead to difficulties in mental health professional in separating emotional functioning between self, patient, and family of patient. Again, Kerr and Bowen (1988) viewed emotional functioning between therapist and client as a system of interactions—such interactions can be considered as a symbiotic relationship. Skowron, Epps, and Cipriano-Essel (2014) understood that mental health

professionals recurrently come into contact with emotionally driven, high intense situations during therapeutic session, affecting the therapist's stress and overall functioning.

Moreover, a sample of students from a university were tested to see if there is a relationship between differentiation, stress, coping, and overall functioning, uncovering that levels of differentiation were positively associated to reflective coping, negatively correlated to reactive coping, and negatively associated to psychological distress (Murdock & Gore, 2004). The researchers within the study were able to conclude that the relationship differentiation of self has with individuals who experience psychological distress supported the notion that further research is needed to expand on the function differentiation has within the interaction (Skowron et al., 2015). Again, there is literature regarding the effectiveness of marriage and family therapists within healthcare; however, there is not much empirical research regarding therapeutic efficacy in marriage and family therapists being within healthcare (Tyndall et al., 2014).

Currently, there is little to no research on bereavement coordinators in hospice with the application of Bowen's Family Systems Theory. Specifically, there were none examining the mental health professionals' experiences in relation to their differentiation of self within the context of grief narratives within hospice, which relates to the notion of research lacking on therapeutic efficacy within healthcare (Tyndall et al., 2014). The research presented within this section highlighted the importance of differentiation of self in developing coping skills, adapting to stresses, lowering overall functioning in relation to anxiety (i.e., societal, biological, and psychological), increasing cognitive and emotional functioning, and decreasing emotional reactivity. Hospice could be a difficult

environment to work in due to the emotional closeness to clients' that mental health professionals are constantly being placed in. This can make professionals more susceptible to getting wrapped in the emotional orbit of others (i.e., employees, patients, and family members of the patient).

Defining self. Going against the grain, trying to define oneself in relationship to others within an emotionally driven system, can be difficult. During times of anxiety-filled situations or events (e.g., mass shootings, hurricanes, deaths within families), systems will tend to move more towards togetherness in order to ensure the survival of the species (Kerr & Bowen, 1988). In other words, when there is an increase of anxiety, the system will tend to be governed by the emotional system and the feeling system. The process of defining self can be understood as a way for an individual to understand his or her position in relation to other significant relationships within his or her life, accounting for the function and role the person serves within other systems (Titelman, 2014). Bowen (1978) postulated,

I believe that the laws that govern man's emotional functioning are orderly as those that govern other natural systems... There are emotional mechanisms as automatic as a reflex and that occur as predictability as the force that causes the sunflower to turn its face toward the sun. (p. 158)

In essence, "defining a self" within the anxiety of the family, the energy, manifested and generated within a system can be challenging. As stated within Bowen's example, the predictability of the sunflower turning its face toward the sun is recognized; comparably, Bowen's concept on Multigenerational Transmission Process (Kerr & Bowen, 1988), in which familial patterns are repeated throughout generations, can be

understood within a similar context. The effort of changing how the sunflower acquires the light of the sun as in the example can compare to the efforts of an individual trying to change in the face of the energy repeating itself throughout his or her generation.

While most people want to consider themselves as individuals, most, if not all, are not willing to give up the comfort that togetherness is able to provide (Kerr & Bowen, 1988). Though, when individuals are willing to partake on a journey in defining themselves, rejection is bound to happen in effort to increase his or her level of differentiation (Kerr & Bowen, 1988). Again, the person can be thought of as the sunflower that strives to not follow generations on how others are able to get said sunlight. Therefore, potential difficulties within the system will surface in effort to reach emotional equilibrium once more. This process is considered to be automatic and instinctual. Furthermore, Bowen (1978) elucidated,

When one member of a family can calmly state his own convictions and beliefs, and take action on his convictions without criticism of the beliefs of others, and without becoming involved emotional debate, then other family members will start the same process of becoming more sure of self and more accepting of others. (p. 252)

Again, the higher the degree of differentiation, the more likely an individual can be a self while in emotional contact with the system. Fundamentally, when the self is well developed the person is able to not impose their own welfare on the welfare of others, and not function at another's expense (Kerr & Bowen, 1988). Kerr (1988) emphasized how people are willing to be individuals to the extent that their emotional unit allows and

approves of, suggesting that a degree of rejection would occur until relational harmony has been met once more.

By defining a self, an individual will not be emotionally reactive to others (undifferentiated), proceeding in a direction to enhance oneself and take responsibility for the function and purpose each person serves within the system, and become less dependent on the acceptance of others (Bowen, 1978; Kerr & Bowen, 1988). The more the individual is able to define a self, the more the individual is able to balance both forces of individuality/togetherness in the face of emotionally intense situations (Kerr & Bowen, 1988). Perhaps, the ability to balance both phenomena is a vital component for mental health professionals during sessions by being a part of the client's world, and by being apart from the client's world. This can be related to Bowen's intellectual system where both components can exist in balance, allowing for higher integration of thoughtful, process questions to deliver effective treatment to the client.

Self-differentiation: The therapeutic significance. Self-differentiation of the therapist is a fundamental part of the therapeutic interaction between a mental health professional and a client. Bowen (1978) discussed the significance of the therapist on working on their own differentiation of self within their family of origin to minimize emotional reactivity and responses during intense sessions. Bowen (1978) explained,

It was more than a state of two people *responding* and *reacting* to each other in a specific way but more a state of two people *living and acting and being for each other*. There was a striking lack of definiteness in the boundary of the problem as well as lack of ego boundaries in the symbiotic pairs. The relationship was more than two people with a problem involving chiefly

each other; it appeared to be more a dependent fragment of a larger family problem. (p. 10)

Again, due to the symbiotic interactions between the therapist and client(s), there could be transfers of energies, of anxiety, within said unit, making it difficult to separate the emotional functioning of the mental health professional from the emotional functioning of client sitting in front of the therapist. These interactions of said energies play a role in shaping therapy as similar as how the manifestation, generation, and distribution of anxiety shapes the functioning and roles within an emotional unit, yielding to a system of interactions (Bowen, 1988).

Moreover, when a clinician is able to become mindful of his or her familial concerns and begin to work on such problems, the therapist will be able to grow and mature, as will the clients being provided services from the very clinician (Bowen, 1988; Regas, 2014a). Similarly, Bowen (1978) explained that a therapist is only able to help a client to a certain extent due to having to work within the limitations of the therapist's own level of differentiation, which yields to the concept of the therapist having to grow (personally and professionally), mature, and work on their own level of differentiation in order to assist the client beyond such constrictions of their own anxieties (Regas, 2014b).

Interestingly enough, there have been researchers who have suggested that clinicians that have an increase of psychological well-being are able to intervene within a therapeutic session, providing more range in terms of choice (therapeutic maneuverability), insight, and creativity (Aponte & Carlsen, 2009). Again, researchers, Murdock and Gore (2004), were able to uncover how students within a university with higher levels of differentiation of self-correlated to lower levels of psychological distress,

which led to better coping skills and overall functioning. Essentially, the mental health professional with higher levels of differentiation is able to be neutral during a therapeutic session, allowing for a greater range in providing services that may benefit rather than hinder the client.

Furthermore, a mental health professional with different levels of differentiation of self will look different within session. For instance, mental health professionals with lower levels of differentiation will tend to react in different ways (Kerr & Bowen, 1988) by accommodating to others in order to alleviate client's anxiety symptomology or lashing out at other individuals due to stress (i.e., burnout). Thus, mental health professionals provide ineffective therapy to clients when lower levels of differentiation are present for the clinician. In addition, Titelman (2014) explained that a mental health professional is more likely to over-function within the client's treatment, worrying and overly involving themselves to relieve their own anxiety, which could cause more harm during the client's treatment. On the other hand, clinicians with a higher level of differentiation are able to not become emotional prisoners to their own clients, avoiding the gravitational pull their client's anxiety can exert. Papero (1990) discussed that those mental health professionals with higher levels of differentiation are able to balance their individuality as well as their connectedness to their clients. Bowen Theory would argue that clinicians would be able to be less emotionally reactive, more secure with their clinical decisions and treatment without being impacted by the opinions and criticism of the client(s), and manage their emotional involvement (Bowen, 1978; Kerr & Bowen, 1988).

In conclusion, the level of differentiation of self the therapist has can potentially impact the therapeutic session for the better or for the worse. Objectivity versus subjectivity during sessions is vital in order for the mental health professional not to get wrapped within the client's own emotional system—emotional responses to external stimuli yields to non-objective logic. When clinicians are able to work on themselves, the professional is able to remain non-reactive and neutral when facing emotionally intense situations (Papero, 1990). When mental health professionals are caught within the client's emotional system, a superficial therapeutic relationship develops; ineffective interventions are done during session; and there is consistent burnout for the therapist.

Differentiating Grief and Loss

Loss is a part of life that is unavoidable, and grief is a part of the healing that takes place from such losses. Dealing with loss can be one of the most difficult times for an individual's life, and the effects of loss are constantly impacting people. Loss can take many forms within a person's life: graduation from school, death of a significant figure within an individual's life, leaving home, death of a pet, loss of one's occupation, divorce/separation from spouse, generational loss, loss of independence, loss of monetary and assets, loss of status with a family, and so forth.

Once more, loss can be defined as "Deprivation, bereavement; failure to retain possession or control of something" (Medical Dictionary for the Health Professions and Nursing, 2012). The Hospice Foundation of America (2018a) describes grief as a reaction to the loss an individual had, or is currently, undergoing, and the experiences of both can be individualized among the members of the family and friends facing said loss. Essentially, grief and loss can look different within each member of the system due to

many impacting contextual factors for every individual: spiritual practices, culture, race, ethnicity, beliefs on mourning and death and dying, and so forth (Walsh & McGoldrick, 2004). As explained before, the emotional functioning of an individual can be rooted within the individual's family of origin along with the emotional reactivity and responses to certain stimuli (Bowen, 1978; Comella, 2011), resulting in the shaping of the individual's emotional functioning within the energy (anxiety) generated within their own system. The energy assist in influencing one's way of thinking, behaviors, cultural values, spiritual notions, and expectations within life, which can serve as a foundational point on how the individual will interact outside of their system (Bowen, 1978; Comella, 2011). This notion coincides with the concept of grief and loss being different and subjective for each individual within, and outside, of their family of origin.

Kerr and Bowen (1988) agreed that less differentiated individuals with higher levels of chronic anxiety, become more dysfunctional under stress and were more prone to getting wrapped into the emotional orbit of others, which could manifest more anxiety symptomology— bounded into physical, psychological, and social symptoms (Kerr, 2008). Grief may generate such symptomology, yielding to common reactions: fatigue and/or exhaustion, difficulty concentrating, depression or sadness, irritability, anxiousness, guilt, remorse, numbness, lack of motivation, changes in appetite, and so forth (HFA, 2018a; NHPCO, 2018).

In essence, there are no universal stages to grief due to the concept being as distinctive as a fingerprint. The style in which an individual grieves to the loss within their life varies depending on different contextual factors the individual associates with, which may also indicate that one's own journey to recovering from grief, and returning to

similar levels of emotional functioning, follows at a subjective pace. Additionally, hospice bereavement coordinators may be asked by any member of the interdisciplinary team to see patients and families of the program, and community referrals that have faced many types of losses: (a) sudden loss, (b) anticipatory grief, (c) complicated grief, (d) traumatic loss, (e) ambiguous loss, and (f) non-death loss.

Types of Grief and Loss

Sudden loss. The concept of sudden loss can be broken down as the loss of an individual from sudden causes. Most of the time, the individual's family members do not have much time to prepare for the loss of their loved one. Granted, the finality of death is never something one can prepare for; however, sudden loss defers in which the family members did not have a chance to say what needs to be said to the deceased, leaving things unsaid and in a state of confusion and members of the family with unanswered questions. Sudden loss tends to be suicides, car accidents, murders/homicides, heart attacks/strokes, tragic events, and so forth. In other words, imagine talking to someone significant within your life, and finding out that significant person passed away that very day. Sudden loss may be difficult for the family to recuperate from due to the high shock value of the unexpected loss.

Anticipatory grief. Anticipatory grief can be defined as “an emotional construct describing the experience of grief and bereavement prior to the actual death of the mourned individual” (Glick et al., 2018, p. 1). The death of the loved one is not necessary in order for anticipatory grief to take place due to holding onto the anticipation of not having the significant figure within his or her life—one is expecting the death, knowing that it is imminent. According to different researchers, anticipatory grief tends to be most

present within a variety of clinical and medical settings where individuals are in hospice care or suffering from chronic illness (e.g., multiple sclerosis, parkinson's disease) (Grimby et al., 2015; Johansson & Grimby, 2014). In addition, within a study, researchers found that those affected by higher levels of anticipatory grief within an Intensive Care Unit correlated to higher levels of depression and anxiety, with associations of worsened social problem solving, which suggested poorer decision-making skills in surrogates (Glick et al., 2018).

Complicated grief. According to researchers, complicated grief has been referred to by a variety of different names such as traumatic grief, complicated grief disorder, and prolonged grief (Shear et al., 2012). Complicated grief can include different symptoms such as chronic yearning of the loss of the significant figure and thoughts surrounding the deceased, lasting longer than six-months and beyond, and is often resistant to antidepressants (Saavedra Pérez et al., 2015). Additionally, the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V) included complicated grief under the name persistent complex bereavement disorder (Boelen & Prigerson, 2012), describing the debilitating depression and sleep deprivation that occurs during the wake of complicated grief. In addition, researchers have found a significant link with those individuals affected by complicated grief and symptoms precluding sleep deprivation, depression, suicidal thinking, substance abuse, and poor health (Saavedra Pérez et al., 2015).

Traumatic loss. Throughout life, we are expected to have a certain loss of someone significant within our lives; however, traumatic events can bring about certain feelings of anxiety, unpredictability, and a sense of no control within the lives of those

experiencing such loss. When an individual dies from traumatic causes, the family members may feel an extra sense of burden to their grief—the added factor of the member dying from unforeseen reasons. Drescher and Foy (2010) provided three-categories in describing traumatic losses: (a) natural disasters, “Acts of God” (i.e., hurricanes, tornadoes, earthquakes, floods, and so forth); (b) unintentional human-caused events (e.g., car accidents, falls, structural collapses, and so forth); and, (c) intentional human-caused traumas (e.g., terrorist attacks, assaults, murders, domestic violence, military combat, and so forth). Additionally, individuals who experience traumatic loss will tend to experience prolonged or complicated grief (Drescher & Foy, 2010).

Within hospice, many family members tend to experience traumatic loss due to having to be the caregivers for their loved ones (e.g., parent/parents, child, spouse, and so forth), and watching the decline of said person. The family members, or friend, would have a sense of anxiety and of having no control over the situation, which can be difficult for the members of the family to process before, during, and after the loss of the patient. Bereavement coordinators tend to deal with traumatic loss on a regular basis.

Ambiguous loss. Ambiguous loss can be broken down into two distinct types (Boss, 2010): (a) *physical absence* with psychological presence (e.g., missing individual due to traumatic event, divorced families, war, and so forth), or (b) physical presence with *psychological absence* (e.g., development of a mental disorder, Alzheimer’s Disease, addiction, and so forth). Boss (2010) further explained that ambiguous loss is different from ordinary loss due to its ambiguity—feelings of closure can be impossible and grief could be halted due to the uncertainty of death and unanswered questions. Furthermore, ambiguous loss, like every other loss, can be conceptualized as a relational

phenomenon due to individuals potentially withdrawing themselves from familial affairs, becoming preoccupied with the loss (Boss, 2010).

Non-death loss. Individuals often experience grief in relation to losses that are not related to death. Non-death losses can trigger a variety of intense emotional, physical, and psychological reactions that can seem similar to those of grief associated to the death of someone significant within one's life (Harris & Winokuer, 2016). Non-death loss can be seen as the loss of an occupation, loss of able-ness, loss of spouse (due to divorce), loss of status within community (or family role), loss of health, loss of child (when leaving to university and living on campus), loss of gendered identities (for family members facing individuals transitioning from one gender to the opposite [transgender]), and so forth. In addition, complicated grief and non-death loss can be of one due to multiple losses, of complications (e.g., divorces) (Shear et al., 2012). Empirical research on non-death loss is scarce, suggesting additional research to be done in regards to non-death losses.

The Context of Death and Dying

The act of dying and the event of death can be a stressful transition for the family to endure, allowing an influx of different, intense feelings and emotions—fear, happiness, sadness, anger, remorse, guilt, shame, and so forth. The process of dying and the death of an individual member of the nuclear family can cause major shifts within the system's dynamic, causing stress and anxiety for the members in range of the initial diagnosis of the terminal illness and the final impact, death, of the patient. Mental health professionals, physicians, registered nurses (RNs), certified nursing assistants (CNAs),

and spiritual advisors may also be affected by the decline of a patient and family they each have come to serve.

As stated previously, death and dying are completely different constructs and should not be looked at as being one of the same; however, one can acknowledge the separateness and connection both have to one-another. Essentially, death can be perceived as the event, and the act of dying can be seen as a process. Each person, every second throughout his or her life, is constantly inching toward death—we are literally in the process of dying; therefore, survival is never guaranteed to any individual. We question our own mortality when there is a significant death within our emotional system, generating anxiety due to the universal phobias of death (Peters et al., 2013).

Similar to grief and loss, death and dying cannot be viewed as an event and a process that holds the same cultural values, expectations, and notions for every person who encounters those constructs. Death and dying can be viewed differently based on a variety of contextual factors and cultural influences (Walsh & McGoldrick, 2004). Working within hospice, the interdisciplinary team cannot begin treatment on a patient and members of the family without conducting an assessment on the personal culture and spiritual beliefs on death and dying the patient and family hold. According to Reese (2013), professionals should not assume that a cultural group is homogenous due to other potential contextual factors that may impact how death, dying, grief, and loss can be viewed: social economic status (SES), educational level, occupation, geographic residence, and so forth. Not all Americans are the same—nor the Cuban population, nor the French population, and so forth.

According to a study that focused on mortality within the United States, researchers found the 10 leading causes of death in 2016 (Kochanek et al., 2017): heart disease, cancer, unintentional injuries, chronic lower respiratory diseases, stroke, Alzheimer's disease, diabetes, influenza and pneumonia, kidney disease, and suicide. Additionally, data was collected on services provided to Medicare beneficiaries by the National Hospice and Palliative Care Organization (NHPCO, 2018), finding that a total of 1.04 million individuals died while enrolled within the care of hospice in 2016. The locations in which the death of the patient occurred tended to preclude a variety of different settings (NHPCO, 2018): home (44.6%), nursing facilities (32.8%), hospice inpatient facilities (14.6%), acute care hospitals (7.4%), and other (0.7%). In essence, within hospice care, the patient and/or family has the privilege to disclose where care will take place in order to ensure comfort for the patient. In addition, the principal hospice diagnosis that contributed to the decline of patients tended to be affected by a magnitude of terminal prognoses in 2016 (NHPCO, 2018): cancer (27.2 %), cardiac and circulatory (18.7%), dementia (18.0%), respiratory (11.0%), stroke (9.5%), and other (15.6%).

Death and dying are constructs that can cause many transitions and shifts within one's family system, educational system, work system, and more. Mental health professionals who work in hospice come into close emotional contact with many patients who are diagnosed with these terminal prognoses, traveling to specific locations where the patient calls home in order to ensure quality in comfort for the patient and family. Coming face-to-face with many of these diagnoses may take a toll on the mental health professional, and how they function within their own personal nuclear family and

workplace. The finality of death is never something one is ready to embrace nor is the decline of a loved one.

Response to Death and Dying: A Bowenian Perspective

Bowen (1978) understood death to be an event that terminates one's life, explaining the implications in which death can stir within the emotions of those surrounding the impact of said death, resulting in an increase of emotional thinking and emotional reactivity. Therefore, death can increase automatic emotional responses due to the high anxiety present when losing someone significant within an individual's life. Death is inevitable and the construct reminds us that survival within the world is never guaranteed for any individual person. Remarkably, as the older generation dies off, the subsequent generation becomes the replacement for the prior generation and the energy (the prior anxiety present) transmits to the new generation through a process called multigenerational transmission process (Bowen, 1988). Essentially, the information passed through relationships within the generations is conscious and unconscious programming of emotional responses and reactions.

A change in one part of the system is followed by subsequent changes within other parts of the system (Bowen, 1978). When a significant death is presented within the life of an individual, the system itself feels the initial impact of the death and the aftershocks of the death of a patient. These shockwaves can create significant changes within the family system. The death of a family member can generate, manifest, and distribute the anxiety among other members of the nuclear family—the energy rippling through the current generation and those to come. Anxiety is an imperative component within Bowen's Family Systems Theory that surrounds relationships: Every species is in

accordance with and exchanges anxiety with one-another in the spirit of survival (Bowen, 1988). In addition, Bowen (1978) explained,

A family unit is in functional equilibrium when it is calm and each member is functioning at a reasonable efficiency for that period. The equilibrium of the unit is disturbed by either the addition of a new member or the loss of a member. The intensity of the emotional reaction is governed by the functioning level of emotional integration in the family at the time, or by the functional importance of the one is added to the family or lost to the family. (pp. 324-325)

When the family emotional equilibrium is disturbed, the effects of the disturbance commence to travel throughout the system. Bowen (1978) would describe this disturbance as an emotional shockwave— “a network of underground ‘aftershocks’ of serious life events that can occur anywhere in the extended family system in the months or years following serious events in a family” (p. 325). Furthermore, the “underground network” refers to the emotional dependence of family members upon each other (Bowen, 1978). Death can trigger a chain reaction within the members of the nuclear family (or work family) yielding to a multitude of differences due to the emotional shockwave.

Nonetheless, emotional shockwaves occur after the death of a significant figure(s) within the family; not every death has the same importance within the family as the next. The loss of a figure within the family can be as intense as a tsunami, or the loss of a figure within the family can be as benign as the waves caressing the shores of the sea. Depending on the role and function the member of the family played, the emotional

shockwave due to death may or may not be present. For instance, Bowen (1978) explained that the death of an individual could yield to intense emotional reactions from members of the family, emotional neutrality (i.e., normal grief responses), or better functioning of the system due to said death. Those significant figures that can be considered the clan leaders of the family “influence future family functioning” (Bowen, 1978, p. 328).

In addition, Bowen (1988) further elucidated, “After the death of someone significant, such as the family’s matriarch, changes in functioning may occur that more accurately reflect the family’s basic level” (p. 100). In essence, the emotional shockwave due to the loss of a significant figure within the family system can create a tsunami of differences in rewriting the roles and function those within the system already hold, altering, adapting and transforming self in the process of adjusting to said loss. Again, the higher the level of basic differentiation, the more likely an individual can maintain higher emotional functioning during intense and stressful situations (Kerr & Bowen, 1988). Moreover, with higher levels of basic differentiation, an individual can face losses and adapt faster than those with lower levels after the birth of a new member of the family or the death of one (Kerr & Bowen, 1988).

Differentiation simply put is a way in which a person can remain in emotional contact with the group without forgetting self within the process. When an individual is poorly differentiated, the person is more likely to act within the emotional and feeling system, becoming an emotional prisoner, which can make distinguishing ones emotions, feelings, and thoughts from the emotional system challenging (Bowen, 1976). As stated previously, lower levels of differentiation can increase susceptibility to anxiety-

provoking situations, which can inhibit emotional independence (Bowen, 1978; Kerr & Bowen, 1988).

The death of a significant figure can create emotional shockwaves, causing fluctuations of an individual's functional level of differentiation. Kerr and Bowen (1988) would explain that when a person's basic level of differentiation is low, the individual's functional level of differentiation would fluctuate until the person has established a livable equilibrium once more. Hospice bereavement coordinators tend to notice these emotional shockwaves as soon as the family discloses the want and need to see a mental health professional. From the researcher's perspective, anticipatory grief is grief where a person expects and anticipates the death of a loved one; therefore, waves can begin as early as diagnosis of the illness, creating differences and changes in the functioning of the family.

Within hospice, bereavement coordinators come face-to-face with many families who experience the rippling effects of death within an emotional system. Some families can be more intense than others, and the effects can be fairly notable as compared to the next. For instance, some families would come to an understanding of knowing the important role a member played in the family, some members within families would emotionally cutoff with one-another due to end-of-life decisions for a family member, some families would alter traditions and rituals held within the system due to the loss and that is a loss in itself to many within the family, and so forth. These shockwaves are only some of the tsunamis (waves) seen within a hospice setting, and have a correlation to the differentiation of the individual within the family emotional system.

As stated in prior sections, differentiation is a cornerstone of Bowen's Family Systems Theory where other Bowenian concepts intercept and mingle. The explained concepts within this chapter define ways in which each impacts differentiation of self and vice-versa: chronic anxiety, the emotional system, and triangles (interlocking triangles). Higher levels of chronic anxiety are associated with lower levels of differentiation (Kerr & Bowen, 1988; Titelman, 2014). In addition, with lower levels of differentiation, individuals tend to be held emotionally captive within the emotional system due to being unable to separate self (personal thoughts, emotions, and beliefs) from the system, which can yield to triangles forming to persevere emotional stability (Kerr & Bowen, 1988). Within hospice, many of the patients and families have intense emotions and feelings occurring throughout their time within the emotionally intense environment. From the researcher's perspective, hospice bereavement coordinators have the ability to absorb some of the emotional aftershock from the family system, assisting the patients and families to understand the functioning of the system in the face of death and grief. In a way, bereavement coordinators could be compared as the shock absorbers for steady functioning of the vehicle. Bowen (1978) explained,

Knowledge of the total family configuration, the functioning position of the dying person in the family, and the overall level of life adaptation are important for anyone who attempts to help a family before, during, and after a death. (p. 328)

Essentially, when an individual is mindful of the interconnectedness those closest to them serves, individuals will be better equipped to manage their emotional reactions and to adapt to the loss. Death literally alters the equilibrium of interdependences within

a family. Shifting and modifying said equilibrium can result in anxiety symptomology—e.g., physical, psychological, and social symptoms (Kerr, 2008). Death allows for the subsequent generation to replace the prior generation, potentially permitting for those to replace the functioning and role of the person who has died.

Summary of Literature

Defining self is a complicated process in which an individual is striving for constant emotional balances with ones own logical, coherent thinking and that of the emotional unit. Connecting to, yet separating from, the emotional functioning of a group can be as challenging as pulling a thread through the eye of a needle or as simple as putting on shoes. The process of defining oneself can look different depending on the context in which the person is. Defining self may look different for someone within their emotional system as compared to within their work environment. Within a similar premise, Bowen (1978) elucidated that the emotional functioning of one individual cannot be seen separate from the emotional functioning of another person. A higher level of differentiation contributes to a higher sense of self allowing for the person to distinguish between emotions, feelings, and intellect within themselves and others part of their system.

Kerr (1988) explained differentiation of self as a way for a person to be emotionally present and part of the system while maintaining autonomy (footnote, p. 63). A higher level of differentiation occurs when an individual is able to remain aware of their own anxiety without the anxiety contaminating others in the process of its manifestation, which can enhance their own well-being and develop an improved sense of self (Bowen, 1978; Comella, 2011; Kerr & Bowen, 1988; Titelman, 2014). A person

who is able to cultivate their sense of self, coherently think throughout a situation, regardless of the intensity and duration of the anxiety being exerted has the capacity to think more logically rather than emotionally react to presented stimuli, yielding to the person recognizing the function and role they play within the generated anxiety.

Likewise, Bowen's concept on symbiotic relationships can reflect on how an individual's emotional interactions can affect the emotional reactivity or response of another, creating a chain of endless transfers of energy (anxiety) within the emotional dynamic.

In an effort to define oneself, the concept of death and dying, and grief and loss may be difficult constructs to connect to, yet separate from, in the eyes of mental health professionals in hospice. Current grief and loss, or unresolved grief, for therapists working within a hospice setting may be challenging when presented with similar situations that resemble their own family of origin. The process of defining self can become stunted due to the context in which the mental health professional has been placed in, resulting in lower levels of differentiation. Moreover, Bowen (1978) explained the significance of the therapist working toward higher differentiation, expressing that a mental health professional will only be able to help a client within the limitations of the therapist's own anxiety. Death tends to be an anxiety-provoking topic for many individuals, which may impact the way therapists effectively treat patients and the patient's family members.

To define self in the face of death and grief can be complex due to the intense, emotional orbit present within certain families. The push and pull of these emotional orbits, these interactions or transfers of energy, can shape therapy and the therapeutic interventions and direction in which treatment would head. Again, the mental health

professional is in a symbiotic relationship with the patient and their family members, which can suggest that the emotional functioning of their nuclear family is in understanding with the emotional functioning of the clinician. Anxiety can be reciprocated by both parties, which may hinder the therapeutic process depending on if the mental health professional has lower levels of differentiation due to having to act within their anxiety's limitations.

Prior empirical research proposed within the chapter has focused on the quantitative aspects of differentiation of self where studies highlighted how higher levels contribute to individuals developing coping skills, adapting to stresses, lowering overall functioning in relation to anxiety (i.e., societal, biological, and psychological), increasing cognitive and emotional functioning, and decreasing emotional reactivity. A therapist with higher levels of differentiation would be able to have a higher sense of self, connecting with, yet remaining separate from, the patient's emotional functioning. There is little to no empirical research within the intersecting concepts of hospice and Bowen theory, which emphasizes the need for such a study to understand how dealing with grief and loss on a daily basis could impact bereavement coordinators.

CHAPTER III: METHODOLOGY

Research Question

The primary research question in this study was, “How does dealing with grief on a daily basis affect the functioning of mental health professionals in both their work and family system?” This study explored how the grief narratives of the patients and family members impacted hospice bereavement coordinators informed by a Bowenian framework. Due to the qualitative paradigm and exploratory nature of the research, additional follow-up questions were developed in order to help capture the essence of the study and to answer the research question. See Appendix A for the interview questions used.

Qualitative Paradigm

I utilized the qualitative paradigm due to the nature of the research question being explorative. Qualitative research provides a deeper description and richer understanding of underlying explanations, opinions, and motivations behind participants’ actions and thoughts on the research topic (Creswell & Poth, 2017). Dahl and Boss (2005) explained, “The goal of phenomenological inquiry is to produce as deep, clear, and accurate understanding of the experiences of participants and of the meanings found in or assigned to those experiences” (p. 80). Denzel and Lincoln (2005) defined qualitative research as

A situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative

research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. (p. 3)

Utilization of a qualitative paradigm allows for inductive data analysis, assisting with establishing patterns and themes within the collected data through the research participants (i.e., interviews, surveys, and observations), and allows for the reflexivity of the researcher (Creswell & Poth, 2017). In other words, qualitative researchers develop patterns, themes, and categories from the “bottom-up” (inductive data analysis), organizing abstract data into more concrete, structured, and filtered units of information. This process allows for collaboration of the participants with the researcher until a set of themes and categories have been established through working “back-and-forth” between the data collected and checking in with the research participants, shaping and refining the themes or abstractions that emerged within the qualitative study.

Interpretative Phenomenological Analysis

I utilized interpretative phenomenological analysis (IPA) for this study. Smith, Flowers, and Larkin (2012) define interpretative phenomenological analysis as sharing

The view that human beings are sense-making creatures, and therefore the accounts which participants provide will reflect their attempts to make sense of their experience. IPA also recognizes that access to experience is always dependent on what participants tell us about that experience, and that the researcher then needs to interpret that account from the participant in order to understand their experiences. (p. 3)

Moreover, IPA can be seen as having its epistemology within the realm of constructionism, a phenomenon where an individual constructs their reality through the usage of language (Gergen, 2015), and has two theoretical underpinnings—phenomenology and double hermeneutics (Smith et al., 2012). Constructionism can be viewed as the idea that there is no absolute truth due to an individual's subjectivity based on the perspectives, experiences, and meanings applied within the person's reality (Creswell & Poth, 2017; Gergen, 2015). Additionally, phenomenology, one of the theoretical underpinnings, can be described as the study in how an individual comes to understand their experiences within their reality, whereas double hermeneutics can be understood as the researcher making sense of the participant's lived experiences as the researcher makes sense of their own experiences within the study (Smith, 2011; Smith et al., 2012).

Furthermore, interpretative phenomenological analysis is influenced by idiography, which is concerned with the “particular,” operating at two distinct levels (Smith et al., 2012). Much of psychology tends to be “nomothetic,” concerning itself at a group or population level, establishing general laws for human behavior (Smith et al.). The first distinct level is the detailed gathering of data from individuals, part of the research study, yielding to a thorough, in-depth, and systemic view of the analysis. The second distinct level concerns itself with the comprehension derived from participants from a particular event, process, or relationship within a particular context. In other words, having uniformity within the study can assist in enhancing a richer description for the phenomenon in question—seeking specific individuals for the study within a specific environment (i.e., bereavement coordinators who work in a hospice in south Florida).

Lamiell (1987) argued on the flaws of utilizing nomothetic inquiry,

The empirical findings generated by individual differences research cannot be interpreted at the level of the individual, and consequently cannot possibly inform in an incision manner a theory of 'individual' behaviour/psychological functioning. Moreover, and for this very reason, individual differences research cannot possibly be suited to the task of establishing general laws or nomothetic principles concerning individual behaviour/psychological functioning. That is, the empirical findings generated by such research cannot logically establish that something is the case for each of many individuals. (pp. 90-91)

Utilization of the interpretative phenomenological analysis allowed me to not just conduct interviews, but also immerse myself within the research and within the lived experiences of the participants, allowing for an active role of the researcher. Thus, the role and function of the researcher was to explore, describe, interpret, and situate meaning from the participant making sense of their experience, and the meaning the researcher ascribes from his personal experience while conducting the study. Due to the explorative nature of the research study, interpretative phenomenological analysis fit with the research question based on the subjective meaning (constructionism) of the lived experiences each participant held within hospice work (phenomenology), and how the researcher interpreted his research findings utilizing a Bowenian framework (double hermeneutics), which ascribes to a non-nomothetic inquiry.

Data Collection

Recruitment

In order to recruit participants for the study, I utilized purposive sampling to identify participants for the study. According to Patton (2002), purposive sampling is a widely used technique in qualitative research due to the ability of the researcher to choose information-rich cases. In essence, purposive sampling allowed me to identify and select the research participants that are well informed about or proficient within the scope of the study's research question (Creswell & Plano Clark, 2011). Essentially, purposive sampling can potentially allow for higher invariability since I selected participants based on specific criteria (i.e., profession, occupation, years of experience, and so forth). In addition, Creswell (2013) postulated that interpretative phenomenological analysis would need at least 3-10 research participants. For the purpose of this study, I sought out 6 research participants in order to achieve saturation of themes for collected data.

Participants were recruited from a hospice located in South Florida. I sent an IRB approved letter of intent (refer to Appendix B) to request permission from the hospice in order to conduct the study with the organizations' employees to upper management through email. Once approval was obtained, I contacted the hospice bereavement coordinators via telephone calls or through email while being mindful of those that satisfied the inclusion criteria of the study. Each method of contact explained the research question, the purpose of the study, and the role and function each participant has within the research study. Additionally, I sent an email to each research participant containing the informed consent for review in regards to possible limitations and rights to privacy, risk factors and protection, confidentiality, and the rights of the participants (Creswell &

Poth, 2017). Moreover, the informed consent form provided additional information for the research participants, such as the name of principal investigator and of co-investigators, the affiliation to the university, inclusion criteria for the study, potential benefits and risk of the study, and contact information (refer to Appendix C).

Inclusion Criteria

For the purpose of this study, I utilized purposive sampling in order to establish a homogenous sample. Inclusion criterions will be employed in order to attain such a sample:

- Participants must have a master's degree or above;
- Participants must be practicing in the role of a therapist
(licensed/registered intern not required) within the hospice in one of the three fields: marriage and family therapy, social work, or mental health counseling;
- Participants must have maintained their position at the hospice for six months or more, providing therapeutic services to those affected by loss and impacted by grief;
- Participants must be able to read, write, and speak English; and
- Participants must be willing to participant in an hour and a half long, in-person, face-to-face interview that would be audio recorded.

Interview Process

Prior to the interview process, I contacted each participant via telephone or by email in order to schedule a time, date, and location that best fits for the individual. The informed consent form was reviewed between me and each of the participants for

adequate understanding of the material presented, signing the needed documents, and providing copies to each of the participants. I also ensured that each participant understood the length of time the interview will last, the audio recording method for the study, and the participants' rights and benefits and potential risks to the study.

The interviews were held in the hospice's main office, lasted 90 minutes, and were audio recorded. For each participant, I constructed a genogram. In addition, I constructed a list of questions for the semi-structured interviews that were conducted once each participant's genogram has been composed (please refer to Appendix A). The list of open-ended questions and prompts served as a guide for me during the interview process to capture the experiences of hospice bereavement coordinators dealing with grief narratives, and the impact those narratives had on the professionals' work and family system.

After each interview, safeguarding every participant's personal information was imperative; therefore, to ensure HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations and policies were being followed. I locked documents collected throughout the study containing participant information within a personal, private safe in my home office. In addition, documents containing research participant's personal information were changed and given a specific letter except for the informed consent forms to maintain confidentiality. Each research participant was assigned a letter in order to protect the identity of the individual (i.e., Participant A, Participant B, Participant C, etc.). Furthermore, all digital files were stored in an encrypted flash drive.

Location of Interviews

Interviews took place in one of the many facilities the hospice has located in

South Florida. Participants had the choice in selecting one of the locations that best fit the proximity to the research participants' territories. Additionally, I worked around the participants' professional and personal schedule. Locations were secure and allowed for privacy throughout the research process.

Data Analysis

After the process of collecting the data, I entered into the analysis phase of the study. I transcribed the collected data from each interview's audio recording. Immersing oneself within some of the original data by reading over the transcript while listening to the audio recordings can be helpful. Smith et al. (2012) explained,

To begin the process of entering the participant's world it is important to enter a phase of active engagement with the data. Repeated reading also allows a model of the overall interview structure to develop, and permits the analyst to gain an understanding of how narratives can bind certain sections of an interview together. (p. 82)

In addition, the process of reading and rereading the transcripts allowed me to acknowledge any personal biases and bracket them, adding to the personal journal that kept track of my personal journey throughout the research project.

Then, I read each participant's transcript and highlighted any significant statements that related to the overall research question. I examined the transcripts of each participant, noting the semantic content and language utilized. The initial exploratory process allowed me to "identify specific ways by which the participant talks about, understands, and thinks about an issue" (Smith et al., 2012, p. 82). I made notations of significant statements made within the transcripts on the right-hand margin,

deconstructing the participants' words and meanings into component parts.

Afterwards, I developed emergent themes from the deconstructed, significant findings from each of the transcripts. Clusters and themes were synthesized from the available data sets, comparing and contrasting the emergent themes and the relationships among the codes that assisted in explaining the research question. Super-ordinate themes were then introduced, which involves "putting like with like and developing a new name for the cluster" (Smith et al., 2012, p. 92). I developed super-ordinate themes by searching for connections across emergent themes. The data analysis process was repeated for each participant: (a) reading and re-reading the transcripts, (b) looking for significant statements and findings, (c) developing emergent themes from the synthesized data set, and (d) creating super-ordinate themes. Once each case was processed individually, I looked for patterns across each transcript.

I remained transparent with the participants, dissertation chair member, and committee members in regards to the collected data and the results of the data to ensure accuracy and reliability. According to Dahl and Boss (2005), an increase in trustworthiness and validity of the research findings can occur by asking participants to continually clarify meanings within the interview, comment on findings, and further participate in the research study, if necessary. This process was done throughout the duration of the research study.

Ethical and Legal Considerations

Ethical and legal concerns are imperative to the research process in order to protect the participants from potential harm the research process can bring forth. In order to ensure the protection of the participants, I adhered to statutes and the ethical code of the

American Association of Marriage and Family Therapy (AAMFT), the guiding principles of Nova Southeastern University Institutional Review Board (IRB), and the propositions of the American Health Care Association (AHCA).

To assist in the reduction of harm of human subjects, I gave special attention to the ethical and legal standards that need to be abided from different associations. The American Association of Marriage and Family Therapy (AAMFT) highlighted their understanding of harm reduction for researcher participants under “Standard V: Research and Publication” written within the Code of Ethics, emphasizing *5.1 Institutional Approval*, *5.2 Protection of Research Participants*, *5.3 Informed Consent to Research*, *5.4 Right to Decline or Withdraw Participation*, and *5.5 Confidentiality of Research Data*. In addition, Nova Southeastern University’s Institutional Review Board (2018) explained the research participants’ rights, describing the safety, protections, and welfare a participant has within a study. The American Health Care Association also highlighted the importance of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) policy and procedure in relation to confidentiality, and the principles for safeguarding participant data and information (AHCA, 2017).

Participants were explained the informed consent at the time of the interview prior to them signing the documentation. Participants were advised that involvement in the study is voluntary and participation can be withdrawn at any time without consequences. In addition, in order to maximize benefits and minimize risk for participants, I was transparent throughout the study, explaining any significant findings, and the risk and benefits for the participant. Confidentiality was held throughout the research process in order to safeguard participant data and information during the collection and analysis

phase. However, due to the nature of phenomenological research, confidentiality may have to be broken if I become aware or suspect the abuse of children, elders, mentally impaired individuals, and/or potential self-harm of participant and/or others. I was transparent in informing the research participants on the limitations and rights to privacy, risk protection, confidentiality, and risk/benefits of the study (Creswell & Poth, 2017).

Furthermore, supplementary measures were taken in order to minimize any potential risk for the research participants: (a) confidential information was discussed in private, away from other individuals; (b) research participants were informed that data collected and analyzed will be kept for a period of at least three-years from the completion of present study; (c) audio recordings of interview sessions will be locked in my private safe; (d) digital data gathered, analyzed, and documents that contain personal information will be kept in a encrypted flash drive and locked in my private safe for safekeeping; and (e) if potential role of researcher thusly becomes the role of a therapist, I will provide three therapeutic resources to the participant.

Research Validity

Validity is an important aspect to consider throughout the research process, which builds on the believability and trustworthiness of the findings (Creswell, 2013; Creswell & Poth, 2017). Essentially, validity determines whether the study measures what it intends to measure, and the integrity of the research findings.

In order to ensure a greater degree of validity within the study, I continued a “back-and-forth” movement between gathering the data and analyzing the data. Researchers have confirmed that developing this movement between the present research study, previous research, and the development of theory enhances the validity of a study

(Gilgun, 1992). Dahl and Boss (2005) posits,

In addition, we expect participants to find that phenomenological inquiry invites them to reflect on their own lived experiences by co-constructing meaning with one another and with the researcher. We would also expect that such reflection would result in new or different meanings at another time. (pp. 79-80)

The “back-and-forth” movement ensured that participants have an active role in the study, assisting me in interpreting the findings. Again, by asking participants to continually clarify meanings, comment on findings, and further participate in the research study, an increase in trustworthiness and validity of the research findings can occur (Dahl & Boss, 2005).

Moreover, the process of bracketing off biases and assumptions is essential to increase validity and trustworthiness of the study, decreasing personal assumptions that may effect or impact the research findings. To assist in recognizing the potential biases and assumptions, I read and reread the participants’ transcripts, noting personal reflections and judgments within a journal. Dahl and Boss (2005) explained, “To increase awareness of the impact of the researcher as instrument, the therapist-researcher might keep a journal detailing experiences, emotions, insights, and questions resulting from the data collection process” (p. 73).

In addition, I was transparent with the dissertation chair and the committee members in order to support the integrity of the research. Creswell (2013) elucidated that the dissertation chair and committee members assisted in keeping the “research honest; ask hard questions about methods, meanings, and interpretations; and provide the

researcher with the opportunity for catharsis by sympathetically listening to the researcher's findings" (p. 251). Allowing for transparency throughout the research process between all members assisted in validating and verifying the integrity and trustworthiness of the study.

Epoché or Bracketing

Acknowledgement of the assumptions and biases one holds can be beneficial for the study, and not taint the findings. In order to restrict one's influence on the data, Epoché or Bracketing was introduced throughout the research process. Tufford and Newman (2010) explained the bracketing process as "a method used in qualitative research to mitigate the potentially deleterious effects of preconceptions that may taint the research process" (p. 80). Bracketing is an important aspect for the researcher because it assists in recognizing the potential biases that could influence the findings. In addition, due to the close relevancy to the researcher, bracketing is essential. A list of my personal biases and assumptions include:

- The patients and families' grief narratives impact hospice bereavement coordinators, affecting their work and family system.
- Familial experiences held by the hospice bereavement coordinators shape the course and therapeutic treatment of the patients and family being serviced.
- Hospice bereavement coordinators manifest anxiety symptomology during sessions reflecting personal experiences within their own emotional system.
- Hospice bereavement coordinators internalize their experiences with

their patients and families, learning different tactics on how to navigate life and death.

Self of the Researcher

The researcher's personal experiences, biases, expectations, beliefs, and philosophical assumptions about the topic can influence the direction of the research study, where the researcher may focus on specific information and dismiss other information, affecting how they will interpret the data (Creswell & Poth, 2017). In essence, one's personal worldview may be challenging to detach from the research; however, by remaining aware of my assumptions, biases, and beliefs the researcher holds throughout the process, their views will be less impactful on the finding's interpretations (Creswell & Poth, 2017). As a researcher, reflecting on my own personal biases, personal philosophical assumptions, and personal beliefs assisted in facilitating the effects I had on the study, especially since I am the primary collector and analyst of the data.

Currently, I work as a bereavement coordinator. My job can be described as being an emotional support to the patients and the family members of each patient who are experiencing grief and loss, providing therapeutic services in different medical settings to those who are terminally ill: nursing homes, patient homes, assisted living facilities, and inpatient units (IPU) within hospitals. Loss is a common factor that every person in the world faces within and outside of hospice, which may affect his or her psyche. Working in hospice has affected me in different ways, which have changed me for the better and given me a new set of eyes on life and death. Below are some of the life lessons taught to me in hospice that has changed my worldview:

- We only live once and we have to make each moment count;
- Fostering good relationships creates more stability in one's life rather than letting bad ones fester;
- If someone is not interested in what you have to offer, then continue to move forward without having to look back;
- Do not hold other's expectations on a pedestal because what I think and how I perceive myself is what matters most;
- Place value on the people that add to your life because those individuals are not going to be here forever;
- Growing old alone and remaining distant from others as I age is a fear of mine; and
- Everyone dies but not everyone lives the life they hope to have lived.

As previously stated, my paternal grandmother passed away due to Pancreatic Cancer in 2009, my maternal grandfather passed away due to heart failure in 2016, and my eight-year relationship came to a close with my significant other in 2018. I have personally suffered losses within my own life, and I relive each of those losses every other day I work in hospice. A teenager grieving his dying grandmother and grandfather is hard to sit through and process for me. However, the end of my eight-year relationship was the catalyst that brought the research question to life. While conducting several sessions with widows, I found it difficult to sit through the narratives, experiences, grief, and loss shared by the clients because it reminded me of my loss (non-death loss). My anxiety would

increase due to my own personal experiences with loss and how I related to the story the client was sharing with me. The anxiety within myself would manifest as nervousness, unable to think coherently, replaying tapes pertaining to each scenario, and difficulty in remaining present with the patients and/or their families. My own function and role as a therapist was being tampered with by the memories of my own lineage, my own anxiety, and my own losses—and experiences of those losses.

Bowen (1978) once explained the significance of the mental health professionals on working on their own differentiation of self in order to minimize emotional response and reactivity during sessions, stating that the therapist works only within their anxiety's limitations. As a researcher, if we work only within the constrictions of our own anxiety, then our findings would be influenced by our own biases and assumptions. Being mindful of my assumptions, expectations, and beliefs within the research is vital. Therefore, bracketing my biases would be crucial.

Challenges in Using a Bowen Framework in Research

Bowen (1978) explained, “The theory of behavior is an abstracted version of what has been observed. If it is accurate, it should be able to predict what will be observed in other similar situations” (pp. 305-306). Bowen's work is considered a theory, which alludes to the notion of unpredictability in uncovering patterns in terms of research due to the subjectivity of the participants. Frost (2014) proposed different concerns when attempting to research Differentiation of Self due to its complex nature: (a) functional levels of differentiation vs. basic levels of differentiation; (b) interlocking concepts with

differentiation; (c) stress measurement vs. adapting from stressors; and, (d) gathering historical data. By utilizing a genogram, a symbolic diagram that shows family dynamics and historical data, and developing questions within the study that are tailored to Bowenian concepts assisted in addressing the challenges to the research proposed by Frost. I constructed a genogram for each participant.

Functional Levels of Differentiation vs. Basic Levels of Differentiation

Differentiation of Self tends to occur within a continuum, where one end can be described as a poorly differentiated individual and the other end can be seen as a highly differentiated individual; however, assigning an individual a specific level on the scale can prove to be difficult due to the differences within basic and functional levels of differentiation (Kerr & Bowen, 1988). Basic Level of Differentiation in summation can be defined as “functioning that is *not dependent on the relationship process*” (Kerr & Bowen, 1988, p. 98); whereas Functional Level of Differentiation can be defined as “functioning that *is dependent on the relationship process*” (Kerr & Bowen, 1988, p. 98).

Within the continuum, within the two concepts, exist solid self and pseudo self. Solid self is part of one’s basic level of differentiation where an individual is able to undergo emotional pressure from the system and not deviate from his or her own logical thinking based on groupthink; however, pseudo self, which is part of one’s functional level of differentiation, can be described as a person impacted by emotional pressure due to groupthink (Kerr & Bowen, 1988). Bowen (1978) postulated that an accurate estimation of an individual’s level of differentiation would prove to take a lifetime to determine due to the differences between people and their emotional and cognitive functioning within different contexts. Measuring cognitive and emotional functioning

among different people and within different families, can prove to be a challenge during research due to how the participants' basic and functional levels of differentiation impacts each person differently (Frost, 2014).

In addition, for qualitative research purposes, certain research participants could claim to be able to do certain things and answer questions in certain ways; however, one cannot be certain if a research participant would have the same emotional reaction as they described—there are things people say and there are things people do. While amidst the situation, one can emotionally react differently as opposed to how one would say they would believe they would react within a verbal conversation with the researcher.

Interlocking Concepts with Differentiation

According to Frost (2014), an important challenge in researching differentiation of self is to note the ways in which the other concepts and variables explained within Bowen's Family Systems Theory interconnect with differentiation. In essence, from a Bowenian perspective, in order to be able to see differentiation, I captured a broad panoramic view of the participants' experiences with the help of the other Bowenian concepts. The emotional circuitry of an individual can be governed by, or emotionally fused, to the individual's family of origin. In other words, conducting research on Bowen concepts would require the researcher to not only look at the participant, but the participants' family throughout the study due to specific patterns that may manifest within the family unit from emotionally driven thinking. In order to capture potential generational patterns, I constructed a genogram for each participant. I developed an interview schedule that could assist in capturing the essences of some of the Bowenian concepts. Bowen (1978) understood that change within one part of the family could send

shockwaves of additional changes to other parts of the system, which concludes on the vitality of needing to capture the “full picture” of the research participant, tracing the generated energy from generation to generation. Moreover, differentiation of self and the level of anxiety can be thought of as the two main variables of the theory that influence the way each of the other concepts interlock with each other (Frost, 2014).

Stress Measurement vs. Adapting from Stressors

According to Bowen Theory, anxiety can be defined as “the response of an organism to a threat, real, or imagined” (Kerr & Bowen, 1988, p. 112). Because of the fluctuating nature of Differentiation of Self (i.e., basic and functional levels of differentiation) and the continuum in which each research participant exists, assessing for the amount of stress and degree of emotional reactivity could be challenging (Frost, 2014). Also, chronic anxiety can be thought of as a learned response manifested through ones lineage, conceptualizing a framework in which the person can survive the world based upon their family’s genetic formula related to survival of their clan (Bowen, 1978; Kerr & Bowen, 1988). In other words, families have their own, unique signature, defining the boundaries according to the type of energy that manifests itself, or generates itself, within the system. Every species and every person is not the same. Survival and adaptation to the environment surrounding the species can look differently within each emotional unit, which can further elucidate the inimitability each family possesses. Adaptation of stressors will look differently among the participants, and the measurement of stressors, or anxiety, could vary due to every individual possessing a comfortable threshold for their anxiety, fluctuating in relation to the system as an energy force that increases and decreases by duration and intensity (Kerr & Bowen, 1988).

Gathering Historical Data

One of the eight concepts of Bowen is the Multigenerational Transmission Process, which can be defined as how the level of differentiation from one generation of the family, or system, gets transmitted to the subsequent generation (Bowen, 1978; Kerr & Bowen, 1988; Frost, 2014). As mentioned in prior sections, Bowen's concepts interconnect with each other, constructing the foundation to differentiation of self; therefore, similar patterns of the family functioning tend to generate and manifest themselves within subsequent generations (i.e., chronic anxiety, triangles/interlocking triangles, and so forth) as conscious and unconscious learned responses to emotional reactions and behaviors. In essence, the individual's "self" is shaped by the energy that ripples throughout the generations. Frost (2014) proposed that a potential challenge could be utilizing the multigenerational facts to achieve a higher understanding of the individual's differentiation due to tracing the energy within every generation.

Summary

The research study was explorative, finding the meaning mental health professionals make on how grief and loss within the emotionally intense environment of hospice impacted their work and family systems, informed by Bowen Family Systems Theory. The aim of the research was to expand on mental health professionals' understanding on how clients impacted and changed the way therapists interpret the world from a Bowenian lens. In order to capture the meaning mental health professionals make of their experiences within hospice, I utilized interpretative phenomenological analysis for deeper descriptions and richer understanding of the participants' thoughts on the subject matter, which allowed the researcher an active role within the study where

they explored, described, interpreted, and situated meaning from the participant making sense of their experience, and the meaning the researcher ascribes from his personal experience while conducting the study (Smith et al., 2012).

Due to my prior, personal experiences with grief and loss and working within a hospice setting, I kept my biases in check. I was aware of any expectations, beliefs, and philosophical assumptions because each can influence the direction of the research study, and how the data was interpreted (Creswell & Poth, 2017). Since I will be the primary collector and analyst of the data, I kept a journal filled with my own personal thoughts and reflections, writing an entry after every interview to capture potential biases that impacted the study. In addition, once the interviews were transcribed, and I entered the first phase in analyzing the data where I read and re-read the transcripts, I bracketed to reduce tainted interpretations of the synthesized data.

Furthermore, Frost (2014) proposed potential challenges when constructing a study based on the notion of differentiation: (a) an individual's level of differentiation can prove to be difficult to determine within a 90 minute interview since Bowen (1978) explained that a lifetime is needed to show ones' true differentiation since people are different, functioning at varying emotional and cognitive levels depending on the context; (b) in order to assess the differentiation an individual has, a panoramic picture of the generational patterns was completed; (c) stress and the management of stress looks different for every person, within every context; and, (d) when gathering historical data, not everyone is going to remember every detail about their familial past. In order to approach these challenges carefully, I incorporated Bowen's genogram, a symbolic

diagram that shows family dynamics and historical data, into the study, constructing a diagram for each interviewee.

Lastly, participants for the study were recruited from a hospice located in Florida through purposive sampling. For the purpose of the research study, hospice bereavement coordinators were from the following disciplines: marriage and family therapy, social work, and mental health counseling. A total of six participants were recruited, and each will be interviewed in the hospice's main facility, in a secluded and private office.

CHAPTER IV: RESEARCH FINDINGS

For this study, I interviewed six mental health professionals with proficiency working within the field of hospice. I first present demographic information about the participants. Then I present the results from the data analysis. Three superordinate themes and ten subordinate themes emerged from the interviews. Bowen's family systems theory was utilized as my conceptual framework to analyze the collected data, which assisted in the construction of each major theme and the subthemes within.

Participant Demographics

Each of the participants had six months or more of on-the-job training and experience, and were either licensed within the state of Florida or were working towards licensure. Table 1 provides pertinent demographic information, such as age, race, ethnicity, profession/discipline, educational level, licensure status, and the amount of months or years worked within hospice. Since the hospice's psychosocial team is a reasonably small department, explicit details were not provided in order to protect the privacy of the research participants and maintain participant anonymity.

Table 1: *Participant Demographics*

Age	Between 24-62 years old
Average age	47.6 years old
Ethnicity	White and African American
Level of education	Six masters level degrees
Clinical training	Marriage and family therapy, and social work
Length of time worked in hospice	Between 10 months-11 years of experience
Average length of time worked in hospice	4.9 years
Licensure Status	Four registered interns, and two licensed professionals

Themes

Table 2 displays the three superordinate themes and the ten subordinate themes that emerged from the data analysis. The superordinate and subordinate categories displayed the interconnectedness between clients in hospice and the mental health professionals that dealt with grief narratives on a daily basis. Based on the themes and processes that were revealed, clients impact the functioning of a mental health professional, and how the therapist interprets the world. The superordinate and subordinate themes and processes that emerged relate to the lived experiences of a mental health professional working in hospice. However, certain themes and processes can be generalized and applied to other disciplines and professions due to the mutual relationships held within each system.

Table 2: *Superordinate and subordinate themes*

Superordinate theme	Subordinate themes
The Time Traveller Effect	Familial Training Time Distortion Exploration of Prior Losses Metamorphism Indirect Client Differentiation of Self
Anxiety and the Management thereof	Amplification of Anxieties Dynamic Equilibriums
Death-pertise	Shift in Meaning Shift in Understanding

The Time Traveller Effect

The first theme, the time traveller effect, describes the research participants' reciprocal experiences between themselves and their clients. The first theme includes six subordinate themes: familial training, time distortion, exploration of prior losses, metamorphism, indirect client, and differentiation of self. The theme essentially focuses on how a participant's past intersects with their present to shape their future. This intersection is based on subjects' prior significant losses and the lessons learned from their clients, values held within their families, and metamorphic changes within themselves and their systems based on interactions with hospice patients and families.

All of the research participants were able to describe the ways in which they have been affected by the clients they have provided services to, denoting the mutual relationship between the mental health professional and the patients in hospice. As described above, research participants' pasts and futures intersect with their present during and after therapeutic sessions with patients and families. How much depends on the amount of anxiety being experienced within the relationship between the mental

health professional and client. Essentially, some sessions can be thought of as time machines, or gateways, that can travel into the research participants' past and/or distant futures, which can affect the outlook and general attitude on life within the present. Findings suggest that the effects of time travelling for a therapist can leave the mental health professional emotionally reactive in session. This can be because of prior experiences in their past, or because of the higher emotional reactivity created when clients give them a glimpse into their potential futures.

During conventional psychotherapy, change is usually described as occurring to the client, with the mental health professional guiding the clients to their preferred future while being in the present. Fundamentally, some therapists are able to be that time machine for the client. The concept of the time traveller effect on a therapist is similar to that of a client during session. Figure 1 represents what the reciprocal relationship between a mental health professional and a client can look like.

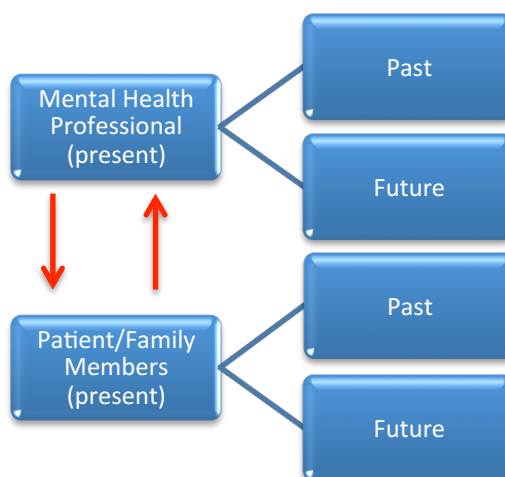


Figure 1: Denotes the reciprocal relationship between clients and mental health professionals during and after session, and how each of their pasts and futures can influence the persons in session.

Familial training. The first subordinate theme in this group is familial training. Three of the research participants explained how growing up within their family system was a means of preparing themselves for their role as a mental health professional in hospice. One participant, prior to starting their career as a social worker, said "... the family comes to me for many of the resources. My family comes to me for questions that they may have so it's kind of like ... sounds kind of weird but I feel like the head of the family." Later on, during the interview, the same participant described how growing up within their own family dynamic was a way for them to recognize different relational interactions. She stated:

Umm, because my family has so many dynamics in its own unit, I think that shaped me into coming in into hospice in a way of understanding that different family units have a different way of dealing with emotions. My family is the best way of seeing that. Although, let's say the three of us—me, my brother, the little brother— we dealt with the separation of my mom and my dad differently. But we still went through the same event, right? So it is kind of like understanding that we all have a different perspective, and a different way of viewing loss and grief. It all comes into hospice because our patients are our number one priority, but so are the families going through it—their caregivers. So they all deal with that differently, and it's understanding that not everybody is going to have the same reaction to the same thing. That helped me out a lot.

Another participant described the family values held within their family, which denotes how working within a hospice setting fits for her. She explained:

My family is very giving, caring, so maybe it was... I don't know. My mom... she always helped people out. My sisters always helped people out, sick people, elderly people, and it was just something that we got from her. You know, she used to take us to the nursing home when we were young to see her brother and we had to go around to all these old people's hands and shake 'em. Scared the heck out of me, but you know, I guess it was from her, teaching us that you have to give back and have to be helpful to people. You can't do people wrong.

One participant specified:

Umm... very strong belief in people's inherent equality, standing up for your rights, standing up for what you believe, umm, compassion, helping others—that was real strong in my father's family... and in my mother's family, too, to a certain degree, but not so much [laughter]. Umm... yeah, I think my father had a big imprint on my life much more than my mother. Yeah, my family values helped me open up to do that for the patients and families. And I can also see it like a blueprint for me before meeting the patient.

Time distortion. The second subordinate theme in this group is time distortion.

Four out of the six research participants described how working in hospice had increased their anxiety revolving around time and their loved ones. Due to the distortion within their personal time field, the mental health professionals noted that forever is “not really guaranteed.” Because of the distortion of time, the participants experience time differently due to knowing that death could be hiding behind any corner. Time dilation, (time slowed down) or time compression (the speeding of time) becomes more prevalent within the context of their own family system when working within the context of

hospice. Thus, the mental health professional can feel like they are glimpsing their future, which, in turn, can affect their present. When asked about how her emotional interactions between herself and her family has changed since working in hospice, this participant responded:

If anything, I am more compassionate. Even though, I am already. I am more drawn to them. I feel like even though you are close, you want to be even closer to them in case something happens. Especially, since you see other families here, and some are not close with their families, so you tend to tell yourself, “I am glad I got me a good family.” You don’t want to get to that point where those other people are with their family.

When asked if working within hospice has sparked a change in closeness between her and her family, a participant explained that directly after tough cases, she feels inclined to reach out to her children in order to “feel closer” to them. The participant stated:

You know, I call them or text them or whatever, “Love you.” You know, just wanting to make sure that they know that I love them. I guess, yeah... that feeling sometimes just wanting to... letting my children know that I love them emerges, wanting to hear their voice...

Two of the research participants were able to articulate how spending as much time as possible with their loved ones is one of their top priorities, and how minor situations should not hinder precious time with members of their family. One participant explained:

And my family, again, is the whole idea of I want to spend as much time with them while they are here than thinking about the times that I could’ve spent with them and I didn’t because of something stupid.

Another said:

I am trying to do my stuff and be on time, but I need to spend time with my husband, so I'll spend time with him. When he gets home, when he is tired and we get to eat together, we talk about our day. He talks about all his students and all the crazy things that they are doing, and I will tell him a little bit about my day. And then, I hit the computer. I try to keep that... personal time is very precious. Then, I do this or I get up early and do that. But I want to make sure that I spend some time with him. Do you see what I am saying? That is very important.

She went on to explain, "I think you have to not neglect the time that you have."

This participant highlighted that if one of her grandchildren or members within her family had a significant event going on, she would put things aside in order to be present with them during the functions. The participant expressed, "I stop everything that I am doing because they won't remember what I give them, but they will remember that I was there."

Exploration of prior losses. The third subordinate theme in this group is exploration of prior losses. All of the participants have expressed that they have faced some sort of significant loss; however, four of the six participants reported that they have each faced different losses that had reflective meaning within the context of therapy. Each of the research participants explained that when their losses have a similar storyline as their client, they have been able to utilize their prior losses in session, drawing from a personal space. In essence, the mental health professional has been able to utilize past losses as a means to assist the client in coping with their current situation, time traveling from their own personal past to the present. One of the participants stated:

Sometimes it helps me understand how they are feeling because I know the impact that you are going through. I try not to get too personal, and sometimes I have. I have given them examples of what happened, and how I dealt with it.

Sometimes you put yourself in that families place, and I understand what they are going through.

Another explained that due to her own family values of “compassion” and “standing up for what you believe in” was a way to help her share her story in order to assist her clients. The participant said:

Well... I think something like Alzheimer’s I do let it come in because, you know, there is a lot that I have learned: caring for someone with that condition and I have some, you know, knowledge to, umm, offer, and I am open about that. And I think that people, umm, appreciate that. I mean... I don’t go into ... I don’t spend the whole time talking about myself, but... you know, so I don’t necessarily keep my own things to myself, I do share some things.

One participant mentioned that she went through a divorce, facing the non-death loss of her husband, and the life they both created together. The participant explained that she sometimes has been able to explain different family dynamics, from different perspectives, by utilizing her own family as a model. The participant took it a step forward and would enlighten her clients on ways that has helped her cope in hopes of assisting them on their own journey through grief.

I would say to them, “The best thing I learned was to write my feelings down. The therapist said I would destroy the family, so if you are very upset, and you really feel like you can’t share it or you feel uncomfortable, write it down, get it out, do

something—take a walk. Because it will help you take that loss off your chest for a little bit.” And I said, “And sometimes you can’t share everything because your family is too involved if you start saying things, it could be taken wrong and twisted around.” I said, “A lot of times, those are your feelings, so writing it down will help you get those feelings out without destroying your family. It is something I have learned, and my family has stayed together.” So I said, “I thought it was the stupidest thing the lady could have told me.” I said, “How is that going to help me? And I am telling you right now that it is going to help a lot to write your feelings down.” So I have used those little tools to help families understand that those feelings are genuine and real, but you don’t have to destroy everything in the process.

Another participant elucidated:

I think that sometimes you could have that insider that if someone was to ask you a question in having to deal with a situation, it gives you the insight to ask them the question. That, perhaps, what if someone had asked me, right? How to help them open up... If they don’t go for it, if they don’t see it, or process it, then they are not ready. But I think... it is almost like you already been there, but it is different players, different situation, different dynamics. You know, there could be a lot of similarities in our lives.

Metamorphism. The fourth subordinate theme in this group is metamorphism.

Five of the six participants expressed that working within a hospice setting has caused a shift within their lives, and ways in which each can live their lives. Based on the responses of the participants, the metamorphic process starts with the lessons each patient

and members of their families have given directly, or indirectly, to the mental health professional. This shift in thinking can alter the mental health professional's present time, changing the dynamic and functioning each has within their given system. Again, like taking a glimpse into the future, the participant can be affected, sending shockwaves throughout their respected systems. When asked about the changes she noticed in herself, one of the participants simply stated, "Don't be greedy; be caring; be close to your family; love your family; care for them." The participant disclosed that being close to her family was something she took to "her heart." Another participant expressed that she was better able to understand clients who are different from her due to everyone's days being numbered, stating:

Well, I think that, umm, in a sense not necessarily particular to hospice, but, umm, in general just being opened minded to other people and other things, and how they live, and how they dress... blah... blah... blah. You know, just because people live once.

Another participant went on to explain how she took an indirect life lesson from the patients and families she served. The participant expressed that by noting how members within the family have to deal with end-of-life care, that it was "harder to enjoy them during their final hours." The participant remarked:

Oh my god, they taught me a lot about being prepared. Umm, the more you do, the less traumatic it is. They shown me that preparation is key to them because then you can be more with the patient instead of doing things that you really should have already done. So I always encourage them, and what I found for my life lesson, is if you are more prepared, you are ready to handle things better.

Umm, and to enjoy life, to enjoy every minute because you don't know when it is going to stop.

Two of the research participants were able to express how putting themselves first is an important lesson learned within hospice. One of the participant's specified ways in which she has been affected by the life lessons clients have gifted her. The participant went on to say:

Find someone that is going to understand me in every level, and is going to want to support me. Umm, umm, relationships are very important and finding someone that would understand what you are going through. People are always going to want to be there during your good moments, but not the bad moments. So I have learned that when you are going through hospice, you really need people that are, that are going to want to stand there by your side. That is why I have closed my circle so much because I want people that are actually going to be there when I need them. Umm, and it has also taught me the importance of self-care, putting myself as a priority—one hundred percent. That's something that... I, I knew before but I never knew the importance of putting yourself first.

The same participant went on to say later on in the interview ways in which her friends have noticed she has changed.

They notice my interest; my conversation; my way of managing things; my interest in the conversations; the plans that I want to make; umm, how I take care of myself. And I don't think they understand it because they don't, they don't, they don't do this.

The other participant stated:

Keep some of it for yourself, and I have heard that from a couple—a lot of elderly patients. In other words, do not give everything you have to offer—keep some of it; whether it's your family or with patient's families. Don't give it all away... and that lesson, and I heard that, like I said, from a lot of elderly patients. And I think that goes back to, I mean, you know, in school, in theory, even in practice give, give, give... When do you hear anybody say, preservation?

Similarly, both of the participants were able to discuss how putting themselves first is an important lesson learned within hospice. In other words, conservation of their energy is essential when functioning within certain intense systems; hence, the self-reflective piece placing self as a priority and knowing when no more should be given.

Indirect client. The fifth subordinate theme in this group is indirect client. Three out of the six participants expressed during their interviews how they have seen themselves become a client indirectly to absorb some of the life experiences, wisdom, and knowledge of the patients and families in order to apply within their current lives and situations. Two of the participants expressed ways in how they each became indirect clients with their patients and families, focusing their attention on romantic relationships and the potential secrets in maintaining those relationships for years. One participant expressed:

So every time I see an old couple, I ask them, "How do you do it?" Every time! And some have been together for 40, 60, 70 years and I am like... that is more than I have been alive. And they always tell me: patience, understanding, not going to bed mad at each other. Umm, and it is so funny that I go directly to that question and I think that that is just me trying to gather some information and

doing my own little self-study on other people because that is what I want. I want to grow old with a person, and have a beautiful life together even though we are going to have some hardships because all lives do. But, that is the main positive thing about working with older people. It is about getting their life knowledge.

Along similar lines, another participant stated:

It impacts me now with, umm, I have to be more... umm, I just try to dig more in the relationship that I have with them in order to see if I could get a helpful tip for me. Like a helpful reflective tip or something that I should do differently with my relationship in order to get that.

The last participant communicated that she has been affected working with clients indirectly, also. She expressed that she has had different hardships throughout her life, stating that the patients and families she assist on a daily basis always tends to “teach me something new to apply within my life.” The participant specified:

I feel lucky. I feel like it’s a gift because a lot of different situations and clients has helped me look into different things, and has helped me maybe work on certain things about myself.

Differentiation of self. The final subordinate theme in this group is differentiation of self. Five out of the six participants were able to display how their differentiation was affected during certain sessions throughout their hospice career. In order to capture the essence of differentiation, a genogram was constructed within each interview, followed by questions that helped uncover certain aspects of the phenomenon (refer to appendix A). One of the participants explained that her family is “very giving” and “caring,” explaining how her mother “always helped people out.” The participant

went on to discuss how her siblings always helped “sick,” “elderly people,” discussing how those teachings as a young girl to “give back” and “to be helpful to people” was instilled inside her—“You can’t do people wrong.” During the interview, the participant discussed how she becomes emotionally triggered when a client goes against her familial core values.

The thing that gets to me is when the family, when you know it’s a money thing. It is not a care thing. It is not a love thing. It is a money thing. As soon as the patient pass, you know, “I am going to come into some money.” I’ve seen it. Do you really care about this person? No you don’t. Give them more medication, you know. And then you have some families who had an estranged relationship, and they have to make a decision, “No don’t give them no morphine.” Its like... let them feel the pain. How can you be so...? That is when I start to pull back, you know. I don’t want to help you... but I have to. This is when it is just a job for me. When you act like that, I am not going to give you any extra. I am not going to put my all in it because you are not being compassionate to that person. You are not treating that person the way they should be treated— regardless of what happened. If you feel that way, then don’t have nothing to do with them at all. If there is an endgame, something for you, or are trying to get back at them. I just don’t like that...

One participant disclosed during the interview that she was diagnosed with ovarian cancer, expressing the difficulties she has faced during her treatments. The participant went on to discuss her support system during her illness, stating that she use to go to a survivors’ group and developed meaningful relationships with two other

members. The participant expressed that throughout the years, those friends passed away due to the illness coming back “aggressively.” During the interview, the participant explained a case that affected her during her career.

Interviewee: I just gave this example to somebody the other day. There was a patient who was in her thirties with Ovarian Cancer who would not do chemo. And, umm, you know, she was saying she was going raw, or whatever, which is fine for other kinds of cancer but not ovarian. Ovarian is super aggressive and, if you don’t strike at it, you’re dead. And she was in her 30s... she was gorgeous. I mean... and I just had to... just shut it down. I couldn’t... I am not there to convince her to do something else or... you know, and it was already too late always. Obviously, she was in hospice.

Researcher: So what do you mean that you had to “shut it down”?

Interviewee: Like say, “Why didn’t you do chemo?” [raises voice].

Researcher: Oh. So based on your own personal experiences, you wanted to tell her things that you felt could have been helpful...

Interviewee: Yeah... even earlier. I mean it was just... maybe, maybe if she had come to me as a client, you know, in a one-on-one session, and had just found out she had ovarian cancer and was thinking that she didn’t want to do chemo, maybe I would have been more ... interventionist.

The participant went on to explain that having a discussion with her patient and their family member brought her back to her own situation with ovarian cancer, and the “family reaction,” “personal struggles,” and “my own mortality” due to her cancer. During the genogram portion of the interview, another participant explained that as a

child she grew up witnessing her mother undergoing domestic violence, stating that her main role within her family served as the “protector to my other siblings.” The participant stated that she was, and still is, considered the main “go-to-person” in her family. The participant explained:

Not that every child has a happy home but I didn’t have a structure. I had to create that structure. Umm, being first generation, I was the translator in my family. I was the “[insert participant’s name] knows everything so lets go to [insert participant’s name].” Umm, I never felt that my mom was the head person in the family because it doesn’t feel like that for me because a lot of the times, the family comes to me for many of the resources. My family comes to me for questions that they may have so it’s kind of like ... sounds kind of weird but I feel like the head of the family.

Due to her past and the experiences she has had, the participant went on to discuss how she was a social worker before starting her career in college. She also discussed how her understanding of vulnerability within the context of her past translates to the present patients and families she faces on a daily basis in hospice.

I understand them. I also understand the patients, and what they are going through. Having to be in a vulnerable setting and needing someone to be there for them and the ones that don’t have that caregiver is what gets me the most because I identify with them because I, myself, was vulnerable and needed someone... the person that was suppose to take care of me, didn’t have that. But I think that when I see patients that are truly by themselves, it gets to me more—aside from them not having that family value that I have within my own family. I feel bad for

them. I mean... I wish I had a social worker when I was young. And I did, but she wasn't really involved within the family. She was more involved with my mom than the kids. Umm, so I want to be a source of comfort and a source of reliability for my families and for my patients as well.

During certain intense cases, the participant went on to specify:

I would be more involved within the family. And if that person dies, I will be more distraught. And I will be less able to keep that professional boundary. I don't think that I will be able to stay professional during that time. I will probably cry, and be mad, grief my own self because, in a sense, I will be so connected because there are so many similarities to my own family. That would be kind of like a vicarious trauma.

During another interview, a participant explained her estranged relationship with her mother, stating that she has been feeling as though no one can comprehend her and how she sees the world within her family. The participant kept saying, "no one can understand me in my family and that frustrates me." The participant went on to discuss a case that affected her during her hospice career.

It is like taking a Tylenol. I avoid the feelings. I am always going to remember this one client because she was crying because her mom passed away, and she asked me, like, "Oh, do you speak... how is your relationship with your mother?" And she got me, like, I really stood out, and like... blank. I was, like, you know, I didn't even know how to respond. And I just try to avoid everything that I am feeling. Sometimes, after the session, I do really think a lot about it, which I think is good because it makes me kind of like reflect.

Cases that involved motherly figures affected one participant because they reminded her of the relationship she has with her own mother. Due to the lack of understanding within her own family context, the participant expressed how she thrives during sessions when her patients and their family members “understand” her. She said:

Something that really affects me in this work environment is that when I meet people for the first time, one of the first comments is, “Oh... you are so young.”

And that really affects me. I don’t know why. It really, really affects me as a person. And I just feel that once I prove myself, they are like... “Oh, you are so young but you are so understanding, like, I don’t understand how you do this.”

And they, like, getting that feedback, like, that they understand that I am able to understand, I never gotten that from my family. It makes me feel like I know what I am doing—like, I am on the right track.

During another interview, one of the participants disclosed that she grew up in an orphanage, explaining that her mother gave her up in exchange for money. The participant stated that she grew up feeling like she “wasn’t sure where I fit in,” and “feeling of lost—being completely lost.” The participant went on to describe a significant case that affected her during her hospice employment where the mother developed end stage breast cancer.

The kid got away from the nanny. There were like three or four kids and the nanny was there. The family had a beautiful home, beautiful house. I mean it was absolutely a dream house. And the family was very close. But all of a sudden, the little boy got away from the nanny, and he pulled on my sleeve and said, “I don’t think that my mom loves me anymore. She doesn’t talk to me.” I just... I didn’t

know what to say. I dropped everything that I was doing and I said, “Listen to me, she loves you more than life itself. She can’t talk to you because she is sick. It is not that she doesn’t love you. She loves you more than anything.” And he goes, “But she doesn’t talk to me.” And I go, “because she can’t. She can’t talk to you anymore because she is too sick.”

The participant explained that during the family visit, she felt triggered due to her past experiences in an orphanage and resurfacing feelings of her mother giving her up. The participant stated that it “hit home” and “it was like a trigger.” The participant went on to explain that the case still affects her present day because of “having the image of the kid crying was hard to process for me.” Lastly, each of the participants stated that they are able to manage anxieties within sessions, depending on the case; however, when presented with closer ties to their own significant losses, the more difficult it became to manage their own emotional reactivity during session.

Anxiety and the Management Thereof

The second theme, anxiety and the management thereof, denotes anxieties that have been intensified/amplified throughout the mental health professionals’ employment in hospice care. The second theme includes two subordinate themes: amplification of anxieties and dynamic equilibrium. The theme centers on different anxieties that have intensified for the participants, and how anxiety is managed when one is faced with death on a daily basis. Triangulation is also a way to explain how participants have been able to survive and protect themselves within the field of hospice care.

Many of the research participants were able to discuss ways in which anxiety has manifested itself within the context of hospice and how they have been able to survive

the symptoms of the exhibited anxiety, which can further emphasize the mutual relationship between the mental health professionals and the patients and their families. Throughout some of the mental health professional's career, they stated that anxiety has been a force that has intensified throughout their professional identity and within their own self-identity. In addition, all of the participants were able to describe ways in which they have been able to relieve some pressure within the emotional and forceful environment held within hospice. Due to coming face-to-face with death on a daily basis, mental health professional can develop certain anxieties, or certain anxieties that they have can be enhanced or amplified. In order to manage such anxieties, mental health professionals in this study instilled coping strategies to ease the anxiety that was manifested, generated, and distributed throughout their caseloads.

Additionally, the idea of time can be applied to the concept of anxiety and the management of anxiety. Time has a tendency of exerting itself within every person's life in specific ways, dilating (speeding) or compressing (slowing down) time. As stated before, when working in hospice, the idea of time becomes a less linear concept and more of a circular one for the mental health professionals' past, present, and/or future. The exertion of time within an individual's life differs with each person, resulting in different anxieties that can be brought to the forefront within each person's present self.

Amplification of anxieties. The first subordinate theme in this group is amplification of anxieties. Three out of the six research participants discussed how working with death and dying on a daily basis has manifested different anxieties within themselves. The participants discussed stories of how being affected has impacted their daily routine within each of their respected lives. The three participants were able to

touch on how time is important to them in different ways, stating the effects of how the idea of time has affected them and manifested certain anxieties within their lives. One of the participants explained that death is a growing concept within her life, stating how she has witnessed many of her friends die due to age or illnesses. The participant disclosed, “When my parents died, it was a realization to me that now I am part of the old generation... like that is kind of scary.” The participant expressed that working with hospice patients and their families amplified her anxiety of death potentially being “at every corner.” The participant stated:

My daughter just got married in June so that was so special as is with any mother when their daughter gets married. And, having arrived at that date, because I do feel that at any time I could go. I mean, I guess we all feel that way to a certain degree, but I really feel it [laughter]. I mean I don’t stay up at night worrying about it because I don’t let myself go there and I don’t have an anxiety type of personality. And in that way, I am more like my mother—just go with the flow. And live life and love and ... just get the most of everyday.

Another participant went on to discuss how “the whole idea of that the future is not certain to me, tomorrow is not certain, and wasting time is the worst thing you can do for yourself and for the people that you love.” The participant explained the implications of “time wasting,” and how that has affected her romantic relationship and her relationships with her friends.

So... the whole idea of I want to have a kid, and I want to be married. I want to hit all of these milestones now because I don’t know if within the next year that would happen. You know, I don’t want to be 30, thinking s*** I just wasted years

in a failed relationship and nothing came out of it—not even a kid. I’m more impatient, I would say, in relationships. For example, I have this friend that she has no sense of respect for other people’s time. So, we would make plans to hang out and a minute, two minutes before we are suppose to meet up, she doesn’t meet. She cancels. She just doesn’t answer my phone, my text. And again, it’s reoccurring, and every time it happens, I get even more frustrated because I am literally giving you my time, which is the most precious and most valuable thing that I have to give... and you are wasting it? And you have no respect for it on top of it? And there are people out there that would kill to have the time that we have, the health, everything, and you are just f***** wasting my time. So I get very angry—short-tempered. And my boyfriend, he doesn’t understand why that happens, and why it affects me so much. And I try to explain it, but he just doesn’t get it. And, also, when I have an argument about the whole lifestyle of getting married and having kids, all of that, he is just like you are rushing into things and I am just like we have been together for 2 years, if you know, you know. You are sure that you are going to spend the rest of your life with the person no matter how difficult the relationship dynamics is it could still work if both people put the time and effort into it.

During the interview, the participant described herself as “short-fused” and “short-tempered,” recognizing herself as a “source of anxiety” for her partner. Since the idea of the future not being guaranteed is intensified in hospice, the participant’s anxiety has been amplified on needing to hit each “milestone” in her personal life without “wasting time.” Another participant was able to articulate how working in hospice has

“motivated” her to search for a romantic relationship, describing the anxiety she faces in finding someone that compares to a level of understanding she notes in the couples seen in hospice. The participant stated that since seeing the interactions couples have with each other in hospice motivates her to “keep searching for my significant other, knowing that I am going to find someone that is going to be there for me and give me everything that I need.” The participant went on to say:

I feel that I have everything in my life that I need to have—like, financially, socially, everything, but I am missing, like, a partner. And I, I have a lot of boys behind me, but I think that haven’t been able to find someone because I don’t feel that, that, that I find someone that is on my level. I hate to say it that way, and I feel like that is a loss for me every day because I feel like I want to share my things with someone. But I just don’t feel that anyone is going to give me what I need right now because of the work that I do. I stand from another level. I understand that people are not on our level, like, in every sense. Like, my problems are I see them from another perspective, and I just feel like that is a loss because I don’t know if I am the problem or if I am asking too much or yeah...

Dynamic equilibrium. The last subordinate theme in this group is dynamic equilibrium. All of the research participants were able to describe ways in which they were able to manage their anxiety within the context of hospice, introducing a third-party within their relationship when dealing with death and dying on a daily basis. A dynamic equilibrium can be described as a system held within a steady state, denoting the variables presented within the equation are unchanging over time due to the reactions being equal. In hospice, each of the mental health professionals are held within their own

dynamic equilibriums. The introduction of a third-party to alleviate anxieties within hospice eases the tension; however, death and dying will always remain present within the participants' personal or professional lives. It is inescapable. Therefore, the idea of a dynamic equilibrium can be thought of as a suspension of time from presented anxieties held within each of the professionals' lives. Figure 2 captures Bowen's concept on triangles, and the relationship between the participants and death and dying, and how introducing a third-party assists in managing relational energy.

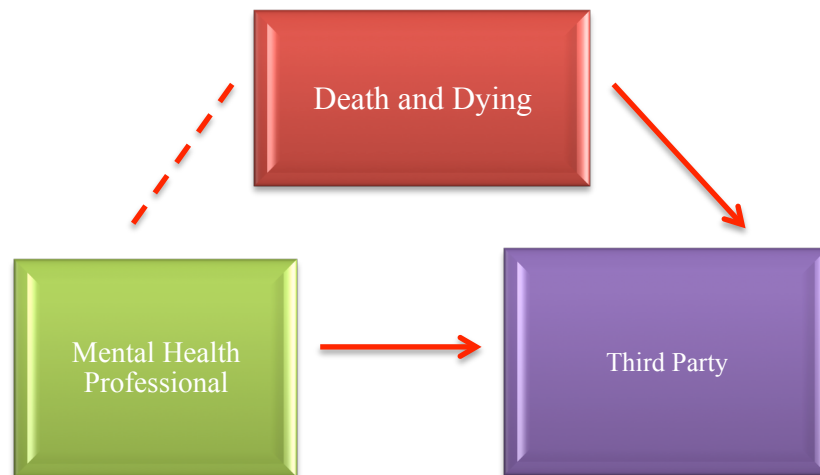


Figure 2: Example of a triangle to manage relational energy within hospice between death and dying and the mental health professional by involving a third party.

Each of the research participants utilizes different ways to suspend time in order to continue doing the work that they do on a daily basis. Two participants went on to describe how their spirituality plays a major part in their daily functioning as a mental health professional. When asked how she coped, one of the two participants exclaimed:

The good Lord! [laughter] You know, before I get out of my bed, every morning I pray. And I ask for guidance. I don't know what today is going to bring, so my spirituality plays a big part in it. Umm... my upbringing and the way I would want to be treated, the way my mother raised me. You always want to treat people the way you would want to be treated. If I treat someone with respect and dignity, I expect the same thing in return.

The other participant stated:

I have my ritual—a prayer. It is just something that I do, and I have been doing it for years, umm, to get me going for the day. It gives me some strength, and I also always ask that everyone that I meet today, please enlighten me, keep me open. You know, help me be sensitive to what they have to present, and if I don't have the answer to help me find the answer for them. And I have all of that written down, so I have a little ritual that, umm, some days I do. But, most often, I do do that in the morning. Like, people who exercise in the morning or whatever you do to get you going, to get you started...

Another participant discussed how her partner is someone she utilizes to cope with many of her life stressors, especially when presented with difficult cases in hospice. Throughout the interview, the participant revealed that she was diagnosed with ovarian cancer and has been in remission for years, explaining how her boyfriend has been her “go-to-person” when dealing with life.

Interviewee: Actually I met my boyfriend in the last... right after I finished chemo. I was still bald and, umm, he's just been so wonderful. You know, he is just one of those people that... well... he, umm, likes to have a good time. He likes

to do things. He likes to go places. He never says [mockingly], “I don’t want to go there.” He’s just like up for it. And he has just enriched my life.

Researcher: So he helps alleviate some of the anxiety of being next?

Interviewee: Yeah. I guess I would just say he makes my life just fun and adventurous. We’ve traveled a lot together and spend a lot of time together. He is my neighbor, so he lives in the apartment building next to mine. He comes, spends time, goes home. You know, but we have that separation that I like because I am not ready to, umm, mesh my life.

Two of the participants were able to highlight and discuss how nutrition and exercise play a vital role in maintaining their own dynamic equilibriums. In addition, the participants discussed other items they utilized to manage any anxieties exerted in and out of sessions. One mental health professional bellowed:

Yeah, food! That is why I have gained weight. Umm, now I am going to the gym. There was a point where that was all that I was doing. Literally, I wouldn’t even go home after work. I would go straight to the gym, and I would just... It was a healthier way of coping cause I had so much energy and I could take on the day. But then, I stopped doing that and I went straight to food and that was that. But now, again, it’s just like... I don’t want to hear about anything else. I just want to sit down and watch a mindless show—some TV that has nothing to do with death or dying, grief or loss. I hate dramas. I cannot watch it because my whole life is a drama [laughter]. I don’t need it, and I don’t need it on my TV either. So literally just putting it all behind me and not dealing with it. Drinking some wine here-and-there. I swear I am not an alcoholic [laughter].

The other said:

Maintaining a routine and my prioritizing. Like, doing... like, some things of my daily routine that I would not pass. Umm, because I know if I let them pass that they are going to affect me, so like not going to the gym. If I wouldn't have gone to the gym today early in the morning, I know that today I am going to get home very tired. And I know. And I was very tired in the morning when I woke up, but I know that going to the gym changed my day, so, like, I try to do those things. I have to eat today at the office, so I did a massive meal that I like and I know that that is going to maintain me good and happy throughout the day. I love going to the office because it makes me speak to people. I feel very good at the office. I love the coffee at the office, so those are small things that sounds stupid but that really motivate me to be in the grief environment, and, and having to do the things that I have to do.

Lastly, one of the participants expressed how checking in with other mental health professionals is a way for her to process and “self-reflect” with things that have gone on throughout her workday. The participant explained, “sharing with other people that work in the field” is important for her, stating, “I think that helps a lot. And talking with them about a case, I think is helpful because you are sharing what are their emotions and your emotions.” When asked about what has assisted her in throwing herself into the job's role, the participant responded:

Umm, talking with other social workers and going over what works for them. I think that helps. Umm, seeing another way of seeing it cause sometimes they would have a different idea than mine. Umm, I think going to, umm, functions

that have speakers helps me to see it differently, too, and seeing other options out there because that helps me with the families. Because then I can offer them more options and I know more stuff. The more I know, the more I could help them. It does help me feel like I am making a difference.

Death-Pertise

The third theme, “death-pertise”, encompasses descriptions of the research participants’ personal and familial understanding of death and dying before the start of their career in hospice. The theme describes how those meanings of death and dying have been altered throughout their employment in hospice. The third theme includes two subordinate themes: shift in meaning and shift in understanding. Additionally, the superordinate theme will focus on the research participants’ altered relationship with death and the experiential practices from those teachings and experiences.

Some of the research participants were able to express how their meaning and understanding of death and dying has shifted since the beginning of their employment to their present-day selves. In hospice, research participants explained how having been exposed to death and dying on a daily basis predisposes them to newer meanings of death and dying as compared to their past meanings, and assisted them in learning about other ways to help those in distress. Findings within the participants suggested that each are able to talk about death in different ways as compared to those who do not work within the field, and serve as a resource guide to others when needed.

Shift in meaning. The first subordinate theme in this group is shift in meaning. Three out of the six participants were able to discuss how their meaning of death and dying has changed throughout their employment in hospice. All of the participants stated

that death and dying was considered a “taboo” topic within their families, and “something we wouldn’t talk about with each other.” One participant went on to say:

I think we never had that discussion—what it means when somebody passes away. I think its... the meaning that I have gotten from it—myself—is it’s just a new beginning for that person. It is a new beginning for the family as well because then you have to live a normal life without your loved one. So... all together it is just this transition from one state to another, so that’s really... I mean I really haven’t had that discuss with my family.

When asked if her definition on death and dying has remained the same within the context of hospice, the participant simply replied that she has a “newly developed” view. The participant explained:

I think that being around death so much kind of gave me a new perspective and lens to look at what it is. Before, it was taboo. We didn’t want to talk about death. Umm, it was super sad. It was depressing. It was grim. It was a lot of things. Now seeing it through a hospice lens, and seeing how much people suffer at the end of life, and they don’t have a quality of life, just giving them that release of “Now you can let go.” Their physical body and not living with that pain continuously is something so beautiful for them, you know, because they get to get rid of all that stuff they are holding onto physically. Umm, so before hospice, I didn’t have this view. It was a lot different. I would not talk about it.

Another participant expressed how she has noted changes in her perspective on the relationship on death and “loss” in the context of everyday life. The participant went on to explain that she has felt “immortal” prior to beginning her work in hospice;

however, the participant disclosed that “taking things slow” and taking “more appreciation in things” that are “important” are now at her forefront with her newer meaning of death and loss.

I didn't see grief. I always saw grief and loss as something related to death. I never realized that grief and loss was something for everyday life—something that you experience everywhere. That's something that really changed the perspective of how I see things. And, I mean, I, I... the death experience I just see it now as something that you really have to take appreciation for life and of your loved ones because they are not always going to be here for you and on how you should communicate things. But, I am not afraid of dying. I am less scared of dying.

Another participant specified that she attributes her novel meaning of death and dying from the patients and families she serves on a daily basis within her “discipline.” The participant stated that what has helped has been: “being able to talk about things, working with people, listening to their experience, seeing different cultures, and, umm, meeting with different families.” The research participant went on to discuss how her meaning of death and dying changed over time.

The way it brought it together for me I think is growing up somebody died, dress in black. You didn't listen to music. You didn't laugh. You didn't enjoy yourself. You know, you had to be sad for about week. And nobody talked about anything. It was just the weirdest thing. We didn't have grief counselors or anything, I mean, you just went on. It was part of life. Being in hospice, like, it has given me... it has added something to my life where it is something to be honored. You

know, it is just not like death is not only just sadness, dark, and gloomy. It is something like someone's birth. We are going to celebrate. You got a whole life in front of you, and now at the end, you have lived that life, so we are going to honor you for living the life that you led.

Shift in understanding. The final subordinate theme in this group is a shift in understanding. Four out of the six research participants were able to capture how they have become a resource for others in understanding the process of death, guiding and educating in the process. Working within the context of hospice has granted some of the participants with the ability to “normalize” death; however, many of the participants expressed how individuals outside of their work system are not able to comprehend their newer meanings due to the “taboo” surrounding on death and dying. One participant explained how working in hospice has further “normalized death for me even more than it was before which it was already kind of normalized.” The participant went on to describe a story.

Like my boyfriend, his mother got to turn 90 and sometimes I'll talk, you know, about things related to death, and he gets very upset. And, you know, even thinking about his mother dying... And I guess for me, you know, she is going to be 90, so it's just a normal thing to talk about death, and what is going to happen afterwards. You know, and the arrangements, whatever the topic is, and he doesn't talk about it very easily. I guess its, you know, I bring that normalization into my life and realize that other people aren't at that level just yet. Well... I feel comfortable with death and sometimes I feel like it's too normalized [laughter] and my system is not ready for me to discuss it.

Another participant explained how even though she has a different understanding of death and dying, grief and loss, the participant's understanding is mostly related to external loss (deaths outside their system) as compared to internal loss (family death) The participant went on to describe that if and when a significant loss within her family was to occur in the future that she may not be "as prepared." The participant specified:

Yes. I mean... essentially, yeah, I will be more prepared. I am just not prepared right now, and I may not even be close to being prepared for something like that no matter what experience we have under our belt. It's easier to have an understanding, and it is easier to have the tools to cope with that once it does happen, but you will never be prepared for someone to die—especially if they are close to you.

The same participant went on to discuss how she has been transformed throughout her career as a mental health professional, and her change in understanding death.

When I was in grad school and undergrad, I use to be more caring, more loving, more, like, understanding. Everything was good for me, right. Now working through hospice, I have developed such thick skin that I don't get as emotional. I don't get as attached. I don't get as affected by things that would have affected me when I was younger. When friends, family members die, I am better able to help them deal with that grief. When so-and-so is going through some struggle, I am better able to say, " Hey listen... you should go here and here and they could help you out." But I think that the biggest thing is is building that tougher skin, and I think that I have. Now I talk to people about my job as if it was nothing. And they

always ask... how can you do that? How can you deal with people who are going to die on a daily basis? And I now I am just like... it just happens. It is part of life.

When asked if when working with death, dying, grief, or loss has been influential on her understanding on processing those aspects with herself and with her family, the participant simply stated, “I can process it easier because I live with it everyday, so I know the steps and I know what it looks like.” The participant went on to explain that her prior husband passed away from sepsis—“the kidneys, the liver, everything got an infection.” The participant went on to recount a realization she had with her daughter during the end of her prior husband’s life, displaying the shift in understanding death and dying between the participant and her daughter.

When my daughter was telling me about my ex-husband, I said, “That sounds like hospice.” But I, I didn’t know if she could follow what I was saying, but everything she was saying was a hospice patient. And I said, “Everything you are saying about dad, that sounds like a hospice patient. That doesn’t sound like someone that is going to go home.” Because she kept saying that he was going to go home, and I kept on saying, “I don’t think so sweetheart.” Yeah, so I kind of knew at that moment that this was not happening. And I didn’t know if she understood that, but I understood that he wasn’t going to come home.

One of the participants explained that anything that relates to the topic and realm of death and dying, grief and loss, makes her a needed “resource” within her friend group; however, the participant disclosed that when she brings up the same topics without the permission of her friends, then she is met with resistance. The participant went on to express how her understanding of death intermingles within her relationships.

Yes, it affects the way that I interact with them cause, again, I am more aware than they are of certain things as they are talking to me. For example, I was talking with my mom. My mom has dementia. And I was talking to my sister about bereavement. And I said, “Oh, because in hospice we offer bereavement for our patients.” So I was telling her that she has to remember that we grieve our mom... we have been grieving our mom from the moment that we found out about this dementia. Now, during, we keep grieving every time we lose her cause now we have to get use to the new person. She has no idea. So, to me, it is, like, an opportunity to educate, but in a nice way.

Each of the participants seem to have a level of comfort with the topic of death and dying that others outside of the field may not have, making it difficult to connect with others during certain situations. Death is normalized. Participants seem to utilize their skills only when requested by their friends and family when needed, which allows them to hone in on their understanding of the topic and the resources that can be provided. Many of the participants seem to also take an educational stance when approaching family members and friends with potential resources and coping strategies by reference of their understanding.

Participant Representation

Each of the participants was able to respond moderately to every theme (see Table 3). Once the process in analyzing the transcripts was completed, superordinate themes were generated from the synthesized data. Five out of the six participants were able to provide feedback on the three superordinate themes. The participants went on to contribute fairly to each of the 10 subordinate themes: four of the participants contributed

to six themes, while two other participants contributed to eight themes. Overall, the percentage of participants contributing to each theme ranged between 50-100% of the total.

Table 3: *Participant contributions to themes*

	A	B	C	D	E	F	% of participants contributing to theme
The Time Traveller Effect	X	X	X	X	X	X	100%
Familial Training	X	X	X	O	O	O	50%
Time Distortion	X	X	X	O	X	O	67%
Exploration of Prior Losses	X	X	O	O	X	X	67%
Metamorphism	X	X	O	X	X	X	83%
Indirect Client	O	O	X	X	O	X	50%
Differentiation of Self	X	X	X	X	X	O	83%
Anxiety and the Management of	X	X	X	X	X	X	100%
Amplification of Anxieties	O	X	X	X	O	O	50%
Dynamic Equilibrium	X	X	X	X	X	X	100%
Death-pertise	X	X	X	X	X	X	100%
Shift in Meaning	O	O	X	X	O	X	50%
Shift in Understanding	O	X	X	O	X	X	67%
Percentage of themes contributed to by participant	69%	85%	85%	69%	69%	69%	

Note. Items in bold are superordinate themes.

In addition, throughout the process of analysis from the synthesized data, participants focused on individualized responses to each of the interview questions based on prior or current experiences they had within their own personal and professional lives. Upon analysis of the transcripts, participants displayed different styles of communicating and understanding to the researcher, which can indicate that the participants may have had different ways of understanding the questions during the interview phase of the

study. For instance, some of the participants were more logical than emotional. Some were more reserved than others, some were more voluble than others, some provided examples to questions while others provided little to no examples.

Summary

This study utilized an Interpretative Phenomenological Analysis (IPA) methodology to explore how the grief narratives of patients and family members in hospice have affected the mental health professionals who work with them. A total of six participants were recruited. Each of the participants had more than six months of experience working within hospice as a mental health professional (marriage and family therapist or social worker). In addition, all of the participants were interviewed for 90 minutes, utilizing a semi-structured interview format (refer to Appendix A) and constructing a genogram for each of the participants.

After synthesizing data from each of the participant's transcripts, three superordinate themes and 10 subordinate themes emerged (see Table 2). Moreover, participation for each theme was moderately represented by each of the six research participants (see Table 3), resulting in the contribution to themes ranging between 50-100%. There were a total of 10 subordinate themes, and each participant was able to contribute to six or more of the themes that emerged.

Furthermore, the research findings, as informed by a Bowenian framework, can suggest the existence of a reciprocal relationship system between patients, family members, and the mental health professional. The superordinate themes that emerged were: (a) the time traveller effect, (b) anxiety and the management thereof, and (c) death-

pertise. These are all significant factors in ways the mental health professional is impacted by clients in hospice on a daily basis.

CHAPTER V: DISCUSSION

This study explored how dealing with grief on a daily basis affects the work and emotional system of a mental health professional. It did so from the theoretical framework of Bowen's Family Systems Theory. Kerr and Bowen (1988) stressed how a therapist and their client's emotional functioning are viewed as a system of interactions, a transfer of energy—of anxiety. The findings from this study were significant in bringing another application of Bowen's Family Systems theory to the healthcare community.

The Relation Between Previous Literature and the Present Study

Prior research using Bowen's theory focused on quantifying differentiation of self, or developing scales to measure participant's responses in relation to a variety of contexts, focusing on trait anxiety (Griffin & Apostol, 1993; Haber, 1993; Peleg-Popko, 2002; Skowron & Friedlander, 1998), marital satisfaction (Haber, 1984; Richards, 1989; Skowron, 2000; Skowron & Friedlander, 1998), greater psychological adjustment (Skowron & Friedlander, 1998), and substance abuse (Thorberg & Lyvers, 2006). Each of the mentioned studies were able to conclude that lower differentiated individuals become more dysfunctional under stress, and were more prone to getting wrapped into the emotional orbits of others within the system. Similarly, Skowron et al. (2014) were able to understand that mental health professionals recurrently come into contact with emotionally driven, high intense situations during therapeutic sessions, affecting the professional's stress levels and overall functioning. These findings were similar to that of Kerr and Bowen (1988) in how mental health professionals could be limited in session when acting within their own anxiety. Likewise, Kerr (2008) further discussed the physical, psychological, and social symptoms that may arise for the individual due to

heightened systemic anxiety. These findings highlighted a phenomenon called symbiotic relationships, where Bowen (1988) was able to discuss the premise of relationships acting in terms of one another. The general interaction between the individual and the system contributes to the emotional climate impacting both.

Hospice can be viewed as an emotionally intense environment, creating stress and anxiety-provoking situations. The mental health professional, the patient, and their family members create the emotional climate of the hospice environment. The superordinate and subordinate themes that emerged focused on how these exchanges of energies impacted the mental health professionals. Bowen described relationships as being symbiotic in nature. I presented evidence that relationships are reciprocal for a mental health professional and a client in the hospice context. These findings suggested that not one party benefits from the therapeutic services, but that both parties benefit from the systemic exchange. Reciprocal relationships can be better understood as both parties benefiting from the relational interaction. All of the superordinate themes within the study were able to highlight reciprocal relationships between the clients and mental health professionals.

The first superordinate theme, the time traveller effect, emphasize these reciprocal relationships, and how these types of relationships intersect with the participants' pasts and futures. The participants discussed how past familial values act as blueprints for current sessions, and how prior significant losses may surface during sessions, affecting the flow of therapy. Participants were then able to discuss how interactions with their clients were a way for them to take a look at what their future may look like, resulting in changing their present to alter their future. In addition, participants explained how this

type of relationship aided in them working on themselves, which created changes within their own respective systems. Interestingly, findings suggest that the more anxiety exerted by the patient or family member during a session, the more likely the time traveller effect will be activated for the mental health professional, depending on the context.

For example, within the same superordinate theme, a subordinate theme emerged, differentiation of self. Each of the participants was able to explain how managing their anxiety in sessions came effortlessly for them. However, the more intense a session with close relations came to their own personal, significant losses, the more difficult it became for them to manage their own emotional reactivity during session. These findings coincided with prior studies that explored differentiation of self within different contexts. The higher the level of differentiation of self is, the lower chronic anxiety is present. Higher differentiated individuals with lower chronic anxiety tend to have increased cognitive functioning due to lower levels of anxiety (Knauth & Skowron, 2004); higher levels of problem solving-skills (Knauth et al., 2006); higher ability to manage one's emotional responses within interpersonal relationships, and increasingly mature relational functioning (Aldea & Rice, 2006; Wei et al., 2005). They also tend to display lower levels of psychological distress and higher mental health well-being (Murdock & Gore, 2004; Skowron et al., 2015) and higher psychological adjustment (Skowron & Friedlander, 1998). Research participants within this study were able to mirror these findings during sessions with lower levels of anxiety being expressed by the patient and family member. Sessions where the family's expression of emotional content was high impacted their differentiation of self, and made them more prone to getting wrapped into

their client's emotional orbit, which became a catalyst to activating the time traveller effect.

The balance between individuality and togetherness becomes disrupted, making it difficult for the participants to be a "self" within the context of the presenting systems. The concept of "self" can become difficult to separate from the system when differentiation is low, leaving the participants emotionally captive within the emotional system (i.e., increase of emotional reactivity vs. logical stance). The more personally related the stories of the patients or family members were to the participants, the more likely each would be wrapped into the emotional responses of the system. These findings correlated with previous studies that explained the need for mental health professionals to work on past problems in order to assist with clients beyond the limit of their own anxiety (Bowen, 1978; Regas, 2011, 2013, 2014a, 2014b; Wampold, 2001).

The more differentiation the participants demonstrated during sessions, the more a sense of self was present—allowing the professional to connect with, yet remain separate from, the patient's emotional functioning (i.e., individuality/togetherness). From a Bowenian perspective, participants who were able to interact with a higher level of differentiation were better able to act in accordance with the intellectual system when dealing with client families. During intense cases with similar, personal narratives, chronic anxiety increases and differentiation is harder to maintain. Most of the participants were able to discuss the implications of having such cases, describing them as being "more distraught," "unable to keep professional boundaries," and so forth. Similarly, Aponte and Carlsen (2009) found that higher anxiety during sessions affected the mental health professional's therapeutic maneuverability, insight, and creativity.

The second superordinate theme, anxiety and the management thereof, and third superordinate theme, “death-pertise,” can best be understood in light of Bowen’s understanding of the role of survival in a natural systems framework. From this point of view life itself is an anxiety-provoking process, and the prospect of death can induce just as much anxiety on the family system. The participants were able to discuss how being employed within a hospice environment has amplified their natural anxiety around death. Much of the discussed anxieties were future-oriented, which became “How do I live today, so that I have the tomorrow I am looking for?” The participants literally are able to have glimpses of their future, so that they can adjust and change their present to create the future they want to see for themselves and their own families. During the interview process, many of the participants were able to recognize the anxiety they generate and distribute within their own family system from these adjustments. The concept of survival is amplified in hospice for the employees, altering priorities and relational dynamics with friends and families.

Moreover, participants were able to recognize the need to manage their own anxiety when facing death on a daily basis. Bowen’s concept on triangulation helped explain the varying ways participants have been able to survive and protect themselves within the field of hospice. Being saturated on a daily basis by a difficult topic can take a toll, and the participants explained how introducing certain rituals and self-care activities assisted them to manage their emotional selves within the demands of the job. The lower the level of differentiation, the more imperative the role of triangles to preserve emotional stability is (Kerr & Bowen, 1988). Moreover, the participants spoke about “self-care” mostly on days where it was “rough” and when there were “intense cases.”

The reciprocal relationship between the clients and mental health professional was clearly evident, supporting Bowenian ideas that included chronic anxiety, the emotional system, individuality/togetherness, differentiation of self, triangles, symbiotic relationships, and the concept of self. The energy a mental health professional gives to clients can be reciprocated in the energy clients give to mental health professionals during sessions, which makes it challenging to separate the emotional functioning of both parties. The energy, the anxiety, that is manifested, generated, and distributed shapes the outcome of therapeutic sessions, creating a system of interactions (Bowen, 1988). When the therapist has more chronic anxiety and more emotional reactivity, the more interlocking triangles are used to manage anxiety. Figure 3 displays the process in which Bowenian concepts become catalyst to the Time Traveller Effect.

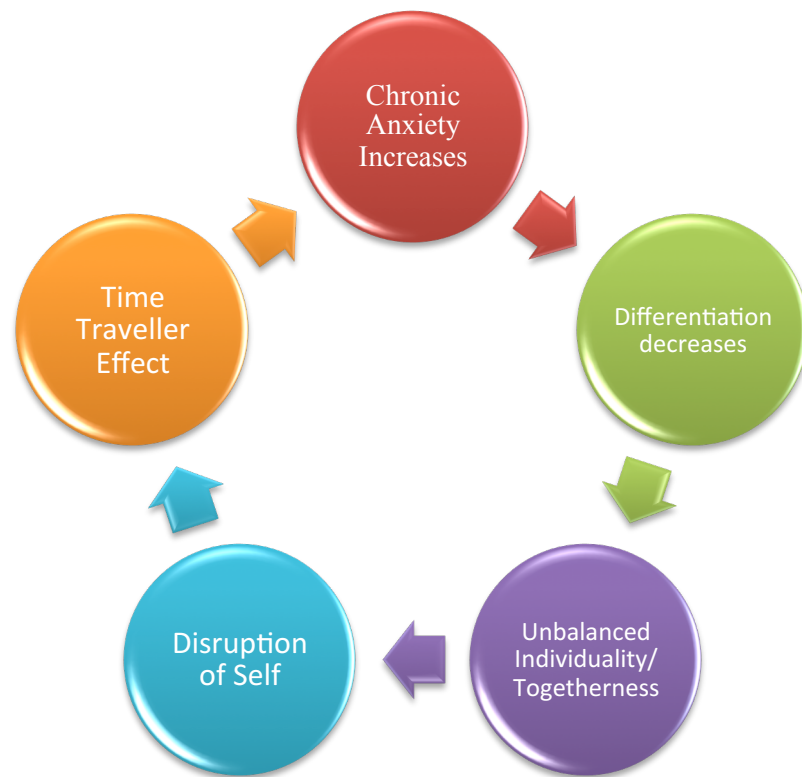


Figure 3: Denotes the process of the Time Traveller Effect through Bowenian Lens.

Expanding on Prior Literature

In general, literature involving marriage and family therapists within the medical industry has grown exponentially throughout the years, but not at the same rate as other clinical work in varying integrated settings (Pratt, Wittenborn, & Berge, 2019; McDaniel, Doherty, & Hepworth, 2014). In terms of prior literature, I noted a lack of empirical studies involving bereavement counselors within the context of hospice. When researching for studies involving hospice, bereavement counselors, and the application of Bowenian concepts, the gaps within literature were even more evident. Nichols (2014) explained the need for more research on Bowenian concepts due to the lack thereof. The presented study addressed this gap, but more needs to be done.

Moreover, most prior literature associated with Bowen dealt with differentiation of self from the perspective of a quantitative researcher. This study expanded on prior literature by utilizing a qualitative method to gather and synthesize data. Utilizing this methodology brought a different sense of understanding the research participant's perspective and reality, which is not completely captured in quantitative research. Exploring the subjective meaning of the participants is ideal for a Bowenian study due to being able to understand and comprehend the generational dynamics within each of their families, and how those dynamics interplay within their present lives throughout differing contexts (i.e., work system and family system).

Additionally, this research study was able to connect the different notions and beliefs within Bowen's Family Systems Theory. Prior research has focused mostly on how levels of anxiety affects levels of differentiation; however, this study was able to expand on how the concepts within the theory interconnect with each other, expanding on

chronic anxiety, the emotional system, individuality/togetherness, differentiation of self, triangles, symbiotic relationships, and the concept of self. Prior literature focused on differentiation of self; however, these findings focused on mental health professionals who work in hospice, uncovering how each of the mentioned Bowenian concepts interact with each other when anxiety is exerted within the system.

Research Implications

Managing Emotional Intensities in Hospice

Based on these findings, mental health professionals explained the difficulties in coming face-to-face with difficult cases throughout their careers in hospice. The participants discussed how certain cases caused certain emotional responses to unfold during session as compared to other cases. An implication would be to create mandatory peer counseling services that could be rendered to the bereavement counselors. Counseling services could be provided on a monthly basis, so as not to impact their routine schedule. Likewise, process groups could be developed for employees in order to understand their own losses. Dealing with personal losses along with the varying types of losses that surface with patients and families could be a difficult thing to balance. The benefits for implementing peer counseling and process groups within the work environment are substantial. From my personal perspective, conducting peer counseling and process groups for hospice employees can potentially:

- Relieve tension and anxiety;
- Promote unity and understanding between the individuals within their work environment during process groups;

- Suspend time for a moment to take a break and unwind and be catered to instead catering to others;
- Reflect on underlying feelings and emotions in regards to personal losses and cases;
- Foster optimal end-of-life care within hospice due to the reduction of intense emotional responses and feelings; and
- Impact personal family systems due to relieving some of the stressors during sessions.

Another added component can be implementing reflective mindfulness trainings to mental health professionals in hospice. These trainings could also benefit from being mandatory for the employees. Again, due to the demanding schedules that can arise from the professionals, the mindfulness trainings could be employed once a month. Mindfulness could aid in potentially increasing attention, improving focus, and assisting in stress management, which may reduce burnout and compassion fatigue (Mindful, 2019). Additionally, a bonus for mindfulness trainings is the potential for teaching mental health professionals the value of remaining present with the families and patients each are providing services to (Mindful, 2019). The findings of this study suggest that mental health professionals have a tendency to time travel during sessions. Perhaps implementing mindfulness trainings can contribute to less stress and clearer thoughts, which can minimize the overall time travel experience and help the therapist remain present with the patients and families. Mindfulness trainings can be as simple as developing and executing meditative techniques, promoting and applying breathing exercises, and so forth.

Lastly, Bowen (1978) proposed that mental health professionals are only able to help clients within the limitations of their own level of differentiation. In order to grow as a therapist, both professionally and personally, mental health professionals have to work on themselves to provide comprehensive care to clients beyond the constructions of their own anxieties (Regas, 2014b). The peer counseling, process groups, and mindfulness trainings will help in minimizing emotional responses and reactivity during intense sessions, helping therapists with the ability to achieve a level of balance between both forces of individuality/togetherness in the face of an emotionally intense climate (Kerr & Bowen, 1988). This ability helps the clinician be part of the client's world and apart from the client's world, which can provide active access to the intellectual system and contribute to a deeper therapeutic relationship with the client, effective interventions and outcomes during sessions, and diminution of therapeutic burnout. These implications could potentially promote overall mental health well being for the professional in both their work and family emotional system.

MFTs and Managing Emotional Intensities Outside of Hospice

The field of marriage and family therapy has a plethora of academic research in many areas; however, an expansion of empirical research surrounding the context of Bowen's Family Systems Theory within hospice settings needs more attention. Marriage and family therapists can benefit from contributing to these fields by dissecting, generating, and distributing the research for the benefit of the field. During the recruiting phase of the study, the researcher noticed that the field of hospice was dominated by social workers as compared to marriage and family therapists. Perhaps adding empirical research within the field of hospice and medical care can contribute to higher visibility in

healthcare settings for MFTs. Looking from a systemic perspective, this can also be viewed as a reciprocal relationship. Adding knowledge to the field will benefit not only the marriage and therapy field, but also the medical field, which can yield to systemic changes within both disciplines. The researcher suggests MFTs to advocate for the profession in healthcare and to justify how systems theory can be applicable to the industry by submitting proposals to healthcare conferences, writing articles for journals involving medical care and practices, and providing in-services to different hospitals, nursing homes, hospices, and so forth.

During this study, many of the research participants expressed feeling that people within their respective system did not understand them. These misunderstandings come from a place where the mental health professional dealing with death, dying, grief and loss on a daily basis are unable to connect newer understandings and meanings with individuals in their personal lives. Marriage and family therapists could benefit from attending more trainings in relation to the hospice population. Findings from this study suggest that clinicians had a taboo understanding of death and dying prior to their employment in hospice. Being employed in hospice changed those meanings and gave newer understanding to difficult topics. Therefore, it could be concluded that therapists outside of hospice do not have adequate training and understanding on the concepts of death, dying, grief, and loss. Perhaps, bringing light to the stigma that those concepts have can potentially influence and create a difference in how marriage and family therapists language their questions and discussions towards their clients and those individuals within their personal lives. I suggest MFTs to go to different trainings that reflect topics of death and dying, grief and loss; attend hospice conferences; and attend

bereavement support group, and so forth for additional trainings to build their own understanding and meaning on the subject.

Another implication for marriage and family therapists is being mindful of the time traveller effect during session with clients. The time traveller effect can be rendered in a multitude of settings—not only in hospice. Being mindful of these effects and reflecting on self before, during, and after session can better assist the clinician in implementing optimal care to their clients. Perhaps, investing in therapeutic care for themselves can also be fundamental in sustaining and surviving the intense emotional climates that clients can bring to session. The power of presence not only reverberates for mental health professionals in hospice, but also for those outside of it. The researcher recommends MFTs to implement self-care and practice ways to remain present within session during intense cases with minimum, emotional input from their past.

Personal Reflections

This study was a transformative process for me in both my own personal and professional emotional systems. As a researcher, there was a deeper understanding as to what hospice bereavement counselors go through on a daily basis, and how their prior losses affect the therapeutic outcome and tone of the session. Outside of the present research, I work as a bereavement counselor within a hospice. I felt as though my own prior losses and past experiences would sometimes surface during session, changing the pace, the tone, the direction, and the interventions that would be utilized in session. As the findings of the study suggested, the clients affect mental health professionals as much as mental health professionals affect them. In being able to hear about these reciprocal

relationships during my interviews, I was able to hear that other mental health professionals faced similar issues, helping me feel less alone in the matter.

In addition, I found myself developing a strong connection with my interviewees due to some of the challenging conversations each touched on. All of the topics came from a personal perspective during the construction of their genograms and interviews, ranging from domestic violence, marital infidelity, adoption and abandonment, and other forms of familial concerns. Having each of these conversations was a way for me to get to know the employees of the hospice, helping me to understand them at a personal level instead of just as a mental health professional within the healthcare industry. Being able to grasp onto each participant's past helped me comprehend them, as who they are, in the present, and how that can impact the way they interact emotionally within their personal and professional lives.

Within the same pages, some of the topics of conversations were a bit difficult to digest for myself. I recognized that my own level of "reactivity" was lowered during certain interviews than in others. Similar to the findings of the present study, the more personal and closely related the narratives of the participants were to my own, the more likely my emotional reactivity would be impacted. Bowen (1978) proposed the importance of mental health professionals working on their own level of differentiation of self in order to minimize emotional responsiveness during session. I would argue that researchers can have varying levels of differentiation within their own work, depending on the context and subject matter and how they relate to their own family of origin. During certain interviews, I felt that I was working within my own constraints of my own anxiety because of the participant's past experiences and current struggles within their

own family and love life. Being mindful of the anxieties that manifested during the interviews, and being able to reflect afterwards during the journaling of the research project, was an imperative way to sort my thinking, and not let my biases, assumptions, expectations, and beliefs stir the direction of the research. In conducting these interviews, I realized that differentiation of self is a force that will need to be continually worked on within myself, extending to contexts beyond the family and work system.

Strengths and Limitations

A major strength of the research can be the homogeneity of the sample. The research participants were recruited by utilizing purposive sampling in order to choose information-rich cases, which allowed the researcher to identify participants that are well informed or proficient within the scope of the research question (Creswell & Plano Clark, 2011). By utilizing purposive sampling, there was higher invariability, which resulted in the quality of uniformity within the study and the lack of variation among the participants. Additionally, interpretative phenomenological analysis is influenced by idiography, which is concerned with the “particular,” assisting with detailed gathering of data from a specific group or population and a specific context or a particular event (Smith et al., 2012). Idiography within the research helps add to the homogeneity of the sample.

Moreover, literature regarding the effectiveness of marriage and family therapists within healthcare has grown at a prevalent rate; however, literature on marriage and family therapists in relation to other clinical work in integrated settings seems to dominate research (Pratt et al., 2019; McDaniel et al., 2014). This study was able to add to literature on healthcare in relation to the context of hospice mental health professionals

through a Bowenian lens. Furthermore, the present study provides an insight on how mental health professionals are impacted by clients throughout their emotional systems, which has little to no research. In summary, a major strength of the research is how three fields could benefit from the significant findings: the medical and healthcare community, mental health community, and the Bowen community.

In addition, another major advantage of the study is the generalization of the findings. Bregman and White (2011) explained how Bowen's Family Systems Theory could be practical to many facets in life besides the mental health field due to the naturalistic conceptualizations the theory proposes. Due to the general applicability of the theory, the suggested findings could be practical for mental health professionals employed in different fields besides hospice (i.e., foster care, LGBTQ, substance abuse, and other treatment and outpatient facilities).

Within the study, the participants were selected from a specific hospice located in Florida. Many of the participants have aspects of cultural and regional commonality, which may have impacted the responses given during each interview. Due to the given limitation, I minimized the impact by acquiring rich and detailed experiences of each of the research participants. Consequently, application to other contexts can be employed in order to assess different mental health disciplines in each region and throughout other hospices, and being mindful of cultural diversity in future study.

One limitation of the study is the potential for my biases to impact the data that was analyzed. In order to minimize the impact, I consulted with my chair for guidance. Additionally, the I was able to discuss with each participant the results of the study, asking for opinions, thoughts, or suggestions in regards to the captured findings.

Research participants had no comments or suggests during the process, which assisted with guiding the researcher on the interpretation of the findings. In addition, participants were able to meet with the researcher to clarify and answer any additional questions the researcher had.

Directions for Future Research

There are a number of directions that can be taken for future research. Future studies can broaden and diversify the participant group, acquiring varying cultural backgrounds, ethnicities, race, sex, gender and so forth within the context of hospice. In addition, instead of focusing on work and family systems as whole, future studies could focus on one aspect of the study, and how working within a hospice setting has impacted their professional selves or their familial selves.

One of the overall main findings within the research study was reciprocal relationships—how clients affect mental health professionals as much as mental health professionals may affect clients. Because of the findings, the construction and implementation of peer services, process groups, and mindfulness trainings need to be developed for hospice employees. As discussed before, the anxiety-provoking environment can trigger certain feelings and emotions within the bereavement coordinators; therefore, hospices need to employ self-care measures for the professionals. Directions for future studies can focus on how these services could allow professionals to work on self, and the effects of how working on self impacts both their work and family emotional systems. Additionally, hospices can conduct a company-wide study on how providing these therapeutic services to their employees can potentially have a direct impact on overall customer satisfaction. Also, future directions can shine light on how

working on self can help with the employees family systems. The proposed research can be conducted as longitudinal studies in order to fully capture the effects of self-care on the employee, and how delivering therapeutic services within an intense environment affects the system, focusing on and tracking the emotional responses and reactivity.

From an organizational perspective, future studies can focus on the overall emotional climate between the employees and senior management. Hospice organizations can be viewed as an emotional unit, a family system, coming together for the sole purpose of collaborating and providing optimal, end-of-life care to terminally ill patients and their family members. The hierarchy within these organizations can cause tension and anxiety to spread from one part of the system to another due to differing functions and roles, cultures, and means toward survival of the organization. Again, survival and adapting within the environment could look different for every species, every person, which contributes to distinct comfort levels in relation to the generated anxiety (Bregman & White, 2011). The system itself has a genetic formula toward survival, sanctioning each member's energy in the overall shaping of the system (Bowen, 1978; Kerr & Bowen, 1988). This, too, can be viewed as reciprocal relationships. Perhaps, future studies can focus on the exploration on self (individual employees) within a system (senior management) that already has their own formula toward survival (the hospice organization), and how building off of these relationships may be able to fortify cohesion within the organization.

Differentiation of self is such a pivotal concept within Bowen's Family Systems Theory. Throughout the genogram and interview process with certain participants, I experienced my own level of differentiation lowering itself, impacting my own way of

conducting and thinking objectively about the research. An interesting direction for future research would be on exploring how researchers are impacted by their own research participants, investigating the effects of those reciprocal relationships and how each has been able to manage to connect, yet separate themselves from the overall research experience. How can the researcher manage themselves within the emotional climate between themselves and their participant? How does the research participant influence the researchers overall differentiation of self, and what are the implications, if any? These explorations would probably benefit in being conducted from a qualitative methodological perspective.

Lastly, Bowen's Family Systems Theory is applicable to many facets in life due to the naturalistic conceptualization behind the theoretical framework (Bregman & White, 2011). Along the same pages, AAMFT (2018) explained how people exist within relationships that directly and indirectly affect their overall well being, influencing and fabricating their own individual experiences and reality. Utilizing the theories within the present research could allow for additional studies to be done outside the field of mental health. Perhaps, future studies may focus on recreating the current research within different disciplines (i.e., chaplains, nurses, doctors, certified nursing assistants, police officers, lawyers, teachers, and so forth). Maybe, by reproducing the study and dividing the participants by disciplines could yield to different or similar results, accentuating how individuals of different professions are not just passive givers, but active receivers.

References

- Aldea, M. A., & Rice, K. G. (2006). The role of emotional dysregulation in perfectionism and psychological distress. *Journal of Counseling Psychology*, 53, 498-510.
- American Association for Marriage and Family Therapy (AAMFT). (2017). *About Marriage and Family Therapists*. Retrieved February 26, 2019, from https://aamft.org/About_AAMFT/About_Marriage_and_Family_Therapists.aspx?hkey=1c77b71c-0331-417b-b59b-34358d32b909
- Aponte, H. J., & Carlsen, J. C. (2009). An instrument for person-of-the therapist supervision. *Journal of Marital & Family Therapy*, 35(4), 395-405.
doi:10.1111/j.1752-0606.2009.00127.x
- Bartle-Haring, S., & Gregory, P. (2003). Relationship between differentiation of self and the stress and distress associated with predictive cancer genetic counseling and testing: Preliminary evidence. *Families, Systems, & Health*, 21, 357-381.
- Bartle-Haring, S., & Probst, D. (2004). A test of Bowen theory: Emotional reactivity and psychological distress in a clinical sample. *American Journal of Family Therapy*, 32, 419-435.
- Bateson, M., Brilot, B., & Nettle, D. (2011). Anxiety: An evolutionary approach. *The Canadian Journal of Psychiatry*, 56(12), 707-715.
doi:10.1177/070674371105601202
- Boelen, P. A., & Prigerson, H. G. (2012). Commentary on the inclusion of persistent complex bereavement-related disorder in DSM-5. *Death Studies*, 36, 771-794.

- Bohlander, J. R. (1995). *Differentiation of self, need-fulfillment, and psychological well-being in married women*. Unpublished doctoral dissertation, New York University.
- Boss, P. (2010). The trauma and complicated grief of ambiguous loss. *Pastoral Psychology*, 59, 137-145. doi:10.1007/s11089-009-0264-0
- Bowen, M. (1976). Theory in the practice of psychotherapy. In P. J. Guerin (Ed.), *Family therapy: theory and practice* (pp. 42-90). New York: Gardner Press.
- Bowen, M. (1978). *Family therapy in clinical practice*. Northvale, NJ: Jason Aronson.
- Boyd, T. V., Watters, Y., Canfield, M. S., & Nativ, I. (2011). Creating a team: A systemic view on collaboration among health care providers and medical family therapists. *Annals of Behavioral Science and Medical Education*, 17(1), 28-31.
- Bregman, O. C., & White, C. M. (Eds.). (2011). *Bringing systems thinking to life: Expanding the horizons for Bowen Family Systems Theory*. New York, NY: Taylor & Francis Group.
- Checkland, P. (1997). *Systems thinking, systems practice*. Chichester, UK: John Wiley & Sons Ltd.
- Comella, P. A. (2011). Observing emotional functioning in human relationship systems: Lessons from Murray Bowen's writings. In O. C. Bregman & C. M. White (Eds.), *Bringing systems thinking to life: Expanding the horizons Bowen Family Systems Theory* (pp. 3-30). New York, NY: Routledge.
- Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage.

- Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). Los Angeles, CA: Sage.
- Creswell, J. W., & Poth, C. N. (2017). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). Thousand Oaks, CA: Sage.
- Dahl, C. M., & Boss, P. (2005). The use of phenomenology for family therapy research. In (Eds.) *Research Methods in Family Therapy* (pp. 63-84). New York: Guilford Press.
- Davis, B., & Jones, L. C. (1992). Differentiation of self and attachment among adult daughters, *Issues in Mental Health Nursing*. 13, 321-331.
- Death. (2012). *Farlex Partner Medical Dictionary*. Retrieved February 9 2019 from <https://medical-dictionary.thefreedictionary.com/death>
- Denzin, N. K., & Lincoln, Y. S. (2005). *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.
- Drescher, K., & Foy, D. W. (2010). When horror and loss intersect: Traumatic experiences and traumatic bereavement. *Pastoral Psychology*, 59(2), 147-158. doi: 10.1007/s11089-009-0262-2
- Dying. (2009). *Farlex Medical Dictionary*. Retrieved February 9 2019 from <https://medical-dictionary.thefreedictionary.com/dying>
- Elieson, M. V., & Ruben, L. J. (2001). Differentiation of self and major depressive disorders: A test of Bowen theory among clinical, tradition, and internet groups. *Family Therapy*. 29, 125-142.

- Frost, R. T. (2014). Challenges of conducting Bowen family systems research on differentiation of self. In (Eds) *Differentiation of self: Bowen Family Systems Theory perspectives* (pp. 303-329). New York, NY: Routledge.
- Gergen, K. J. (2015). *An invitation to social construction* (3rd ed.). Los Angeles, CA: Sage Publications
- Gilgun, J. F. (1992). Definition, methodologies, and methods in qualitative family research. In (Eds) *Qualitative methods in family research* (pp. 22-39). Newbury Park, CA: Sage.
- Glick, D. R., Motta, M., Wiegand, D. L., Range, P., Reed, R. M., Verceles, A. C., Shah, N. G., & Netzer, G. (2018). Anticipatory grief and impaired problem solving among surrogate decision makers of critically ill patients: A cross-sectional study. *Intensive and Critical Care Nursing*, 49, 1-5.
doi:<http://dx.doi.org.ezproxylocal.library.nova.edu/10.1016/j.iccn.2018.07.006>
- Griffin, J. M., & Apostol, R. A. (1993). The influence of relationship enhancement training on differentiation of self. *Journal of Marital and Family Therapy*, 19, 267-272.
- Grimby, A., Johansson, A., & Johansson, U. (2015). Anticipatory grief among close relatives of patients with ALS and MS. *Psychology and Behavioral Sciences*, 4(3), 125-131. doi:10.11648/j.pbs.20150403.16
- Haber, J. E. (1984). *An investigation of the relationship between differentiation of self, complementary psychological need patterns, and marital conflict*. Unpublished doctoral dissertation, New York University.

- Haber, J. E. (1993). A construct validity study of differentiation of self scale. *Scholarly Inquiry for Nursing Practice*. 7, 165-178
- Haefner, J. (2014). An application of Bowen Family Systems Theory. *Issues in Mental Health Nursing*, 35, 835-841. doi:10.3109/01612840.2014.921257
- Harris, D. L., & Winokuer, H. R. (2016). *Principles and practice of grief counseling* (2nd ed.). NY: Springer Publishing Company.
- Holland, S. (1997). Personal authority related to family origin work in clinical training, therapeutic relationships, and gerbil psychological health (Doctoral dissertation). Biola University.
- Hospice Foundation of America. (2018a). *What is Grief?* Retrieved February 9, 2019, from [https://hospicefoundation.org/Grief-\(1\)/What-to-Expect](https://hospicefoundation.org/Grief-(1)/What-to-Expect)
- Hospice Foundation of America. (2018b). *What is Hospice?* Retrieved February 25, 2019, from <https://hospicefoundation.org/Hospice-Care/Hospice-Service>
- Jackson, M. (2003). *Systems thinking: Creative holism for managers*, Chichester, UK: John Wiley & Sons, Ltd.
- Johansson, U., & Grimby, A. (2014). Anticipatory grief among close relatives of patients with Parkinson's disease. *Psychology and Behavioral Sciences*, 3(5), 179-184. doi:10.11648/j.pbs.20140305.15
- Johns Hopkins Medicine. (2012). *Hospice Care Statistics*. Retrieved February 4, 2019, from https://www.hopkinsmedicine.org/healthlibrary/test_procedures/urology/hospice_care_statistics_85,p00608

- Kochanek, K. D., Murphy, S. L., Xu, J., & Arias, E. (2017). Mortality in the United States. *National Center for Health Statistics*. Retrieved February 9, 2019, from <https://www.cdc.gov/nchs/products/databriefs/db293.htm>
- Kerr, M. E. (1988). Chronic anxiety and defining a self. *The Atlantic Monthly*, 262, 3, 35-58.
- Kerr, M. E. (2003). *One family's story: A primer on Bowen theory*. Washington, DC: Bowen Center for the Study of the Family Georgetown Family Center.
- Kerr, M. E. (2008). "From individual homeostasis to family homeostasis." Lecture presented to the Special Postgraduate Program, Bowen Center for the Study of the Family, Washington, DC, March 2008.
- Kerr, M. E., & Bowen, M. (1988). *Family evaluation: An approach based on Bowen theory*. New York, NY: W.W. Norton.
- Knauth, D. G. & Skowron, E. A. (2004). Psychometric evaluation of the differentiation of self inventory for adolescents. *Nursing Research*, 53, 163-171.
- Knauth, D. G., Skowron, E. A., & Escobar, M. (2006). Effect of differentiation of self on adolescent risk behavior: Test of the theoretical model. *Nursing Research*, 55, 336-345. doi:10.1097/00006199
- Lamiell, J. T. (1987). *The psychology of personality: An epistemological inquiry*. New York: Columbia University Press.
- Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. In A. Thompson & D. Harper (Eds.), *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners* (pp. 99-116). Oxford: John Wiley & Sons.

- Licht, C., & Chabot, D. (2006). The Chabot emotional differentiation scale: A theoretically and psychometrically sound instrument for measuring Bowen's intrapsychic aspect of differentiation. *Journal of Marital and Family Therapy*, 32, 167-180.
- Loss. (2012). *Medical Dictionary for the Health Professions and Nursing*. (2012). Retrieved February 9, 2019, from <https://medical-dictionary.thefreedictionary.com/loss>
- McDaniel, S. H., Doherty, W. J., & Hepworth, J. (2014). *Medical family therapy and integrated care* (2nd ed.). Washington, DC: American Psychological Association.
- Mele, C., Pels, J., & Polese, F. (2010). A brief review of systems theories and their managerial applications. *Service Science*, 2(1-2), 126-135.
doi:10.1287/serv.2.1_2.126
- Mindful. (2019). *How to Meditate with Anxiety*. Retrieved January 30, 2020, from <https://www.mindful.org/mindfulness-meditation-anxiety/>
- Murdock, N. L., & Gore, P. A. (2004). Stress, coping, and differentiation of self: A test of Bowen theory. *Contemporary Family Therapy*, 26(3), 319-335.
- National Hospice and Palliative Care Organization (NHPCO). (2016). *Hospice Policy Compendium: The Medicare Hospice Benefit, Regulations, Quality Reporting, and Public Policy*. Retrieved from https://www.nhpc.org/sites/default/files/public/public_policy/Hospice_Policy_Compndium.pdf
- National Hospice and Palliative Care Organization (NHPCO). (2018). *Facts and Figures: Hospice Care in America*. Retrieved from

https://www.nhpco.org/sites/default/files/public/Statistics_Research/2017_Facts_Figures.pdf

National Institute of Aging, (2017). *What Are Palliative Care and Hospice Care?*

Retrieved February 2, 2019, from <https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care#hospice>

Nichols, M. P. (2014). *The essentials of family therapy* (6th ed.). Boston, MA: Pearson Education.

Papero, D. (1990). *Bowen family systems theory*. Needham Heights, MA: Allen and Bacon.

Papero, D. V. (2014). Assisting the two-person system: An approach based on the Bowen theory. *Australian and New Zealand Journal of Family Therapy*, 35(4), 386-397.
<https://doi.org/10.1002/anzf.1079>

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Peleg-Popko, O. (2002). Bowen theory: A study of differentiation of self, social anxiety and physiology symptoms. *Contemporary Family Therapy*, 25, 355-369.

Saavedra Pérez, H. C., Ikram, M. A., Direk, N., Prigerson, H. G., Freak-Poli, R., Verhaaren, B. F. J., Hofman, A., Vernooij, M., & Tiemeier, H. (2015). Cognition, structural brain changes and complicated grief. A population-based study. *Psychological Medicine*, 45(7), 1389-1399. doi: 10.1017/S0033291714002499

Peters, L., Cant, R., Payne, S., O'Connor, M., McDermott, F., Hood, K., Morphet, J. & Shimoinaba, K. (2013). How death anxiety impacts nurses' caring for patients at the end of life: a review of literature. *The Open Nursing Journal*, 7, 14-21.

- Pratt, K. J., Wittenborn, A. K., & Berge, E. M. (2019, February). Research methods and models to advance MFTs in healthcare. *Family Therapy Magazine*, 18(1), 32-36.
- Rambo, A. H., Boyd, T. V., & Marquez, M. G. (2016). *The marriage and family therapy career guide: Doing well while doing good*. New York, NY: Routledge.
- Richards, E. R. (1989). Self reports of differentiation of self and marital compatibility as related to family functioning in the third and fourth stages of the family life cycle. *Scholarly Inquiry for Nursing Practice*. 3, 163-175.
- Richmond C. (2005). Dame Cicely Saunders. *BMJ : British Medical Journal*, 331(7510), 238.
- Reese, D. (2013). *Hospice social work (End-of-life care: A series)*. New York, NY: Columbia University Press.
- Regas, S. (2011, August). Fellow Address: *You can enhance emotional maturity in a graduate level course*. Symposium conducted at the American Psychological Association, Washington, D.C.
- Regas, S. (2013, August). *Metamorphosis: In treatment and in person of the therapist*. In S. Regas (Chair), *Therapeutic Models and Person of the Therapist: Can We Talk?* Symposium conducted at the meeting of American Psychological Association, Honolulu, Hawaii.
- Regas, S. (2014a). Turn the tables and look inward. *The Family Psychologist*, 30 (1).
- Regas, S. (2014b). The Heart of the Matter: Training the Therapeutic Instrument. In S. Regas & J. Caffaro (Co-Chairs), *Can You Leave the Self of the Therapist Outside of the Therapy?* Symposium conducted at the meeting of American Psychological Association, Washington, D.C.

- Romig, D. A. (2011). Bowen theory and the chain reaction of bad leadership and good leadership. In O. C. Bregman & C. M. White (Eds.), *Bringing systems thinking to life: Expanding the horizons for Bowen Family Systems Theory* (pp. 229-238). New York, NY: Routledge.
- Schooley, A., & Boyd, T. V. (2013). What does it take to be a “good” family therapist? Questions of competence. In A. Rambo, C. West, A. Schooley, & T.V. Boyd (Eds.), *Family therapy review: Contrasting contemporary models* (pp. 9-10). New York, NY: Routledge.
- Schnarch, D., & Regas, S. (2012). The crucible differentiation scale: Assessing differentiation in human relationships. *Journal of Marital and Family Therapy*, 38, 639–652.
- Shear, M. K., Simon, N., Wall, M., Zisook, S., Neimeyer, R., Duan, N., Reynolds, C., Lebowitz, B., Sung, S., Ghesquiere, A., Gorscak, B., Clayton, P., Ito, M., Nakajima, S., Konishi, T., Melhem, N., Meert, K., Schiff, M., O'Connor, M. F., First, M., Sareen, J., Bolton, J., Skritskaya, N., Mancini, A. D., & Keshaviah, A. (2012). Complicated grief and related bereavement issues for DSM- 5. *Depression and Anxiety*, 28, 103–117.
- Skowron, E. A. (2000). The role of differentiation of self in marital adjustment. *Journal of Counseling Psychology*, 47, 229-237.
- Skowron, E. A. (2004). Differentiation of self, personal adjustment, problem solving, and ethnic group belonging among persons of color. *Journal of Counseling & Development*, 82, 447-456.

- Skowron, E. A. (2005). Parent differentiation of self and child competence in low-income urban families. *Journal of Counseling Psychology, 52*, 337.
- Skowron, E. A. & Dendy, A. K. (2004). Differentiation of self and attachment in adulthood: Relational correlates of effortful control. *Contemporary Family Therapy: An International Journal, 26*, 337-357.
- Skowron, E. A., Van Epps, J. J., & Cipriano-Essel, E. A. (2014). Toward a greater understanding of differentiation of self in Bowen family systems theory: Empirical developments and future decisions. In P. Titelman (Ed.), *Differentiation of self: Bowen family systems perspectives*. New York: Routledge.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health, 11*, 261-271.
- Smith J.A. (2011) Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*(1), 9–27.
- Smith, J. A., Flowers, P., & Larkin, M. (2012). *Interpretative phenomenological analysis: Theory, method and research*. Los Angeles: SAGE Publications.
- Titelman, P. (2014). *Differentiation of Self: Bowen Family Systems Theory Perspectives*. New York: Routledge.
- Tuason, M. T. & Friedlander, M. L. (2000). Do parents' differentiation levels predict those of their adult children? And other tests of Bowen theory in a Philippine sample. *Journal of Counseling Psychology, 47*, 27-35.
- Tufford, L., & Newman, P. (2010). Bracketing in qualitative research. *Qualitative Social Work, 11*(1), 80-96. doi:10.1177/1473325010368316

- Tyndall, L., Hodgson, J., Lamson, A., White, M., & Knight, S. (2014). A review of medical family therapy: 30 years of history, growth, and research. *Medical Family Therapy*, 13-32. doi:10.1007/978-3-319-03482-9_2
- Von Bertalanffy, L. 1968. *General System theory: Foundations, development, applications*. New York: George Braziller.
- Walsh, F., & McGoldrick, M. (2004). *Living beyond loss: Death in the family* (2nd ed.). New York: W.W. Norton.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.
- Wei, M., Vogel, D. L., Ku, T.-Y., & Zakalik, R. A. (2005). Adult attachment, affect regulation, negative mood, and interpersonal problems: The mediating roles of emotional reactivity and emotional cutoff. *Journal of Counseling Psychology*, 52, 14-24.
- Weinberg, G.M. (2001). *An Introduction to General Systems Thinking*. Dorset House Publishing Company, Incorporated; 25 Anv edition, April.
- Wittenberg-Lyles, E., Oliver, D. P., Demir, G., & Regehr, K. (2010). Interdisciplinary collaboration in hospice team meetings. *Journal of Interprofessional Care*, 24(3), 264-273. doi:10.3109/13561820903163421
- World Health Organization. (2018). *The Top 10 Causes of Death*. Retrieved February 2, 2019, from <https://www.who.int/en/news-room/fact-sheets/detail/the-top-10-causes-of-death>

World Health Organization (2001). *The world health report 2001: Mental health: New understanding, new hope*. Geneva, Switzerland: World Health Report, 5.

Retrieved from http://www.who.int/whr/2001/en/whr01_en.pdf

Xu, J., Murphy, S. L., Kochanek, K. D., Bastian, B., & Arias, E. (2018). Deaths: Final Data for 2016. *National Vital Statistics Reports*, 67(5), 1-76.

Appendices

Appendix A

Interview Questions for Research Study Entitled

The Impact of Grief Work on Hospice Mental Health Providers Through a Bowen Family Systems Lens

1. How did you come into the field of hospice?
 - a. Tell me more about what may have gotten you interested within the field.
 - b. What has kept you working within an emotionally intense environment?
2. Can you describe to me the meaning you and your family of origin place on death, dying, grief, and loss?
 - a. Do the meanings you have of each item differ from the meaning your family has of them since working in hospice?
 - b. How did your family of origin train you in dealing with the process of death dying, grief, and loss as a mental health professional in hospice?
3. Please describe to me some of your grief narratives and/or significant losses within your own life and family of origin.
 - a. Do the grief narratives and losses you have had time ago affect you presently?
 - b. How do you manage to not let your prior, significant losses affect your therapeutic sessions with clients who have also had losses?
4. How have you been affected working with patients and families of patients who express their grief narratives to you on a daily basis?
 - a. Has working with death, dying, grief, and loss prepared you on processing those aspects within your own family of origin?

- b. Has the grief narratives you have worked with in the past or are currently working with manifested any anxiety within yourself?
- 5. Can you describe some of the narratives that have affected you profoundly during the course of your therapeutic work within hospice?
 - a. Please tell me more of the profound effects you have had or are having associated with these cases.
 - b. What makes this cases more significant and impactful to you at an emotional level as compared to the other cases you had or currently have?
- 6. How have you changed your interactions with those around you in relation to dealing with grief narratives on a daily basis?
 - a. Has the change of these interactions created a difference within your family or work system?
 - b. How have you been affected by the change of interactions within your systems?
- 7. When working with patients and families of patients in relation to grief, loss, death, and dying, how has your approach on working with clients in hospice changed?
 - a. During the course of your interactions with the family or patient, do you become more involved in the grieving process or less involved?
 - b. Have the changes associated with your emotional interactions with the patients and families impact the way you interact with your nuclear and extended family?

8. How do you deal with the death, dying, grief, and loss of a client(s) when the grief narrative has a personal impact on your own family of origin?
 - a. Can you describe the difference you felt during sessions when the narratives of the patient or patient's family were similar to your family of origin?
 - b. How have your emotional responses and reactivity change in the face of a patient or family member going through a similar narrative you have gone through?
9. As a mental health professional, what does it mean to deal with death, dying, grief, and loss at work, and how do you proceed forward outside of work once you get home with these meanings?
 - a. How do you survive and protect yourself when dealing with emotionally intense situations in hospice?
 - b. What has assisted you in throwing yourself into the job's role in order to thrive in the functioning of a Hospice Bereavement Coordinator?
10. Can you describe to me some of the life lessons from patients and families of patients you have learned during the course of your employment as a Hospice Bereavement Coordinator?
 - a. Please tell me more about the lessons that have impacted you and what made them significant.
 - b. Have these lessons been implemented within your daily life? If so, how have these lessons altered the relationships you currently have or will

foster in the future (i.e., intimate, work, familial, friendships, and so forth)?

Appendix B
Letter of Intent for Hospice

Date

Contact Name

Organization

Address

City, State, ZIP

RE: *The Impact of Grief Work on Hospice Mental Health Providers Through a Bowen Family Systems Lens*

To whom it may concern,

I am a doctoral student in the Department of Family Therapy, College of Arts, Humanities, and Social Sciences at Nova Southeastern University. I am conducting research for my dissertation on exploring how Hospice Bereavement Coordinators deal with grief narratives on a daily basis and the impact of those narratives on the mental health professionals' functioning in both their work and family systems.

The research will seek to explore the lived experiences of mental health professionals impacted by the grief narratives of the patients and families each serve within your organization. The aim of the study is to expand mental health professionals' understanding on how working with hospice patients may impact and potentially change the way therapists' experience the world. In order to proceed with the study, I am requesting your permission to obtain participants from your organization to be utilized for research purposes. I am hoping to solicit participation from your Hospice Bereavement Coordinators to fulfill the research criteria. Interviews with each solicited participant will be approximately an hour and a half (90 minutes), and will be followed by transcriptions of the conducted interviews, which will allow me to synthesize the information and develop emergent themes.

If you agree to the research study, I would like to reach out to your Hospice Bereavement Coordinators and provide each with information regarding the study. Prior to reaching out to the mental health professionals, I will construct a letter in which I will send you for approval prior to sending to the coordinators through email. Should the Hospice Bereavement Coordinators agree to the study, documents and forms would be sent to them before the commencement of data gathering for needed signatures.

Thank you for taking the time in reading this letter. If you have any questions, please do not hesitate in contacting me via e-mail at john DOE@emailserver.com or telephone at 123-456-7899.

Respectfully,
Joshua E. Hernandez



NOVA SOUTHEASTERN UNIVERSITY
College of Arts, Humanities, and Social Sciences

Appendix C

Research Participant Informed Consent Form NSU Consent to be in a Research Study Entitled

I, _____ consent to be part of the research study entitled *The Impact of Grief Work on Hospice Mental Health Providers Through a Bowen Family Systems Lens*.

Who is doing this research study?

Principal Investigator:

Joshua Hernandez, MS, LMFT

3301 College Avenue

Davie, FL 33314

Tel: (123) 456-7899

Email: johndoe@email.com

Faculty Advisor/Dissertation Chair:

Dr. Christopher F. Burnett, Psy.D.

3301 College Avenue

Davie, FL 33314

Tel: (123) 456-7899

Email: professor@email.com

Institution:

Nova Southeastern University
College of Arts, Humanities, and Social Sciences
Department of Family Therapy
3301 College Avenue
Davie, FL 33314

Site Information:

[Hospice Name]

[Hospice Address]

[Hospice Phone Number]

What is this study about?

This is a research study, designed to test and create new ideas that other people can use. The purpose of this study is to explore how Hospice Bereavement Coordinators deal with grief narratives on a daily basis and the impact of those narratives on the mental health professionals' functioning in both their work and family systems.

Why are you asking me to be in this research study?

You are invited to participate within the research study because you are a mental health professional who is currently employed within Catholic Hospice, who provides therapeutic services to those affected by loss and impacted by grief. You are also invited to participate within the research study due to your experiences with working within Catholic Hospice for six months or more in a therapeutic role. It is expected five to six participants will be recruited from the organization.

What will I be doing if I agree to be in this research study?

In the event that you agree to participate within the study, you will participate in a one hour and a half, face-to-face interview with the principal investigator, Mr. Hernandez, where you and he will meet within a private space at Catholic Hospice's main office. The time of interview will be discussed with you that best fits your current schedule. Interviews will last approximately one hour and a half (90 minute session) in order to capture the essence of the phenomena being explored. During the interview, the participants will be asked to answer semi-structured questions in regards to how working with grief on a daily basis has impacted the individual's work and family, precluding family history, personal grief and loss interpretations, and contextual and influential factors that may impact you before, during, and after therapeutic sessions. Participants will be called upon for review of the synthesized analysis of their interview for additional clarification and interpretations of the findings within the research study.

Are there possible risks and discomforts to me?

This research study involves minimal risk to you. To the best of our knowledge, the things you will be doing have no more risk of harm than you would have in everyday life. Minimum psychological discomfort may be experienced due to the participant having to recall experiences before, during, and after therapeutic sessions in reference to personal familial matters, and those of the patients and families each serve. If potential role of researcher thusly becomes the role of a therapist due to the psychological discomfort experienced by the participant, the researcher will be prepared to offer referrals to appropriate support services.

What happens if I do not want to be in this research study?

You have the right to leave this research study at any time or refuse to be in it. If you decide to leave or you do not want to be in the study anymore, you will not get any penalty or lose any services you have a right to get. If you choose to stop being in the study before it is over, any information about you that was collected **before** the date you leave the study will be kept in the research records for 36 months from the end of the study and may be used as a part of the research.

What if there is new information learned during the study that may affect my decision to remain in the study?

If significant new information relating to the study becomes available, which may relate to whether you want to remain in this study, this information will be given to you by investigators. You may be asked to sign a new Informed Consent Form, if the information is given to you after you have joined the study.

Are there any benefits for taking part in this research study?

There are no direct benefits from being in this research study.

Will I be paid or be given compensation for being in the study?

You will not be given any payments or compensation for being in this research study.

Will it cost me anything?

There are no costs to you for being in this research study.

How will you keep my information private?

Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law and will be limited to people who have a need to review this information. The researcher will lock documents collected throughout the study containing personal identifying information in a personal, private safe. In addition, documents containing research participant's personal information will be changed and given a specific letter except for the informed consent forms to maintain confidentiality. Each research participant will be assigned a letter in order to protect the identity of the individual (i.e., A, B, C, etc.). Digital files will be stored in an encrypted flash drive and locked in a cabinet within the researcher's home office. The data will be available to the researcher, the Institutional Review Board, and the other co-investigators listed within the consent form. If we publish the results of the study in a scientific journal or book, we will not identify you. All confidential data will be kept securely. All data will be kept for 36 months from the end of the study and destroyed after three-years.

Will there be any Audio or Video Recording?

This research study involves audio recording. This recording will be available to the researcher, the Institutional Review Board, and the other co-investigators listed within the consent form. The principal investigator, Mr. Hernandez, will transcribe audio recordings. The recordings will be kept, stored, and destroyed as stated in the section above. Because what is in the recording could be used to find out that it is you, it is not possible to be sure that the recording will always be kept confidential. The researcher will try to keep anyone not working on the research from listening to the audio recordings by utilizing headphones and listening to audiotape interviews within the privacy of researcher's home office.

Whom can I contact if I have questions, concerns, comments, or complaints?

If you have questions now, feel free to ask us. If you have more questions about the research, your research rights, or have a research-related injury, please contact:

Primary contact:

Joshua Hernandez, MS, LMFT

3301 College Avenue

Davie, FL 33314

Tel: (123) 456-7899

Email: johndoe@email.com

If primary is not available, contact:

Dr. Christopher F. Burnett, Psy.D.

3301 College Avenue

Davie, FL 33314

Tel: (123) 456-7899

Email: professor@email.com

Research Participants Rights

For questions/concerns regarding your research rights, please contact:

Institutional Review Board

Nova Southeastern University

(954) 262-5369 / Toll Free: 1-866-499-0790

IRB@nova.edu

You may also visit the NSU IRB website at www.nova.edu/irb/information-for-research-participants for further information regarding your rights as a research participant.

All space below was intentionally left blank.

Research Consent & Authorization Signature Section

Voluntary Participation - You are not required to participate in this study. In the event you do participate, you may leave this research study at any time. If you leave this research study before it is completed, there will be no penalty to you, and you will not lose any benefits to which you are entitled.

If you agree to participate in this research study, sign this section. You will be given a signed copy of this form to keep. You do not waive any of your legal rights by signing this form.

SIGN THIS FORM ONLY IF THE STATEMENTS LISTED BELOW ARE TRUE:

- You have read the above information.
- Your questions have been answered to your satisfaction about the research.

Adult Signature Section

I have voluntarily decided to take part in this research study.

Printed Name of Participant

Signature of Participant

Date

Printed Name of Person
Obtaining Consent and
Authorization

Signature of Person Obtaining Consent &
Authorization

Date

Appendix D Letter of Invite

Date

Contact Name
Organization
Address
City, State, ZIP

RE: *The Impact of Grief Work on Hospice Mental Health Providers Through a Bowen Family Systems Lens*

Dear Potential Participant,

You are invited to participate in a study where the premise of the research will focus on exploring how mental health professionals deal with grief narratives on a daily basis and the impact of those narratives on the professionals' functioning in both their work and family systems. I am a doctoral student at Nova Southeastern University's College of Arts, Humanities, and Social Sciences, and the research is part of my partial fulfillment of my degree plan. Working within hospice, I have personally identified the need of exploring the effects of working within an emotional intense environment, and how each patient and the families of patients can potential impact our emotional responses within our workplace and within our personal lives. My hope is that this study can shed more light on the effects patients and their family have on mental health professionals, exploring the meaning others working in a therapeutic, supportive role may be experiencing in hospice.

The research study will require potential participants to sign an informed consent form, agreeing to an hour and a half (90 minute) interview prior to the start of the study. You will also have the option of reviewing the synthesized data collected throughout your interview for further commentary and feedback to me. Should you would want to withdraw from the study, you may do so at any time throughout the process with no penalty.

Thank you in advance for taking the time to read this letter. For your convenience, I have also attached the informed consent form for your review. If you have additional questions or do decide to participate within the research study, please do not hesitate in contacting me via email at johndoe@emailserver.com or by telephone at 123-456-7899 to schedule a time to meet.

Respectfully,
Joshua E. Hernandez

Biographical Sketch

Joshua Hernandez was born and raised in Naples, Florida. He graduated with his Bachelor of Arts in Psychology from Florida Atlantic University in 2014. He continued on his academic journey, receiving his Masters in Family Therapy from Nova Southeastern University in 2016 and pursued his doctorate thereafter. Joshua is a licensed marriage and family therapist, who has presented his academic work locally, nationally, and internationally on topics related to bereavement, hospice, compassion fatigue, and palliative care. Joshua has conducted self-care workshops within different hospices in order to better assist nurses, doctors, and other staff by integrating measures to relieve tension through utilizing experiential techniques and mindfulness trainings. As a marriage and family therapist, Joshua has worked with individuals, couples, and families from different walks of life. Joshua is currently an activist for LGBT rights, equality, feminism, and the geriatric population.