MAKING SENSE OF LOSS: A CONTENT ANALYSIS OF END-OF-LIFE PRACTITIONERS’ THERAPEUTIC APPROACHES

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ABSTRACT
Clinical professionals working in end-of-life (EOL) contexts are frequently relied upon to address questions of meaning with dying and bereaved persons. Similar to the gulf between researchers and practitioners besetting the larger healthcare community, the voices of EOL practitioners are often underrepresented in the empirical literature. This study aimed to further the dialogue in the field of thanatology by surveying and describing the therapeutic approaches that EOL practitioners most commonly report using to facilitate meaning-making. A total of 119 practitioners from a range of EOL disciplines were surveyed to write about their intervention strategies for helping clients/patients make sense of loss. Overall, participants discussed using 23 different therapeutic approaches that comprised three overarching categories: 1) presence of the helping professional; 2) elements of the process; and 3) therapeutic procedures. Importantly, the results also indicated that practitioners from the different EOL occupations are converging on many of the same strategies for promoting meaning-making. Implications for future research on evaluating the effectiveness of meaning-making interventions are also discussed.
INTRODUCTION

The human effort after meaning-making has gained an increased appreciation over recent decades among professionals working in end-of-life (EOL) contexts (Breitbart, Gibson, Poppió, & Berg, 2004; Neimeyer, 1998, 2001, 2006). This greater attention to the existential significance of coping with one’s own death or the death of a loved one reflects a growing consensus that the experience of loss can challenge and even shatter people’s cherished beliefs about themselves and the world around them (Janoff-Bulman, 1992). Even though people are commonly driven by a deep psychological need to find a sense of meaning or purpose in their lives (Frankl, 1962), this need appears to become especially critical when they are confronted with death in some fashion (Yalom & Lieberman, 1991). Beyond the management of physical and psychiatric symptoms, EOL professionals therefore often find themselves journeying with the dying patient or the bereaved loved one on a profound and sometimes painful search for understanding. Whether through religious or secular means, this process customarily entails weaving together the remaining fragments of one’s pre-loss identity with the changes in one’s “assumptive world” (Janoff-Bulman, 1992) to recreate an existence that has purpose and some semblance of predictability and order. Given the emerging emphasis on issues of meaning in EOL settings, the purpose of this article is to provide a summary of the therapeutic approaches that “real world” EOL practitioners report to most commonly use in their attempts to facilitate meaning-making with dying and bereaved persons.

Notwithstanding a minority who do not pursue questions of meaning (Davis, Wortman, Lehman, & Cohen Silver, 2000), research has shown that meaning-making has an ameliorative impact on the pain that follows loss for those who feel compelled to engage in such a quest (Brady, Peterman, Fitchett, Mo, & Cella, 1999; Davis, Nolen-Hoeksema, & Larson, 1998; McIntosh, Silver, & Wortman, 1993; Silver, Boon, & Stones, 1983). Although this process has been conceptualized in many ways (see Park & Folkman, 1997, for review), one important construal of meaning involves “sense-making” or the capacity to develop a subjective sense of understanding of the loss (Davis et al., 1998, 2000; Gillies & Neimeyer, 2006; Janoff-Bulman & Frantz, 1997). In our own research involving a diverse sample of over a thousand bereaved persons, we found sense-making to differentiate between violent and non-violent causes of death more powerfully than the degree of grief complication \( (d = .79 \text{ vs. } .54, \text{ respectively}; \text{ Currier, Holland, Coleman, & Neimeyer, 2007}) \). Subsequent analyses revealed that the capacity to develop an understanding of the loss experience largely explained the heightened grief symptoms seen after deaths by homicide, suicide, and accidents (Currier, Holland, & Neimeyer, 2006). Moreover, we found that a high degree of sense-making reliably predicted low levels of grief complication across the first two years of bereavement, but that other factors like benefit-finding (i.e., paradoxically finding a silver-lining) and time since the death each failed to show
a significant relation to adjustment (Holland, Currier, & Neimeyer, 2006). Overall, these findings converge with longitudinal research (Davis et al., 1998) to suggest that the capacity to develop an understanding of the loss experience can serve as a critical part of the healing process.

In view of the association between making sense of loss and adjustment, there has been surprisingly little attention given to how EOL professionals may facilitate such a process in actual therapeutic contexts. According to task analyses of meaning-making following a problematic experience (Clarke, 1989, 1991, 1993, 1996), which could presumably include experiencing a terminal illness or losing a loved one to death, people often experience an emotional protest and feel confused, surprised, and unable to formulate a sense of understanding. In particular, the clinical indicator for meaning creation has three identifying features: 1) strong emotional arousal; 2) challenge to a cherished belief; and 3) a lack of understanding or insight into the strong feelings. Once the person specifies the problematic nature of the experience and articulates the challenged belief, Clarke found that therapy often involves an exploration phase with four components: 1) proposition of “Why this feeling?”; 2) hypothesis as to the origin of the cherished belief; 3) evaluation of the tenability of the cherished belief; and 4) judgment about tenability in view of recent experience. Clarke also found that the creation of a meaning event was facilitated by a revision phase in which the client: 1) modifies or eliminates the cherished belief; 2) specifies the exact change necessary; and 3) plans for the future. Importantly, successful meaning episodes could also be distinguished from unsuccessful ones by four core processes: 1) symbolization of the cherished belief that was challenged; 2) symbolization of emotional reaction to the challenge; 3) formulation of a hypothesis as to the origin of the cherished belief; and 4) subsequent evaluation of the tenability of the cherished belief (Clarke, 1996).

Even though this general model does not focus specifically on issues of death and dying, there are clear parallels to qualitative findings on meaning reconstruction following loss. For example, in a grounded theory analysis of the meaning-making process for 10 mothers who experienced the death of a child, Braun and Berg (1994) found that the mothers progressed through phases of discontinuity and disorientation on the way to adjustment. Braun and Berg (1994) observed that the mothers felt compelled to reinterpret and frequently revise the beliefs that they had held prior to their child’s death. They also found that mothers with preexisting meaning structures that could accommodate the loss had a greater ability to make sense of their child’s death than those who needed to undergo substantial revision to their beliefs. Similarly, focusing beyond the level of the individual person, Nadeau (1998) found that meaning-making was critical for families as well. In a grounded theory analysis of how 10 multigenerational families interactively constructed meaning following the death of a family member, Nadeau (1998) observed that the families felt a shared need to make sense of the death. Additionally, she found that the families used many...
strategies to construct meaning of the loss as a collective, including storytelling and “family speak” or the interweaving of stories, characterization of the lost family member, and “coincidancing” or attributing meaning to circumstances surrounding the family member’s death.

Although the need remains for clearer empirical support on the efficacy of meaning-oriented strategies for persons experiencing the pain of loss, researchers have made important strides in designing psychotherapeutic interventions that accord with a meaning reconstruction framework. In the spirit of Frankl (1962), Breitbart and his associates (Breitbart & Heller, 2003; Breitbart et al., 2004; Greenstein & Breitbart, 2000) have designed “meaning-centered group psychotherapy” (MCGP) for advanced cancer patients to sustain or even deepen a sense of meaning, peace, and purpose in their lives. Using psychoeducation on the philosophy of meaning, experiential exercises, and open-ended discussions, MCGP aims to alleviate the multifaceted distress of dealing with cancer via increased personal awareness and meaning in life. Implementing strategies for addressing the debilitating emotional pain that often follows bereavement, “complicated grief therapy” (CGT; Shear, Gorscak, & Simon, 2006) has shown relative success compared to other respected approaches, such as interpersonal psychotherapy (Shear, Frank, Houck, & Reynolds, 2005). Similar to Breitbart’s MCGP, CGT includes a blend of psychoeducation about the adjustment process and CBT (e.g., exposure), featuring such meaning-making exercises as evocative retelling and recording of the story of the loss and the projection of new life goals. Considering the existential crisis commonly precipitated by terminal illness or the death of a loved one, MCGP and CGT represent thoughtful and innovative approaches for addressing questions of meaning.

Notwithstanding these attempts to evaluate the impact of meaning-making on adjustment to loss, describe the process of finding meaning, and develop meaning-oriented therapeutic strategies, an important question still arises: How are real world EOL practitioners helping suffering persons find meaning in the wake of loss in actual therapeutic contexts? Representative of an endemic problem besetting the larger healthcare community as a whole, the gulf between research and practice in the field of death and dying engenders an unfortunate breakdown in communication for both sides (Bridging Work Group, 2005). Therefore, in an effort to address this gap, we conducted a content analysis of how EOL practitioners help their clients/patients to make sense of loss. In this study, we describe the therapeutic strategies that various EOL practitioners report using to promote meaning-making in a multitude of clinical settings. A secondary aim of the current study was to explore differences among the various types of professionals and examine to what degree having a strong grounding in theory and empirical research influence the approaches one uses for facilitating meaning-making. Contrary to the task analyses or grounded theory investigations discussed earlier, we will not provide an in-depth model of the meaning-making process. Instead, this study was designed to provide a preliminary survey of the approaches
to meaning-making that EOL practitioners find the most useful in their day-to-day therapeutic work with persons suffering the pain of loss.

METHODS

Participants

Following institution review and approval of the study, 149 participants were recruited from presentations on EOL issues for healthcare workers given by the third author (R.A.N.). This data set represents an expanded sample that was initially surveyed to examine the link between EOL training, spirituality, and workplace burnout (Holland & Neimeyer, 2005). Any attendee whose occupation involved working directly with individuals dealing with terminal illness or bereavement was eligible to participate. Of the 149 recruited participants, 119 responded to the following open-ended prompt: In what ways do you help clients/patients make sense of loss? Please describe any techniques or strategies you believe encourage those dealing with loss to gain a new perspective, reconstruct a meaningful identity, or look to a more hopeful future. Of the 30 participants who did not respond to this question, most tended to be nurses (n = 15) and social workers (n = 5). There were no significant differences between those who did and did not respond to the open-ended prompt in terms of age, gender, or ethnicity.

The 119 participants who make up the present sample were mostly recruited in the United States (n = 60), followed by Canada (n = 36) and then Great Britain (n = 23). These participants reported that 34.0% of the persons they worked with were terminally ill and 65.1% had lost a spouse, parent, or child to death, indicating a considerable amount of contact with situations involving death and dying. The sample ranged in age from 20 to 74 years old with a mean age of 48.0 years (SD = 11.37). The majority (80%) of the participants were women and 20% were men. Most of them (87.4%) were Caucasian, 7.6% were African American, 2.5% were Asian, and 2.5% reported other ethnicities. A quarter of the participants (25.6%) reported working as nurses, 21.8% as chaplains, 15.0% as social workers, 10.0% as psychologists, 8.5% as Master’s-level therapists, and 19.1% worked in other health-related fields. Sixty-five percent of the participants had attained a Master’s degree or higher in their health-related discipline and the mean number of years experience in the EOL occupation was 12.7 (SD = 8.66).

Procedure

Each eligible participant completed a one-time End-of-Life Care Questionnaire that included the open-ended question about how they help the client/patient to make sense of loss, questions about their level of education and amount of experience working in EOL situations, and other demographic questions concerning the participants and the nature of their work (e.g., What best describes your occupation?). Participants also responded to two questions assessing the
degree to which they: 1) feel that their work is influenced by empirical research and 2) guided by a coherent theory of grief and loss, using a 3-point scale whereby 1 = Not at all, 2 = Somewhat, and 3 = Quite a bit.

Data Analysis

The participants’ written responses to the open-ended question about making sense of loss were transcribed and organized into meaning units by the first author (J.M.C.). Meaning units were defined as segments of the responses that seemed to capture a distinct idea or therapeutic approach. Ranging in length from 1 to 157 words, 437 independent units were identified across the 119 respondents. These meaning units were next organized into 23 content categories by the first author (J.M.C.) through an inductive process that involved comparing and differentiating each meaning unit with the other meaning units. The meaning categories were then compared with the other meaning categories to derive three higher order categories, each of which were comprised of varying numbers of the basic content categories.

Following the derivation of the 23 basic content categories, all of the 437 meaning units were coded independently by the first (J.M.C.) and second (J.M.H) authors, both of whom are advanced doctoral students in clinical psychology who possess strong research and clinical interests in grief and loss. Using the 23 content categories, the coders achieved a kappa value of .89, which is considered excellent agreement (Fleiss, 1981). Altogether, the two coders had 45 disparities across the meaning units, all of which were successfully resolved by consensus. So as not to unduly put more weight on the responses of participants who provided longer written narratives (which often led to more meaning units for those participants) and to also avoid problems with non-independence, the meaning units were aggregated to the level of the respondent. Specifically, 23 variables were created (one for each category) by assigning a value of 0 = No or 1 = Yes to indicate whether or not a participant gave a response that fell into a given category. This approach allowed for the percentage of practitioners who endorsed a particular strategy to be calculated, in such a way that the results would be unbiased by the length of their response. These variables were also used to create dependent variables in several statistical analyses that allowed for the examination of how one’s occupation and use of theory and empirical research might be associated with their self-reported techniques for promoting meaning-making.

RESULTS

The 3 P’s: Presence, Process, Procedure

As presented in Table 1, three higher order categories emerged from the participants’ written narratives: presence of the helping professional, elements of the process, and therapeutic procedures. Nearly half (41.2%) of the participants
Table 1. Frequency of EOL Practitioners' Approaches to Meaning-Making in Total Sample and by Occupation

<table>
<thead>
<tr>
<th>Category</th>
<th>Total sample (N = 119)</th>
<th>Nursing (N = 30)</th>
<th>Chaplain (N = 26)</th>
<th>Social work (N = 17)</th>
<th>Psychology (N = 12)</th>
<th>Master's therapist (N = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of the helping professional</td>
<td>41.2%</td>
<td>50.0%</td>
<td>53.8%</td>
<td>41.2%</td>
<td>33.3%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Cultivate a safe and supportive relationship</td>
<td>16.0%</td>
<td>20.0%</td>
<td>23.1%</td>
<td>23.5%</td>
<td>8.3%</td>
<td>0%</td>
</tr>
<tr>
<td>Provide deep and empathic listening</td>
<td>28.1%</td>
<td>33.0%</td>
<td>38.5%</td>
<td>23.5%</td>
<td>8.3%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Assume respectful and non-judgmental stance</td>
<td>15.1%</td>
<td>10.0%</td>
<td>19.2%</td>
<td>17.6%</td>
<td>25.0%</td>
<td>0%</td>
</tr>
<tr>
<td>Elements of the process</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitate integration or finding meaning</td>
<td>77.3%</td>
<td>60.0%</td>
<td>76.9%</td>
<td>88.2%</td>
<td>83.3%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Promote narrative sharing or storytelling</td>
<td>13.4%</td>
<td>0%</td>
<td>11.5%</td>
<td>23.5%</td>
<td>25.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Focus on the good or look for benefits</td>
<td>23.5%</td>
<td>6.7%</td>
<td>26.9%</td>
<td>29.4%</td>
<td>16.7%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Encourage the expression and processing of emotions</td>
<td>7.6%</td>
<td>6.7%</td>
<td>3.8%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Exploration of spirituality and existential concerns</td>
<td>9.2%</td>
<td>13.3%</td>
<td>11.5%</td>
<td>11.8%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Psychoeducation about death, grief, and coping</td>
<td>16.0%</td>
<td>20.0%</td>
<td>30.8%</td>
<td>5.9%</td>
<td>8.3%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Assist person to draw and expand upon existing resources</td>
<td>30.3%</td>
<td>6.7%</td>
<td>19.2%</td>
<td>35.3%</td>
<td>41.7%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Transmission of hope and re-orienting toward future</td>
<td>16.8%</td>
<td>13.3%</td>
<td>19.2%</td>
<td>17.6%</td>
<td>25.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Facilitation of continuing bond with loved one</td>
<td>9.2%</td>
<td>6.7%</td>
<td>3.8%</td>
<td>11.8%</td>
<td>16.7%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Therapeutic procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Narrative techniques</td>
<td>5.0%</td>
<td>3.3%</td>
<td>3.8%</td>
<td>17.6%</td>
<td>8.3%</td>
<td>0%</td>
</tr>
<tr>
<td>Implement rituals</td>
<td>37.0%</td>
<td>56.7%</td>
<td>61.5%</td>
<td>64.7%</td>
<td>41.7%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Cognitive-behavioral therapy techniques</td>
<td>26.9%</td>
<td>0%</td>
<td>30.8%</td>
<td>41.2%</td>
<td>8.3%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Psychodynamic approaches to therapy</td>
<td>11.8%</td>
<td>3.3%</td>
<td>15.4%</td>
<td>11.8%</td>
<td>16.7%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Humanistic approaches to therapy</td>
<td>11.8%</td>
<td>3.3%</td>
<td>0%</td>
<td>5.9%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Pastoral care or religion-based interventions</td>
<td>3.4%</td>
<td>0%</td>
<td>0%</td>
<td>8.3%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Short-term, solution-focused, practical interventions</td>
<td>10.9%</td>
<td>13.3%</td>
<td>23.1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Cognitive-behavioral therapy techniques</td>
<td>4.2%</td>
<td>0%</td>
<td>0%</td>
<td>5.9%</td>
<td>0%</td>
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<td>3.3%</td>
<td>0%</td>
<td>8.3%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Follow-up efforts via phone, card, or face-to-face</td>
<td>18.5%</td>
<td>33.3%</td>
<td>19.2%</td>
<td>11.8%</td>
<td>0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Referral to support group or other helping professional</td>
<td>5.0%</td>
<td>3.3%</td>
<td>3.8%</td>
<td>5.9%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Note: The percentages add up to more than 100% because most of the practitioners used multiple therapeutic approaches.
discussed ways that they promote a therapeutic presence with dying or bereaved individuals by emphasizing the quality of the relational environment as a crucial determinant of meaning-making. Over three-fourths (77.3%) of the participants discussed various elements of the process through which they help the client or patient make sense of the loss experience. A response was classified as a process-oriented strategy if it mentioned broad therapeutic goals that seemed to supersede one’s theoretical orientation or referred to attending to general processes that take place for grieving and or dying patients, beyond simply being present. About a third (37.0%) of the EOL practitioners responded to the question by sharing intervention procedures, such as concrete techniques and preferred theoretical orientations. Using some of the actual meaning units to illustrate the basic content categories, we will now discuss each of the “3 P’s” in turn.

**Presence of the Helping Professional**

Similar to the Rogerian triad of authenticity, empathy, and unconditional positive regard (Rogers, 1961), practitioners discussed three ways of promoting a therapeutic presence. In particular, 16.0% of the participants explicitly stressed the quality of the relationship with the dying or bereaved person, stating such approaches as “I let the patient know that they can tell me anything” and “I provide for my patients and their families a safe holding environment.” About a quarter of the sample (26.1%) highlighted the relevance of empathic attunement. Example meaning units that fell within this second basic category include: “Listen, listen, listen”; “I attempt to validate the patient’s feelings”; and “Being present to their pain.” Lastly, 15.1% of the participants emphasized the centrality of respect and not casting judgment. For instance, practitioners shared that “[meaning-making] is all dependent on the degree of the client’s readiness” and “I try to go to where the person is in their journey rather than where I might want them to be.”

**Elements of the Process**

EOL practitioners emphasized nine different elements of the process through which they facilitate meaning-making (see Table 1). Among those surveyed, 13.4% discussed integration or finding meaning in the loss in broad terms. For example, one participant shared using “integrative work to help patients process their loss and to incorporate the meaning of that experience into their cognitive and spiritual schemas.” Almost a quarter (23.5%) relied on storytelling, such as those who help the bereaved to “share stories of life together before the death and life since the loss” and “encourage them to tell their stories and to describe the actual death.” A smaller percentage of the sample (7.6%) focused on uncovering benefit or a paradoxical silver lining that can sometimes be found in the loss experience (Davis et al., 1998; Holland et al., 2006): “I try to evaluate what sense of fulfillment can be gathered from this loss.” Several participants (9.2%) stressed the centrality of emotional expression in their work, stating that “I facilitate the
sharing of feelings regarding the loss.” A larger percentage (16.0%) reported focusing on the spiritual or existential significance of the loss by encouraging the client or patient to “look at their own mortality in the spiritual realm” or “fit [the loss] into their picture of God and the world.” Often through teaching or the provision of reading materials, nearly a third (30.3%) used a psychoeducational approach to “normalize the grief situation as much as possible” and “assure the person that they are not losing their minds.” A substantial percentage (16.8%) also attempted to draw upon or expand the individual’s psychosocial resources or other personal strengths. Two meaning units that illustrate this category include: “I affirm the supports and meaningful relationships that continue” and “I help the person to find new hobbies and coping strategies.” EOL practitioners (9.2%) also reported transmitting a sense of hope by “punctuating choices or new directions,” “moving or looking to the future,” and “goal setting.” Finally, a small percentage (5.0%) attempted to facilitate a continuing bond or lasting connection for the bereaved: “I focus on the individual’s relationship with the deceased person and how the relationship may be continued.”

**Therapeutic Procedures**

On average, even though only a little more than a third (37%) of the EOL practitioners shared a reliance on therapeutic procedures, 11 concrete interventions were discussed. In fact, about a quarter of the sample (26.9%) mentioned using specific narrative techniques, such as journaling, life review, eulogy writing and writing epitaphs, imaginary letter writing, and empty chair or imaginary dialogue with a significant other. Over a tenth (11.8%) reported implementing rituals around death and dying, which included both religious and secular memorial services and planting a bulb or rosebush. Of those who espoused a particular theoretical orientation in the sample, 4.2% discussed cognitive-behavioral therapy (CBT; e.g., “relaxation training and guidance,” “thought diaries and positive self-talk”), 3.4% expressed an allegiance to psychodynamic ideas (e.g., object relations, attachment theory), and 3.4% assumed a humanistic perspective (e.g., “looking at personal constructs,” gestalt, client-centered). A significant minority (10.9%) assumed a pastoral care role or what was often a distinctively Christian approach. For example, one participant shared using “guided meditation on what the Lord was doing at the time of their loss, guided meditation on the Lord going before them into difficult situations, and inspiration from the Holy Spirit.” A similar percentage of practitioners (9.2%) reported focusing on brief practical interventions, including “physical care,” helping the client to “sort out their needs,” and “practical strategies as needed for living.” A few of the participants (1.7%) simply identified individual counseling or psychotherapy as being helpful. Of those surveyed, 12.6% indicated implementing procedures that allow for the symbolic expression of thoughts and feelings, including art and play therapy techniques. A small percentage (3.4%)
also stated that they provide follow-up support to the bereaved via phone, cards, and face-to-face visits. Lastly, almost a fifth indicated that they regularly refer the dying or bereaved individual to a support group or other helping professional who may surpass their level of training and expertise.

**Therapeutic Approaches by Occupation**

Beyond investigating the prevalence of the meaning-making approaches in the total sample, we also looked at the frequencies within the five most common EOL occupations for the present group of practitioners (i.e., nurse, chaplain, social worker, psychologist, and Master’s-level therapist; see Table 1). Considering the diversity of training experiences and therapeutic roles in the sample, there was a surprising amount of convergence in that individuals from the five occupations utilize many of the same therapeutic approaches. From a descriptive standpoint, a trend emerged for practitioners from each of the occupations to discuss elements of the process of meaning-making with the greatest frequency, followed by attention to creating a therapeutic presence and then implementing specific procedures, which were used most sparingly.

**Nursing**

Nursing was the only exception to this trend, as 33.3% of the nurses mentioned that they take the procedural step of referring to other helping professionals who can likely focus more explicitly on the dying or bereaved individual’s psychological well being. However, this is not to say that the majority of the nurses also did not attend directly to issues of meaning-making in their work. For example, one of the nurses responded:

> I try to be a supportive presence in their personal search to make sense of loss. I reflect back what I hear being said and ask for clarity to help the patient and their family find clarity themselves. In addition to listening, I also suggest alternative possibilities in conversation. Depending on the person, I validate what I hear being said when the person appears to be coping or not. I also offer or suggest ongoing therapy if needed.

Similarly, like a seasoned psychotherapist, another nurse shared:

> I rely on empathy and the willingness and openness to hear the patients’ stories. I am particularly careful about the timing of my inquiries and I always do a suicide risk assessment. I encourage the dying patient to share pictures, journals, etc. I let the patient know they can tell me anything.

**Chaplaincy**

As chaplains are customarily identified as pastoral or religious figures who provide spiritual care, it is not surprising that the chaplains in this sample discussed exploring spirituality (30.8%) and using religion-based procedures
(23.1%; e.g., prayer, scripture reading) with some regularity. Nevertheless, the majority of the chaplains did not discuss what would be considered a clearly religious approach to meaning-making. For instance, as highlighted in the below response, religious themes were only one aspect of most of the chaplains’ interventions:

I both facilitate the sharing of feelings regarding the loss and the process of drawing meaning and understanding of loss. I often find that it’s important to explore how faith helps and hinders the process of drawing meaning. However, I primarily provide a safe place to express feelings and look for coping skills and support networks.

Likewise, another chaplain discussed the following therapeutic approach that she uses with the dying and the bereaved:

Most patients and or families that I work with are looking for meaning in life. I try to provide a listening presence to let people express feelings. Through life review, many patients are able to see a better view of all they have done in life. This leads to emotional and/or spiritual healing also.

Social Work

In general, the social workers had a balance of therapeutic approaches from each of the 3 P’s as well. For example, the following social worker mentioned 9 of the 23 basic content categories in her approach to helping bereaved individuals make sense of loss:

I identify what the loss means to them and work within their paradigm—using past strengths and coping skills of the bereaved. I also focus on the individual’s relationship with the deceased and how the relationship may be continued through legacy and memory preserving. I identify the learning style of the individual and work within that as a strength or a means to reconstruct meaning of the loss. Specific tools of witnessing the story include journaling, using photography, guided imagery, connection to others, and working at grieving within the family context. I also try to normalize grief by educating them on the grief process and connecting the person with written material. I have found that identifying and working within their spiritual context can be critical as well. Also, the relation between the bereaved and myself is often key.

Highlighting the within-group variability for each of the occupations, another social worker seemed far less concerned with therapeutic processes or procedures, instead focusing on the importance of presence in her approach to meaning-making:

I find that the technique that works best for me is being truly present and to provide for my patients a safe holding environment. I try not to be hung up on technical acuity but rather to rely on fostering a trusting environment for people to feel safe in expressing what they are feeling and dealing with.
Only then, after expression and acceptance, can patients gain a new perspective or reconstruct a meaningful identity.

Psychology

Psychologists mentioned psychoeducation at a relatively high frequency (41.7%). Nonetheless, they also had a tendency to assume a multifaceted approach to meaning-making, as exemplified by this woman’s response:

By first starting where the client is and following his or her lead along with being as present as possible while listening. Then, I also try to encourage awareness and actions as the person seems ready. I include educational interventions to help normalize their response to the loss. I use time-limited sessions which can be 1 or 8-10 in length, the latter being more usual. Working with the terminally ill, I try to be a friendly confidante who can take in and hear what other people close to the terminally ill might have a hard time with. For example, I allow them to list thoughts and feelings related to the “wreck my body is.” I also use brief visits or longer as he or she is able to tolerate.

Although they emphasized many of the same themes as other occupations, the psychologists tended to be relatively brief in describing their approaches to making sense of loss. For example, focusing his efforts on the processes of facilitating narrative integration, psychoeducation about the grieving process, and transmitting hope, one of the psychologists shared: “I encourage the coherence of narrative, normalize the grief response, and re-orient toward a focus on the future.” Another psychologist stressed the importance of respect and the affirmation of spiritual beliefs, describing her approach as simply “providing a space to talk about their loss using their own language and by tapping into spiritual beliefs as a resource.”

Master’s-Level Therapist

Of the 10 master’s-level therapists, 90% highlighted various elements of the therapeutic process. Half of them discussed narrative sharing or storytelling, and potentially reflective of similarities in training and practice with psychologists, 40% of the master’s-level therapists used psychoeducational approaches, and 30% discussed CBT. For example, the following therapist describes a blending of psychoeducation and CBT procedures:

I facilitate support groups for caregivers of Alzheimer’s and or dementia patients that are based on cognitive-behavioral therapy techniques. We offer groups for both current caregivers, who almost always are suffering grief in an ongoing, changing way, as their loved one with dementia moves further in the disease and for those caregivers whose relative has died. For the former group, we use education and teach problem solving techniques to empower and give confidence to caregivers. We also work with caregivers
to find meaning in their roles as well, often through use of thought diaries and positive self-talk.

As reflected in the next response, other therapists integrated CBT with therapeutic approaches besides psychoeducation: “I use metaphor to expand the narrative beyond the problem laden story. I also explore the why, encourage storytelling, connect the person with resources, explore and revise assumptive beliefs about one’s world, and use CBT strategies.” Additionally, the majority of the therapists did not rely on psychoeducation or CBT, instead emphasizing such alternative processes of meaning-making as the exploration of existential issues: “For me, acceptance is the key, acceptance of where he or she is on their journey toward death. It’s important to acknowledge existential angst and the value of each person’s life. I use life review as well to aid clients in their search for meaning.”

**Influence of Empirical Research and Theory**

In addition to the primary aims of surveying and describing the EOL practitioners’ approaches to meaning-making, we also assessed the degree to which their clinical work is guided by a coherent theory of grief and loss and influenced by empirical research. In general, 53% felt that they are guided by a coherent theory of grief and loss “quite a bit,” 41.9% felt “somewhat” guided by theory, and 5.1% felt that their work with dying or bereaved person is guided “not at all.” Similarly, 33.1% of the sample felt that their work was influenced by empirical research “quite a bit,” 55.1% reported that they are “somewhat” influenced by research on grief and loss, and 11.9% reported being influenced “not at all.” Despite the fact that many of the EOL practitioners seemed to rely on a sound conceptualization of the experience of loss and to place significant value on empirical findings, it is notable that just as many of them do not feel that their work is considerably influenced by theory or research.

**Quantitative Analyses**

In an effort to go beyond simply describing the content and relative frequency of participants’ responses, we performed quantitative analyses that aimed to examine factors that might have influenced participants reported meaning-making strategies. To this end, a series of two-tailed Fisher’s exact tests were first performed to examine the extent to which respondents of different professions (categorized as nurses, chaplains, social workers, psychologists, and master’s-level therapists) varied in their responses across the 23 types of meaning-making strategies. Among the 95 participants included in these analyses, significant differences were found across the different occupations in the frequency of reported meaning-making strategies (dichotomized according to whether or not a participant indicated using a particular strategy) for facilitating integration or finding meaning \( (p = .01) \), promoting narrative sharing or storytelling \( (p = .03) \),
psychoeducation \( (p = .02) \), narrative techniques \( (p < .001) \), CBT \( (p < .001) \), and expressive or creative therapies \( (p = .02) \).

In order to uncover exactly which professions differed across these types of meaning-making strategies, the overall analyses were followed up with several Fisher’s exact tests that examined the frequency of responses for these six therapeutic approaches across all possible combinations of occupation pairs (e.g., nurses vs. chaplains, social workers vs. psychologists). In summary, these follow-up analyses showed that: 1) social workers, psychologists, and master’s-level therapists were more likely than nurses to explicitly report facilitating integration or finding meaning; 2) master’s-level therapists were more likely than nurses to report promoting narrative sharing or storytelling; 3) social workers, psychologists, and master’s-level therapists were more likely than nurses to report using psychoeducation; 4) the use of narrative techniques were reported more frequently by chaplains, social workers, and master’s-level therapists compared to nurses and were also reported more frequently by master’s-level therapists compared to psychologists; 5) master’s-level therapists were more likely to report using CBT compared to nurses, chaplains, social workers, and psychologists; and 6) chaplains and social workers were more likely than nurses to report relying on expressive and creative therapies.

In addition to these analyses, three binary logistic regressions were performed that aimed to simultaneously examine how EOL professionals’ occupation and use of theory and research might be associated with their reported usage of therapeutic strategies to promote meaning-making. In all of the analyses, type of occupation, the influence of theory, and the influence of empirical research on one’s practice were used as the independent variables. Additionally, one of three dichotomous dependent variables was used for each individual analysis, which assessed whether or not a participant reported using any technique for promoting meaning-making that was related to each of the 3 P’s. When presence and procedure were used as the dependent variables, the overall models were found to be non-significant, Model \( \chi^2 (6) = 7.21, p = .30 \) and Model \( \chi^2 (6) = 8.48, p = .21 \), respectively. However, when the process variable was used as the dependent measure, a statistically significant model was obtained, Model \( \chi^2 (6) = 17.36, p = .008 \). As can be seen in Table 2, the coefficients for the independent variables revealed that the only significant predictor of whether or not a practitioner reported using a process-oriented strategy was the degree to which they felt that their work was influenced by theory, \( B = 1.57 \), Wald Statistic = 7.19, \( p = .007 \). Namely, a one unit increase on the theory variable was associated with a 4.83 times greater likelihood of reporting the use of a process-oriented approach. Subsequent analyses revealed that this relation was particularly strong for psychoeducation, transmission of hope and re-orienting toward the future, and facilitating a continuing bond.
There is a growing acceptance that the experience of loss can necessitate the revision of previously held beliefs about the self and the world, thereby engendering a profound and painful search for meaning for many dying (Breitbart, Gibson, Poppito, & Berg, 2004) and bereaved (Neimeyer, 1998, 2001, 2006) persons. This study attempted to further the dialogue between clinical researchers and practitioners in the thanatology community (Bridging Work Group, 2005) by surveying and describing the approaches that EOL professionals report using to help their clients/patients make sense of loss. Overall, 23 different therapeutic strategies were mentioned that fell into three overarching categories (see Table 1). The majority of the practitioners appeared to implement multiple approaches and showed a well-balanced concern for issues of therapeutic presence, process, and procedure. Indeed, participants of different professions did not significantly differ in their reported meaning-making strategies for most therapeutic approaches (i.e., 17 of 23). Furthermore, even with the diversity of training experiences, backgrounds, areas of expertise, and health-related roles represented in the sample, there was considerable convergence among how EOL professionals from the different occupations drew upon the meaning-making strategies. Irrespective of one’s professional discipline, there was a general consensus among the practitioners that therapeutic approaches like cultivating a safe and supportive relationship, empathic listening, exploration of spiritual and existential concerns, affirming and expanding psychosocial resources, and implementing rituals are all helpful.

Table 2. Logistic Regression Analysis Predicting Usage of Process-Oriented Strategies (N = 93)

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE</th>
<th>Odds ratio</th>
<th>Wald statistic</th>
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<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaplain</td>
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<td>.69</td>
<td>1.37</td>
<td>.20</td>
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<td>.91</td>
<td>2.37</td>
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<td>.00</td>
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<td>1.20</td>
<td>3.25</td>
<td>.96</td>
</tr>
<tr>
<td>Empirical research</td>
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<td>.54</td>
<td>.89</td>
<td>.05</td>
</tr>
<tr>
<td>Theory</td>
<td>1.57</td>
<td>.59</td>
<td>4.83</td>
<td>7.19*</td>
</tr>
</tbody>
</table>

Note: The occupation variable was coded in such a way that each type of profession was compared to nurses, who had the lowest reported usage of process-oriented strategies. *p = .007
Despite the high degree of similarity in the responses among participants of differing professions, some differences were observed, mostly in expected directions, indicating that different practitioners might have some unique ways of promoting meaning-making in EOL settings. For example, nurses were less likely than some other professions to use several of the more psychologically-oriented approaches, such as psychoeducation, facilitating a process of integration, and narrative sharing or storytelling. Nonetheless, the majority of the nurses also implemented approaches that may not be considered a standard part of their therapeutic repertoire. For instance, 50% of the nurses emphasized that they explicitly attend to the quality of the relational environment with their patients and 60% mentioned using at least one of the process elements. It is also noteworthy that master’s-level therapists were more likely to use CBT to facilitate meaning-making compared to practitioners of other disciplines. This finding was somewhat unexpected and deserves further investigation. Although there are many possible explanations for this finding, this endorsement of CBT by master’s-level therapists potentially reflects the vast proliferation of CBT over the past couple of decades (see Hollon & Beck, 2004 for review) and the strong emphasis it now receives in graduate programs designed for the special purpose of training professional therapists.

Even though many practitioners did not report that theory or research had much influence on their clinical work, it appears that most of them are also practicing in a way that is reasonably consistent with the current theoretical conceptions and empirical knowledge. For example, many practitioners endorsed engaging in therapeutic activities that fit with Clarke’s (1989, 1991, 1993, 1996) model of meaning creation work that emphasizes the symbolization and exploration of cherished beliefs and difficult emotions. Namely, storytelling, expressing and processing painful emotions, examining one’s spiritual or existential concerns, using rituals and expressive/creative therapy techniques were all mentioned with considerable regularity. Likewise, over a quarter of the practitioners reported that they implement narrative techniques similar to Breitbart’s life review and other components of meaning-centered group psychotherapy (Breitbart & Heller, 2003; Breitbart et al., 2004; Greenstein & Breitbart, 2000). Similarly, there was convergence with critical aspects of Shear and her colleagues’ complicated grief therapy (Shear et al., 2005, 2006). In particular, many of the practitioners relied on psychoeducation based on a specific model of bereavement (e.g., Dual Process Model; Stroebe & Schut, 1999), re-orienting toward the future and establishing new life goals, and revisiting the story of the loss via verbal sharing, journaling, and other modes of expression.

It is also noteworthy that many of the practitioners endorsed strategies for meaning-making beyond any particular therapeutic techniques. As highlighted earlier, practitioners generally emphasized the components of the therapeutic process and the quality of the relationship and seemed relatively less concerned with concrete interventions. Such a focus diverges somewhat from much of the
scientific literature where the presentation of a theoretical model or manualized intervention can often overshadow concerns about crucial relationship and process factors. Of the processes that the practitioners cited, many tended to rely on storytelling and psychoeducation, both of which represent fairly straightforward approaches to validating or normalizing one’s painful reactions to loss. Thus, it appears that a considerable number of practitioners facilitate the process of making sense of loss by forming a trusting relationship and offering rather clear-cut interventions, like affirming the dying or bereaved individual’s feelings and the content of the loss narrative as a legitimate response to coping with one’s own impending death or the passing of a loved one. As the quantitative analyses revealed that having a coherent theoretical grounding significantly increased the probability of focusing on process elements such as psychoeducation and re-orienting toward the future, it also appears that many of the practitioners draw upon their own understanding to help their clients/patients negotiate a path toward adjustment.

Limitations and Future Directions

This qualitative analysis indicates that EOL practitioners are implementing a wide range of therapeutic approaches to help their clients/patients make sense of loss. Of course, it could be the case that all of the interventions are efficacious to some degree. However, unfortunately we know far too little at the present time about the actual efficacy of meaning-making interventions and more research is clearly needed using experimental designs to determine if some of the strategies are particularly beneficial with respect to promoting meaning-making and adjustment to loss. Given that this study was an open-ended survey of what EOL practitioners believe is helpful, we are not in a position to comment on the relative efficacy of the particular approaches or speculate as to the relationship with therapeutic outcomes. Nevertheless, the identification of frequently used interventions derived from this study will hopefully give useful direction to future research on the outcome of EOL interventions and grief therapy by suggesting popular therapeutic processes or procedures whose impact could be evaluated in experimental studies. In particular, it will be important to both clarify the types of therapeutic approaches that promote meaning-making and the resultant impact of meaning-making on reducing distress symptoms, neither of which has been evaluated to our knowledge in a randomized controlled study.

Despite the fact that directly surveying the therapeutic approaches via written means at presentations for EOL professionals allowed us to sample well over 100 participants from three countries, this method has several additional limitations. First, it prevented us from requesting clarification or elaboration on ambiguous responses or important themes that one could do in a face-to-face interview. Second, the information provided in this study was based on participants’ self-report, and it is possible that there are discrepancies between reported
meaning-making strategies and what one actually does in clinical practice. Third, in order to prompt participants to discuss their preferred meaning-making strategies, we had to assume that EOL practitioners would perceive meaning-making as a relevant aspect of their work. It is of note that only one of the EOL practitioners in the sample reported that meaning-making was not germane to clinical work with dying or bereaved persons, which suggests that most participants saw the value of finding meaning in loss. However, with this said, a fourth limitation of our method pertains to how participants were recruited at presentations given by the third author (R.A.N.), a well-known constructivist researcher and psychotherapist who emphasizes narrative interventions. Hence, there might have been a priming and/or selection effect resulting in an over-representation of EOL practitioners who value constructivist/narrative approaches and draw upon these strategies in their clinical work. Considering the possibility that the sample was overly committed to such an approach, future research would do well to replicate and expand on these preliminary findings with other groups of EOL practitioners.

In spite of these limitations, this study still represents the first attempt to systematically describe the meaning-making approaches most commonly used in actual therapeutic contexts with the dying and bereaved. To this end, it is interesting that practitioners, as a whole, tended to emphasize the importance of process-oriented interventions, like offering psychoeducation and normalizing one’s experience, as well the relational aspects of treatment. Thus, it appears that many of the practitioners felt that these more straightforward approaches were sufficient to meet the needs of dying or grieving patients/clients and tended to use specific therapeutic techniques somewhat sparingly. This finding begs further attention in the form of research that examines which clients might be in need of more than support and reassurance and would benefit from a treatment that incorporates specific therapeutic techniques. Interestingly, preliminary findings from the grief literature suggest that bereaved individuals exhibiting higher levels of distress might benefit more from an intervention compared to “normal” grievers (Currier, Holland, & Neimeyer, 2007; Schut, Stroebe, van den Bout, & Terheggen, 2001). Based on the findings from this study, it appears that some EOL practitioners are mindful of the varying needs of clients or patients and draw upon some sort of guidelines or heuristics when matching individuals to treatment. For example, 18.5% of the sample mentioned referring grieving or dying individuals for further intervention and/or another helping professional, and one practitioner indicated that she altered her therapeutic approach when working with more distressed individuals. Nonetheless, further research is needed to determine exactly how practitioners are making these sorts of decisions, and whether or not these efforts translate into greater treatment efficacy.

Future work would also do well to examine whether different types of bereaved people (e.g., in terms of ethnicity, religious affiliation, type of loss) may benefit from different therapeutic approaches with professionals with different areas of
specialty. Such research could yield important information on how to best match a dying or bereaved individual with the type of professional best suited to provide the ideal type of therapeutic intervention. For example, a client with a strong religious commitment may work the best with a professional who shares the same values and can draw upon his or her faith orientation to help find a sense of understanding in the context of his or her religious worldview. Despite our inability to address these larger questions directly, this study stands as a first attempt to hear directly from “real-world” EOL practitioners and provides valuable information about what kinds of interventions are being used in everyday practice to assist clients/patients in making sense of loss.

REFERENCES


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