Engaging in ritual after client suicide: the critical importance of linking objects for therapists

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Abstract: Within the counselling field it has long been known that engaging in ritual after the loss of a significant other has positive therapeutic benefits for the mourner. In contrast, little is understood about therapists' experiences of ritual in response to their clients' deaths by suicide. Based on interviews with six therapists whose clients had died by this means, this article explores the place of ritual in these individuals' lives. Little evidence was found to suggest that the need for therapists to engage in ritual, post-client suicide, was recognised, supported or met, by others. As a result, the grief of these therapists became disenfranchised, transforming them into 'forgotten mourners' and forcing them to engage in 'peripheral' rituals using linking objects. It is hoped that this article, by highlighting the critical importance of ritual for therapists mourning the loss of a client by suicide, will help to ameliorate the current void in the literature relating to this issue.

Keywords: therapist, mourner, ritual, linking object, disenfranchisement, client suicide

The healing place of ritual in grief work

Rituals, which are defined by Martin and Doka (2000, p15) as 'special acts that offer sacred meaning to events', have traditionally provided a vehicle through which mourners can openly acknowledge the deceased's transition from life to death and their own changed relationship with them.

Kollar (1989, cited in Beder, 2002 p400) states that participation in rituals, such as funerals, is vital for the mourner since it accomplishes four major goals in grief resolution that are critical to the healing process. These are: the physical goal of meeting the biological needs of mourners; the social goal of providing a sense of community and social support in which mourners can express their changed relationship with the deceased; the psychological goal of confirming the reality of the loss to those in attendance; and the religious goal of offering a spiritual vision of life, death and the afterlife.

Romanoff and Terenzio (1998) note, however, that whilst rituals are important vehicles for transition and connection, their grief resolution efficacy may be diminished if they do not also include a transformation phase, 'a recasting of the mourner's sense of self in relation to the deceased' (p698). This phase may include such rituals as choosing a treasured keepsake or 'linking object' (Volkan, 1972) which, from a psychoanalytic perspective, offers 'an extension of the body of the disappeared' (Jurcevic & Urlic, 2002, p234) and therefore 'a point of [ongoing] connection' with the deceased (Gibson, 2009, p14). Since people use possessions to define both their place in the world and their relationship to others (Rosenblatt, 1999 p103), Elison and McGonigle (2003 p164) argue that, 'just as public rituals invest objects with universally recognised symbolic value, linking objects acquire private meaning every bit as potent to the individual.' Thus, linking objects become a critical source of meaning for the self, solace for the changed life

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situation, and 'a token of triumph over the loss' (Meyers, 2002 p257). Furthermore, the fact that linking objects that once belonged to the deceased, such as grandma's diary, dad's old dressing gown or a daughter's artwork *are* such an integral part of the mourning process illustrates the mourner's need to find familiar and continuing connections in life narratives that have been ruptured by the death (Gibson, 2009; Hall, 2001; Neimeyer, 2000; Volkan, 1972).

The importance of ritual in instances of disenfranchised grief

Whilst ritual clearly has the capacity to provide the mourner with a powerful medium through which grief may be resolved (Beder, 2002; Orlandini, 2009), disenfranchised individuals, be they family, friends, personal or professional acquaintances, are often denied this opportunity because their loss is not recognised, validated or socially supported (Doka, 1989). One of the most highly disenfranchised loss experiences is death by suicide (Grad *et al*, 2004; Lester & Walker, 2006; Mehraby, 2005; Sudak, Maxim & Carpenter, 2008), with Sudak, Maxim and Carpenter (2008) contending that, 'the intense stigma associated with suicide attempters, completion, and being the family, close friend or therapist of someone who has attempted or completed suicide…remains nearly as stigmatised as ever' (p136). Culturally defined factors that might contribute to this stigmatisation include juridical laws, religious sanctions and discrimination by social communities and insurance agencies (Grad *et al*, 2004).

Furthermore, when the relationship in which the death has occurred is a non-kinship one, such as the professionally-based association created within a therapeutic relationship, it becomes extremely difficult, if not impossible, for grief resolution to occur within the context of the mourner's social system. This is because the mourner is often excluded from being assigned any pivotal roles in either the dying process or any post-death rituals such as funerals, anniversary dinners and the like; activities which are instrumental to the healing process (Glassock, 2001; Hall, 2001). Whether implicitly or explicitly given, the message received by those whose grief has become disenfranchised is to, 'get over it, deny the persistence of feelings of loss, and encourage breaking the ties with the deceased' (Moss *et al*, 2003 p4).

Clearly then, since it is only through engaging in ritualised activities that the deceased becomes transformed to an 'inner representation based on memory, meaning and emotional connection' (Romanoff & Terenzio, 1998, p701), linking objects become of *critical* importance in instances of disenfranchisement, where there has been no acknowledgement of the loss or social recognition of the mourner's relationship with the deceased (Doka, 1989). In these cases, linking objects become a way of 'honouring the self through private ritual' (Elison & McGonigle, 2003 p163), by providing a symbolic representation of the deceased and the 'forgotten mourner's' relationship with them.

How do therapists become 'forgotten mourners'?

Without question, therapists, like any other individual faced with the death of another, are influenced by some, if not all, of the variables that research into the bereavement of surviving spouses, parents or children has identified. It is critical to remember, however, that the roles and relationship that exist within the therapeutic context inherently expose therapists to variables that do not exist within the deceased's relationships with their family members or friends – variables which inform, shape, and at times constrain the therapist's response to loss. Whilst acknowledging the significant interplay that occurs between these variables (Bonanno & Kaltman, 1999), for the purpose of this discussion, these variables have been divided into three distinct sections – confidentiality, boundaries and organisational practices including supervision.

Maintaining confidentiality

According to McWilliams (2004) the confidential nature of the therapeutic alliance inherently creates 'idiosyncratic' challenges for therapists dealing with the death of a client or ex-client. In such instances, she notes, the therapist's mourning can be especially lonely and disenfranchised, since 'the pain of losing a confidential relationship is not recognised and eased by common rituals and shared norms of consolation' (McWilliams, 2004 p276). McWilliams recounts her own struggle, upon learning of a client's death, to maintain the confidentiality of that relationship whilst simultaneously supporting her client's husband and friends. The cost of this, she recalls, was that her own grief remained unseen and went mostly unexpressed, a situation she was partially able to redress by arriving ahead of schedule at the funeral service so that she 'would not have to socialise and could stand quietly at the back and weep at the premature loss' (p277).

Further complicating this unmet need to grieve is the requirement for therapists to remain vigilant about the appropriateness of both what they share in relation to their cases and with whom (Hodelet & Hughson, 2001). McWilliams (2004) observes that because therapists must protect their clients' anonymity, even when they are off duty they are constantly monitoring themselves to ensure that breaches of confidentiality do not occur. As McWilliams (2004, p268) notes, 'it is an irony of being a therapist that for all we cherish both genuineness and straightforward emotional expression, our occupation sometimes prohibits our behaving with either one.'

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Professional boundaries: the interplay between the personal and professional selves of the therapist

A second variable that impacts upon therapists' bereavement, leading them to become forgotten mourners, is the need to maintain appropriate professional boundaries both during the therapeutic relationship and post-client death. This includes a 'discrete' professional self in which it is 'clinically, ethically and legally important to keep one's personal needs out of the treatment room' (O'Connor, 2001 p346).

However, whilst this clear-cut delineation between professional and personal selves may be objectively mandated by professional organisations, regulatory bodies, codes of conduct and training programmes, it is not subjectively experienced this way (Lewis, 2004). Furthermore, since the breaching of professional boundaries remains such a controversial and taboo subject within therapy (Cleret, 2005); and engaging in such breaches can be 'professionally ruinous' (Glass, 2003, p429); therapists are left having to second-guess about the ethics of their behaviours and interventions (Schank & Skovholt, 1997).

The fact that the majority of literature relating to professional boundaries is also, 'terse, rigid, pathologising [and based on] fear tactics' (Cleret, 2005, p48) means that therapists are often extremely hesitant to have discussions with either their colleagues or supervisors about any dilemmas they might have with regard to maintaining their boundaries (Clark 2009b; Schank & Skovholt, 1997). In instances of client death, this hesitancy and fear is likely to be heightened, since whilst rules and codes currently exist in relation to what constitutes 'appropriate' professional conduct in relation to boundaries within the therapeutic relationship, there is a void in the literature about what constitutes appropriate therapeutic conduct after a client has died. Therefore, challenges often arise when the different roles in which therapists find themselves conflict during the mourning process (Neimeyer, 2000). For example, whilst remaining in the professional role of therapist to others bereaved by the death or adopting additional professional grief-related roles is regarded as being 'apt', occupying the personal role of mourner is likely to be considered 'inappropriate and unprofessional'.

As O'Connor (2001, p346) observes, the fact that the role of therapist requires, 'a willingness to meet other's needs before one's own, the ability to withhold emotional response in the face of reported trauma and intense emotion, and the ability to tolerate intense emotion with limited or no outward personal response', means that in instances of loss and grief, therapists are often required to 'repress [these] basic human responses' (p346) to a degree not expected within any other profession. Sidell, Katz and Komaromy (1998) support such contentions, noting that the imposition of stringent boundaries and the need for professional distance cannot help but leave caregivers, including therapists, struggling to ascertain just what are acceptable ways and levels of expressing their emotions in the presence of the deceased's relatives, their colleagues, and their own families – a situation that can leave them feeling unacknowledged and ultimately disenfranchised (Hazen, 2003).

Myers and Fine (2007) provide a different slant to the challenges that experiencing grief in a professional context evoke. These authors claim that the fact that the language of the professions in relation to loss is expected to be technical, cognitively-focussed and emotionally distant, whilst that of the mourner is personal, anecdotal and subjective, means that it can be 'distancing, highly intellectual and devoid of feeling' (p123). In the aftermath of their client's death, therapists may become caught in the gap that this jargon creates between the profession they find themselves operating within and their own 'humanness and vulnerability' (p124) in relation to the loss.

Organisational practices

It is ironic that the organisations to which therapists belong may also contribute to the difficulty felt in expressing grief in relation to their client's death (Ashby, 2005; Becvar, 2003; Charles-Edwards 2000; Clark, 2009a, Clark 2009b). Becker (1973, 1975) was one of the first to draw attention to the fact that the denial of death within organisations means that conversations relating to death and dying become silenced. Within such a conspiracy, normal grief reactions such as crying, confusion, lack of motivation and withdrawal are viewed as being inappropriate within the workplace (Clark, 2009a; Wolfelt, 2005).

This lack of organisational sensitivity and the use of 'tokenistic gestures' (Ashby, 2005 p7) of professional support promotes 'stifled grief' (p470), since it denies the bereaved the opportunity to allow their grief to take its natural course within its natural timeframe. Numerous researchers and clinicians uphold this viewpoint, arguing that at a time when an employee clearly requires supervisory or therapeutic support and/or encouragement to take time off to attend funerals and the like, fear of legal and/or insurance proceedings may compel the organisation to invoke investigatory or disciplinary action instead (O'Connor, 2001, Clark, 2009b). In O'Connor's words, in cases of professional distress or impairment, 'current [policies] tend to emphasize code enforcement more than prevention and education' (p345) and therapists are infrequently advised to seek therapy (McWilliams, 2005). This 'code enforcement' (O'Connor, 2001), has also been noted by researchers in relation to supervision. While not disputing the fact that speaking with supervisors and work colleagues after the death of a client is the most commonly sourced means of support, followed by family and friends (Knox *et al*, 2006; Linke, Wojciak & Day, 2002; Pilkinton

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and Etkin, 2003), the *quality* of the supervision offered has been found to be highly variable (see Campbell & Fahy, 2002; Carroll, 2008; Knox et al, 2006; Pilkinton & Etkin, 2003) leading to, 'varying degrees of therapist satisfaction in relation to the supervisory process' (Clark, 2009b).

Since, in organisational cultures such as these, 'arguments for time and resources to be devoted to thinking and feeling are not always heard' (Ashby, 2005 p7), and symptoms relating to stress, trauma or grief carry the risk of being viewed as signs of 'weakness' or of 'not coping' (deKlerk, 2007; Williams, 2001), the likelihood that professionals will seek supervisory or therapeutic assistance when they need it has been found to decrease even more so. Clark (2009b) offers a comprehensive discussion about the varying degrees of satisfaction experienced by Australian therapists with regard to supervision, post client suicide.

Therapist interviews

The original study (Clark, 2009a) from which this article arises sought to explore the impact of client suicide on therapists. Using a multi-faceted recruitment process, ten therapists who had had a client die by suicide whilst under their therapeutic care participated. In-depth, unstructured, open-ended interviews, of between one and one-and-a-half hours duration, were undertaken to encourage the richest narratives to emerge in relation to the area under investigation. These narratives were audio-taped, transcribed and analysed using narrative-type narrative enquiry (Polkinghorne, 1995; White & Hedde, 2008); component story analysis (Nuttgens, 1997) and paradigmatic-type narrative enquiry (Polkinhorne, 1995; White & Hedde, 2008).

In the original study, three core narratives and their associated sub-plots were identified (Clark, 2009a). One sub-plot that spontaneously arose (without prior prompting) within six of the therapists' narratives was their need to engage in 'peripheral rituals' in response to their clients' deaths and the critical role that linking objects played in this process. Extracts from the narratives of these six therapists, two female and four male (aged 37 – 66 years), practicing as counsellors (N=3), psychologists (N=2) and school counselors (N=1) in Australia at the time of their clients' suicides, are presented in italics below (names have been changed).

Whilst the therapists' interviews reflected their acute awareness of the importance of using ritual when working with individuals who, like them, had been impacted by another's death, for the majority of therapists, participation in publicly held rituals arising from their client's suicide was, *at best*, a marginalising experience.

With the exception of one therapist, who was prohibited by his client's parents from attending their son's funeral, the marginalisation experienced was due not to having been banned from participating in the rituals *per se*, but because of the discrepancy experienced between the therapists' personal needs and their professional roles, rules, and responsibilities in relation to such an event.

Aiden, for example, a relatively inexperienced counsellor at the time of his client's suicide, readily acknowledged that his decision to accompany his client's father to view his client's body was a professionally based one: *I knew I had to go because that's what Carl's father wanted [despite] my own fear of 'What will I see?'*. The only way he had been able to *hold together the professional stuff* [so that he could care for Carl's father] was to engage in *detachedness from myself, detachedness from my gut*.

For Aiden then, the fact that he was *running on autopilot* throughout this process meant that he was unable to use this ritual (and those subsequently associated with the funeral during which he held a pivotal role) as a vehicle through which to express his own grief. As he noted:

> *[It was only] once the funeral service was over that [the grief] then actually started to catch up with me.*

Like Aiden, Jude, an experienced counsellor in his late forties, found that having to remain in his professional role in order to facilitate his client's funeral meant that it was not the most beneficial form of ritualism he was to experience. Instead, *the most useful exercise* was instigated by his client's doctor who *took him into the morgue and left [him] there [with his client's body] which was really nice because [he] got to sit with Rose for about half an hour*, not in his role as Rose's therapist, but as an individual mourner deeply affected by her death.

Even therapists who did not have a designated part to play during the funeral proceedings found themselves feeling marginalised, nonetheless, by their professional role. The following account by Catherine, a psychologist, captures the agony that this role created for therapists as they tried to decide whether or not to engage in publicly shared rituals such as their client's funeral:

> *I kept going through this, 'Will I or won't I go to the funeral? Should I or shouldn't I go? Is it correct in terms of my workplace? Who's going to benefit? There might be some of my other clients there. If I go to one funeral, should I go to every funeral of every client? What do I do with the information about [Barney] in terms of the family? How does this fit in with confidentiality and ethical issues? Should I be supporting his relatives? As the service provider, should I be making some sort of statement to them?' So I was looking at the personal as well as the professional sorts of issues but also the need for closure for me and even up to the last minute I tossed and turned about that.*

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Having made the decision to attend their client's funeral, therapists still found themselves unable to participate as fully as other mourners. Murray, for example, a psychologist in his late fifties, whose reason for attending his client's funeral was because *it was important for [him] to honour the relationship [he] had had with Simon*, remembered the acute sense of alienation he had felt whilst he *had stood apart after [the funeral] looking at all the family and wondering what their experience was*.

Whilst Murray spoke of the physical distancing he had experienced, other therapists recounted their sense of having to remain emotionally distant during the service as the reason why their participation had felt compromised. As Faith, who chose to take a back seat during the proceedings, explained:

> *Anyone who wanted to speak at the funeral could. I didn't. I was going to speak but I couldn't trust my emotions. I knew I would crack up and no-one would have been able to hear me anyway. I just could not stop sobbing when I talked about it, the pain in my heart was so intense.*

Whilst a fear of becoming highly emotional was also Catherine's primary reason for choosing not to speak at the funeral, her decision was also tempered by her need to maintain confidentiality with regard to her relationship with her client:

> *I went through that, 'Will I or won't I?'[speak at the funeral] because Barney had such lovely qualities. And I thought, 'No I shouldn't because I shouldn't divulge confidentiality' and 'Maybe this is for the family and I haven't even met the family.' So I jostled with that as well.*

That therapists avoid attending their client's funeral has been well documented by past researchers, with reasons for non-attendance being given as either the fear of being blamed by angry family members for the death's occurrence (Alexander *et al*, 2000; Pilkinton & Elkin, 2003; Yousaf, Hawthorne & Sedgwick, 2002) or the fear of legal proceedings being instigated (Cryan, Kelly & McCaffrey, 1995). The results of these interviews provide insight into a further reason for therapists' hesitancy to be present at the funeral – the challenge that having to remain 'in role' presents and the 'role uncertainty' (Grad, 1996) this creates. As the above accounts illustrate, the discrepancy therapists experienced between their personal need to grieve and their professional requirement to remain contained, confidential and comforting to others led to compromised participation and compromised mourning. For these therapists then, having to occupy this 'delicate role' (LoboPrabhu *et al*, 2008 p134), in which the needs of others took precedence over their own, made the full and open expression of their grief near impossible.

Despite these drawbacks, several therapists spoke of their satisfaction at having chosen to attend the funeral, a result reflected in the literature (see Campbell & Fahy, 2002; Hendin *et al*, 2000). Faith, for example, acknowledged that *it had been very helpful to go to the funeral* since only through listening to stories about her client that had *sounded as if he'd been saying goodbye*, had she been given proof of Ryan's suicidal ideation, proof *and a big picture to sit something in*.

For Catherine, having engaged in the most agonising of decision-making processes about whether or not to attend the funeral and how best to portray herself there, choosing to go had ultimately made her *glad* because:

> *I think if I hadn't gone I don't think I'd have gotten so much in touch with my feelings about him and his death.*

However, the fact that the majority of therapists interviewed *did* find themselves either excluded from or hovering on the periphery of publicly shared rituals in relation to their client's death by suicide, *and* had found supervision to be an unsatisfactory arena in which to express their grief (see Clark, 2009b), left them with little choice but to find their own personally designed (and privately executed) ways of ritualising their loss. For most of those interviewed, this occurred through the attainment of a linking object with the deceased.

As Gibson (2009) has noted, linking objects, which are items that once belonged to or are associated with the deceased, serve as reminders of the relationship and provide solace for the bereaved. They are, therefore, a critical part of the mourning process since they meet the mourner's need to find familiar and continuing connections in a life story disrupted by loss (Hall, 2001; Neimeyer, 2000).

For Murray, *keeping the actual funeral service sheet in [his] files, from where, occasionally, [he'd] see it,* became his means of *acknowledging the grief he was experiencing* in relation to Simon's suicide. For Jude, *having Rose's ashes holding up a stack of books on [his] shelf [was] very graphic [since he] thought about her often;* whilst for Aiden, the gift he had received from a colleague shortly after his client's suicide provided an ongoing connection for him. In Catherine's case, holding on to the plant she had bought during her therapeutic work with her client helped ritualise his death. As she acknowledged:

> *The plant's a nice memory of him. [I took it out of my office] and I've got it at home now. It's lasted and it's been part of the process for me and that's been helpful.*

However, the poignant question raised by Catherine at the conclusion of her interview, *'What if the plant dies?',* clearly illustrates the significance that this linking object had for her.

It is evident from the above that due to their lack of involvement in the wider, more visible arenas of their

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clients' lives and deaths, therapists often had to be very enterprising in terms of procuring a linking object. However, because these linking objects were associated with a socially unsanctioned loss (that is, suicide) that had occurred within a professional relationship, therapists who chose to keep such objects risked being judged harshly by others for having done so (Meyers, 2002).

This was graphically illustrated during a presentation of my interview-findings-to-date where attendees unanimously announced how 'appalled' they had been at Jude's 'breach of professional boundaries' by keeping his client's ashes in his office. Reactions such as these vividly highlight the risks that therapists expose themselves to when, having found themselves marginalised within community-based rituals, they choose to engage in more personalised forms of ritualism as a means of signifying their changed relationship with the deceased.

Discussion

The limited sample size of the current study necessitates that caution be exercised when considering the applicability of the findings to the broader professional context. However, the needs expressed by the therapists interviewed to engage in some form of ritual in the aftermath of their client's death supports contentions by both DeSpelder and Strickland (2002) and Hunter (2007/2008) that for reconstruction of meaning within grief to occur, private rituals and 'rituals of remembrance and new meaning' (Hunter, 2007/2008, p153) are absolutely essential. This need appears to be particularly strong in instances of disenfranchisement such as those described above, where individuals have been excluded from the 'common rituals and shared norms of consolation' (McWilliams, 2004, p276) by factors such as the stigma attached to the loss; the confidential nature of their relationship with the deceased; the expectations that stringent boundaries be maintained between professional and personal roles and responsibilities; and an unsupportive organisational culture (Lewis, 2004).

As a consequence of the above, therapists in this study found themselves having to put their grief-related needs on hold in order to avoid the occurrence of any perceived boundary violations, and to grieve 'invisibly' through the use of linking objects. In fact, it was only by working exceptionally hard to find a vehicle, in the form of linking objects, through which to maintain and re-narrate their ongoing relationship with the deceased, that many of the therapists were able to acknowledge the loss and engage in a process of meaning reconstruction.

In light of the above, this article is one of the first not only to explore the significance of both ritual and the use of linking objects in instances of disenfranchised grief arising from client suicide, but to also dispute the value of adopting a phase/stage/task framework to loss, grief and mourning in instances of client death since 'getting over' and 'letting go' of their relationship with the deceased was not the desire of these therapists. To the contrary, the fact that therapists were so emphatic about not wanting to let go of this relationship supports McGee's (1995, p18) belief that 'holding on to grief might be the most growth-producing and liberating experience' for the mourner.

These findings also underscore the necessity for every aspect of the counselling profession (ie. training, practice and supervision) to consider the adoption of more flexible models of loss, grief and mourning that acknowledge, support and celebrate the ongoing nature of the therapist-client relationship, post-suicide. The Dual Process Theory of mourning (Stroebe 2002; Stroebe & Schut, 2001), for example, which contends that grieving involves a process of oscillation between connecting with the loss and re-orientating oneself towards reconstruction and reorganisation in its wake, marries nicely with the constructivists' belief that meaning-making and the creation of 'continuing bonds' (Silverman & Klass, 1996; Neimeyer & Anderson, 2002) is critical to the mourning process. In light of the above, it might be argued that only through the provision of greater time and space for the processing of grief, and access to adequate leave to attend funerals, memorial services or undertake other personally significant rituals, will the disenfranchisement which currently leads therapists to become 'invisible mourners' engaging in 'peripheral rituals' be minimised. ■

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