

Reactions of Mental Health Professionals
To the Death of Clients From
Acquired Immune Deficiency Syndrome (AIDS)

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ABSTRACT

Reactions of Mental Health Professionals To the Death of Clients From Acquired Immune Deficiency Syndrome (AIDS)

Joseph Robert Kachik Jr.

This study examined the reactions of mental health professionals to acquired immune deficiency syndrome (AIDS)-related bereavement. Ninety-six mental health professionals from across the United States (e.g., counselors, social workers, and psychologists) completed questionnaires concerning the loss of a client to AIDS. Measures included the Texas Revised Inventory of Grief, Impact of Event Scale-Revised, Brief Symptom Inventory, and Satisfaction with Life Scale. There were no significant relations between client deaths (number and recency) and indices of grief, trauma, psychological distress, or satisfaction with life. Symptoms of distress did not increase with number of deaths or in relation to recency of a client's death. Subsequent analyses revealed a significant relation between an avoidant response and many client deaths (11 to 500 deaths), and between recency of a client's death (greater than four months) and a reported greater satisfaction with life. Participants reporting a traumatic stress response (high IES-R scores) showed significantly higher grief (past and present) scores and GSI score on the BSI. An "HIV/AIDS traumatic-grief syndrome" was posited for some mental health professionals who lose clients to AIDS. In addition, there were no significant differences between participants in therapy/support group to address their own grief and loss issues related to the death of clients to AIDS, and participants not involved in therapy across all measures. Multiple regression analyses revealed that the demographic characteristics, suicide, gender (females), age (younger participants), and sexual orientation (gay and lesbian) emerged as predictors of distress variables, while percentage of clients with HIV/AIDS (2% to 50%), number of deaths (less number), sexual orientation (heterosexuals) and academic degree (graduate training) were associated with a greater satisfaction with life. Supplemental analyses showed that participants with 75% to 100% of clients with HIV/AIDS, participants working at an AIDS Center or AIDS Project, and gay and lesbian participants were demographic characteristics associated with distress in response to AIDS-related bereavement. The results also showed that female participants scored significantly higher on the measure of Intrusive symptoms and male participants scored significantly higher of the measures of Interpersonal Sensitivity and Phobic Anxiety. Additionally, years worked with persons with HIV/AIDS (greater number of years) was associated with a greater satisfaction with life. The findings seem to identify mental health practitioners who may be at risk or susceptible for distress following the death of a client with AIDS.

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Table of Contents

Abstract.....	ii
Acknowledgments.....	iii
List of Tables.....	viii
Chapter 1: Introduction.....	1
Statement of the problem.....	8
Definition of terms.....	9
Chapter 2: Literature review.....	13
Normal grief reactions.....	14
Abnormal and pathological grief reactions.....	17
AIDS-related bereavement among gay men.....	22
Multiple loss and bereavement overload.....	24
AIDS-related bereavement among the non-gay population.....	28
AIDS and health care providers.....	29
Health care providers reactions to bereavement.....	32
Mental health professionals and AIDS-related bereavement.....	36
Death Anxiety.....	37
Bereavement Overload.....	38
HIV status of providers.....	38
Literature on bereavement reactions for mental health professionals.....	39
HIV/AIDS caregivers' stress syndrome.....	42

Table of Contents (continued)

Mental health professionals: Unresolved and pathological grief	45
Summary of literature review	49
Research questions	54
Chapter 3: Method	58
Participants	58
Procedures	59
Measures	61
Chapter 4: Results	75
Research Question 1	85
Research Question 2	89
Research Question 3	92
Research Question 4	92
Research Question 5	93
Additional analyses	106
Chapter 5: Discussion	112
Research Question 1	113
Research Question 2	121
Research Question 3	125
Research Question 4	125
Research Question 5	127

Table of Contents (continued)

Additional analyses.....	131
Summary and implications of the study.....	147
Limitations of the study.....	151
Future directions.....	156
References.....	158
Appendices.....	169
Appendix A: Cover letter.....	170
Appendix B: Demographic questionnaire.....	172
Appendix C: Reminder postcard.....	176
Curriculum Vitae.....	178

List of Tables

Table 1. Demographic Characteristics of the Participants, Frequencies.....	76
Table 2. Demographic Characteristics of the Participants, Means.....	82
Table 3. Means, Standard Deviations, and Range for Research Instruments.....	86
Table 4. Analyses of Variance Results for Low, Medium, and High Scores on the Impact of Event Scale-Revised.....	91
Table 5. Intercorrelations Between Demographic Variables.....	96
Table 6. Intercorrelations of Research Instruments.....	98
Table 7. Correlational Data for Research Instruments/Subscales and Demographic Variables.....	100
Table 8. Summary of Multiple Regression Analyses for Predictors of Bereavement and Psychological Distress.....	103

CHAPTER I

Introduction

Acquired Immune Deficiency Syndrome (AIDS) is the most devastating plague of modern times, with over 300,000 deaths attributed to the disease since its discovery nearly two decades ago (Centers for Disease Control and Prevention, 1995). When someone dies from AIDS, the death sends ripples out into the community of people associated with that individual. Mothers, fathers, siblings, spouses, significant others, relatives, and friends, are affected by the death of their loved one, and become the bereaved survivors.

During the often long and degenerative course of AIDS illness, family members, companions and friends are the core support and stability most needed by the person infected with the Human Immunodeficiency Virus (HIV). Lennon, Martin, and Dean (1990) suggested that AIDS-related deaths are particularly distressing, given that the majority of individuals who develop and die from AIDS are in the prime of their lives. That is, AIDS takes its untimely toll on individuals between the ages of 25 and 44. Given this statement, the eventual death and loss is especially traumatic and painful for those surviving the deceased.

Adding to the tragic nature of the loss is the fact that a social stigma is attached to AIDS; and, because of that stigma, the cause of death is often kept secret. Murphy and Perry (1988) have suggested that the secrecy surrounds a family's uneasiness with its loved one's sexual orientation or a history of substance abuse. Often, prior to an AIDS-related death, the family feared the loss of social support and isolation if members of their

social network became aware of the diagnosis of their adult child or sibling (Richmond & Ross, 1994). Given this unspoken need for silence, the bereaved often hide their mourning. Perreault (1995) noted that when there is a loss due to AIDS, grief is barely discussed, and mourners often feel isolated, confused, and scared.

The group that has faced and endured the AIDS epidemic the longest, while incurring the greatest losses due to AIDS, is the population of gay men: that is, men who have sex with men (Lennon, Martin, & Dean, 1990; Martin, 1988; Neugebauer et al., 1992). As the gay community has been hit the hardest by AIDS deaths, this group has received the most attention in the literature concerning the reactions and consequences of AIDS-related bereavement. A phenomenon resulting from the AIDS epidemic, and common to the gay male community, is that of multiple loss: that is, the accumulation of deaths over time. This phenomenon emerges from the sheer volume of deaths due to AIDS. The experience of multiple losses is found within this circumscribed population where one has knowledge of, witnesses, is surrounded by, and is affected by multiple deaths.

An outgrowth of multiple loss is what Kastenbaum (1969) termed, “bereavement overload.” This term originally was framed to describe the serial loss of social contacts experienced by the elderly. Rando (1984) defines this as the experience of the griever who sustains many deaths either at one time or serially. Bereavement overload occurs when an individual has not finished mourning the loss of one person when another dies (Hirsch & Enlow, 1984). Mourning past deaths may be emotionally depleting for the griever, and may not permit the current loss to be adequately addressed (Rando, 1984).

It is suggested that bereavement overload is common within the gay community.

The bereavement literature has examined reactions to individual losses, as well as multiple losses from AIDS, among gay men. It is only within the last eight years that researchers began studying grief and bereavement issues for survivors who had lost someone to AIDS. Prior to that time, anecdotal and journalistic reports of AIDS-related bereavement were the only sources of information. To date, research in this area is produced from quantitative as well as qualitative studies. However, the depth, breadth, and amount of empirical data surrounding AIDS-related bereavement is lacking.

An overview of the literature indicates that significant psychological consequences result from AIDS-related bereavement among gay men (Martin, 1988; Neugebauer et al., 1992; Viney, Henry, Walker, & Crooks, 1992). Some of these consequences are: anger, anxiety, hopelessness, helplessness, symptoms of posttraumatic stress disorder (PTSD), and preoccupation with and searching for the deceased. Richmond and Ross (1994) found respondents describing loneliness and feelings of emptiness as the outgrowth of bereavement. The meager amount of research indicates that little is known empirically about bereavement and how it affects gay men.

AIDS-Related Bereavement Among Caregivers

A second group facing AIDS-related bereavement is the large number of caregivers who are exposed at the front lines of direct service provision to individuals with AIDS. This cohort encompasses those working in nursing, medicine, family caretakers, and volunteer AIDS caregivers. The literature in this domain does not focus on bereavement reactions after the death of an individual with AIDS, but rather examines

the symptomatic expressions and concerns of health care providers who work with AIDS patients. Not surprisingly, given the scant amount of literature, studies looking at the impact of AIDS-related caregiving are primarily qualitative in nature.

In a review of the literature of AIDS-care-related psychosocial distress, Silverman (1993) reported anecdotal descriptions of prevalent reactions experienced by health care professionals. The common symptomatic experiences included AIDS-related nightmares, intrusive thoughts and mental images concerning HIV-related care activities, psychological numbing, irritability, aversion to patients with HIV illness, physical exhaustion, and diminished interest in professional and personal activities. Guinan, McCallum, Painter, Dykes, and Gold (1991) identified four stressor factors indicating general emotional stress that is experienced by volunteer AIDS caregivers. These factors included emotional overload, client problems (e.g., negative aspects of the volunteer's relationship with the client, such as rejection by the client or death of client), lack of support (e.g., lack of resources and support available for volunteers and clients), and lack of training.

Health care professionals are often unprepared for the impact of the deterioration of their patients. "Staff witness their clients losing weight and physical appearance, losing vitality and health, losing jobs, friends and living standards" (Bennett, 1995, p. 94). Weiner and Siegel (1990) found that health care providers attending to persons with AIDS experience high levels of stress, anxiety, guilt and depression. Silverman (1993) has suggested that individuals working with this population may experience an

HIV/AIDS caregivers' stress syndrome. Mirroring the symptoms of posttraumatic stress disorder (PTSD), caregivers of people with AIDS have exaggerated fears of contagion, recurrent intrusive thoughts and dreams, avoidance of stimuli associated with the stressors, emotional numbing, and detachment. Trice (1988) found that mothers who took care of their sons prior to their sons' death, showed a cluster of symptoms similar to PTSD.

Clearly, working with persons diagnosed and dying from AIDS engenders a myriad of psychological distresses. However, there is an apparent lack of literature which addresses the reactions that these health care providers and other caregivers experience when the individual they have worked with and cared for dies from AIDS. The literature calls for a formal inquiry into the incidence and prevalence of physical, mental, interpersonal, or occupational symptoms or disorders of those working with people who have AIDS (Silverman, 1993). However, the literature also appears to neglect the same inquiries of those who have worked with individuals that have perished from AIDS. Perhaps the latter is not addressed because the former has not adequately been answered. Many of the individuals who have worked with this population for a significant amount of time will be facing not only the ongoing stressors while the AIDS patient is alive, but simultaneously are facing and grieving the losses of past patients.

AIDS-Related Bereavement and Mental Health Professionals

The group with which this study is primarily concerned, and perhaps the one most neglected in the literature, are mental health professionals. Included under this rubric are bachelor, master's, and doctoral-level counselors and therapists. These mental health

practitioners come from the fields of counseling, psychology, psychiatry, and social work. This unique group of professionals has been a mainstay in the battle against AIDS. Farber (1994) noted that mental health practitioners provide services that are vitally important in meeting the psychological and emotional needs of persons with HIV and AIDS.

The literature suggests that the reactions of mental health professionals parallel the reactions of the aforementioned health care providers while working with persons with AIDS. An additional phenomenon experienced by mental health providers is presented by Farber (1994), who suggests that a sense of helplessness emerges from this work. This is defined as “an experience of powerlessness, impotence, or defenselessness generated by the perception that a particular aversive event cannot be controlled, altered, or remedied” (Farber, 1994, p. 716). This ineffectualness is echoed throughout the HIV and AIDS literature which notes the pervasive feelings of helplessness and hopelessness that occur for therapists who are involved with AIDS mental health work.

The publications concerning the psychological reactions for mental health professionals are almost exclusively descriptive and based on personal experiences, clinical observations, anecdotal reports, and questionnaire surveys (Silverman, 1993). Perhaps the dearth of empirical data, and overall lack of research concerning the mental health professional, is due to the near-exclusive focus on the individual living with AIDS. The preponderance of literature examines the medical, education, prevention, and psychosocial needs of the person diagnosed with HIV/AIDS, while ignoring the professionals who care for individuals with HIV and with AIDS.

Although research predominately emphasizes and examines the needs of the person with AIDS, a knowledge base concerning the individual practitioner begs for empirical investigation. As mentioned earlier, individuals having worked a substantial amount of time with the HIV/AIDS population will have experienced multiple deaths of clients, while actively engaged in ongoing therapeutic work with clients with AIDS.

It is the accumulation of multiple losses that presents the greatest concern for mental health professionals. Dane (1992) has suggested that when the loss of clients to death occurs in a serial fashion, without the opportunity to process the multiple deaths, professionals are susceptible to bereavement overload and an emotional state of chronic mourning. Perreault (1995) identified issues resulting from multiple loss including grief, survivor guilt, individual burnout (e.g., loss of normal emotional responsiveness, numbness, and isolation), workplace burnout (e.g., loss of interest and involvement in work, decrease in productivity and morale, and increased absenteeism), and responses similar to posttraumatic stress disorder. "Health care providers who work with AIDS patients must survive many losses during the course of their work; their experience of loss parallels the grief of the dying patient and his or her survivors" (Dane, 1995, p. 279).

According to the existing literature, the reactions and coping strategies of mental health practitioners to AIDS-related bereavement are varied. The range of reactions encompasses adaptive or normal responses, to maladaptive responses; from a healthy mourning at one extreme, to psychological distress indicative of pathology at the other extreme. Although the range of responses intuitively makes sense, it is ostensibly based on personal experiences and anecdotal reports. Lacking in the literature is empirical

documentation of the reactions of mental health professionals to AIDS-related bereavement. Silverman's (1993) review article emphatically states that:

Critical questions have not been asked nor have the relevant data been elicited, and so it must be left to speculation whether job transfers, career changes, and so-called "burnout" among HIV caregivers are related to unaddressed, unacknowledged, and, most important, untreated physical, psychiatric, and psychosocial morbidity (p. 706).

Silverman's charge is not the only acknowledged call for research examining this topic. Dane (1995) stresses the need for empirical studies to validate the descriptive assertions present in the literature. She specifically notes that not much is known about mental health professionals who experience bereavement overload, and likens this experience to posttraumatic stress disorder of those who survived floods, earthquakes, wars, and concentration camps (Dane, 1995).

Statement of the Problem

In reviewing the literature, there is a conspicuous lack of empirical research that examines the reactions of mental health professionals when a client dies from AIDS. Moreover, it is suggested that multiple losses and subsequent bereavement overload may have deleterious effects on those providing mental health services. A relevant concern then, is how AIDS-related bereavement may or may not be affecting mental health professionals who are working with this population. Because AIDS publications are primarily based on personal experiences and anecdotal reports, and empirical research on this topic is lacking, this researcher believes that it is important to examine the reactions

that mental health practitioners' experience after the death or multiple deaths of clients with acquired immune deficiency syndrome.

Purpose of the Study

During this second decade of AIDS, mental health professionals will continue to be called upon to provide psychological services to the HIV/AIDS population. As this is the present day charge, it will continue to be necessary to study the psychological status of the person with AIDS, the experience of the person with HIV/AIDS, and treatment interventions for AIDS infected individuals; but increasingly important, to begin to study the experience of mental health practitioners who work closely with this group. The present research was undertaken to examine the phenomenon of multiple loss of clients with AIDS and the impact on mental health practitioners. This study seeks to understand and answer the question of what specific and unique reactions mental health practitioners experience after the death of clients with AIDS. The study was undertaken to add to the empirical literature on AIDS-related bereavement.

Definition of Terms

Acquired Immune Deficiency Syndrome (AIDS)

Dorland's Illustrated Medical Dictionary (1988) provides a definition of AIDS:

An epidemic, transmissible retroviral disease due to infection with human immunodeficiency virus (HIV), manifested in severe cases as profound depression of cell-mediated immunity, and affecting certain recognized risk groups, including men who have sex with men, bisexual males, intravenous drug

users, hemophiliacs and other blood transfusion recipients, female sexual contacts of males in at-risk groups, and newborn infants of females at risk for AIDS.

At the heart of acquired immune deficiency syndrome (AIDS) is the human immunodeficiency virus (HIV). Progressive lethal degeneration of the immune and central nervous systems results from long-term chronic replication of the human immunodeficiency virus (Haseltine, 1992). AIDS is the end result of infection with this virus. Opportunistic infections are the most important clinical manifestations of advanced immunodeficiency in HIV disease (Valenti, 1992). It is the development of AIDS defining opportunistic diseases that lead to life-threatening illness and death.

Human Immunodeficiency Virus (HIV)

Dorland's Illustrated Medical Dictionary (1988) defines HIV as:

A human T-cell leukemia/lymphoma virus that is the agent of acquired immune deficiency syndrome. HIV has a selective affinity for helper T-cells; in vitro infection of helper T-cells results in cytopathic effects and cell lysis (Cytopathic refers to pathological change in the cells and, lysis means destruction).

Human immunodeficiency virus is transmitted through three primary sources: sexual contact with an infected person, significant exposures to infected blood or blood products (including needles shared among intravenous [IV] drug users), and perinatally from an infected mother to her child (Lifson, 1992).

AIDS-related Bereavement

This term refers to the state of having suffered a loss due to the death of someone with acquired immune deficiency syndrome (AIDS).

Bereavement Overload

This is a term attributed to Kastenbaum (1969). This term originally was framed to describe the serial loss of social contacts experienced by the elderly; however, it also is used to describe the griever who experiences many bereavements either at one time or in a series. For both cases, the “past experiences with death may leave the griever depleted emotionally and unable to adequately address the current loss” (Rando, 1984, p. 47)

HIV/AIDS Caregivers’ Stress Syndrome

Silverman (1993) has suggested that this syndrome is evidenced by the symptoms of caregivers of individuals with AIDS, and likens these symptoms to those of posttraumatic stress disorder (PTSD). These symptoms include: recurrent intrusive thoughts and dreams, avoidance of stimuli associated with the stressors, emotional numbing and detachment.

Mental Health Professionals

This group is comprised of bachelor, master’s and doctoral-level practitioners who provide individual and group counseling and psychotherapy. These mental health service providers hail from the fields of counseling, psychology, psychiatry, and social work. The term mental health professional and mental health practitioner will be used interchangeably in the current study.

Multiple Loss

Multiple loss is the accumulation of multiple deaths over time; it refers to the experience of losing more than one person to death. This term is particularly relevant to the community of gay men who have lost numerous persons to AIDS. A second group experiencing multiple loss due to AIDS, are the mental health practitioners who work with individuals infected with HIV or diagnosed with AIDS.

CHAPTER 2

Literature Review

Bereavement has been defined as the state of having suffered a loss (Rando, 1984). In his seminal work on loss, Bowlby (1980) states, “Loss of a loved person is one of the most intensely painful experiences any human being can suffer” (p. 7). As AIDS continues to take the lives of individuals in the prime of their lives, bereavement and grief will significantly touch the community of survivors left in the wake of the AIDS epidemic.

AIDS primarily strikes individuals between the ages of 24 and 44. When an individual succumbs to AIDS, bereavement is more intolerable to the survivors because the loss signifies the premature death of the individual. “When a young person dies, it is normal to feel grief associated not only with the death but also with the lost potential inherent in the terminated life, which leads one to interpret the death as a ‘tragedy’” (Nord, 1996, pp. 394-395).

The untimely death interrupts the normal sequence of the life cycle. It is this interruption that is especially deplorable and difficult for survivors to comprehend. Regardless of the cause of death, Weisman (1973) noted that damages result from the premature death of a child, including one’s belief in a future in which potentials become fulfilled. The ravenous toll that AIDS deaths incur are multifarious, and experienced deeply by those left following the loss.

In order to provide a context for the present research, it is necessary to examine the literature on bereavement, specifically, literature that addresses the grief reactions to loss. To establish a foundation upon which this study may be grounded, prominent theories in the area of bereavement and grief will be discussed. This examination encompasses the range of normal grief reactions, as well as the abnormal or pathological reactions to loss.

Normal Grief Reactions

Literature on death and bereavement has examined grief reactions following loss. Erich Lindemann (1944), a pioneer in grief work, described grief as a normal reaction to a distressing situation. In his paper on acute grief, he suggests that people exhibit common reactions to grief, and that these responses are remarkably uniform (Lindemann, 1944). He offered five characteristic reactions of grief: somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions, and a loss of organized patterns of activity. A sixth characteristic, shown by people who border on pathological reactions, was the appearance of traits of the deceased in the behavior of the bereaved, especially the symptoms shown during the deceased's last illness (Lindemann, 1944).

In his treatise on loss, John Bowlby (1980) commented on how individuals respond to the loss of a close relationship, suggesting that these responses usually move through a succession of four phases. While individuals may oscillate between any two of these phases, an overall sequence is discernible. The four phases are: (a) phase of numbing that constitutes varying degrees of denial of the loss, marked by periods of intense distress and/or anger; (b) phase of yearning and searching for the lost person,

exhibited by a strong urge to find, recover, and reunite with that individual; (c) phase of disorganization and despair, characterized by giving up the searching attempts to recover the deceased often resulting in depression; and (d) phase of greater or lesser degrees of reorganization in which the individual relinquishes attachments to the lost loved one, and starts to establish new relationships and ties to others.

Other bereavement theorists have also suggested the existence of normal grief reactions in response to the death of a loved one. Kubler-Ross (1969) has suggested five stages an individual encounters when coping not only with imminent death, but the grief reactions and sequence that follows a loss. The first stage is characterized by denial and isolation, which acts as a buffer against the overwhelming reality of the situation. Anger toward the loss is experienced in the second stage. Following this stage, a state of bargaining is often found in which pleas are made to God or the doctor to forestall the loss, or behaviors are undertaken to avoid grieving over the loss after it has occurred. At some point depression will emerge, indicative of the fourth stage. Finally, to complete the grief work an individual comes to accept the loss.

James Worden (1991) contributes to the bereavement literature by offering a broad range of grief reactions that are common after a loss. He suggests four general categories encompassing the manifestations of normal grief: (a) feelings: anger, sadness, guilt, self-reproach, anxiety, helplessness, shock and numbness; (b) physical sensations: hollowness in the stomach, tightness in the chest and throat, shortness of breath, weakness in the muscles, lack of energy, and a sense of depersonalization; (c) cognitions: disbelief, confusion, preoccupation, and thinking that the deceased is

still present; and (d) behaviors: sleep and appetite disturbances, absent-minded behavior, social withdrawal, searching for the deceased, crying, avoiding reminders of the deceased, and conversely, visiting places that remind the survivor of the deceased.

Worden's (1991) approach is congruent with Bowlby's (1980) view of the four mourning phases that occur after a loss; that is, numbing, yearning and searching, disorganization and despair, and reorganization. It is suggested that the mourner must experience and transcend the aforementioned phases before mourning is finally resolved.

A final leading bereavement theorist, Rando (1984), focused her work on the psychological reactions to normal grief. She categorized the grief reactions into three broad areas of avoidance, confrontation, and reestablishment. In the avoidance phase, the individual seeks to avoid the reality of the loss, and employs denial as a protective, coping defense. The confrontation phase occurs when the individual confronts the loss and its implications. This phase is characterized by a multitude of emotions, especially the prevalent emotions of anger, guilt, depression, and despair. Denial is still possible in this phase and may continue to occur. During this period there is a preoccupation with the deceased, exhibited by excessive rumination, searching for the deceased, and a feeling of emptiness. The reestablishment phase signifies the lessening of feeling of loneliness, anger, and sadness, and the reinvestment and involvement in life.

The preceding leading theorists all describe a constellation of normal reactions and stages following the passing of an individual. Implied in various stage and phase theories of bereavement is a simple, invariant, and sequential course. Sherr (1995) suggests that stages are useful in describing and defining the range and extent of

bereavement experiences, however are limited when utilized literally without the flexibility to adjust and accommodate individual variation. Rando (1984) counters the presence of a static, absolute bereavement course stating, “Not all people will have the same experience, need the same interventions, or follow the same clinical course” (p. 29). Stages or phases of bereavement are in fact rarely followed in a uniform fashion during the process of grieving. Theoretical formulations demarcating paths of grief merely act as guideposts and can provide professionals with intervention pathways to assist the bereaved. Sherr (1995), in her discussion of stages of grieving states, “They can never incorporate the nuances of every individual experience” (p. 2).

Grief, as illustrated, is the normal reaction to loss; it is the process of psychological, social, and somatic reactions to the perception of loss (Rando, 1994).

Rando (1984) suggests that grief is:

(a) manifested in each of the psychological, social, and somatic realms; (b) a continuing development involving many changes; (c) a natural, expectable reaction (in fact, the absence of it is abnormal in most cases); (d) the reaction to the experience of many kinds of loss, not necessarily death alone; and (e) based upon the unique, individualistic perception of loss by the griever, that is, it is not necessary to have the loss recognized or validated by others for the person to experience grief (p. 15).

Abnormal and Pathological Grief Reactions

Although the bereavement literature suggests a commonality among theories of normal grief reactions, it also attends to and enumerates the reactions, symptoms, and

behaviors indicative of grief reactions that are not viewed as normal. Abnormal grief has been found under different titles: that is, pathological grief, unresolved grief, complicated grief, chronic grief, delayed grief, or exaggerated grief (Worden, 1991). Horowitz, Wilner, Marmar, and Krupnick (1980) define pathological grief as:

The intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behavior, or remains interminably in the state of grief without progression of the mourning process towards completion. [It] involves processes that do not move progressively toward assimilation or accommodation but, instead, lead to stereotyped repetitions or extensive interruptions of healing (p. 1157).

In an investigation of acute grief, Lindemann (1944) conducted interviews with bereaved individuals and presented the following manifestations of unresolved grief reactions: (a) the delay or postponement of reactions with little or no reaction for weeks or much longer; (b) overactivity without a sense of loss; (c) the acquisition of symptoms belonging to the last illness of the deceased; (d) development of a psychosomatic medical illness (i.e., predominantly ulcerative colitis, rheumatoid arthritis, and asthma); (e) alteration in relationships with friends and relatives (i.e., a progressive social isolation); (f) furious hostility against specific persons somehow connected with the death (e.g., doctor, nurse); (g) wooden and formal conduct that masks hostile feelings and resembles a schizophrenic reaction in which there is a lack of emotion; (h) lasting loss of patterns of social interaction (e.g., individual cannot initiate any activity and only starts

activity when primed by someone else); (i) acts detrimental to one's own social and economic existence (e.g., giving away belongings, making foolish economic deals); and (j) agitated depression with tension, agitation, insomnia, feelings of worthlessness, bitter self-accusation, obvious need for punishment, and perhaps suicidal tendencies.

Additional symptoms of abnormal or unresolved grief were suggested by Worden (1991): (a) a depressive syndrome of varying degrees of severity since the time of death, often marked by persistent guilt and lowered self-esteem; (b) experiencing a false euphoria subsequent to a death; (c) cannot speak of the deceased without experiencing intense and fresh grief; (d) relatively minor events triggering intense grief reactions; (e) unwillingness to move the material possessions of the deceased after a reasonable amount of time has passed; (f) making radical changes in their lifestyle following a death or excluding from their life friends, family members, and/or activities associated with the deceased; (g) somatic symptoms representing identification with the deceased, often the symptoms of the terminal illness; (h) overidentification with the deceased leading to a compulsion to imitate the dead person; (i) self-destructive impulses; (j) diminished participation in religious and ritual activities that are part of the mourner's culture, including avoidance of visiting the grave or taking part in death-related rituals or activities; and (k) developing phobias about illness or death that is often related to the specific illness that took the deceased.

The above symptoms and reactions may be present in various degrees during the acute stage of grief and might not appear remarkable given the circumstance of

bereavement. These very symptoms and reactions become major indicators of unresolved grief when they are manifested beyond the expected time for resolution of grief (i.e., continuing beyond 6 months to 1 year) (Lazare, 1979; Rando, 1984). Horowitz (1980) noted that pathology is more related to the intensity or the duration of a grief reaction rather than to the simple presence or absence of a specific behavior. Siggins (1966) remarked that any one of the following three variables demarcate unresolved grief: absence of a normal grief reaction, prolongation of a normal grief reaction, and distortion of a normal grief reaction.

Worden (1991) presented four styles that characterize abnormal grief reactions. The first style is chronic grief reactions: these are reactions that are excessive in duration and never come to a satisfactory conclusion. Delayed grief reactions are often termed inhibited, suppressed, or postponed grief; this second style is exhibited by an emotional reaction at the time of the loss, however the reaction is insufficient to the loss. Because grieving was not adequately done at the time of the original loss, the reactions are more intense and excessive at the time of a current loss. The third style, exaggerated grief reactions, typifies the person who experiences an intensification of a normal grief reaction and feels overwhelmed, engendering disabling symptoms. Following a loss these individuals may develop clinical depression, panic attacks, phobic behavior, alcohol and substance abuse, and signs and symptoms of posttraumatic stress disorder. Masked grief reactions, the fourth style, are found in individuals who experience symptoms and behaviors that are problematic but do not see or recognize the fact that these are related to the loss. Masked grief usually manifests itself in one of two ways: either it is masked

as a physical symptom or it is disguised through some type of maladaptive behavior, such as acting out and delinquent behavior.

The literature offers a substantive account of the abnormal or pathological reactions to bereavement, while also suggesting psychological and social reasons for these types of reactions, and for failure to grieve. Worden (1991) views abnormal grief reactions stemming from relational, circumstantial, historical, personality, and social factors. He reports that relational factors stem from the type of relationship the individual had with the deceased, with ambivalent and dependent relationships engendering difficult grief work. Circumstantial factors are those specific circumstances that may preclude a person's grieving or grief resolution (e.g. unexpected and untimely deaths, and multiple losses). Historical factors refer to the notion that those individuals who have had pathological grief reactions in the past will likely experience pathological grief reactions in the future. Personality factors denote an individual's character style such as avoidance of feelings and emotional distancing, a self-concept that includes being the strong one in the family, and, a lack of social support and reinforcement in reaction to the loss (Worden, 1991).

Lazare's (1979) work on unresolved grief yielded several important psychological and social factors resulting in unfinished grief and abnormal grief reactions. The psychological factors were as follows: guilt, loss of an extension of the self (e.g., over dependence or reliance on the deceased), reawakening of an old loss, multiple loss, inadequate ego development (i.e., failure to achieve the state of object constancy; severe ego impairments, e.g., borderline personality), and idiosyncratic

resistance to mourning. The social factors in unresolved grief were: social negation of a loss (i.e., loss is not socially defined as a loss, such as an abortion, a miscarriage, an infant given up for adoption), socially unspeakable loss (i.e., loss is result of drug overdose, murder, suicide), social isolation and/or geographic distance from social support, assumption of the role of the strong one, and uncertainty over the loss.

From the psychological and social factors presented by Lazare (1979), specific factors emerge which may be construed as contributors to the grief reactions, or the failure to grieve, following the death of an individual with AIDS. One of the major suppositions of the current investigation is that individuals, specifically mental health professionals, may be susceptible to and experience abnormal grief reactions, and may not resolve their grief subsequent to the death of a client with AIDS. These crucial factors will be presented and examined in detail in a later section to substantiate the research questions under investigation.

The literature on the grief reactions of the community of gay men, who have experienced losses due to AIDS, is presented to delineate the constellation of reactions following the loss of a person with AIDS. Specifically, the review of the literature aims to distinguish the features of bereavement that may be specific to AIDS-related deaths for persons from the gay population.

AIDS-Related Bereavement Among Gay Men

The gay community in the United States has been devastated by the AIDS epidemic (Neugebauer et al., 1992). As this group has incurred the greatest losses due to AIDS, many of its members have experienced the multiple loss of friends and

lovers. Biller and Rice (1990) suggest that members of the gay community who have experienced the multiple loss of persons with AIDS, struggle to resolve grief because of society's inability and unwillingness to accept the gay identity, and the exacerbation of grief induced by repetitive loss over a brief period of time.

Society, even prior to the AIDS epidemic, has not been accepting of the gay community. In many instances, gay men have not had the support of their families, often because family members are unable to accept their homosexuality. Persons with AIDS may have already felt the withdrawal of parents, relatives, and friends because of their sexual orientation and lifestyle (Murphy & Perry, 1988). When a gay man has AIDS it is not unusual for him to be rejected by his biological family (Lennon, Martin, & Dean, 1990). The stigma attached to AIDS, and the fear of contagion have acted in tandem to further distance and isolate gay men with AIDS.

The death of someone from AIDS within the already shunned and isolated gay community has exponential effects for the survivor of the deceased. Studies have shown that bereaved individuals describe intense feelings of isolation and disconnection from family, experiencing loneliness, sadness, and confusion (Richmond & Ross, 1990; Sowell, Bramlett, Gueldner, Gritzmacher, & Martin 1991). Individuals reported that they could not talk with their families about the bereavement, nor could they discuss their feelings with friends or work colleagues (Richmond & Ross, 1990). The findings from the Sowell et al. (1991) study confirmed that the social stigma attached to both the diagnosis of AIDS and the homosexual lifestyle profoundly influence the bereaved survivor's ability to progress through the grieving process.

The singular study found in the literature that examines the grief reactions experienced by gay men who have lost a lover or close friend to AIDS is the investigation of Lennon et al. (1990). One of the key findings of this study was that men who were involved in taking care of a lover or close friend with AIDS had more intense grief reactions: that is, numbness, detachment, denial, and preoccupation with the deceased, compared to non-caretakers. Lennon et al. (1990) suggest that caretakers of those with AIDS are vulnerable to pathological consequences of bereavement, prolonged or unresolved grief reactions, and high levels of distress due to the AIDS epidemic.

Several authors have commented that when gay men experience an AIDS-related death, the pain is especially sharp because the bereaved are at increased risk both for developing AIDS themselves, and for experiencing additional AIDS-related bereavements (Lennon et al., 1990; Sowell et al., 1991). Regardless of whether gay men are HIV positive or have AIDS, they will have experienced multiple losses of friends and lovers (Neugebauer et al., 1992).

Multiple Loss and Bereavement Overload

The term multiple loss refers to the overwhelming task of living in a situation where continual loss has become commonplace (Kain, 1996). Addressing multiple loss, Martin (1988) suggested, “multiple bereavements occurring close in time may influence the expression of distress or vulnerability to illness in ways not normally observed in the more usual bereavement situation in which a single loss occurs” (p. 856). In a study exploring the grief and bereavement issues of survivors experiencing multiple loss of

persons with AIDS, Biller and Rice (1990) concluded that multiple loss is different from normal bereavement, in that individuals facing loss after loss cannot be expected to “bounce back”, for each grieving process is compounded by the one before it. “Gay people experiencing multiple loss do not have enough time between traumas to work through the many feelings of the grief process” (Biller & Rice, 1990, p. 288).

Because of the experience of multiple AIDS bereavements in succession, the term “bereavement overload” is used in the literature to describe this phenomenon. Kastenbaum (1969) first used the term “bereavement overload” to refer to elderly people who experience the death of many friends within a relatively brief period. Leham and Russell (1985) applied this term to individuals who deal with multiple losses caused by AIDS, noting that the loss of many friends within a relatively brief period is especially devastating and frightening for gay men. “Clients rarely have sufficient time to mourn the loss of a friend or loved one before they must mourn, or at least prepare for mourning, the loss of another” (Kain, 1996, pp. 227-228).

Viney, Henry, Walker and Crooks (1991-92) examined the cumulative psychosocial impact of multiple deaths due to AIDS within two AIDS-affected gay communities (i.e., Sydney and Melbourne, Australia) differing in the extent of their bereavement. The two communities differed in that the Sydney community, in comparison with the Melbourne community, had more AIDS-deaths and had organized both informal and formal support networks. Two hundred fifteen men participated, 141 from the more bereaved community, and 74 from the less bereaved community. The results indicated that the more bereaved sample experienced higher levels of anxiety

and anger. The anxiety was related to anticipating their own possible death, fear of mutilation to their own body (i.e., loss of bodily integrity/disfigurement due to AIDS), and separation from many of the people important to them. Their anger was related to the death and loss of friends, work mates, and lovers. Both groups of bereaved gay men expressed distress, with the less bereaved community experiencing depression. No explanations were offered for the group differences; however, the authors suggested that the distress is the probable result of the cumulative impact of multiple deaths by AIDS (Viney et al., 1991-92)

Martin (1988) conducted one of the nascent studies aimed at quantifying AIDS-related bereavement consequences from multiple losses. The study was undertaken to determine which symptoms are most likely to develop in response to AIDS-related bereavement among gay men. The sample consisted of 745 gay men who did not have a diagnosis of AIDS. However, a small group (i.e., 50) knew of their HIV status, with 16 (34%) of these HIV positive. Bereavement was experienced by 27% of the sample ($n = 198$). The results indicated that the types of distress associated with AIDS-related losses were symptoms of traumatic stress response (intrusive and avoidant thoughts and emotions about AIDS), demoralization (depression, hopelessness, and helplessness), sleep problems (going and staying asleep, and waking early), using sedatives and recreational drugs, and the use of psychological services because of AIDS concerns. A direct relation was found in that these symptoms increased as a function of increases in bereavement. Martin (1988) cautions that these findings may be the result of

the bereaved sample being at risk for AIDS or because of incipient illness and declining health of the bereaved who were HIV positive.

A later quantitative investigation examining the effect of multiple losses on gay men associated with the AIDS epidemic, yielding two important findings (Neugebauer et al., 1992). The results show that bereavement reactions specific to loss (namely, preoccupation and searching for the deceased) rose with increasing numbers of losses (i.e., lovers, former lovers, and close friends combined) since the start of the epidemic. The second finding was that the experience of multiple AIDS deaths did not increase the overall level of depressive symptoms, the presence of specific symptom clusters, nor the presence of a diagnosed depressive disorder (Neugebauer et al., 1992). The authors interpreted the second finding as possibly resulting from the gay community having developed effective coping mechanisms (e.g., social support, membership in gay organizations, reading gay newspapers) to assist gay men in dealing with multiple losses.

A recent empirical investigation by Summers et al. (1995) examined the effects of multiple loss on grief resolution and psychiatric morbidity in 286 (222 HIV positive and 64 HIV negative) gay men. Of the 171 who reported a loss within the previous 12 months, 18% (31 of 171) met the criteria for unresolved grief. Men with unresolved grief demonstrated an elevated prevalence of current major depression and panic disorder when compared with resolved grievers. In addition, multiple loss is common in this population, yet not related to either grief resolution or psychiatric sequelae. The authors caution that selection bias may be evident, in that gay men volunteers for HIV research

may have more access to community resources, and more support than bereaved counterparts who fail to participate in HIV research. They also noted that unresolved grief respondents were less likely to attend funeral or memorial services than their bereaved counterparts. Grief rituals and the special rituals of the gay community (i.e. AIDS Walk, World AIDS Day, AIDS quilt, red ribbon pins), are viewed as supportive in promoting the resolution of one's loss (Summers et al., 1995).

AIDS Bereavement Among the Non-Gay Population

Although gay men continue to make up the largest percentage of AIDS cases, namely, 48%, (Centers for Disease Control and Prevention [CDC], 1997), the profile of the United States AIDS epidemic has changed and now includes an increasing number of cases, especially female, resulting from heterosexual contact (Campbell, 1995). Recent AIDS prevalence data indicate that females now account for 20% of persons with AIDS, intravenous drug users (i.e., male and female) accounting for 28%, and heterosexual transmission accounting for 15% of AIDS cases (CDC, 1997).

Of note, during 1995 and 1996, the non-gay population with AIDS (i.e., females, intravenous drug users, and heterosexual transmission among persons aged over 13) accounted for slightly less than one-half of all deaths reported from AIDS (CDC, 1997). Clearly, the AIDS epidemic is not restricted to men who have sex with men, as this plague has ravaged this country and taken individuals from all walks of life. With the death toll comes the trail of grief for family, spouses, partners, and friends.

To date, there is no research on the impact of AIDS bereavement with the non-gay population. Research with this cohort appears to be aimed at prevention, while

overlooking and neglecting loss and grief reactions of the survivors.

AIDS and Health Care Providers

The group of professionals coming in contact with the HIV/AIDS population most frequently is health care professionals. Physicians and nurses have been serving this group since the outbreak of the AIDS epidemic, and continue to be entrenched at the front lines battling for the health and lives of individuals with AIDS.

To date, medical literature has addressed the attitudes of these caregivers toward AIDS and the individuals with HIV/AIDS illness (Blumenfield, Smith, Milazzo, Seropian, & Wormser, 1987; Richardson & Lochner, 1987; Rizzo, Marder, & Wilkie, 1990). Wallack (1989) studied physicians and nurses investigating AIDS anxiety, fear of contagion, and attitudes toward homosexual behavior. The results indicated that the overwhelming majority of medical health professionals reported feeling greater anxiety concerning caring for AIDS patients than other patients. Also reported was that the majority of physicians and nurses felt at risk for contracting AIDS even when following safety guidelines. Of note, health care providers of an ethnic background, especially Asian nurses, were more uncomfortable working with gay patients.

Because there has been little empirical effort to examine the psychological adjustment of medical practitioners working with AIDS patients, Treiber, Shaw, and Malcolm (1987) examined the psychological impact on physicians and nurses of working with an AIDS patient and a non-AIDS control patient. The medical staff's responses indicated that they experienced psychological distress in work and non-work settings as

a result of working with an AIDS patient. In the work setting, physicians and nurses experienced more emotional discomfort and increased anxiety when working with the AIDS patient. In the non-work setting, they experienced increased ruminations involving worry and concern over potential contraction of HIV, and undesired thoughts and/or mental images of previous work with the AIDS patient.

A paper by Frost, Makadon, Judd, Lee, O'Neill, and Paulsen (1991) presented anecdotal personal experiences of health care personnel caring for patients with AIDS. An overall theme identified was that of isolation and helplessness in the caregivers by their work with AIDS patients. Simmons-Alling (1984) had suggested that work in the AIDS area is emotionally charged, with the chronic and terminal nature of the disease often engendering feelings of hopelessness, isolation, and fear in the care-giver and patient alike.

Also emerging from the Frost et al. (1991) investigation was that caregivers noted that they often experience enormous responsibility when they realize that they are the central figure not only in a patient's illness, but also in the patient's entire life. The authors suggested that an emotional risk develops for health care workers from being either too close or too distant with their AIDS patients (Frost et al., 1991).

Frost et al. (1991) state:

Allowing themselves to get too close to AIDS patients creates issues of identification, loneliness, enormous responsibility, and having to face their own mortality. Maintaining a safer position of clinical neutrality and distance from their AIDS patients runs the risk of the provider's feeling cold and uncaring, the

cost being a sense of guilt and diminished self-esteem (p. 165).

Because health care professionals were affected emotionally and in personal ways by these patients, they struggled to manage the intensity of their feelings, and this affected their current work with AIDS patients, as well as their willingness to take on new AIDS patients (Frost et al., 1991).

An important investigation examined the psychological stresses for physicians treating patients with AIDS (Frierson & Lippmann, 1987). Most significantly, physicians identified feelings of helplessness and powerlessness over the fatal condition and prognosis of AIDS. Other stresses included discomfort in treating homosexual patients, fear of contagion, and grief. Interestingly, the authors made specific note of the lack of research examining the grief experiences of physicians working with AIDS patients. As this was the only study located that addressed grief reactions of physicians, it appears to reveal significant anecdotal information.

In addition, Frierson and Lippmann (1987) discovered that the degree of grief experienced by physicians varied considerably, depending on their experience and level of involvement with AIDS patients. Many physicians acknowledged feelings of anger and despondency, and the heavy emotional toll when there is no possibility of survival for AIDS patients. Physicians who had cared for 10 or more AIDS patients rarely mentioned grief as a significant concern. What emerged was that denial of the emotional impact of patient death was important and psychologically protective for the physician, and this denial appeared to be stronger in AIDS cases than in other terminal illnesses. Somewhat contrary to this finding, McKusick, Horstmann, Abrams, and Coates (1986)

found that health care workers were more likely to experience stress related to caregiving to persons with AIDS the longer they worked with this population. The lack of empirical research in this area may account for the inferred discrepancy in the two investigations.

Health Care Providers Reactions to Bereavement

While there is an apparent lack of empirical research examining the effect of AIDS-related bereavement on health care professionals, the literature examining bereavement reactions of physicians and nurses to the death of non-AIDS patients are reviewed. Like the modicum of literature on AIDS-related bereavement, literature concerning professional bereavement is scant. The preponderance of research examines the bereavement of the surviving spouse, parent, or child (Saunders & Valente, 1994). A scholarly paper by Weisman (1981), however, discussed the ramifications of being a cancer caregiver: namely, health care professionals engaged regularly in cancer care. It was suggested that distress among caregivers increases as patients with cancer near death, and a vulnerability often exists leading to a set of symptomatic responses termed “Caregiver’s Plight.” Examples of these symptoms are: guilt, unusual indecisiveness, pangs of sadness, flashes of antipathy, chronic hopelessness, unexpected weeping, conviction of being totally ineffective, and denial of fallibility combined with inflated self-opinion.

Weisskopf and Binder (1976) offered descriptions of grieving medical students, finding that when students did not deal with a recent death, but avoided it, they experienced anxiety, insomnia, poor school performance and depression. The authors

suggested that the manner in which students perform the emotional work of their own grieving is likely to affect their later reactions to dying patients and their families.

Physicians and nurses are confronted on a regular basis with patients who are seriously ill, and these intense interactions generate a significant amount of personal emotional stress. Gray-Toft and Anderson (1981) investigated the causes of nursing stress in the hospital environment. Two important findings were that nurses on all units reported stress resulting from attempts to meet the emotional demands of patients and families, and exposure to death and dying. The authors commented that death evokes discomfort in nurses and doctors because it permits them to view themselves as failures. Schulz and Aderman (1976) suggested that physicians tend to avoid dying patients and their families, leaving the nurse much of the responsibility for the care of the patient.

Rafferty (1983) examined the stresses of working with individuals diagnosed with cancer and other life-threatening illnesses. His paper reviewed the physical and behavioral symptoms of maladaptive responses to stress. The physical manifestations of stress included symptoms such as: a sense of physical exhaustion not due to a lack of sleep or poor nutrition, a lingering illness such as a cold, and psychosomatic complaints such as headaches, sleeplessness or gastrointestinal problems. Behavioral manifestations of stress included: a proneness to anger, irritability or frustration at events that would not usually provoke such a response, a negative attitude at work, increased use of alcohol or drugs, and increased conflict in marital or family relations.

A second relevant proposal by Rafferty (1983) was that patient variables exacerbate the amount and intensity of stress the caregiver experiences. He suggested

that the patient's subjective experience of helplessness generates a similar sense of helplessness in the caregiver, especially when there is little likelihood in successful change or cure. The caregiver's stress is also increased when the patient's situation resembles the caregiver's own real or potential experience.

Although the previous articles examined the reactions of health care professionals working with the seriously ill, few studies are available delineating the bereavement reactions of physicians and nurses. Saunders and Valente (1994) presented a review of the factors that influence the bereavement of oncology nurses. Three hundred oncology and hospice nurses completed questionnaires and interviews about personal and professional bereavement during bereavement workshops. A prevalent response to the death of patients was hiding emotions, and this was attributed to having to maintain professional standards that led to angry, depressed, frustrated, helpless, and hopeless feelings. This descriptive study of oncology nurses found that when they had not been able, for whatever reasons, to assist a patient to die a good death, or if they were off duty when a patient died, they stated that their grief was more difficult, using terms such as more complicated, difficult, painful, and distressing to describe the grief. Grief was also exacerbated by multiple deaths. Bereavement overload occurred when nurses lacked the time to reflect upon or come to terms with their own responses to patients' deaths. Oncology nurses experiencing difficult or multiple deaths hesitate to engage in caring relationships with patients, while an unresolved patient's death may in fact cause nurses to question their professional identity or self-esteem. Grief was also identified as more difficult when a young person dies, when the death is sudden and unanticipated, and

when a stigma (e.g., suicide, AIDS) is associated with a death (Saunders & Valente, 1994).

Mount (1986) addressed the cumulative effects of repeated losses experienced by clinical oncologists. It was noted that each loss reminded physicians of previous bereavements, thereby mobilizing coping strategies. Mount stated, “The weight of such repeated losses may lead to a burden that is increasingly intolerable and frequently difficult to define” (1986, p. 1128).

Although the literature does not provide empirical data on the bereavement reactions of health care providers, studies have documented the effects of stress on physicians. Job-related stress in physicians is linked to alcoholism (Rafferty, 1983), drug addiction (Rafferty, 1983; Sakinofsky, 1980), suicide (Sakinofsky, 1980), and marital discord (Rafferty, 1983).

A discourse by Davidson and Jackson (1985) noted the prevalence of long-standing hidden symptoms of trauma in nurses. The authors suggested that a post-traumatic stress reaction is possible for nurses because the nurse, while not directly in a life-threatening situation as is the patient, is forced to witness, and perhaps powerlessly, catastrophic events taking place at close hand in the lives of their patients. Because a relatively common experience for nurses is the sequential exposure to repeated trauma incidents, there is a longer-term psychological impact on nurses. It was further suggested that a psychological burden exists for individuals who have witnessed death, accident,

and trauma at first hand; and, this witnessing destroys the myth that the world is safe, predictable and secure, and that personal death is still far away. Davidson and Jackson (1985) state:

The traumatized individual constructing a domain of secret threat, gazes more clearly upon a different and harsher reality, because he has directly experienced it - that we may all be victim of an unpredictable, unjust, or unanticipated death, and that we all must live with the potential for death at any moment (p. 3).

Mental Health Professionals and AIDS-Related Bereavement

Mental health professionals have been involved in therapeutic care of individuals with HIV and with AIDS since the outbreak of the epidemic almost two decades ago. Due to the intimate nature and quality of the therapeutic relationship, some mental health professionals often become deeply attached to their clients with AIDS. Conversely, some mental health professionals, like physicians and nurses working with this population, respond to persons-with-AIDS with a fear of contagion, fear of death and dying, denial of helplessness, anger, homophobia, and the need for professional omnipotence (Dunkel & Hatfield, 1986).

Counselors and therapists working with this population work in the shadow of almost certain death. Bernstein and Klein (1995) state, “Although therapists can help patients to improve the quality of their remaining lifespans, they cannot solve their clients’ central problem-premature death” (p. 92). Knowing that, for individuals with AIDS, time is growing shorter, coupled with an inability to prolong life, often leaves professionals feeling impotent and defeated.

Mental health professionals working with individuals who are HIV positive or have AIDS are forced to examine and confront issues of finitude and death. Namir and Sherman (1989) state, “Perhaps the most salient issue that therapists working with persons with AIDS must confront is their own mortality” (p. 268). Most individuals do not face the inevitability of their own death, but live their lives using a system of denial and invulnerability (Namir & Sherman, 1989).

Death Anxiety

Farber (1994) suggested that practitioners are continually challenged to defend against death anxiety. Yalom (1980) defined death anxiety as man’s fundamental fear of death, of non-being, and of no longer existing. Viney, Henry, Walker and Crooks (1991) noted that the inevitable deaths of clients with AIDS confronted professionals with their own mortality and provided the prime source of death anxiety. One of the challenges encountered working with persons with AIDS is the onset of feelings of helplessness associated with underlying death anxiety (Farber, 1994).

Farber (1994) states:

Such a response is likely to be elicited not only by the fact that these patients are dying, but also by limits on the ability to provide significant relief from the overwhelming emotional distress that many patients experience. In this regard, as therapists witness the suffering of their patients, they are confronted with awareness of their own limits and finiteness (p. 720).

Bereavement Overload

One of the almost inevitable risks and hazards facing AIDS mental health work is the multiple and continuing losses of clients due to AIDS. Gabriel (1991) noted that new losses occur and accumulate without appropriate adaptive acknowledgement in therapists' lives. In discussing "bereavement overload," Dane (1995) stated, "The pervasive, unrelenting feelings of sorrow, loss, and abandonment can be overwhelming" (p. 281). Murphy and Perry (1988) identified care providers in the AIDS epidemic as "hidden grievers": individuals who face death, perhaps a number of times in each day, and still retain their composure and professional decorum, regardless of the cost to their personal feelings and thoughts. Perreault (1995) addressed the effects of multiple losses and offered, "It is virtually impossible to be fully present to the many HIV/AIDS-related losses faced by our clients, colleagues, and communities when their stories strike at the chords of our own undealt-with grief" (p. 34).

HIV Status of Providers

Whether the mental health professional is HIV-positive or HIV negative, or diagnosed with AIDS, may also have bearing upon the bereavement reactions. Dane (1995) suggested that it is common for survivors to endure multiple bereavements, and this experience is compounded for those professionals who are concurrently facing the imminence of their own death. Stress is multiplied for volunteer counselors who are HIV positive due to poor immune system function and bodily deterioration (Viney, Crooks, & Walker, 1995).

Kain (1996) noted that HIV-negative counselors are susceptible to survivor guilt, especially when clients feel that an uninfected person could not understand what it is like to be HIV positive or to have AIDS. Guilt is also experienced when professionals continue to live when their clients die and remain healthy when their clients are ill (Viney et al., 1995). Bereavement reactions may in fact be different dependent upon serostatus: that is, the state of being positive or negative for HIV antibodies.

Literature on Bereavement Reactions for Mental Health Professionals

To date, there is a conspicuous lack of empirical research addressing the bereavement reactions of therapists and counselors experiencing the loss of clients with AIDS. Silverman's (1993) article pointed out that of 372 articles referenced in an international annotated bibliography of the psychosocial impact of AIDS on health care providers by Eakin and Taylor (as cited in Silverman, 1983), published in 1990, only 5.4% appeared in journals from psychology; the majority of the literature comes from nursing, medicine, dentistry, public health, and health education. Of the articles that have been located, most have utilized descriptions, personal experiences, observations, anecdotal reports, and questionnaire surveys (Silverman, 1993).

In the book, The Second Decade of AIDS: A Mental Health Practice Handbook, Dane's (1995) chapter on the grief associated with caring of AIDS patients offers common responses of mental health professionals to multiple deaths from AIDS. The responses include apathy, helplessness, depression, anger, guilt, and loss of self-esteem. The author remarks that multiple losses are particularly difficult because practitioners come to discover that their system of beliefs and values have become ineffective.

As Dane (1995) does not expound on the aforementioned assertion, other AIDS investigators discuss practitioners' ineffectual belief and value systems in the face of deaths due to AIDS. Namir and Sherman (1989) write that the beliefs of therapists in the efficacy of their therapeutic skills, and therapeutic hope, may be diminished or destroyed with AIDS work. As losses accumulate, a sense of incompetence and powerlessness may emerge. In addition, Kain (1996) notes that the loss of faith in the future and a loss in the meaning of life are consequences of multiple loss. The core of what a therapist holds and values is often shaken and sometimes shattered as a result of facing loss after loss. The last statement refers to the psychological as well as religious and spiritual domains.

Gabriel's (1991) anecdotal and descriptive investigation of countertransference reactions of group therapists to multiple deaths from AIDS yielded informative findings. Mourning reactions included: issues of merged identifications (i.e., merging of boundaries between AIDS client and therapist, in that death, disability, and disfigurement become issues that exert impact on the therapist as well as the AIDS client); disidentifications (i.e., therapist's avoidance of topics of death and dying; detachment); denial of death and deaths; overwhelming feelings of helplessness, failure and guilt, leading to behaviors such as missed appointments or missed groups sessions, lateness, numerous self-revelations, isolation and displacement of anger (Gabriel, 1991). In a second study examining countertransference issues in group therapy with HIV and AIDS patients, Bernstein and Klein (1995) offer common reactions experienced by therapists who are dealing with dying clients and AIDS-bereavement. It was suggested

that therapists' reactions were depression, helplessness, death anxiety, emotional detachment and withdrawal, and anger.

While the previous meager findings provide descriptive information, there is an absence of empirical research addressing bereavement reactions of mental health practitioners. The literature reports potential deleterious effects of bereavement overload on therapists. Silverman (1993) states, "It is possible and in fact likely that the enormous stress of HIV-related work and the constant exposure to the suffering of people with HIV illness can lead to the onset of symptomatic disorders in some susceptible providers" (p. 706).

Counseling clients who are HIV positive or have AIDS can be physically, emotionally, and spiritually depleting (Kain, 1996). Dane (1995) remarks that professionals inevitably will experience significant distress when their emotional resources become depleted and they are unable to further give of themselves in a psychological sense. In addition, Namir and Sherman (1989) suggest that professionals are vulnerable in the face of losses, feared losses, and emerging existential anxiety concerning the issues of life and death, and this can lead to depression, phobic reactions, and burnout. Moreover, numerous authors caution of the existence and likelihood of burnout when working with this population. Perreault (1995) contends that burnout is an "occupational hazard," and occurs when professionals are not supported in

acknowledging and working through the impact of AIDS-related deaths. When a “burnout problem” exists, the professional’s ability to perform effectively becomes diminished (Perreault, 1995).

AIDS-related work can engender internal conflict in therapists, which may have lasting implications for the professional. Farber (1994) suggests that therapists who witness the suffering of patients with HIV/AIDS are challenged to examine their existing views of the world. This self-reflection often precipitates a “crisis of meaning” in the therapist, with related feelings of helplessness, hopelessness and despair. When there is a “crisis of meaning,” therapists may begin to question the meaning and value of the therapeutic endeavor, their professional role as a caregiver, and the ultimate usefulness of their profession (Farber, 1994). He states, “More broadly, an acute struggle about the meaning of life and human suffering may ensue, with accompanying emotional immobility that severely compromises professional functioning” (Farber, 1994, p. 721).

HIV/AIDS Caregivers’ Stress Syndrome

A circumscribed horror of working with individuals diagnosed with AIDS is the grim reality that the appearance and health of the person with AIDS will deteriorate as their immune system ceases to function. As time passes, the individual with AIDS will metamorphose physically, emotionally, and psychologically in the presence of the therapist. The cumulative effect of witnessing this over time and with many clients suffering with AIDS, is posited by the author of this investigation to have an enduring impact on the therapist. Death, for the therapist, represents the culmination of bearing

witness to a long period of painful, ravaging and disfiguring physical as well as psychological illnesses and difficulties.

Pearlman and Mac Ian (1995) present a definition of “vicarious traumatization,” that is, “the transformation that occurs with the therapist (or other trauma worker) as a result of empathic engagement with clients’ trauma experiences and their sequelae” (p. 558). Pearlman and Saakvitne (1995) suggest that this occurs as a result of listening to graphic descriptions of violent events, being exposed to people’s cruelty to one another, and participating in traumatic reenactments. Employing the descriptions by Pearlman and Mac Ian (1995) and Pearlman and Saakvitne (1995), counselors and therapists exposed to the psychological stress of working with AIDS individuals are subjected to trauma and represent survivors of traumatic life events. According to Pearlman and Mac Ian (1995), vicarious traumatization engenders changes in the therapist’s ways of experiencing self, others, and the world, while its effects permeate the therapist’s inner world and relationships.

Gabriel (1994) reports that mental health professionals who witness the narratives of those living with and dying from AIDS comprise a group experiencing what Figley termed “secondary trauma” (as cited in Gabriel, 1994) or McCann and Pearlman’s “vicarious trauma” (as cited in Gabriel, 1994). Her article suggests that group therapists who experience deaths of group members from AIDS are currently manifesting many of the traumatic stress symptoms observed in trauma survivors. Vignettes taken from supervision sessions with group therapists found that therapists experienced: (a) death images after group members’ deaths, (b) survivor’s guilt for their inability to save

people, (c) a “psychic numbing” with the diminished capacity to feel (resulting in patterns of withdrawal, apathy, depression, and despair), (d) the shattering of the survivor’s basic moral assumptions about the world (resulting in patterns of mistrust in human relationships as well as antagonism toward others), and (e) the struggle for meaning (i.e., a responsibility to the deceased to bear witness and a reestablishment of meaning in life).

Nord (1996) discusses the impact of multiple AIDS-related loss and the resultant traumatic stress responses that arise from the ongoing and unrelenting AIDS tragedy. He suggests that survivors of multiple AIDS-related loss suffer from symptoms that are consonant with the Diagnostic and Statistical Manual of Mental Disorders-IV (American Psychiatric Association, 1994) definition of post-traumatic stress disorder. Multiple-loss survivors find death permeating nearly all aspects of their lives and they experience intrusive symptoms (e.g., recurrent and intrusive images), avoidant symptoms (e.g., avoiding reminders of the trauma), and arousal symptoms (e.g., sleep, anger and arousal difficulties) (Nord, 1996). As Nord (1996) focuses on the client’s experience of multiple AIDS-related loss, his assertions appear consonant and applicable to mental health professionals who survive loss of clients due to AIDS.

Recent literature on the effects of AIDS-related bereavement on mental health professionals have suggested an HIV/AIDS caregivers’ stress syndrome, one that parallels the typical signs and symptoms of posttraumatic stress disorder (Silverman, 1993). The responses of individuals working with and having lost clients to AIDS

are exaggerated fears of contagion, recurrent nightmares and flashbacks, intrusive thoughts and dreams with images of death, relentless anxiety, avoidance of people with HIV/AIDS, swings between emotional numbing, flooding and detachment, and self-neglect and self-destructive behaviors (Perreault, 1995; Silverman, 1993). Currently, an empirical verification of this syndrome is absent, while this study seeks the defining characteristics of this HIV/AIDS caregivers' syndrome.

Mental Health Professionals: Unresolved and Pathological Grief

The mental health practitioner's professional role is that of helping, and it is from this role that the potential for unresolved and pathological grief reactions emerge when a client stricken with AIDS dies. Grounded in the bereavement theories of Lazare (1979) and Worden (1991), specific factors are identified which suggest and engender unresolved and pathological grief reactions of practitioners who have lost clients with AIDS.

Lazare (1979) and Worden (1991) posited psychological and social factors which contribute to unresolved and pathological grief. Although their postulates represent causal contributors to unresolved grief, they served as explanatory underpinnings for the present study, which questioned whether mental health professionals are susceptible to, and experience abnormal and pathological grief reactions subsequent to the death of a client with AIDS.

Psychological factors in unresolved grief germane to the present study are: guilt, reawakening of an old loss, and multiple loss. Lazare (1979) identified guilt as resulting from bereaved individuals' negative acts or feelings they had directed towards the

deceased, or things they had neglected or failed to do. Practitioners working with individuals with AIDS often harbor intense feelings surrounding not only the myriad of issues confronting their clients, but, due to personal biases, values, and morals concerning homosexuality, drug use, and promiscuity, to the client themselves. As each clinical case varies, as does the individual with AIDS, the practitioner may be over involved, ambivalent, or distant from their client. When a person with AIDS dies, feelings surface that are frequently reflective of the character and quality of the therapeutic relationship. Worden (1991) views abnormal grief reactions as resulting from relational factors: specifically, when the relationship with the deceased was characterized as ambivalent or dependent.

Often practitioners have a sense of impotence for not being able to affect or alter the final outcome for the client, that of death. Mental health practitioners suffer from guilt (Dane, 1995; Gabriel, 1991), and feelings of helplessness (Bernstein & Klein, 1995; Dane, 1995; Farber, 1994; Gabriel, 1991) when a client succumbs to AIDS.

Reawakening of an old loss, a second factor, refers to a reluctance to grieve because the current loss reawakens a significant and painful loss (i.e., any prior death) that has not yet been resolved (Lazare, 1979). Abnormal grief reactions also stem from an individual's inability to tolerate emotional distress, exhibited by avoiding feelings and emotional distancing (Worden, 1991). Not grieving an unresolved earlier loss, and perhaps adopting a coping strategy of avoiding all grief reactions, may be characteristic of practitioners forced to endure the loss of clients with AIDS on a daily basis. In order to survive in an environment that is constantly reacting and adjusting to loss and death,

practitioners may adopt psychological defenses to protect themselves from such loss.

Experiencing multiple losses presents the bereaved with difficulties in grieving and grief resolution (Lazare, 1979; Worden, 1991). The accumulation of multiple losses is one of the inescapable and detrimental certainties of providing therapeutic assistance for persons with AIDS. To date, there has been no empirical research aimed at examining the AIDS-related bereavement reactions of mental health professionals; however, descriptive reports have identified practitioners reactions of depression, isolation, withdrawal, anger, and death anxiety when clients die from AIDS (Bernstein & Klein, 1995; Dane, 1995; Gabriel, 1991; Namir & Sherman, 1989).

The social factors leading to abnormal grief reactions are a socially unspeakable loss, social isolation, and assumption of the role of the strong one (Lazare, 1979; Worden, 1991). When the loss is so “unspeakable,” members of the social system cannot be of any assistance to the bereaved (Lazare, 1979). AIDS continues to be the most “unspeakable” plague and tragedy of this society. It is often the case for practitioners experiencing the death of a client due to AIDS to feel isolated and withdrawn (Bernstein & Klein, 1995; Gabriel, 1991). Because of the unspeakable nature of AIDS, practitioners may lack supportive individuals who can truly understand and empathize with their loss and grief.

The second social factor notes when there are no existing social supports available for assistance, grief reactions can become exacerbated or inhibited (Lazare, 1979; Worden, 1991). The literature on AIDS-related bereavement suggests the essentialness and necessity of support groups for practitioners dealing with loss (Dane, 1995; Namir

& Sherman, 1989; Perreault, 1995). However, not every organization that offers HIV/AIDS related services have support groups for practitioners, and even when in place and operating, practitioners may be reluctant to participate and work through their grief. This reluctance may be due to denial, emotional distancing and withdrawal, death anxiety, and feelings of isolation.

The final social factor asserts that some individuals assume the role of being the strong one in their family and often these individuals miss the opportunity to deal with their own grief due to their assumption of this role (Lazare, 1979; Worden, 1991). When faced with the death of a client with AIDS, practitioners may adopt this role in order to maintain their professional demeanor and composure, and to safeguard their own feelings of grief. Moreover, this submerging of feelings and unaffected facade may lead to unresolved and pathological grief reactions.

Lindemann (1944) and Worden (1991) each offer a listing of abnormal grief reactions that appear relevant, and may be manifest when mental health practitioners lose a client to AIDS. The symptoms indicative of unresolved or complicated grief pertinent to the current investigation are: (a) the delay or postponement of reactions with little or no reaction for weeks or much longer, (b) development of a psychosomatic medical illness/intensified psychophysiologic reactions, (c) alteration in relationships with friends and relatives (i.e., a progressive social isolation), (d) hostility against persons connected with the death, (e) persistent loss of patterns of social interactions, (f) agitated depression (e.g., tension, agitation, insomnia, feelings of worthlessness, self-accusation,

self-punishment, and perhaps suicidal tendencies), (g) activities detrimental to one's social and economic existence, (h) a depressive syndrome marked by persistent guilt and lowered self-esteem, (i) developing phobias about illness or death, (j) diminished participation in activities (e.g., ritual and religious activities), and (k) making radical changes in one's lifestyle (Lindemann, 1944 & Worden, 1991). While this listing is not exhaustive, it does provide direction and substantiated indicators of abnormal grief.

Summary of Literature Review

As the review of the literature has shown, empirical research in the area of AIDS bereavement is modest. To date, the group most affected by the AIDS epidemic is the gay male community (Martin, 1988; Neugebauer et al., 1992); and, this group has received the greatest amount of research attention in terms of examining bereavement reactions (Biller & Rice, 1990; Lennon, Martin & Dean, 1990; Murphy & Perry, 1988; Neugebauer et al., 1992; Richmond & Ross, 1990; Sowell et al., 1991; Summers et al., 1995; Viney et al., 1991-92). This prior research, which began in the late 1980's, indicated that bereaved gay men who had lost a lover or close friends to AIDS, experienced intense and unique grief reactions due to the loss, and most frequently, as is the case, multiple losses. The accumulation of multiple losses has been identified as a major contributor to difficulties experienced with AIDS-related bereavement (Biller & Rice, 1990).

Studies have shown that bereaved gay men experiencing multiple losses are likely to evidence depression (Martin, 1988; Summers et al., 1995), anxiety and panic disorders (Summers et al., 1995; Viney et al., 1991-92), sleep problems, substance

abuse, symptoms of traumatic stress response (Martin, 1988), preoccupation with and searching for the deceased (i.e., strong urge to find, recover, and reunite with the deceased) (Neugebauer et al., 1992). As there is no cure for AIDS, the number of bereaved gay men experiencing loss and the myriad of grief reactions will continue to increase. Summers et al. (1995) noted while research has shown that multiple loss affects grief resolution, additional research needs to be aimed at understanding risk factors and physiological consequences associated with unresolved grief and chronic loss for gay men.

As the bulk of empirical research has primarily focused on the bereavement reactions of gay men, fewer studies, and of less rigorous research quality, have been undertaken with health care providers who serve the HIV/AIDS population. The research efforts, thus far, consist of survey and questionnaire methodology, and examine the attitudes and reactions of physicians and nurses working with this population (Blumenfield et al., 1987; Frierson & Lippmann, 1987; Frost et al., 1991; Richardson & Lochner, 1987; Rizzo et al., 1990; Treiber et al., 1987; Wallack, 1989).

Common themes have emerged from the literature. The findings indicate a fear of contagion (Blumenfield et al., 1987; Rizzo et al., 1990; Wallack, 1989), and emotional discomfort and anxiety (Treiber et al., 1987; Wallack, 1989). In addition, themes of helplessness and powerlessness of health care personnel were identified (Frierson & Lippmann, 1987; Frost et al., 1991). The singular survey study that examined grief reactions of physicians to the loss of AIDS patients, found that denial was an important defensive strategy for physicians (Frierson & Lippmann, 1987).

Although nurses and physicians are crucial in the care of symptomatic AIDS patients, the potential heavy toll that this work takes on these men and women apparently is not being addressed nor examined. Silverman (1993) charges that it is imperative to test hypotheses regarding the existence of undiagnosed occupational, physical, and psychiatric morbidity related to the stress of intensive HIV caregiving.

As the scant literature does not provide adequate descriptions of the impact of the death of patients with AIDS on physicians and nurses, health care professionals facing losses of clients with cancer were reviewed. The literature revealed that cancer caregivers experienced discomfort with exposure to death and dying, and often avoided dying patients and their families (Aderman, 1976; Gray-Toft & Anderson, 1981). A constellation of symptoms including guilt, anger, sadness, frustration, and hopelessness were identified as resulting from caring for cancer patients (Rafferty, 1983; Saunders & Valente, 1994; Weisman, 1981).

Similar to the bereavement overload experienced by AIDS-bereaved gay men, oncology nurses were affected by multiple deaths, and distanced themselves emotionally from their patients (Mount, 1986; Saunders & Valente, 1994). Stress was found to manifest itself in physicians' alcoholism (Rafferty, 1983; Vincent, 1982), drug addiction (Rafferty, 1983; Sakinofsky, 1980), suicide (Sakinofsky, 1980), and marital discord (Rafferty, 1983; Vincent, 1982).

AIDS bereavement literature has examined gay men and health care providers' reactions to deaths as a result of AIDS. As these endeavors have yielded important information, the group lacking empirical research is mental health professionals. This

study will focus on the mental health professionals who provide counseling and therapy for the population of individuals infected with HIV and diagnosed with AIDS.

Conspicuously absent in the AIDS bereavement literature are empirical investigations aimed at examining the practitioner's reactions to the death of clients with AIDS. The descriptive, anecdotal, and journalistic reports that address this issue, have offered relevant and incipient contributions that challenge researchers to engage in further investigation.

One of the overriding and inescapable dimensions of mental health work with persons with AIDS, is the confrontation with the inevitability of a client's death, often forcing practitioners to examine their own mortality (Bernstein & Klein, 1995; Dunkel & Hatfield, 1986; Namir & Sherman, 1989). The literature suggests that death anxiety may be aroused for mental health professionals (Bernstein & Klein, 1995; Faber, 1994; Viney et al., 1991).

Multiple losses of AIDS clients may contribute to bereavement overload (Gabriel, 1991; Perreault, 1995), and engender consequences and reactions such as: helplessness, depression, withdrawal, emotional detachment, and anger (Bernstein & Klein, 1995; Gabriel, 1991). Moreover, it is suggested that working with this population may have deleterious effects on the practitioner (Dane, 1995; Kain, 1996; Namir & Sherman, 1989; Perreault, 1995; Silverman, 1993). Burnout (Perreault, 1995), and personal and professional crises (Farber, 1994) are posited as potential hazards for the mental health professional engaged in providing therapeutic assistance.

Mental health professionals working with individuals with AIDS, like oncology nurses (Davidson & Jackson, 1985), are exposed to and witness first hand the degenerative course of a terminal illness. Pearlman and Mac Ian (1995) used the term “vicarious traumatization” to describe the trauma therapist’s experience in working with traumatized individuals. The prolonged and repeated exposure to patients with AIDS and the experience of having those patients die, is suggested in an HIV/AIDS caregivers’ stress syndrome (Perreault, 1995; Silverman, 1993). Anecdotal verification of traumatic stress reactions and AIDS-related loss was provided (Gabriel, 1994; Nord, 1996).

Finally, the bereavement propositions of Lazare (1979) and Worden (1991) were included to provide a theoretical grounding to illustrate specific psychological and social factors that contribute to unresolved and abnormal grief reactions. The symptoms delineating abnormal grief were also presented (Lindemann, 1944 & Worden, 1991). The aforementioned presentation illustrated how circumscribed factors and symptoms may be explanatory for mental health practitioners grief reactions following the death of a client with AIDS.

Conclusion and Purpose of Study

The void in the AIDS bereavement literature calls for empirical research that examines the reactions of mental health professionals when a client dies from AIDS. The present research was undertaken to examine the phenomenon of AIDS-related bereavement and the impact of client loss on practitioners. This exploratory study attempted to answer the questions related to the specific and unique reactions mental health professionals experience after the death of clients with AIDS.

Research Questions

1. Do mental health professionals experience a constellation of bereavement reactions subsequent to the death of a client(s) with AIDS? Is there a relation between the independent variable of client deaths (number and recency) and dependent variables of (a) grief (including past, present, and unresolved grief), (b) traumatic stress response (including intrusive, avoidant, and hyperarousal responses), (c) global severity of distress (including dimensions of somatization, obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism), and (d) satisfaction with life?
2. Does an HIV/AIDS Caregivers' Stress Syndrome (Silverman, 1993) exist for mental health professionals who lose a client(s) to death due to AIDS? This syndrome may resemble posttraumatic stress disorder (involving intrusive, avoidant, and arousal symptoms) in response to the death of a client(s) with AIDS.
3. Do mental health professionals who are HIV positive or have AIDS experience more severe reactions to the loss of a client(s) with AIDS than practitioners who are HIV-negative? This HIV variable will be examined as it relates to the measures of (a) grief (including past, present, and unresolved grief), (b) traumatic stress response (including intrusive, avoidant, and hyperarousal responses), (c) global severity of distress (including

somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoia, and psychoticism), and (d) satisfaction with life.

4. Do mental health professionals not involved in individual therapy or a support group for themselves experience more severe reactions to the death of a client(s) with AIDS than practitioners participating in individual therapy or a support group focusing on their own grief and loss issues? Mental health professionals will be assessed on (a) grief (including past, present, and unresolved grief), (b) traumatic stress response (including intrusive, avoidant and hyperarousal responses), (c) global severity of distress (including somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism), and (d) satisfaction with life.
5. To what extent do the demographics of gender, age, ethnicity, sexual orientation, academic degree, years worked with HIV/AIDS population, number of deaths, recency of death, suicide, non-client deaths, participation in personal loss/grief therapy, and percentage of HIV/AIDS clients relate to the measures of Past Behavior, Present Feelings, Unresolved Grief, traumatic stress response (i.e., total score), global severity of distress, and satisfaction with life?

Operational definitions. For the purpose of this study, the variables introduced in the research questions are operationalized in the following ways:

1. Severity of distress.

Severity of distress was assessed according to subjects' scores on the Brief Symptom Inventory (BSI) (Derogatis, 1993). Specifically, the Global Severity Index (GSI) is used as a single indicator of the respondent's distress level, combining information about numbers of symptoms and intensity of distress (Derogatis, 1993). Participants were also assessed on the nine symptom dimensions of the BSI: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

2. Traumatic stress response.

Traumatic stress response was assessed using the Impact of Event Scale-Revised (IES-R) (Weiss & Marmar, 1995). An index of traumatic stress response is provided by a total stress score, and three indices of intrusive, avoidant and hyperarousal symptoms.

3. Grief response.

Grief was measured by the Texas Revised Inventory of Grief (TRIG) (Faschingbauer, DeVaul, & Zisook, 1977). Three separate scores were provided that assessed past grief reactions, present grief reactions, and unresolved grief.

4. Satisfaction with life.

Satisfaction with life was assessed using the Satisfaction with Life Scale (SWLS) (Diener, Emmons, Larsen, & Griffin, 1985). A single score is produced which reflects a respondent's general life satisfaction.

Optional Question

1. "How have you changed since the death of a client(s) with AIDS?"

CHAPTER 3

Method

Participants

Ninety-six mental health professionals participated in the study. These individuals are bachelor (only two had less than a bachelor's degree), master's and doctoral-level practitioners from service organizations located throughout the United States who provide mental health services to individuals infected with HIV and who are diagnosed with AIDS. The National Directory of AIDS Care (1996-1997) provided the listing of nation-wide AIDS service organizations. This directory is a referral resource to assist care providers and professionals in locating services for all aspects of AIDS care. The directory contains listings of a variety of organizations (i.e., national, statewide, countywide, and local) that offer HIV/AIDS related services (e.g., mental health services, community services, health departments, home health care, hospice services, hospitals/ clinics, and testing sites).

All mental health professionals who participated in this study met the following criteria. Participants must be currently involved in providing at least one of the following (as listed in The National Directory of AIDS Care): mental health services, individual and/or group counseling/therapy, family therapy, and support groups, to individuals infected with HIV and those diagnosed with AIDS. For the purpose of this study counseling and therapy are broadly defined as all activities engaged in by the professional

with the intent of fostering psychological support, change, and growth in the emotional, cognitive and behavioral domains.

Procedures

Data collection. From the listing of national AIDS service organizations (i.e., The National Directory of AIDS Care: 1996-1997), four-hundred service agencies/organizations were selected at random that met at least one of the inclusion criteria: that is, listed as an agency/organization that provides mental health services, individual and/or group counseling/therapy, family therapy, and support groups. Prior to selection, the rationale was to randomly select eight service agencies/organizations from each of the 50 states (totaling 400) that met inclusion criteria. However, total number of AIDS service agencies/organizations varied by state (e.g., South Dakota – 5; California – approx. 600) and each state varied in number of agencies/organizations that provided mental health services (e.g., Rhode Island– 24 total agencies, 9 providing mental health services; Iowa – approx. 500 total agencies, approx. 60 providing mental health services). Thus, the number of agencies/organizations per state was adjusted down from the initial number of eight (with the intent of identifying at least five-six per state). States with a greater number of AIDS services were then assigned additional contact sites to achieve the 400 total. Moreover, states with few AIDS agencies/mental health services had few sites (e.g., Delaware, $\underline{n} = 3$) while states with numerous AIDS agencies/mental health services had more sites (e.g., Florida, $\underline{n} = 15$); the majority of states had about five to seven sites per state.

A questionnaire packet was mailed to the directors of the four-hundred agencies/organizations throughout the United States that provide mental health services to HIV infected individuals and persons with AIDS. Approval of the research study by the Institution Review Board of West Virginia University was granted prior to the mailing. A letter of introduction was included and explained the need and rationale for the study. The letter also detailed that the research fulfills the requirements for a doctoral dissertation, that participation in whole or in part in the research is voluntary, that the respondent has the right not to respond to every item, and that confidentiality and anonymity will be maintained. Additionally, the letter asked that the questionnaire be distributed to the practitioner most representative of the counseling staff in terms of service provision to HIV/AIDS clientele.

Each packet included the following materials:

- A. A cover letter (See Appendix A)
- B. A Demographic Questionnaire (See Appendix B)
- C. A copy of the following instruments:
 - 1. The Texas Revised Inventory of Grief.
 - 2. The Impact of Event Scale-Revised.
 - 3. The Brief Symptom Inventory.
 - 4. The Satisfaction with Life Scale.
- D. The optional question printed on a single sheet of paper.
- E. Self-addressed stamped envelope.

Respondents were asked to complete the survey and return it in the self-addressed stamped envelope.

Four hundred questionnaire packets were mailed the last week in October 1998. Forty-one packets were returned to sender for various reasons (e.g., not deliverable as addressed, unable to forward). Five weeks after the initial mailing reminder postcards (See Appendix C) were sent to all agencies/organizations that did not return the questionnaire. Eight reminder postcards were returned to sender following this second mailing. In all, 108 questionnaires were returned to the investigator (representing a 31% return rate). Of these, 12 were not usable resulting in a total of ninety-six completed questionnaires. In all, participants were represented from 44 states and the District of Columbia, with approximately two sites per state with the exception of California, Massachusetts, North Carolina, Ohio, Pennsylvania, and Texas which averaged 4.5 sites per state.

Measures

Texas Revised Inventory of Grief. The Texas Revised Inventory of Grief (TRIG) (Faschingbauer, DeVaul, & Zisook, 1977) was used to measure the past and present grief reactions of mental health professionals with respect to their loss of clients due to AIDS. The TRIG contains two sub-scales which measures grief following bereavement and a third section (Related Facts) that taps grief resolution. The two scales are: Past Behavior (a measure of past grief reactions) and Present Feelings (a measure of present grief reactions). The Past Behavior scale is composed of eight items that sample a variety of life events that might be disrupted by grief. This part of the instrument assessed

the respondents' initial reaction to the loss of a client(s) through death to AIDS. Each item is scored on a 1 to 5 Likert scale, with the higher score suggesting a more intense response to the loss and a higher intensity of grieving. The possible responses for each item include "completely true" (scored as 5), "mostly true" (scored as 4), "partly true" and "partly false" (scored as 3), "mostly false" (scored as 2) and "completely false" (scored as 1). The Present Feelings scale is composed of 13 items rated on the same Likert scale and measures thoughts, feelings, memories, opinions and attitudes with respect to the respondent's current feelings about the loss. This part assessed the respondents' current grieving over the death of a client to AIDS. Faschingbauer, Zisook, and DeVaul (1987) presented normative data for various time points following the death of a loved one. Mean scores from the first year post bereavement served as cutoff scores for the present study: Past Behavior, $\underline{M} = 15.7$, $\underline{SD} = 0.9$; Present Feelings, $\underline{M} = 34.2$, $\underline{SD} = 1.5$ (Faschingbauer et al., 1987).

The Unresolved Grief Index (Zisook & DeVaul, 1983) is derived from Part 3 (Related Facts) of the TRIG. Zisook and DeVaul (1983) extracted and augmented three items from Part 3 that, based on their clinical experience, identifies and characterizes unresolved grief. These three items were utilized to determine resolved grievers from unresolved grievers. The Unresolved Grief Index includes three items: (a) "I feel I grieved for the person who died," (b) "I feel I have adjusted well to the loss," and (c) "Now I can talk about the person without discomfort." Each question is answered by using a 4-point Likert scale (0 = "completely true;" 1 = "mostly true;" 2 = "partly true;" "partly false;" 3 = "mostly false;" 4 = "completely false"). The less a respondent agrees

with the three items, the more likely the respondent will meet criteria for unresolved grief. Scores of six or more on the Unresolved Grief Index indicate unresolved grief. The Unresolved Grief Index has been designed to differentiate an intensified, longer term response to loss which may lead to adjustment complications from the more typical grief process, where feelings of disbelief and dysphoria subside over time (Schueter & Zisook, 1993). Zisook and DeVaul (1983) note that the Unresolved Grief Index, while clinically-based, has not been scrutinized for its psychometric properties. However, there is a relation between depression and unresolved grief, and the stability of this relation over time appears to partially validate the scale (Zisook & DeVaul, 1983).

Content and psychometric properties of the TRIG scales have been presented by Faschingbauer et al. (1987). Original tests of reliability for each part found that the alpha coefficient for Part I, Past Behavior, was .77, and the split-half reliability was .74; and, for Part II, Present Feelings, the alpha coefficient was .86, and the split-half reliability was .88. A replication sample (sample size: $N = 145$) indicated that the coefficient alpha for Part I increased to .87, and for Part II to .89; split-half reliability was .79 for Part I, and .82 for Part II (Faschingbauer et al., 1987). Boyer and Hoffman (1993) found alpha coefficients of .79 and .82 for Past Behavior and Present Feelings, respectively, in their study.

Adequate construct validity of both subscales of the TRIG was suggested by Faschingbauer et al. (1987). Construct validity for Part I was substantiated by testing hypotheses about loss. Specifically, it was hypothesized that females, who traditionally have been rewarded for dependency on others and who often are financially dependent

on their husbands' incomes, would suffer greater life disruption following a death than males, whose life training and culturally stereotyped role behavior encourages self-efficiency. It was shown that females demonstrated significantly higher scores on Part I than males. A second hypothesis was supported in that Part I scores were significantly higher for bereaved subjects where the deceased was a younger (< 30) adult than for those where an older family member had died (> 75) (Faschingbauer et al., 1987). Similarly, construct validity for Part II was assessed by testing two distinct hypotheses. First, it was hypothesized that bereaved females would score higher than males, since emotional awareness and expression has traditionally been suppressed among Western males, and secondly, that spouses, due to greater closeness, would likely experience greater levels of grief than would other non-blood relatives. Both hypotheses were supported as females scored higher on Part II than males, and spouses experienced greater levels of grief than did non-blood relatives (Faschingbauer et al., 1987).

The TRIG was developed and written with respect to the death of a loved one. In the original development of the TRIG, an expanded version of the present questionnaire was administered to 260 individuals from all areas of the United States who had experienced the death of a "loved one." Although the initial sample approximated demographics from the United States 1975 Census, the initial experimental sample contained more older persons, females, blacks, and members of upper income families than did the census (Faschingbauer et al., 1987).

For the purpose of the present study, the directions were modified to reflect the death of a client to AIDS.

Impact of Event Scale-Revised. The Impact of Event Scale-Revised (IES-R) (Weiss & Marmar, 1997) is a 22-item Likert-rating scale representing a revision of the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979). The Impact of Event Scale is a 15-item Likert-rating scale that assesses an individual's emotional distress in response to stressful life events. The IES was originally developed as a means to evaluate the degree of subjective distress experienced as a result of a specific stressful life event (Horowitz et al., 1979). The original study with the IES was conducted with 66 adults from an outpatient clinic seeking treatment as a result of reactions to a serious life event (e.g., bereavement, accidents, violence, illness or surgery) and a group of medical students (related to their first experience with a cadaver) (Horowitz et al., 1979). Horowitz et al. (1979) produced a self-report measure that could be anchored to any specific life event and that tapped the two most commonly reported categories of experiences in response to stressful events: "intrusion" (intrusively experienced ideas, images, feelings, or bad dreams) and "avoidance" (consciously recognized avoidance of certain ideas, feelings, or situations) (Zilberg, Weiss, & Horowitz, 1982).

Although the original IES is documented for its usefulness, validity and reliability in assessing psychological response to traumatic events, Weiss and Marmar (1997) concluded that a complete assessment of response to traumatic events required the inclusion of hyperarousal symptoms. Weiss and Marmar (1997) have revised the IES by adding six new items (targeting anger and irritability; jumpiness and exaggerated startle response; trouble concentrating; psychophysiological arousal; and hypervigilance), and

by reassigning an existing intrusion item (“I had trouble falling asleep”) to the new Hyperarousal subscale. These seven items tap the hyperarousal symptoms that are part of the DSM-IV (APA, 1994) diagnostic criteria of posttraumatic stress disorder. In addition, the IES-R contains one new intrusion item tapping flashback-like experiences. Despite the minor modification (i.e., reassignment of the intrusion item), the addition of the six hyperarousal items and additional item tapping flashback-like experiences, the Intrusion and Avoidance subscales of the IES-R remain the same as in the original IES (Weiss & Marmar, 1997).

Two additional changes are found with the IES-R. Respondents are asked to indicate the intensity of response rather than frequency of symptoms, and the response format is modified to a 0-4 scoring rather than the original scoring scheme of 0, 1, 3, and 5. Subscale scoring is also modified to the mean of the non-missing items. These modifications will permit comparability across the IES-R and the Symptom Checklist 90-Revised, and will enhance the validity and utility of the IES-R (Weiss & Marmar, 1997).

Respondents are asked to report the degree of distress of the intrusive, avoidant and arousal reactions that occurred during the prior seven days: “Not at all” (scored as 0), “A little bit” (scored as 1), “Moderately (scored as 2), “Quite a bit” (scored as 3), and “Extremely” (scored as 4). The intrusion subscale contains seven items characterized by spontaneous thoughts and images, troubled dreams, strong pangs or waves of feelings, and repetitive behavior (Horowitz et al., 1979). Scores for the intrusion subscale range from 0 to 28 and are the sum of the ratings on the following items: 1, 2, 3, 6, 9, 16, 20.

Avoidant responses include ideational constriction, denial of the meaning and consequences of the event, blunted sensation, behavioral inhibition, and awareness of emotional numbness (Horowitz et al., 1979). Scores range from 0 to 32 for the avoidant subscale, computed by adding the ratings on the following items: 5, 7, 8, 11, 12, 13, 17, 22. Hyperarousal responses include anger and irritability, jumpiness and exaggerated startle response, trouble concentrating, psychophysiological arousal, and hypervigilance (Weiss & Marmar, 1997). Score for the hyperarousal subscale range from 0 to 28 and are the sum of the ratings on the following items: 4, 10, 14, 15, 18, 19, 21. Higher scores suggest greater stress. A Total scale score is provided by combining all three subscale scores (range is 0-88). To date, there are no cutoff scores to indicate low, medium, or high scores on the IES-R.

The psychometric properties of the original IES have been documented. The split-half reliability of the total scale was .86; internal consistency of the subscales, calculated by Cronbach's alpha, was .78 (Intrusion) and .82 (Avoidance) (Horowitz et al., 1979). The reliability of the scale was supported by test-retest results of .87 for the total stress scores, .89 for the intrusion subscale, and .79 for the avoidance subscale (Horowitz et al., 1979). Reliability was further substantiated by Zilberg et al. (1982); internal consistency (Cronbach's alpha) for intrusion was .79-.92, and .82-.91 for avoidance (completed for each group and pooled across three assessment times).

Construct validity for the IES resulted from the construction of the subscales. A primary cluster of items were based upon clinical observation and inference, and from this pool of items coherent clusters emerged which clinically comprised the intrusion

and avoidance subscales (Horowitz et al., 1979). Studies establishing criterion validity are found in the literature and follow (J. R. Scotti, personal communication, 1998). McFall, Smith, Roszell, Tarver, and Malas (1990), in a study with Vietnam combat veterans, identified correlations of the IES (Intrusion/Avoidance/ Total) with other measures: IES correlations with the Structured Clinical Interview (SCID-R) and a severity rating: .48/.32/.48; IES correlations with the Mississippi Scale (MS): .56/.29/.53; and IES correlations with the Keane PTSD scale: .33/.21/.33 (all significant, $p < .001$, except IES/Avoidance with Keane PTSD was non-significant). Shalev, Peri, Canetti, and Schreiber (1996; as cited in Shear et al., in press) found that IES scores, one week post-trauma (i.e., 61 adults admitted to Israel hospital following accidents, assaults and terrorist acts), predicted PTSD as determined by the Structured Clinical Interview (SCID) at six months post-trauma. At Time 1 (one week post-trauma) IES intrusion scores were greater for individuals with PTSD than Non-PTSD; no differences were found with IES-avoidance scores. Impact of Event Scale/avoidance scores increased from Time 1 to Time 2 (six months post-trauma) for the PTSD group.

Psychometric properties of the Impact of Event Scale-Revised have also been documented. Internal consistency of the three subscales is very high. Weiss and Marmar (1997) present a summary of four sets of estimates of internal consistency based on two studies. Internal consistency of the subscales for study one, calculated by Cronbach's alpha, was .91 (Intrusion), .84 (Avoidance), and .90 (Hyperarousal), and, for Time 2 data: .92 (Intrusion), .85 (Avoidance), and .89 (Hyperarousal). Internal consistency of the subscales for study two by Marmar et al. (as cited in Weiss & Marmar, 1997) for the

Time 1 data, calculated by Cronbach's alpha, was .87 (Intrusion), .85 (Avoidance), and .79 (Hyperarousal), and, for Time 2 data: .87 (Intrusion), .86 (Avoidance), and .79 (Hyperarousal). The reliability of the IES-R was supported by test-retest data for both studies. The first study yielded test-retest correlation coefficients of .94 for the intrusion subscale, .89 for the avoidance subscale and .92 for the hyperarousal subscale (Weiss & Marmar, 1997). For the second study of Marmar et al. (as cited in Weiss & Marmar, 1997), test-retest correlation coefficients were: .57 for the intrusion subscale, .51 for the avoidance subscale and .59 for the hyperarousal subscale.

For the purpose of the current study the directions were reworded to directly assess the stressful event of having a client die from AIDS.

Brief Symptom Inventory. The Brief Symptom Inventory (BSI) (Derogatis, 1993) is a 53-item self-report symptom inventory designed to assess specific symptom domains and overall psychological distress of individuals across various categories (i.e., psychiatric patients, medical patients, and individual in the community who are not currently patients). The BSI is essentially an abbreviated form of the Symptom Checklist-90-Revised (SCL-90-R), a self-report inventory that has been developed and used in a wide variety of settings and applications (Derogatis & Melisaratos, 1983). The BSI is very highly correlated with the SCL-90-R across the nine primary symptom dimensions (correlations .92 - .99), based on a sample of 565 psychiatric outpatients (Derogatis, 1993). There are four published norms available for the BSI. These are based upon: (a) a sample of 1,002 psychiatric outpatients, (b) a sample of 974 adult non-patient normal subjects, (c) a sample of 423 adult psychiatric inpatients, and

(d) 2,408 adolescent non-patients (Derogatis, 1993).

The BSI yields nine specific symptom scales: somatization (SOM), obsessive-compulsive (O-C), interpersonal sensitivity (I-S), depression (DEP), anxiety (ANX), hostility (HOS), phobic anxiety (PHOB), paranoia (PAR), and psychoticism (PSY). In addition to the nine primary symptom dimensions, there are three global indices of distress associated with the BSI: the General Severity Index (GSI), the Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST). Each of these global measures is designed to communicate in a single score the level or depth of symptomatic distress currently experienced by the individual. The GSI is the best indicator of the respondent's distress level and is calculated by adding the sums for the nine symptom dimensions (and additional four items) and then dividing by the total number of responses. The PSDI is a pure intensity measure and provides information about the average level of distress the respondent experiences, and is calculated by dividing the sum of the item values by the PST. The PST reveals the number of symptoms the patient reports experiencing and is derived by counting the number of items endorsed with a positive (nonzero) response (Derogatis, 1993; Derogatis & Melisaratos, 1983). For the purpose of this study only the GSI has been used.

For each of the 53 items, the respondent is asked to indicate "How much that problem has distressed or bothered you during the past seven days including today", on a 5-point scale of distress (0-4). The descriptors are: "not at all" (0), "a little bit" (1), "moderately" (2), "quite a bit" (3), and "extremely" (4). The BSI is scored and profiled in terms of nine primary symptom dimensions and three global indices of distress

(Derogatis, 1993). Raw scores for the nine symptom dimensions and three global indices are converted to standardized T-scores. Derogatis et al. (1993) reported that a GSI score greater than or equal to a T score of 63 (or any two dimension scores greater than or equal to a T score of 63) is considered a positive diagnosis or a positive case.

The psychometric properties of the BSI are well established. The BSI has demonstrated high levels of internal consistency and test-retest reliability. Derogatis et al. (1993) reported coefficient alphas between .71 and .85 for the nine symptom dimensions and test-retest coefficients between .68 and .91. The GSI revealed an excellent test-retest coefficient of .90, providing strong evidence of consistent measurement across time (Derogatis et al., 1993). In a study on bereavement, Moriarty, Carroll, and Cotroneo (1996) found coefficient alphas for the nine subscales ranging from .66 to .89 and a coefficient alpha of .96 for the GSI.

Convergent validity has been established for the BSI. High convergent validity was found between the nine dimensions of the BSI and the clinical scales of the Minnesota Multiphasic Personality Inventory (MMPI) (Derogatis et al., 1993; Derogatis & Milisaratos, 1983). High correlations were also found between the BSI and the SCL-90-R across the nine primary symptom dimensions they share (Derogatis et al., 1993). Construct validity was provided through a factor analysis lending additional weight to the validity of the BSI (Derogatis & Milisaratos, 1983). Predictive validity is also well established (Derogatis, 1993).

The BSI, while psychometrically sound, has been used with many different populations. Importantly, the BSI has been utilized in studies of bereavement (Bachar, Canetti, Bonne, Denour, & Shalev, 1997; Mireault & Compas, 1996; Moriarty, Carroll, & Cotroneo, 1996; Prigerson et al., 1995; Shanfield, Benjamin, & Swain, 1984; Gilbar & Dagan, 1995), and bereavement and AIDS (Goodkin, Blaney, Tuttle, & Nelson, 1996; Kelly, Raphael, Statham, & Ross, 1996).

Satisfaction with Life Scale. The Satisfaction with Life Scale (SWLS) (Diener, Emmons, Larsen, & Griffin, 1985) is a 5-item measure that reveals an individual's own judgment of his or her quality of life. This evaluation is a subjective judgment, rather than a judgment based on some externally imposed objective standard (Diener et al., 1985). The SWLS refers to the cognitive-judgmental aspects of general life satisfaction.

Each item is scored from 1 to 7; the anchor points for the 7-point scale are: "strongly disagree" (1), "disagree" (2), "slightly disagree" (3), "neither agree nor disagree" (4), "slightly agree" (5), "agree" (6), and "strongly agree" (7) (Pavot, Diener, Colvin, & Sandvik, 1991). Item scores are summed for a total score, which ranges from 5 to 35, with higher scores reflecting more satisfaction with life.

In the initial report on the psychometric properties of the SWLS, the instrument's internal consistency was good, with an alpha coefficient of .87. The SWLS also appeared to have good test-retest reliability, with a correlation of .82 for a two-month period (Diener et al., 1985). The instrument was tested for convergent validity using two samples of college students (the mean score on the SWLS was 23.5, with a standard deviation of 6.43). For both samples, scores correlated with a battery of subjective

measures of well-being: that is, the Fordyce Scale (1978), the Gurin Scale (1960), Cantril's (1965) Self-Anchoring Ladder, and Andrews, Withey's (1976) Delighted-Terrible Scale and Bradburn's (1969) Affect Balance Scale (as cited in Diener et al., 1985). In addition, the psychometric properties were assessed with a geriatric population (average age 75). The mean SWLS score for this sample was 25.6. Scores on the SWLS also correlated with independent ratings of life satisfaction among the elderly (i.e., the Life Satisfaction Index and independent ratings) (Diener et al., 1985).

Two studies were designed to provide further validation for the SWLS, using both a sample of elderly persons and a college student sample (Pavot et al., 1991). The results for the geriatric sample indicated a mean score of 24.44 for the first administration and 24.05 for the second administration (standard deviations were 6.99 and 7.82, respectively). The average coefficient alpha was .83. The results of Study 1 also offered considerable evidence for convergent validity of the SWLS with other self-report measures of life satisfaction (e.g., Life Satisfaction Index-A: $r = .82$; Fordyce Global Happiness Scale: $r = .68$; and Philadelphia Geriatric Center Morale Scale: $r = .65$), peer reports of life satisfaction (e.g., peer SWLS: $r = .54$; peer Fordyce: $r = .51$; and peer Life Satisfaction Index-A: $r = .51$), and a memory measure (e.g., Memory Measure of Satisfaction: $r = .42$) (Pavot et al., 1991).

The second study was comprised of undergraduate students and the mean scores for the three administrations were 23.37, 25.37 and 24.73 (standard deviations were 6.53, 5.95, and 6.29, respectively). Test-retest reliabilities for the two-week intervals averaged .84 and for one month was .84. The average coefficient alpha obtained was .85. As in

Study 1, good convergent validity was demonstrated (e.g., with the SWLS and the Affect Dominance Scale) (Pavot et al., 1991).

Demographic data. All respondents were asked to complete demographic information (respondents were informed that confidentiality and anonymity will be maintained). The demographic questionnaire addressed such issues as: gender, age, ethnic background, sexual orientation, education (i.e., academic degree), academic training (e.g., counseling psychology, clinical psychology, mental health counseling, and social work), theoretical orientation, HIV/AIDS status, length of time working with HIV/AIDS population (i.e., years), number of client deaths due to AIDS, number of suicides of clients with HIV/AIDS, non-client deaths during the past year (e.g., family members, spouse/ significant other, child, friends with HIV/AIDS), participation in individual therapy or support group for grief/loss issues, type of work with HIV/AIDS clients (e.g., individual counseling, group counseling), work setting, percentage of clients with HIV/AIDS, and recency of death.

Optional question. At the end of the survey a single sheet of paper was included with the question, “How have you changed since the death of a client(s) with AIDS?” While the question was noted as optional, respondents were asked to provide an answer in writing.

CHAPTER 4

Results

The measures obtained of relevance to the research questions included demographic characteristics and four instruments. These four instruments and their subscales were (a) the Texas Revised Inventory of Grief: TRIG (Past Behavior, Present Feelings, and Unresolved Grief Index), (b) the Impact of Event Scale-Revised: IES-R (Intrusion, Avoidant, and Hyperarousal), (c) the Brief Symptom Inventory: BSI (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoia, and Psychoticism), and (d) the Satisfaction With Life Scale: SWLS.

The demographic characteristics of the participants are presented in Tables 1 and 2. A total of 96 mental health professionals participated in the study. Of the participants, 35 were male and 61 were female. Participants were predominately Caucasian (92%) with minimal racial diversity among the remaining participants: Black (4%), Hispanic (2%), Asian (1%), and American Indian (1%). Participants ranged in age from 28 to 66 years with a mean of 43.3 years of age ($SD = 8.6$).

The majority of respondents (60.4%) possess a Master's degree with 10% of the participants having earned a Doctoral degree; 27% indicated having a Bachelor's degree and 2% reported education below the Bachelor's degree. Fifty-one respondents (53.1%) identified themselves as heterosexual. Nearly one-half of the participants ($n = 43, 44.8\%$)

Table 1

Demographic Characteristics of the Participants (N = 96), Frequencies

Characteristic	Frequency	Column percent
Gender		
Male	35	36.5
Female	61	63.5
Ethnicity		
White	88	91.7
Black	4	4.2
Hispanic	2	2.1
Asian	1	1.0
American Indian	1	1.0
Degree		
< Bachelor's	2	2.1
Bachelor's	26	27.1
Master's	58	60.4
Doctorate	10	10.4

(table continues)

Table 1 (continued)

Characteristic	Frequency	Column percent
Sexual orientation		
Heterosexual	51	53.1
Gay	25	26.0
Lesbian	18	18.8
Bisexual	1	1.0
Did not indicate	1	1.0
HIV status		
HIV negative	83	86.5
HIV positive	3	3.1
AIDS diagnosis	2	2.1
Not known	6	6.3
Prefer not to indicate	2	2.1
Academic training		
Social work	35	36.5
Mental health counseling	13	13.5
Counseling psychology	11	11.5

(table continues)

Table 1 (continued)

Characteristic	Frequency	Column percent
Clinical psychology	6	6.3
Registered nurse/psychiatric nurse	6	6.3
Pastoral/divinity counseling	3	3.1
Psychiatry	3	3.1
Marriage/family counseling	2	2.1
Other (combinations)	17	17.5
Theoretical orientation		
Eclectic	28	29.2
Family systems	17	17.7
Humanistic	16	16.7
Behavioral	7	7.3
Cognitive	5	5.2
Humanistic/family systems	5	5.2
Cognitive-behavioral	3	3.1

(table continues)

Table 1 (continued)

Characteristic	Frequency	Column percent
Psychodynamic	3	3.1
Transtheoretical	1	1.0
Solution focused	1	1.0
Other (combinations)	10	10.3
Work setting		
AIDS center/project	25	26.0
Community mental health	14	14.6
Health department	10	10.4
Hospital	9	9.4
AIDS center/private practice	5	5.2
AIDS center/health department	4	4.2
Private practice	4	4.2
Community mental health/ private practice	3	3.1
Outpatient agency	3	3.1
Hospice/nursing home	3	3.1

(table continues)

Table 1 (continued)

Characteristic	Frequency	Column percent
Addiction treatment center	1	1.0
Other (combinations)	14	15.6
Type of work		
Individual counseling/case management	18	18.8
Case management	17	17.7
Individual counseling	12	12.5
Individual/group/couples counseling	10	10.4
Individual/group/case management	10	10.4
Individual/group/couples/case management	9	9.4
Individual/couples counseling	6	6.3
Group/case management	5	5.2
Individual/medication treatment	2	2.1
Group counseling	1	1.0
Other (combinations)	6	6.1

(table continues)

Table 1 (continued)

Characteristic	Frequency	Column percent
Non-client deaths during last year (e.g., family, friends with or without AIDS)		
No	39	40.6
Yes	57	59.4
Participation in individual therapy		
No	72	75.0
Yes	24	25.0

Table 2

Demographic Characteristics of the Participants (N = 96, except as noted), Means

Characteristic	<u>M</u>	<u>SD</u>	Range
Age of mental health professional	43.3	8.6	28 - 66
Years worked with persons with HIV/AIDS	8.9	4.3	1 - 18
Percentage of clients with HIV/AIDS	61.9	41	2 - 100
Number of deaths from AIDS (<u>n</u> = 90) (<u>Mdn</u> = 13.50) ^a	45.5	85.1	1 - 500
Number of suicides of clients with HIV/AIDS (<u>n</u> = 31)	1.1	3.2	1 - 25

Note. ^aMdn = median number of client deaths from AIDS.

identified themselves as gay ($n = 25$, 26%) or lesbian ($n = 18$, 18.8%); one identified as bisexual, and one did not indicate sexual orientation.

Most of the participants ($n = 83$, 86.5%) were HIV negative; three reported they were HIV positive, and two indicated that they have an AIDS diagnosis. Six participants did not know their HIV status and two checked that they prefer not to indicate their HIV status. The participants worked on average about nine years with persons with HIV/AIDS ($M = 8.9$, $SD = 4.3$), with a range of one to 18 years.

The respondents were trained in various academic programs. As may be noted in Table 1, in descending order of frequency, the academic programs were: social work, mental health counseling, counseling psychology, clinical psychology, nursing, pastoral/divinity counseling, psychiatry, marriage/family counseling, psychiatric nursing, and the remainder with combinations of the above academic training. Almost one-third of the participants ($n = 28$) reported their theoretical orientation as eclectic, with family systems, humanistic, behavioral, and cognitive representing the other major theoretical orientations of the participants.

Many of the participants (26%) worked exclusively in an AIDS Center or AIDS project, while other participants reported working in a community mental health center, health department, hospital, private practice, hospice/nursing home, outpatient agency, and addiction treatment center; the rest worked at combinations of the above work settings. The participants reported providing a variety of counseling and supportive services. The main types of work with HIV/AIDS clients were individual counseling/case management (19%), case management (18%), and individual counseling (13%).

Ninety participants reported having at least one client die from AIDS (Median = 13.50, SD = 85.07), with a range of 1 to 500 deaths. One third of the participants (n = 31) reported having a client(s) with HIV/AIDS commit suicide, with an average of 1.13 (SD = 3.21) reported suicides. The majority (n = 57, 59.4%) of participants indicated that they had a non-client death within the last year (e.g., family member, family member with AIDS, friends, friends with AIDS). Finally, one-fourth of the participants were involved in some form of therapy (i.e., individual therapy, group therapy, or a support group) to address and deal with their own grief and loss issues related to the death of clients with AIDS.

The study was designed to examine the reactions of mental health professionals when a client dies from AIDS. Moreover, this research attempted to answer the question of what specific and unique reactions mental health professionals experience after the death of clients with AIDS. The five research questions posed related to (a) number and recency of death, (b) HIV/AIDS caregivers' stress syndrome (Silverman, 1993), (c) HIV status, (d) individual therapy/support group participation, and (e) demographic characteristics as related to bereavement and psychological reactions. These five research questions are repeated below and addressed through the reported analyses.

Because of the exploratory nature of the study, a .05 significance level was used in all analyses. Although there is a potential for Type I error because of the number of comparisons, it seemed appropriate at this stage of AIDS-related bereavement research with mental health professionals to be more liberal and allow for the discovery of new information, with the hope of generating areas for future investigation.

Research Question 1

Do mental health professionals experience a constellation of bereavement reactions subsequent to the death of a client(s) with AIDS? Is there a relation between the independent variable of client deaths (number and recency) and dependent variables of (a) grief (including past, present, and unresolved grief), (b) traumatic stress response (i.e., total score, including intrusive, avoidant, and hyperarousal responses), (c) global severity of distress (including dimensions of somatization, obsessive-compulsive symptoms, interpersonal sensitivity, depressions, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism), and (d) satisfaction with life?

Although number of deaths was irregularly distributed across the range from 1 to 500 deaths, correlations were computed between raw number of deaths and Past Behavior, Present Feelings, Unresolved Grief, traumatic stress response (i.e., IES-R total score, including Intrusive, Avoidant, and Hyperarousal scales), and global severity index (including Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism scales), and Satisfaction with Life (means and standard deviations for all measures are reported in Table 3). None of these correlations yielded a significant finding. Thus, it appears that number of deaths of clients with AIDS is not related to bereavement or psychological distress.

To further address this question, the numbers of client deaths were divided into two categories (i.e., 1 to 10 deaths and 11 to 500 deaths) for additional analyses.

Table 3

Means, Standard Deviations, and Range for Research Instruments

Measures	<u>M</u>	<u>SD</u>	Range
Texas Revised Inventory of Grief (<u>n</u> = 90)			
Past Behavior	13.9	5.4	8 - 32
Present Feelings	25.4	8.6	13 - 48
Unresolved Grief Index	2.1	1.6	0 - 7
Impact of Event Scale-Revised (<u>n</u> = 90)			
Traumatic Stress Response (total score)	.39	.47	0 – 2.5
Intrusive Symptoms	.57	.62	0 – 2.7
Avoidant Symptoms	.36	.50	0 – 2.4
Hyperarousal Symptoms	.23	.40	0 – 2.4
Brief Symptom Inventory (<u>N</u> = 96) (T-scores)			
Global Severity Index	50.3	12.2	33 - 80
Somatization	48.7	9.3	41 - 78
Obsessive-Compulsive	53.1	11.9	41 - 80
Interpersonal Sensitivity	51.1	10.4	41 - 80
Depression	52.7	10.2	42 - 80

(table continues)

Table 3 (continued)

Measures	<u>M</u>	<u>SD</u>	Range
Anxiety	49.6	10.7	38 - 80
Hostility	50.3	8.9	39 - 80
Phobic Anxiety	49.8	7.5	38 - 80
Paranoid Ideation	49.8	10.6	38 - 80
Psychoticism	54.6	9.5	41 - 80
Satisfaction with Life Scale (<u>N</u> = 96)	25.96	6.18	8 - 35

This distribution resulted in 40 and 50 participants in these two groups respectively. This grouping was used to determine if significant relations exist between number of deaths of clients and bereavement and psychological reactions. Correlations were computed for this dichotomous variable representing few deaths versus many deaths with indices of grief, traumatic stress (including three subscales), global severity of distress (including nine symptom dimensions), and satisfaction with life. Of the indices, only the Avoidant subscale yielded a significant correlation with number of deaths, $r(90) = .21$, $p < .05$. Other correlations did not indicate significant relations. Thus, greater number of deaths of clients with AIDS (i.e., 11 to 500 deaths) appears to be related to one of the three components of a traumatic stress response, an avoidant response.

Recency of a death is also of concern in this research question. When the five categories of months (i.e., 0-3 mo., 4-6 mo., 7-9 mo., 10-12 mo., and >12 mo.) since most recent death was used as a variable to compute correlations with indices of grief, traumatic stress, psychological distress, and satisfaction with life, no significant correlations were obtained. The categories, as would be expected, showed widely varying frequencies of participants with six participants in the smallest category (7-9 mo.) and 38 (0-3 mo.) in the largest. Accordingly, this largest category (0-3 mo., [$n = 38$]) was contrasted with all the remaining categories (> 4 mo., [$n = 52$]) to form the recency variable in supplemental analyses. This dichotomizing was also based on Middleton's (1995, as cited in Wilson & Keane) research which suggests that there is a major decline in bereavement phenomenology after 3-4 months.

In subsequent analyses of variance (ANOVAs) with this recency variable and measures of grief, traumatic stress, psychological distress, and satisfaction with life, a significant difference was found between groups for satisfaction with life. The results indicate that participants reporting recency of a client's death greater than four months had significantly higher scores on the Satisfaction with Life Scale than participants reporting recency of a client's death less than four months ($\underline{M} = 26.9$, $\underline{SD} = 5.7$, $\underline{M} = 24.2$, $\underline{SD} = 6.8$) $F(1, 88) = 4.12$, $p < .05$. Thus, it appears that passing of time following the death of a client is related to a reported greater satisfaction with life for mental health professionals who lose a client to AIDS.

Research Question 2

Does an HIV/AIDS caregivers' stress syndrome (Silverman, 1993) exist for mental health professionals who lose a client(s) to death due to AIDS? This syndrome may resemble posttraumatic stress disorder (including intrusive, avoidant, and hyperarousal symptoms) in response to the death of a client(s) with AIDS.

To address Research Question 2, participants were divided into three groups representing low (.00 - .10, [$\underline{n} = 37$]), medium (.14 - .55, [$\underline{n} = 27$]), and high (.59 - 2.50, [$\underline{n} = 26$]) scores on the IES-R. Although the intent was to divide the distribution of IES-R total scores into equal thirds (i.e., \underline{n} 's = 30), a large number of cases of low scores did not permit equal groupings. To date, there are no cutoff scores to indicate low, medium, or high scores on the IES-R. These three categories of IES-R scores were used as the independent variable in analyses of variance with the dependent

variables of GSI, Past Behavior, Present Feelings, and Unresolved Grief. Least Significant Difference post hoc tests were conducted to explore between-group differences. All reported mean differences were significant at the .05 level.

The one-way analyses of variance are summarized in Table 4. As may be noted in that table, participants reporting a traumatic stress response (i.e., IES-R high scores) showed significantly higher Past Behavior, Present Feelings, and GSI scores. Least Significant Difference post hoc tests revealed that participants with high IES-R scores had significantly higher Past Behavior scores as compared to participants with medium IES-R scores and to participants with low IES-R scores. Participants with high IES-R scores also had significantly higher Present Feelings scores than participants with medium and low IES-R scores; and, participants with medium IES-R scores scored significantly higher than those with low IES-R scores on the Present Feelings scale. Finally, participants with high and medium IES-R scores had significantly higher GSI scores than participants with low IES-R scores.

Thus, it appears that for participants who reported a traumatic stress response, (i.e., high IES-R scores) these individuals also experienced grief (past and present grief reactions) and a global level of psychological distress. From this finding it may be extrapolated that the HIV/AIDS caregivers' stress syndrome suggested by Silverman (1993) may be comprised of not only a traumatic stress response, but of grief reactions and global psychological distress as well.

Table 4

Analysis of Variance Results for Low, Medium, and High Scores on the Impact of Event Scale-Revised (n = 90)

Dependent Variable	High IES-R ^a		Medium IES-R ^b		Low IES-R ^c		df	F
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>		
Past								
Behavior	17.9 _d	5.5	13.7 _e	4.5	11.3 _e	4.4	2, 87	14.6***
Present								
Feelings	32.9 _d	7.3	26.5 _e	7.1	19.2 _f	5.2	2, 87	34.4***
Unresolved								
Grief Index	2.5	1.8	2.4	1.6	1.7	1.3	2, 87	2.8
Global								
Severity Index	56.3 _d	11.9	51.8 _d	9.7	44.8 _e	12.5	2, 87	8.1***

Note. High, medium, and low scores on the Impact of Event-Scale Revised served as the independent variable.

^an = 26, ^bn = 27, ^cn = 37. Means with different subscripts differ significantly at $p < .05$ by the Least Significant Difference Test.

*** $p < .001$.

Research Question 3

Do mental health professionals who are HIV positive or have AIDS experience more severe reactions to the loss of a client(s) with AIDS than mental health professionals who are HIV-negative?

As previously mentioned, the sample consisted of 83 participants identified as HIV negative, three as HIV positive, two with an AIDS diagnosis, six not knowing their HIV status, and two preferring not to indicate. Because the overwhelming majority of participants were HIV negative ($n = 83$), and only five participants comprised the HIV positive/AIDS diagnosis grouping, the small sample size of HIV positive/AIDS diagnosis participants ($n = 5$) precluded analyses with this question.

Research Question 4

Do mental health professionals not involved in individual therapy or a support group for themselves experience more severe reactions to the death of a client(s) with AIDS than mental health professionals participating in individual therapy or a support group focusing on their own grief and loss issues? Mental health professionals were assessed on (a) grief (including past, present, and unresolved grief), (b) traumatic stress response (including intrusive, avoidant, and hyperarousal responses), (c) global severity of distress (including somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism), and (d) satisfaction with life.

Of the 96 participants in the study, 72 reported not participating in individual therapy or a support group, while 24 reported participating in individual therapy or

a support group to address and deal with their own grief and loss issues related to the death of a client(s) with AIDS. To create equal number comparison groups (n 's = 24), 24 participants who reported not participating in individual therapy or a support group were randomly selected by use of a table of random numbers.

Analyses of variance were performed to test differences between participants not in therapy or a support group ($n = 24$) versus participants in therapy or a support group ($n = 24$) on the dependent variables of grief, traumatic stress, psychological distress, and satisfaction with life. There were no statistically significant differences between participants in therapy versus participants not in therapy across all dependent variables. Thus, participation in therapy or support groups does not appear to be a mitigating factor for practitioners dealing with AIDS-related losses.

Research Question 5

To what extent do the demographics of gender, age, ethnicity, sexual orientation, academic degree, years worked with HIV/AIDS population, number of deaths, recency of death, suicide, non-client deaths, participation in personal loss/grief therapy, and percentage of HIV/AIDS clients relate to the measures of Past Behavior, Present Feelings, Unresolved Grief, traumatic stress response (i.e., total score), global severity of distress, and Satisfaction with Life?

To evaluate the contribution of the demographic characteristics to the indices of grief (including past, present, and unresolved grief), traumatic stress, global severity of distress, and satisfaction with life, six multiple regression analyses were conducted.

In all, nine demographic variables were used as predictors: (a) gender (coded “male” = 0, “female” = 1), (b) age, (c) sexual orientation (“heterosexual” = 0, “non-heterosexual” = 1), (d) academic degree (“≤ bachelors” = 0, “graduate” = 1), (e) number of deaths, (f) suicide (coded “no” = 0, “yes” = 1), (g) non-client deaths (“no” = 0, “yes” = 1), (h) participation in personal loss/grief therapy (“no” = 0, “yes” = 1), and (i) percentage of clients with HIV/AIDS.

Prior to conducting the analyses, only demographics of interest and relevance were considered. The demographics, ethnicity, years worked with HIV/AIDS population, and recency of death were not used as predictors because of negligible correlations with the criterion variables; and, the demographic HIV status was excluded because of the small number of HIV positive and AIDS diagnosed participants. Correlations between demographic variables and all measures are presented in Tables 5, 6, and 7 (demographic variables with minimal correlations with the research instruments/subscales were not reported in Table 7; additionally, also not reported were significant correlations between academic degree and satisfaction with life, $r(90) = .26, p < .05$, years worked and satisfaction with life, $r(90) = .21, p < .05$, and recency of death and satisfaction with life, $r(90) = .21, p < .05$).

Multiple regression analyses examined which of the predictors or combination of predictors contributed to the prediction and understanding of the six criterion variables. These six criterion variables were Past Behavior, Present Feelings, Unresolved Grief, traumatic stress response (i.e., total score), GSI, and Satisfaction with Life. An additional regression analysis was run which included the nine demographic variables and the

indices of global severity of distress, Past Behavior, and Present Feelings to predict traumatic stress response (i.e., total score).

Table 5

Intercorrelations Between Demographic Variables

Demographics	1	2	3	4	5	6	7	8	9	10	11	12
1. Gender	--	.07	-.01	-.45**	-.20	-.19	.04	-.06	-.13	.03	-.16	.04
2. Age		--	-.03	-.06	.10	.37**	.05	.10	.05	.15	.14	-.25*
3. Ethnicity			--	.02	.03	.06	-.05	-.09	.03	-.06	.09	.09
4. Sex. orien.				--	.23*	.19	.10	-.03	.25*	-.08	.21*	.17
5. Degree					--	.24*	.12	.00	-.05	.12	.16	-.23
6. Years wkd.						--	.31**	.16	.14	.08	-.03	-.29**
7. # of deaths							--	-.06	.30**	-.09	-.08	.15
8. Recent death								--	-.14	-.04	-.10	-.35**
9. Suicide									--	.12	.01	.23*

(table continues)

Table 5 (continued)

Demographics	1	2	3	4	5	6	7	8	9	10	11	12
10. Non-client dth.										--	.28**	.00
11. Ind. Therapy											--	.11
12. % of clients												--

Note. Gender = males vs. females; Ethnicity = white vs. non-white; Sexual orientation = heterosexual vs. non-heterosexual; Degree = \leq bachelors vs. graduate; Years worked = # of years working with HIV/AIDS population; Number of deaths = number of client deaths to AIDS; Recent death = 0 to 3 months vs. > 4 months since most recent client death to AIDS; Suicide = whether client(s) with HIV/AIDS committed suicide; Non-client death = whether participant had other non-client deaths during past year; Individual therapy = whether participant was involved in personal therapy; Percentage of clients with HIV/AIDS = 2% to 50% vs. 75% to 100%.

* $p < .05$. ** $p < .01$.

Table 6

Intercorrelations of Research Instruments

Measures	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. Past	--	.54**	.21*	.55**	.46**	.57**	.48**	.44**	.36**	.44**	.22*	.38**	.46**	.37**	.34**	.33**	.45**	-.23*
2. Present		--	.16	.72**	.46**	.61**	.62**	.30**	-.00	.33**	.14	.20	.29**	.24*	.25*	.26*	.33**	.01
3. UGI			--	.31**	.19	.34**	.33**	.12	.14	.06	.06	.04	.14	.05	.20	.04	.03	-.08
4. TSR				--	.90**	.92**	.92**	.35**	.12	.33**	.14	.30**	.36**	.32**	.28**	.33**	.34**	-.14
5. INT					--	.69**	.73**	.31**	.04	.28**	.16	.25*	.30**	.28**	.24*	.26*	.27**	-.03
6. AVO						--	.85**	.34**	.16	.33**	.12	.29**	.31**	.30**	.27**	.33**	.35**	-.24*
7. HYP							--	.32**	.13	.27**	.09	.27**	.37**	.28**	.25*	.29**	.32**	-.10
8. GSI								--	.68**	.88**	.79**	.86**	.89**	.82**	.62**	.83**	.84**	-.43**
9. SOM									--	.56**	.51**	.55**	.64**	.53**	.45**	.58**	.51**	-.36**
10. O-C										--	.67**	.71**	.73**	.76**	.49**	.77**	.74**	-.41**

(table continues)

Table 6 (continued)

Measures	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
11. I-S											--	.69**	.72**	.60**	.53**	.71**	.70**	-.31**
12. DEP												--	.79**	.71**	.60**	.66*	.81**	-.55**
13. ANX													--	.71**	.62**	.74**	.80**	-.38**
14. HOS														--	.43**	.75**	.68**	-.37**
15. PHOB															--	.58**	.60**	-.34
16. PAR																--	.73**	-.38**
17. PSY																	--	-.44**
18. SWL																		--

Note. 1 – 3 were scales from the Texas Revised Inventory of Grief; 4 was obtained from the Impact of Event Scale Revised (IES-R) and 5 – 7 were scales from the IES-R; 8 was obtained from the Brief Symptom Inventory (BSI) and 9 – 17 were subscales from the BSI; 18 was obtained from the Satisfaction with Life Scale. Past = Past Behavior; Present = Present Feelings; UGI = Unresolved Grief Index; TSR = Traumatic stress response (total score); INT = Intrusive; AVO = Avoidant; HYP = Hyperarousal; GSI = Global severity index; SOM = Somatization; O-C = Obsessive-Compulsive; I-S = Interpersonal Sensitivity; DEP = Depression; ANX = Anxiety; HOS = Hostility; PHOB = Phobic Anxiety; PAR = Paranoid Ideation; PSY = Psychoticism; SWL = Satisfaction With Life. * $p < .05$. ** $p < .01$

Table 7

Correlational Data for Research Instruments/Subscales and Demographic Variables

Instruments and scales	Demographic variables					
	Gender	Age	Sex.Orien.	Suicide	Non-Client	%AIDS
TRIG ^a						
Past	.01	-.02	.27*	.32**	.01	.15
Present	.14	-.03	.08	.28**	.06	.10
UGI	-.05	-.22*	.00	.00	-.11	.00
IES-R ^b						
TSR	.12	-.02	.10	.32**	.02	.01
INT	.22*	-.02	.03	.29**	.02	.03
AVO	.03	-.01	.14	.30**	.03	.05
HYP	.06	-.02	.12	.27**	-.01	-.05
BSI ^c						
GSI	-.19	-.04	.37**	.24*	-.16	.16
SOM	-.12	.01	.34**	.15	.00	.06
O-C	-.07	.03	.25*	.18	-.18	.13
I-S	-.19	-.05	.35**	.16	-.26*	.13

(table continues)

Table 7 (continued)

Instruments and scales	Demographic variables					
	Gender	Age	Sex.Orien.	Suicide	Non-Client	%AIDS
DEP	-.19	-.07	.29**	.25*	-.21*	.22*
ANX	-.15	-.08	.37**	.25*	-.20	.18
HOS	-.09	.00	.24*	.34**	-.20*	.13
PHOB	-.24*	-.18	.30**	.24*	-.05	.24*
PAR	-.14	-.15	.26**	.30**	-.21*	.14
PSY	-.11	-.15	.35**	.26*	-.17	.24*
SWLS ^d	.17	.12	-.21*	-.11	.09	-.32**

Note. ^aTRIG = Texas Revised Inventory of Grief; ^bIES-R = Impact of Event Scale-Revised; ^cBSI = Brief Symptom Inventory; ^dSWLS = Satisfaction With Life Scale. Consult Tables 5 and 6 for definitions of demographics and instruments/scales.

* $p < .05$. ** $p < .01$.

The stepwise regression method was used for these analyses. The stepwise method was chosen because the variable with the highest correlation with the criterion is added first and variables are removed that are no longer making a significant contribution (Howell, 1992). This method was chosen because of the entry and removal criteria and the author's intent to use predictors with the strongest relations to criterion variables. Prior to running the regression analyses demographic variables with minimal correlations with the dependent variables were eliminated. Additionally, the stepwise regression method is considered as probably the best regression method (Howell, 1992), and as the surest path to the best prediction equation (Tabachnick & Fidell, 1996).

The multiple regression analyses showed that demographic characteristics (i.e., independent variables) significantly predicted Past Behavior, $R^2 = .10$, $F(1, 85) = 9.01$, $p < .01$, Present Feelings, $R^2 = .14$, $F(2, 84) = 6.84$, $p < .01$, Unresolved Grief, $R^2 = .05$, $F(1, 85) = 4.56$, $p < .05$, GSI, $R^2 = .14$, $F(1, 85) = 14.20$, $p < .001$, traumatic stress response, $R^2 = .10$, $F(1, 85) = 9.13$, $p < .01$, and Satisfaction with Life, $R^2 = .23$, $F(4, 88) = 6.50$, $p < .001$. The additional regression analysis revealed that the two indices of grief predicted traumatic stress response, $R^2 = .60$, $F(2, 84) = 111.21$, $p < .001$.

The results of these multiple regression analyses are summarized in Table 8. Both standardized and unstandardized regression weights are provided. One variable contributed to the prediction of Past Behavior, suicide, and accounted for 10% of the variance. Suicide and gender (i.e., females) were the two predictors of Present Feelings

Table 8

Summary of the Multiple Regression Analyses for Predictors of Dependent Variables of Bereavement and Psychological Distress

Dependent variable and predictor variable	Multiple regression analysis				
	<u>F</u>	<u>df</u>	R ²	B	<i>B</i>
Past Behavior	9.00**	1, 85	.10		
Suicide				3.49	.310
Present Feelings	6.84**	2, 84	.14		
Suicide				5.56	.319
Gender				4.01	.234
Unresolved Grief Index	4.56*	1, 85	.05		
Age				-.042	-.226
Global Severity Index	14.20***	1, 85	.14		
Sexual orientation				9.39	.378
Traumatic Stress Response	9.13**	1, 85	.10		
Suicide				.304	.311

(table continues)

Table 8 (continued)

Dependent variable and predictor variable	<u>F</u>	<u>df</u>	R ²	B	<i>B</i>
Traumatic Stress Response	61.82***	2, 84	.60		
Present Feelings				.036	.645
Past Behavior				.017	.201
Satisfaction With Life	6.50***	4, 88	.23		
Percentage of clients with HIV/AIDS				.034	-.232
Number of deaths				.015	.213
Sexual orientation				-3.32	-.279
Academic degree				2.85	.216

Note. * $p < .05$. ** $p < .01$. *** $p < .001$

and accounted for 14% of the variance; and, age (i.e., younger in years) predicted Unresolved Grief, accounting for 5% of variance. For GSI, the significant predictor was sexual orientation (i.e., non-heterosexual) and accounted for 14% of the variance. Suicide also emerged as the sole predictor of traumatic stress response. The four significant predictors of satisfaction with life were percentage of clients with HIV/AIDS (2% to 50%), number of deaths (i.e., less numbers), sexual orientation (i.e., heterosexuals), and academic degree (graduate), accounting for 23% of the variance. Additionally, Past Behavior and Present Feelings emerged from the entire set of predictors as being associated with a traumatic stress response.

Further examination of the results indicated having a client with HIV/AIDS commit suicide emerged as the demographic characteristic that significantly predicted past grief reactions (i.e., Past Behavior). Having a client with HIV/AIDS commit suicide and being female were the predictors of present grief (i.e., Present Feelings). Age, (i.e., the younger the participant) was associated with Unresolved Grief. The results also indicated that the demographic, non-heterosexual, predicted the GSI. That is, elevated global severity index scores were associated with gay and lesbian participants. Participants with a caseload of 2% to 50% of clients with HIV/AIDS, a lesser number of client deaths, being heterosexual, and a higher academic degree, were all related to higher satisfaction with life scores. Finally, grief (past and present) was strongly associated with a traumatic stress response.

Additional Analyses

Additional analyses were performed with demographic variables of interest. The five analyses were conducted to further explore AIDS-related bereavement among mental health professionals.

Years worked with persons with HIV/AIDS. Correlations were computed between number of years worked with persons with HIV/AIDS (range = 1 to 18 years) and the measures of (a) grief (including past, present, and unresolved grief), (b) traumatic stress response (including intrusive, avoidant, and hyperarousal symptoms), (c) global severity of distress (including, somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism), and (d) satisfaction with life. Of all the aforementioned global indices and subscales, only satisfaction with life yielded a significant correlation with number of years worked with persons with HIV/AIDS, $r(90) = .22, p < .05$. Thus, it appears that years worked with persons with HIV/AIDS (i.e., greater number of years) is associated with a greater satisfaction with life.

Percentage of clients with HIV/AIDS. The demographic, percentage of clients with HIV/AIDS, was then examined with the measures of (a) grief (including past, present, and unresolved grief), (b) traumatic stress response (including intrusive, avoidant, and hyperarousal symptoms), (c) GSI (including somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism), and (d) satisfaction with life. Because the

distribution of this demographic variable was bimodal, percentage of clients with HIV/AIDS was split into two categories: 2% to 50% ($n = 35$) and 75% to 100% ($n = 55$). Of note, participants did not report percentages between 50% and 75%.

Analyses of variance were performed to examine whether there were any significant differences between the two categorical groups of high and low percentage of clients with HIV/AIDS on all measures. Significant differences were found for the indices of depression, phobic anxiety, psychoticism, and satisfaction with life. The results revealed that participants with 75% to 100% of clients with HIV/AIDS had significantly higher scores than participants with 2% to 50% of clients with HIV/AIDS on the measures of depression ($M = 54.8$, $SD = 10.9$, $M = 49.5$, $SD = 9.1$) $F(1, 88) = 5.78$, $p < .05$, phobic anxiety ($M = 51.4$, $SD = 8.3$, $M = 47.9$, $SD = 5.9$) $F(1, 88) = 4.76$, $p < .05$, and psychoticism ($M = 56.8$, $SD = 10.2$, $M = 51.3$, $SD = 7.6$) $F(1, 88) = 7.42$, $p < .01$. Conversely, participants with 2% to 50% of clients with HIV/AIDS had significantly higher scores than participants with 75% to 100% of clients with HIV/AIDS on the index of satisfaction with life ($M = 28.2$, $SD = 4.3$, $M = 24.3$, $SD = 6.9$) $F(1, 88) = 9.14$, $p < .01$. Based on these findings it appears that having a caseload with predominately clients with AIDS (i.e., 75% to 100%) is associated with depression, phobic anxiety, and psychoticism, while having a caseload with a lesser percentage of clients with AIDS (i.e., 2% to 50%) is related to a greater reported satisfaction with life.

Type of work setting. Further analyses used the demographic, type of work setting, as a variable of interest. Participants working exclusively at an AIDS Center/

Project ($n = 25$) were contrasted with a group of participants who work at various other non-AIDS center settings (e.g., community mental health center, hospital, private practice) ($n = 32$) to form the dichotomous work setting variable. In subsequent analyses of variance with this work setting variable and measures of grief, traumatic stress, psychological distress, and satisfaction with life, significant differences were found between groups on Past Behavior, GSI, Depression, Anxiety, Hostility, Paranoid Ideation, and Satisfaction with Life scales.

The results show that participants working at an AIDS Center/Project had significantly higher scores than participants working at non-exclusive AIDS settings on the measures of Past Behavior ($M = 16.1$, $SD = 5.7$, $M = 12.4$, $SD = 4.6$) $F(1, 55) = 7.33$, $p < .01$, GSI ($M = 54.8$, $SD = 13.2$, $M = 47.7$, $SD = 12.0$) $F(1, 55) = 4.50$, $p < .05$, depression ($M = 56.9$, $SD = 11.8$, $M = 50.9$, $SD = 10.1$) $F(1, 55) = 4.31$, $p < .05$, anxiety ($M = 55.4$, $SD = 11.6$, $M = 46.3$, $SD = 9.1$) $F(1, 55) = 10.87$, $p < .01$, hostility ($M = 54.5$, $SD = 10.2$, $M = 48.1$, $SD = 8.4$) $F(1, 55) = 6.87$, $p < .01$, and paranoid ideation ($M = 54.0$, $SD = 12.8$, $M = 48.1$, $SD = 9.7$). $F(1, 55) = 3.91$, $p < .05$. The findings also show that participants working in various other non-AIDS Centers had significantly higher scores than participants working at AIDS Centers on the index of satisfaction with life ($M = 27.0$, $SD = 5.8$, $M = 22.9$, $SD = 7.3$) $F(1, 55) = 5.69$, $p < .05$.

Thus, these results seem to indicate that working solely in an AIDS Center or AIDS Project is related to grief reactions as measured by past behavior, a global psychological distress reaction, depression, anxiety, and hostility. Conversely, the results

suggest that working in other types of non-exclusive AIDS agencies (e.g., community mental health center, hospital, private practice) is associated with a greater reported satisfaction with life.

Gender. Gender was also examined for significant differences on measures of (a) grief (including past, present, and unresolved grief), (b) traumatic stress response (including intrusive, avoidant, and hyperarousal symptoms), (c) global severity of distress (including somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism), and (d) satisfaction with life. Analyses of variance were computed for the gender variable representing males ($n = 34$) versus females ($n = 56$) with all measures. Of these, three variables revealed statistically significant differences: that is, one of the three components of traumatic stress response, intrusive symptoms, and interpersonal sensitivity and phobic anxiety. The results indicate that female participants scored significantly higher on the measure of intrusive symptoms than male participants ($M = .68$, $SD = .67$, $M = .40$, $SD = .49$) $F(1, 88) = 4.42$, $p < .05$. However, male participants scored significantly higher on the measure of interpersonal sensitivity ($M = 54.1$, $SD = 10.8$, $M = 49.6$, $SD = 10.0$) $F(1, 88) = 3.97$, $p < .05$, and on the measure of phobic anxiety than female participants ($M = 52.1$, $SD = 8.7$, $M = 48.4$, $SD = 6.4$) $F(1, 94) = 5.58$, $p < .05$. Thus, higher intrusive scores are associated with female participants, as higher interpersonal sensitivity and phobic anxiety scores are associated with male participants. Therefore, it appears that one's gender may leave practitioners susceptible to specific psychological distress following the death of a client to AIDS.

Sexual orientation. Finally, sexual orientation (i.e., heterosexuals versus non-heterosexuals) was examined for significant differences on measures of (a) grief (including past, present, and unresolved grief), (b) traumatic stress response (including intrusive, avoidant, and hyperarousal symptoms), (c) global severity of distress (including somatization, obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoia, and psychoticism), and (d) satisfaction with life. This dichotomous sexual orientation variable included heterosexual participants ($n = 46$) and non-heterosexual participants ($n = 43$: gay, $n = 25$, lesbian, $n = 18$).

The result revealed that non-heterosexual participants, that is, gays and lesbians, showed significantly higher scores on Past Behavior, GSI, somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism, than heterosexual participants. Because the nine subscales comprise and account for the global severity of distress index, only the GSI mean scores will be reported (all nine subscales were significant at the .05 level). Gay and lesbian participants had significantly higher scores than heterosexual participants on Past Behavior ($M = 15.4$, $SD = 6.0$, $M = 12.5$, $SD = 4.5$) $F(1, 87) = 6.91$, $p < .01$, and on the GSI ($M = 55.2$, $SD = 11.6$, $M = 45.5$, $SD = 5.9$) $F(1, 87) = 15.60$, $p < .001$. Conversely, heterosexual participants had significantly higher Satisfaction with Life scores than did non-heterosexuals ($M = 27.1$, $SD = 5.9$, $M = 24.5$, $SD = 6.6$) $F(1, 87) = 3.93$, $p < .05$. Based on these results, it appears that gay and lesbian

practitioners are distressed on multiple fronts following the death of a client to AIDS, as compared to heterosexual practitioners experiencing loss. It followed that heterosexual participants reported a greater satisfaction with life.

CHAPTER 5

Discussion

The purpose of this exploratory study was to examine the experience of mental health professionals who lose a client, or as is more accurate and common, many clients to acquired immune deficiency syndrome (AIDS). Specifically, the study posed research questions aimed at identifying and understanding the specific and unique reactions mental health practitioners experience after the death of a client with AIDS. Importantly, the study was undertaken to add to the empirical literature on AIDS-related bereavement and seeks to establish a knowledge base concerning AIDS-related bereavement among mental health professionals.

As this study was explorative in nature, instruments were selected to tap a variety of reactions for this group of mental health providers who work with individuals with HIV or diagnosed with AIDS. These instruments targeted (a) grief as related to past and current reactions, and grief resolution; (b) traumatic stress, including intrusive, avoidant, and hyperarousal responses; (c) global severity of distress, including nine symptom domains; and (d) satisfaction with life.

What follows is a discussion and exploration of the findings of this research. Interpretations and explanations of the findings will be offered as well as implications of the findings. Limitations of the study and future directions will then be presented. In addition, throughout the text, anecdotal reports will be offered.

These written words are the responses from the optional question included at the end of the questionnaire packet (the question read, “How have you changed since the death of a client(s) with AIDS?”). It is hoped that these more personal reactions will add to the richness of the discussion section, and in the spirit of investigation, help to better understand the experience of losing a client to AIDS.

Research Question 1

Number of client deaths. The first research question sought to determine if a relation exists between client deaths (number and recency), and variables of grief, traumatic stress, global severity of distress (including nine symptom dimensions), and satisfaction with life. When number of deaths, as a continuous variable, was examined in relation to all measures, there were no significant relations. This finding appears somewhat surprising and unexpected given that the range of number of deaths was one to five hundred. Intuitively, it would seem that number of deaths of clients with AIDS might impact a dimension or dimensions of psychological functioning. Carrying this hunch further, two possibilities seemed plausible: one, increases in number of deaths would be related to increases in scores on the measures; and secondly, rises in scores on the measures would be associated with either the loss of a few clients to AIDS, or conversely, to the loss of many clients. However, this was not found with either case. Thus, within the continuum of number of deaths, there is no relation between number of client deaths due to AIDS and indices of grief, trauma, psychological distress or satisfaction with life. It would seem that mental health professionals do not experience

a constellation of bereavement or psychological reactions in relation to number of client deaths.

Before looking to the literature for assistance in understanding this finding, it warrants mentioning that the mean scores on the measures of grief, trauma (including intrusive, avoidant, and hyperarousal responses), and global severity of distress (including the nine symptom dimensions) were below the threshold of clinical significance for the entire group of respondents (only the mean of Past Behavior approached the normative mean of “grief” on this subscale). Collectively, the scores did not indicate grief or psychological difficulties for this group of mental health professionals. In fact, according to the relatively low mean score of the unresolved grief index, this group of practitioners have apparently resolved their grief due to the loss of clients with AIDS.

A look to the literature on grief reactions may help to explain the first finding. Taken at face value, the low mean scores may indicate that this group of professionals have worked through the various stages/phases of grief, and have relinquished attachments to the deceased (Bowlby, 1980), accepted the loss (Kubler-Ross, 1969), are reorganized (Worden, 1991), and are reinvested and involved in life (Rando, 1984).

The following comment by a 51-year-old, female respondent speaks to this:

“I have experienced death of many children with AIDS, and many mothers...

This experience has given me a spiritual connection to life. The grieving process is important and ultimately soothing, so I don’t avoid it.”

However, stage theories may offer an alternative explanation for the apparent absence of elevated indices as related to number of client deaths. A normal reaction, and a stage/phase, posited by all leading bereavement theorists, is that of denial following a loss (Bowlby, 1980; Kubler-Ross, 1969; Rando, 1984; Worden, 1991). One possible explanation of the first finding is that some mental health professionals are working and operating from a position of denial of client deaths. Due to the often times overwhelming nature of the work with persons with AIDS, it may be necessary to deny loss (i.e., past and impending) and to stay numb and/or detached. Denial, numbness, or detachment may assist the practitioner whose work is plagued by continual and multiple loss. Thus, it is possible that some mental health professionals are “stuck” in an earlier phase or stage of mourning, characterized as one of denial, and this may account for the reported low mean scores.

Interestingly, Rando (1984) suggests that the avoidance phase (i.e., where the individual seeks to avoid the reality of the loss) is protective and a coping defense. Following Rando’s (1984) assertion, it seems possible that some practitioners who suffer the loss of clients to AIDS and/or may be anticipating future AIDS-related losses, would adopt a stance of denial or numbness, as this stance may be viewed as necessary, adaptive, or as one of survival in the field of AIDS mental health work. The above appears to be supported by the findings of Frierson and Lippmann (1987) who found that denial of the emotional impact of patient death was important and psychologically protective for physicians who cared for AIDS patients.

The following comment by a 45-year-old, male respondent illustrates this:

“In dealing with my clients. I cannot look at each as someone who will die of their disease. If I did, I’d go mad. I operate on the assumption that some miracle will keep each person alive.”

If the suggested position of denial of death is tenable, it follows that grief reactions, along with other psychological reactions to the death of a client with AIDS, may be denied, inhibited, or minimized, and may account for the absence of such reactions with respect to number of client deaths. On the other hand, the scores, as earlier suggested, may reflect a resolution of grief and an adjusted and mentally healthy group of professionals. Or, to consider yet another explanation, is this a group of “hidden grievers” (Murphy & Perry, 1988) who maintain a professional demeanor and composure even though simply responding to the present research questionnaire.

The literature on abnormal grief reactions may provide an additional explanation of the first finding and lack of elevated mean scores for the group of respondents. Siggins (1966) suggested that the absence of normal grief reactions demarcates unresolved grief, and Worden (1991) suggested delayed grief reactions (i.e., inhibited, suppressed, or postponed) characterize abnormal grieving. In light of this information, it seems worth considering that the absence of grief and psychological reactions in relation to number of deaths for the group of respondents may indicate abnormal grief as defined by Siggins (1966) and Worden (1991).

An additional consideration with the first finding is that a denial may exist that is perhaps more protective and salient in the lives of mental health practitioners who lose

clients to AIDS. While these practitioners are forced to confront issues of finitude and death, this work also forces counselors and therapists to confront their own mortality. Namir and Sherman (1989) suggest that most individuals do not face the inevitability of their own death, but live their lives using a system of denial and invulnerability. Perhaps denying the impact of the loss of clients with AIDS also represents a deeper denial of the knowledge that no one is immortal and that “I too will die.” Of note, the above interpretations should be read with caution, as it is difficult to prove the presence of denial.

The results from additional analyses addressing the first research question may lend support to the above interpretations. To further examine the first research question, the numbers of client deaths were divided into two categories (i.e., 1 to 10 deaths and 11 to 500 deaths). This grouping was used to determine if significant relations exist between number of deaths and bereavement and psychological reactions. From the entire pool of global indices and subscales, only one of the three components of traumatic stress response, an avoidant response, was associated with greater number of deaths. What this appears to indicate is that in relation to practitioners who only experienced one or a few deaths, the experience of losing many clients from AIDS is related to an avoidant response.

This finding appears important and seems consistent with the literature on AIDS-related bereavement reactions for mental health professionals. Authors have posited an avoidance reaction to the death of clients to AIDS: that is, avoidance of topics of death and dying (Gabriel, 1991), emotional detachment (Bernstein & Klein, 1995), a “psychic

numbing” with a diminished capacity to feel (Gabriel, 1994), and avoiding reminders of AIDS deaths (Nord, 1996). Importantly, the items from the Avoidant scale (IES-R) tap denial of the meaning and consequent of the event (i.e., death of client to AIDS), blunted sensation, consciously recognized avoidance of certain ideas, feelings, or situations, and emotional numbness (Horowitz et al., 1979; Zilberg et al., 1982). Moreover, the finding seems to support the notion of denial, detachment, and/or minimization of the experience of losing many clients to AIDS.

Recency of client death. Recency of a client death was also addressed in the first research question. The question sought to examine whether time since the death of a client was related to the measures of grief, traumatic stress, psychological distress, or satisfaction with life. Initial analyses used the five categories (i.e., 0-3 mo., 4-6 mo., 7-9 mo., 10-12 mo., and >12 mo.) since most recent death in relation to the global indices and subscales. Surprisingly, no significant relations were found. Thus, it appears that recency of a client’s death to AIDS is not related to bereavement or psychological reactions.

Although the absence of associations between recency of death and the measures were unexpected, a priori suppositions were disconfirmed. Similar to the number of deaths variable, it intuitively seemed that recency of death might impact dimensions of psychological functioning. Specifically, it seemed that the more recent the death of a client to AIDS, the greater the bereavement and psychological distress. Again however, the findings did not support pre-data collection assumptions.

To further examine this recency of death variable, the literature on bereavement was reviewed and provided meaningful direction. Bereavement theorists suggest that grief symptoms and reactions become major indicators of abnormal or pathological grief when they are manifested beyond the expected time for resolution of grief (i.e., continuing beyond six months to one year) (Lazare, 1979; Rando, 1984). Although this information is helpful in thinking about a time frame for grief resolution, Middleton's (1995; as cited in Wilson & Keane, 1997) research seemed to provide a more meaningful marker for this study. This research suggests that there is a major decline in bereavement phenomenology after 3-4 months. Using this as a guideline, recency of death was made into two categories (0-3 mo. versus >4 mo.) and correlations were computed with all measures. Once again, no relations were found between recency of death and measures of grief, trauma, and psychological distress. Contrary to Middleton's (1995) research, which suggested that grief is most intense during the first few months following death, participants with the most recent client death within the last three months were not reporting distress. Thus, recency of a client's death does not appear to be a factor with AIDS-related bereavement. However, a significant relation was found with satisfaction with life.

Before discussing the significant finding with the recency of death variable and satisfaction with life, a brief discussion of the absence of significant relations between recency of death and indices of distress seems warranted. After twice examining the recency of death variable with all measures, post hoc questions surfaced. The most

compelling question was, “why no relations?” In addition, a more liberal question, in light of using correlation analyses, arose. That is, “wouldn’t the most recent death of a client to AIDS elicit reactions in practitioners?” Clinical acumen seemed to say “yes” to the last question.

Previous interpretations of the findings with the number of deaths variable may help to explain these results. The recency of death findings can similarly be viewed in two possible ways. One, on the whole, mental health practitioners work through their grief and are coping following the loss of clients to AIDS. And two, mental health practitioners are in a state of denial, numbness, and/or detachment, thus, their reactions following the death of a client tend to be denied, inhibited, or minimized. Entertaining yet a third possibility, due to the nature of AIDS mental health work, practitioners may adopt the role of the “strong and tough” one, perhaps taking on an almost “heroic” demeanor, and are impervious to distress following the death of a client. Both Lazare (1979) and Worden (1991) suggest that assuming the role of the “strong one” in a family inhibits individuals to deal with their own grief. Perhaps recency of death was not related to distress because participants are being and need to be the “strong one” when faced with client loss to AIDS.

An important finding however was that the recency variable was related to satisfaction with life. In this case, passing of time following the death of a client was related to a reported greater satisfaction with life. It would seem that gaining some distance, in terms of months passed since the death of a client, assists practitioners in attaining a greater satisfaction with life. Common sense seems to indicate that

this would be the case. Perhaps though, this finding lends credence to previous interpretations, in that mental health practitioners are able to endorse their well being, but fail, for various reasons, to endorse possible distress.

As this last finding was important, it helps to look at participant responses to the question, “How have you changed since the death of a client(s) with AIDS?”

A 57-year-old, male writes, “I am able to celebrate the joy of living and to find joy in my life.” A 65-year-old, female responds, “I’ve treasured relationships with family and friends even more...” A 49-year-old, female writes, “Every time there is a death I realize how short life is and that one must enjoy, take care, and live it.” And, a 30-year-old responds, “I appreciate my life.”

Research Question 2

HIV/AIDS caregivers’ stress syndrome. The second research question sought to determine if an HIV/AIDS caregivers’ stress syndrome exists. This syndrome was posited to resemble posttraumatic stress disorder and was suggested by Silverman (1993). Others (Gabriel, 1994; Perreault, 1995) have also suggested a posttraumatic stress syndrome in response to losing clients to AIDS. Supplemental analyses of the first research question appeared to partially support the presence of a traumatic stress response as the findings indicated a relationship between greater number of deaths (i.e., 11 to 500 deaths) and an avoidant response.

To examine the second research question, participants who had high, medium, and low IES-R scores were contrasted on measures of grief and global severity of distress. The results indicated that for the subset of participants reporting a traumatic

stress response (i.e., high IES-R scores) these individuals also had significantly higher past and present grief scores, and global severity of distress index. Of note, the mean scores of both Past Behavior and Present Feelings approximated or exceeded the normative mean for “grief,” as the GSI approached the threshold of clinical importance.

Moreover, this finding appears to support and establish empirically that an HIV/AIDS caregivers’ stress syndrome (Silverman, 1993) exists. Although Silverman (1993) suggested that an HIV/AIDS caregivers’ stress syndrome parallels the typical signs and symptoms of posttraumatic stress disorder, it is this author’s contention, based on the current findings, that the HIV/AIDS caregivers’ stress syndrome (Silverman, 1993) includes elements of posttraumatic stress, grief, and psychological distress. More accurately, an “HIV/AIDS traumatic-grief syndrome” appears present for some practitioners. This syndrome is comprised of a global traumatic stress response including intrusive, avoidant, and hyperarousal elements, grief that is reflective of past and current reactions to the loss, and a general psychological distress in reaction to the death of clients with AIDS. Raphael and Martinek’s (1997) definition of traumatic bereavement may be seen to capture the experience of losing clients to AIDS: one, which encompasses shocking encounters with death and trauma including bodily distortion, mutilation, shock, threat, horror, and helplessness.

This is an important finding. It appears that exposure to and witnessing the deteriorating health and appearance of a client with AIDS, and the eventual loss of a client or clients to AIDS, is traumatic and can have an enduring impact on practitioners. It is likely that for some practitioners in the AIDS mental health field,

where there is exposure to disfiguring physical illnesses and client death, the work can place a practitioner at risk for an “HIV/AIDS traumatic-grief syndrome.” Importantly, for a subset of mental health practitioners in this study, AIDS mental health work appears not only traumatic, but seems to increase symptoms of grief and psychological distress. Knowing this, it would seem that providing mental health services to those living with and dying from AIDS could lead to “vicarious traumatization” (Pearlman & Mac Ian, 1995). Additionally, this finding appears to support those who have suggested a posttraumatic stress syndrome in response to losing clients with AIDS (Gabriel, 1994; Perreault, 1995). Of note, a limitation of this finding is that participants were not questioned about a personal trauma history, as an unresolved history of trauma may have influenced the results.

To better understand this finding, the characteristics of the subset ($n = 26$) that reported a traumatic stress response (i.e., high IES-R scores), grief reactions, and a global psychological distress were examined. In general, the characteristics of the subset were unremarkable. However, the subset seemed unique in several ways: ten participants worked exclusively in an AIDS Center/Project, three worked at an AIDS Center and a hospice, and four worked at a hospice; 16 participants had a caseload of 75% to 100% of clients with HIV/AIDS; and, half of the subset had a client(s) with HIV/AIDS commit suicide. Thus, it would appear that working at an AIDS Center and/or with the dying at a hospice, carrying a heavy caseload of clients with HIV/AIDS, and losing clients to both AIDS and suicide increases the chance of becoming distressed.

A closer examination of the data for the subset of participants with low IES-R scores proved interesting. The subset with low scores on the IES-R also had very low, sub-clinical scores on the measures of grief and the GSI. This information about these thirty-seven participants seems significant and telling. As noted during the scoring of the research questionnaires, some participants seemed to check off the “not at all” and “completely false” columns for all measures. It would appear that some participants responded to the questionnaire either without giving much consideration to the items, or, as it is this author’s conjecture, some participants responded to the items as if saying “no, that doesn’t apply to me” and/or “I’m not bothered by that.” Permitting an inference from this, some participants, for various reasons, may not have responded to the questionnaire in an open, honest, and forthright manner.

This inference may help to confirm earlier interpretations that some practitioners safeguard themselves and deny the impact of losing clients to AIDS. Perhaps what has been suggested might also explain why only ninety-six of the three hundred and fifty-one delivered questionnaire packets were completed. Maybe the initial response upon receiving and looking over the questionnaire was “I’m okay, no problem here,” or perhaps, “This is too painful, I don’t want to think about it.”

Importantly, it is likely that reported low scores on the IES-R, TRIG, and the BSI pulled the remainder of the scores more toward the “normative” means for these instruments and may account for the appearance of “normal” mean scores across measures. Of note, preliminary analyses of the data revealed that in comparison to participants that had “no” client deaths to AIDS ($n = 6$), a subset of six randomly

selected participants with client deaths had extremely low mean scores on the GSI and all nine subscales of the BSI. Perhaps this may be seen to provide further evidence that some practitioners either avoid or deny the experience of losing clients to AIDS. However, it is also possible that the experiencing of losing clients to AIDS is not distressing for some practitioners.

Research Question 3

HIV/AIDS status. The third research question was aimed at determining whether mental health professionals who are HIV positive or have AIDS experience more severe reactions to the loss of a client(s) with AIDS than mental health professionals who are HIV negative on measures of traumatic stress, grief, psychological distress or satisfaction with life. Because the overwhelming majority of participants were HIV negative, and only five participants comprised the HIV positive/AIDS diagnosis grouping, the small sample size of HIV positive/AIDS diagnosis participants ($n = 5$) precluded analyses with this question.

Research Question 4

Individual therapy/support group participation. The fourth research question sought to determine whether mental health professionals not involved in individual therapy or a support group for themselves experience more severe reactions (i.e., grief, traumatic stress response, psychological distress, or satisfaction with life) to the death of a client with AIDS than mental health professionals participating in individual therapy or a support group focusing on their own grief and loss issues. Because only twenty-four participants were involved in therapy of some type,

twenty-four participants not involved in therapy were randomly selected to create equal number comparison groups.

Surprisingly, there were no significant differences between participants in therapy versus participants not in therapy across all measures. Of note, the means for both groups on all measures were not elevated or clinically meaningful. How is this finding to be interpreted? The literature on AIDS-related bereavement suggests the necessity and essentialness of support groups for practitioners dealing with loss (Dane, 1995; Namir & Sherman, 1989; Perreault, 1995). However, the findings suggest that participation in therapy or support groups is not any more beneficial in dealing with AIDS-related loss than not participating in therapy or a support group.

One hypothesis to explain this finding is that practitioners are dealing with their grief and mourning outside of personal therapy and rely on loved ones, friends, and informal support to resolve their grief. Worth considering is the issue of availability and level of social support for mental health practitioners working with and losing clients with HIV and AIDS. Lazare (1979) and Worden (1991) both suggest that without social support, grief reactions can become exacerbated or inhibited. In light of this last statement two possibilities seem likely: first, this group of respondents have adequate to good social support systems which may account for the non-elevated scores; and, secondly, respondents have little or no social support, thus grief and psychological reactions for this group are inhibited. One limitation of this study is that social support was not assessed, as the presence of an adequate or good level of social support may help to explain the low mean scores.

The comments of a male practitioner seem apropos.

“I performed too many funerals, cleaned out too many apartments, scattered ashes, helped write too many living wills and in general, gave too much of myself without support. There were no support groups to go to and people did not want to hear of those who had died of AIDS. I wrote my poetry and did my art and found other ways to express my grief. Not all towns have support groups that are welcoming to hear not only about AIDS, but of difference.”

Research Question 5

Demographic characteristics. The fifth research question sought to determine to what extent demographic characteristics related to the measures of grief, traumatic stress, psychological distress, and satisfaction with life. Analyses revealed that the demographic, suicide, predicted past grief reactions. Suicide and gender (i.e., being a female) were the two predictors of present grief reactions, and, age of the participant predicted unresolved grief. Sexual orientation (i.e., gay and lesbian participants) was predictive of global severity of distress. The demographic, suicide, also emerged as the sole predictor of traumatic stress (i.e., IES-R total score). Percentage of clients with HIV/AIDS (2 % to 50%), number of deaths (i.e., fewer deaths), sexual orientation (i.e. heterosexuals), and academic degree (i.e., participants with a graduate degree) were the four significant predictors of satisfaction with life. The additional regression analysis revealed that grief (past and present reactions) predicted traumatic stress response. Given the exploratory nature of this investigation these results seem important and contribute new information to this area of research.

The results appear to provide evidence that having a client with HIV/AIDS commit suicide is associated with higher Past Behavior scores. Inferring from this finding, it seems there is a susceptibility for practitioners who have both, clients with HIV/AIDS commit suicide and clients die from AIDS, to experience greater grief reactions at the time of their client's death. Apparently, grief is exacerbated for practitioners who suffer both types of client loss.

Suicide was also predictive of present grief. This finding, in conjunction with the previous finding, appears to suggest that experiencing clients die from AIDS and having clients with HIV/AIDS commit suicide, is reflective of past and current grief. It would seem that having a client commit suicide contributes to an ongoing grief for practitioners who also are losing clients to AIDS. Thus, suicide may be seen as a risk factor for a continuing grief for mental health practitioners working the HIV/AIDS population.

Age was the significant predictor of unresolved grief. Specifically, the younger the participant the greater the scores of unresolved grief. From this finding it appears that younger participants have a more difficult time resolving their grief following the death of a client to AIDS. However, this finding is tempered by the fact that age accounted for only a small amount of the variance in predicting unresolved grief.

A fourth finding was that sexual orientation was related to and predictive of a global severity of distress. In this case, gay and lesbian practitioners seem to be experiencing a general psychological distress in response to losing clients to AIDS.

This seems to be an important finding. The result suggests that these practitioners are currently experiencing psychological difficulties in relation to the death of a client. The literature, in part, appears to support this finding as it indicates that significant psychological consequences and grief reactions result from AIDS-related bereavement among gay men (Lennon et al., 1990; Martin, 1988; Neugebauer et al., 1992; Viney et al., 1992). Of note, the GSI indicates respondents' current general distress level, based on numbers of symptoms and intensity of distress, but does not denote which symptoms are problematic. Additional analyses further examined this issue and will be presented later in the discussion section.

The fifth finding was that the demographic, suicide, also emerged as the sole predictor of traumatic stress response. This finding, like the previous findings with past and present grief, suggests that having a client commit suicide, in addition to losing clients to AIDS, is distressing. Specifically, the combination of experiencing both types of client death appears to be related to a traumatic stress response. Again, this finding seems important as it denotes the impact on the practitioner of clients with HIV/AIDS taking their own lives, and signals suicide as a likely risk factor for a traumatic stress response for practitioners providing AIDS mental health work. Menninger's (1991) study of patient suicide lends support to the current finding that suicide is distressing for AIDS mental health practitioners. The study found that therapists' reactions to a patient's suicide included shock (feeling stunned or surprised), sadness (feeling loss or grief), anger, a sense of guilt, and anxiety (Menninger, 1991). Moreover, it appears that suicide compounds distress for

practitioners losing clients to AIDS.

Interestingly, four demographics were predictive of satisfaction with life: percentage of clients with HIV/AIDS, number of deaths, sexual orientation, and academic degree. First, having a smaller caseload of clients with HIV/AIDS (2% to 50%) was related to satisfaction with life. This appears logical, as it would seem more distressing and taxing to provide services primarily to clients with HIV/AIDS. Clearly, less involvement with HIV/AIDS clientele appears to permit a greater satisfaction with life. Secondly, as client deaths lessen in number, satisfaction with life increases. Again, this seems to make sense, as fewer deaths would likely be related to less distress, hence, a greater reported satisfaction with life. In addition, heterosexual participants were associated with a greater satisfaction with life. Perhaps the inverse that non-heterosexuals are not associated with a satisfaction with life, is more telling and implies bereavement and psychological distress for non-heterosexual practitioners. In fact, an earlier regression analysis found a relationship between global psychological distress and gay and lesbian participants. Finally, mental health practitioners possessing an advanced degree seem to have a greater satisfaction with life. Thus, it would appear that the higher the degree, the higher the satisfaction with life.

An additional regression analysis revealed that the two indices of grief (i.e., Past Behavior and Present Feelings) were strongly associated with a traumatic stress response and accounted for a large portion of the variance. In essence, the finding suggests that practitioners grieving following the loss of a client to AIDS are also likely to be experiencing traumatic stress reactions in relation to the loss. The literature

supports the idea of trauma and grief reactions to the death of clients to AIDS (Gabriel, 1991, 1994; Perreault, 1995). Importantly, this finding appears to add confirmation to the author's contention that the "HIV/AIDS traumatic-grief syndrome" is comprised of elements of traumatic stress and grief.

Additional Analyses

From the list of demographic characteristics, additional analyses were performed with demographic variables of interest. These characteristics were selected because of their value to provide more breadth and understanding of AIDS-related bereavement among mental health professional.

Years worked with persons with HIV/AIDS. This demographic assessed the number of years worked with persons with HIV/AIDS. Number of years worked was examined in relation to the measures of grief, trauma, psychological distress, and satisfaction with life. Interestingly, only satisfaction with life was significantly related with number of years worked with persons with HIV/AIDS.

This finding appears to make sense. It would seem that the longer some mental health practitioners work with the HIV/AIDS population, the more likely they have found ways to manage and survive doing this unique and difficult work. However, more importantly, it is likely they have also found ways to gain perspective and meaning in their personal lives. Perhaps, this translates into a greater satisfaction with life. It seems probable that many mental health practitioners working with the HIV/AIDS population have left the AIDS-related field and/or the mental health field

due to the nature of the work and toll from losing clients. For some practitioners that continue to work and provide services to persons HIV positive or with AIDS, it may be that the experience of working with the HIV/AIDS population has been enriching and transforming, causing personal growth and a more satisfying quality of life.

Supporting this finding, a 49-year-old, female, American Indian, Ph.D. level psychologist writes:

“I believe that I am more aware of each day, of those I meet, the opportunities I have. In essence, I’ve learned to live more truly.”

Percentage of clients with HIV/AIDS. This demographic assessed for the percentage of clients with HIV/AIDS on the respondent’s caseload. Percentage of clients with HIV/AIDS was examined in relation to the measures of grief, trauma, psychological distress, and satisfaction with life. The results indicated that participants with 75% to 100% of clients with HIV/AIDS had higher indices of depression, phobic anxiety, and psychoticism than participants with 2% to 50% of clients with HIV/AIDS. Also shown was that participants with a lesser percentage of clients with HIV/AIDS (i.e., 2% to 50%) had higher satisfaction with life scores than participants with a greater percentage of clients with HIV/AIDS (i.e., 75% to 100%).

The first finding seems significant. The results appear to provide evidence that having a caseload consisting predominately of clients with HIV and with AIDS, and losing clients to AIDS, is associated with symptoms of depression, phobic anxiety, and psychoticism. It seems reasonable to suppose that working strictly with and losing clients to AIDS is demanding, wearing, and tough, and may affect practitioners in a variety of

ways. Examining the depression, phobic anxiety, and psychoticism subscales from the BSI will help to clarify and interpret this finding. Of note, looking at the mean scores of the three subscales for this subset of participants, the depression and psychoticism subscales had higher elevations although not within the clinical range, while the phobic anxiety mean score was not elevated. Interpretations are rendered with this information in mind.

The depression subscale reflects indications of clinical depression; symptoms of dysphoric mood and affect are represented as are lack of motivation and loss of interest in life (Derogatis, 1993). It appears that one possible distress outcome of AIDS-related bereavement for practitioners working primarily with clients with HIV and AIDS is depression. This comes of little surprise as depression is noted as a grief reaction following loss (Bowlby, 1980; Kubler-Ross, 1969; Rando, 1984; Worden, 1991). Depression has also been found as an outcome of AID-related bereavement among gay men (Martin, 1988; Richmond & Ross, 1990; Sowell et al., 1991). Importantly, this result lends credence to reports that depression is a response of therapists to the death of clients with AIDS (Bernstein & Klein, 1995; Dane, 1995; Namir & Sherman, 1989). Moreover, the finding suggests depression as a risk of mental health work with individuals with HIV and AIDS, and AIDS-related bereavement. A limitation of this study is that duration of reactions and symptoms are not known. This information would be helpful as to differentiate between normal and abnormal/pathological grief.

The phobic anxiety dimension is defined as a persistent fear response, to a specific person, place, object, or situation. The response is irrational and

disproportionate to the stimulus and leads to avoidance or escape behavior (Derogatis, 1993). Phobic anxiety may be a fitting reaction given an important and defining characteristic of the entire group of respondents. That is, the overwhelming majority of participants were HIV negative. Seen in this light, it may be that HIV negative practitioners harbor fears of contagion and fears about death and dying in response to working with and losing clients with HIV/AIDS. Fears of this type were found with medical practitioners working with AIDS patients (Treiber et al., 1987; Wallack, 1989) and were suggested as responses of mental health professionals working with individuals with HIV and AIDS (Dunkel & Hatfield, 1986). Worden (1991) noted phobic reactions as indicators of abnormal or unresolved grief. In addition, Namir and Sherman (1989) suggested that mental health professionals are vulnerable in the face of losses and feared losses, and this can lead to depression, phobic reactions, and burnout.

The psychoticism subscale provides for a graduated continuum from mild interpersonal alienation to dramatic psychosis; items indicative of a withdrawn, isolated, schizoid lifestyle are included, as well as symptoms of schizophrenia (Derogatis, 1993). Derogatis and Melisaratos (1983) suggest that in most non-psychiatric populations this dimension measures social alienation. Given this information, the finding seems to suggest that the loss of clients for practitioners carrying a heavy caseload of clients with HIV and with AIDS is also related to social isolation. It appears that primarily working with the HIV/AIDS population and experiencing AIDS-related loss may lead practitioners to withdraw socially and become isolated. The literature on grief reactions seems to support this finding. Social withdrawal and social isolation are suggested as

grief reactions (Kubler-Ross, 1969; Lindemann, 1944; Worden, 1991); isolation and detachment are noted as bereavement responses following the death of someone with AIDS (Lennon et al., 1990; Richmond & Ross, 1990; Bramlett et al., 1991); and, isolation and withdrawal were reported as mourning reactions of therapists following the death of a client with AIDS (Gabriel, 1991, 1994).

A 46-year-old, female with 100% of clients with HIV and with AIDS writes:

“While I am very present and compassionate with my clients I realize I am becoming more frustrated as a person. Burnout is a probability.”

While the findings are tempered by the relatively low mean scores, they offer important information about AIDS mental health work. The symptoms experienced by practitioners with 75% to 100% of their clients with AIDS seem characteristic of grief. Also found with these analyses was that having a caseload with a lesser percentage of clients with HIV and with AIDS is associated with greater satisfaction with life. Given the aforementioned findings, this last finding intuitively makes sense.

Type of work setting. This demographic assessed for the type of setting where practitioners work (e.g., AIDS Center/Project, community mental health center, hospital, private practice). For explorative purposes, participants working exclusively at an AIDS Center or AIDS Project were contrasted with participants working at various other settings (i.e., non-AIDS Centers/Projects) and examined in relation to the measures of grief, trauma, psychological distress and satisfaction with life. The findings appear telling. Participants working exclusively at an AIDS Center or AIDS Project reported experiencing greater past grief reactions, global psychological distress, depression,

anxiety, hostility, and paranoid ideation than participants working at various non-AIDS Centers/Projects. Conversely, participants working in non-AIDS agencies reported a greater satisfaction with life than participants working in AIDS Centers/Projects. This is an important finding as it suggests that practitioners who provide mental health services in AIDS Centers/Projects are distressed on many fronts.

Examining the mean scores for participants at AIDS Centers/Projects, Past Behavior scores were elevated above the normative mean for “grief,” and GSI, depression, anxiety, hostility, and paranoid ideation indices all had higher elevations but were not within the clinical range. Again, a look to the content of the measures assists in framing some of the explanations and interpretations of this finding.

Mental health practitioners working at an AIDS Center or AIDS Project appear to experience grief at the time of their client’s death. This seems like a healthy response, as expressing grief at the time of the loss may help facilitate the grieving process. While the index of present grief was only moderately elevated, it is this author’s contention that the presence of other psychological distress suggests that grief may be an ongoing experience for practitioners at AIDS Centers or AIDS Projects. The elevated global severity of distress index seems to support this contention.

Specific distress outcomes appear to suggest the presence of current grief, that is, depression, anxiety, hostility, and paranoid ideation. Depression has already been noted as an expression of grief (Bowlby, 1980; Kubler-Ross, 1969; Rando, 1984), and as an outcome of AIDS-related bereavement (Bernstein & Klein, 1995; Martin, 1988; Namir &

Sherman, 1989; Richmond & Ross, 1990; Sowell et al., 1991; Summers et al., 1995).

The finding suggests that working in AIDS Centers or AIDS Projects and losing clients to AIDS is related to symptoms of depression.

Derogatis (1993) describes the anxiety subscale as including signs such as nervousness and tension, feelings of terror and panic, feelings of apprehension, and some somatic correlates of anxiety. Importantly, anxiety was also found to be a distress outcome associated with client loss to AIDS for those working at an AIDS Center or AIDS project. The finding is consistent with the literature. Anxiety has been noted as a grief reaction (Gabriel, 1991; Viney et al., 1991-92; Worden, 1991), and Summers et al., (1995) found an elevated prevalence of panic disorder in gay men with unresolved grief.

This last finding, in part, may also be suggestive of a traumatic stress response or of death anxiety. The items from the Anxiety scale that appear to support this statement are: "Suddenly scared for no reason," "Feeling fearful," and "Spells of terror or panic." These items may be seen to imply intrusive symptoms of posttraumatic stress disorder, and/or of a much deeper and intangible anxiety about death. The items seem to speak of a primal anxiety. Yalom (1980) defined death anxiety as man's fundamental fear of death, of non-being, and of no longer existing. Importantly however, anxiety appears to be another distress outcome from AIDS-related bereavement for practitioners working at AIDS Centers or AIDS Projects.

The hostility subscale represents thoughts, feelings, or actions that are characteristic of the negative affect state of anger (Derogatis, 1993). Hostility, too, was associated with practitioners working at AIDS Centers/Projects in response to the death

of a client with AIDS. The literature also provides support for this finding. Hostility and anger have been noted as signs of grief (Bowlby, 1980; Kubler-Ross, 1969; Lindemann, 1944; Rando, 1984; Worden, 1991). And, anger is a common reaction with AIDS-related bereavement among gay men (Viney et al., 1991-92) and with AIDS-related bereavement among mental health professionals (Bernstein & Klein, 1995; Dane, 1995; Dunkel & Hatfield, 1986; Gabriel, 1991). Interestingly, two of the items from the hostility subscale (“Feeling easily annoyed or irritated” and “Temper outbursts that you could not control”) seem to address the arousal criteria (i.e., “irritability or outbursts of anger”) for posttraumatic stress disorder (DSM-IV, 1994). Moreover, the results suggest that hostility and anger are reactions to the loss of a client with AIDS.

Although hostility, as a grief reaction, was just addressed, it is speculated that anger in response to AIDS-related bereavement may be present for other reasons. For example, anger may be in response to frustrations concerning no foreseeable cure for AIDS, anger about discrimination against those working and associated with AIDS, anger concerning bigotry toward individuals infected with HIV and diagnosed with AIDS, or for the plight of those infected with HIV and diagnosed with AIDS.

The paranoid ideation subscale represents a disordered mode of thinking; the cardinal characteristics are suspiciousness, hostility, and fear of loss of autonomy (Derogatis, 1993). The finding appears to suggest that AIDS-related bereavement for practitioners working at an AIDS Center/Project elicits a response of fearfulness and suspiciousness of others. Because AIDS is stigmatizing, it seems likely that those working at an AIDS Center/Project might also experience discrimination and alienation.

Bennett (1995) suggested that AIDS health care professionals may feel angry and despondent because of the discrimination they face. Thus, when a client dies from AIDS it seems conceivable that distrust and suspiciousness of others would be aroused and heightened. This finding seems to point to a unique reaction for practitioners working at an AIDS Center/Project. Suspiciousness may also be suggestive of a hypervigilant response, as found in the arousal criteria for posttraumatic stress disorder (DSM-IV, 1994). Perhaps the constellation of symptoms emerging from this finding (i.e., anxiety, hostility, and paranoid ideation) are pointing to a traumatic-like bereavement reaction in response to losing clients to AIDS. In fact, earlier findings suggested that practitioners working exclusively at an AIDS Center or AIDS Project seem at risk for an “HIV/AIDS traumatic-grief syndrome.”

Of little surprise, participants working in various other non-exclusive AIDS settings (e.g., community mental health center, hospital, private practice) reported greater satisfaction with life. It would appear that non-AIDS Center/Project work environments are less distressing and permit a greater satisfaction with life. The previous explanations and interpretations of the AIDS Center/Project variable seem to assist in understanding this last finding.

Gender. The demographic, gender, was examined as it relates to grief, trauma, psychological distress, and satisfaction with life. The results indicated that female participants reported significantly greater intrusive symptoms than male participants, while male participants reported significantly higher interpersonal sensitivity and phobic anxiety symptoms than female participants. These findings appear to add important

additional information about AIDS-related bereavement among mental health practitioners.

Intrusive symptoms were associated with female mental health practitioners. Intrusive symptoms are characterized as intrusively experienced ideas, images, feelings, or dreams in response to traumatic events (Horowitz et al., 1979). Interestingly, it appears the female practitioners experience intrusive reactions in response to the death of a client with AIDS. This finding seems to ask the question, “Why do females and not males experience intrusive reactions?” Studies have shown that female gender emerged as a risk factor for posttraumatic stress disorder (Breslau, Davis, Andreski, & Peterson, 1991; Breslau & Davis, 1992; Cottler, Compton, Mager, Spitznagel, & Janca, 1992; Nottis, 1992; as cited in Wilson & Keane, 1997). However, these findings are tempered by the fact that females have elevated rates of sexual assault and domestic violence, and high rates of PTSD for survivors, which contributes to the appearance that female gender is a risk factor for PTSD (Wolfe & Kimerling, 1997).

Similarly, Davidson and Jackson (1985) found symptoms of trauma in nurses. They suggested that a posttraumatic stress reaction is likely for nurses because nurses are forced to witness catastrophic events: that is, death, accident, and trauma at first hand. While Gabriel (1994) does not differentiate a gender specific trauma response, she found that group therapists experienced death images after group members’ death to AIDS. As the current study has already shown that some practitioners experience a traumatic stress reaction in response to the death of a client to AIDS, this finding adds support to the proposal that some practitioners working in the AIDS mental health field experience

“vicarious traumatization” (Pearlman & Mac Ian, 1995). Equally important, the finding offers new information that females seem susceptible to intrusive symptoms following the death of a client to AIDS.

Perhaps, to answer the earlier question, males, because of being socialized to be “tough,” experience reminders of the death of a client with AIDS, but hesitate to report this information. In support of this, it has been suggested that gender-role socialization impacts an individual’s willingness or ability to disclose trauma exposure or PTSD symptoms with a tendency for males to suppress symptom experiences (Wolfe & Kimerling, 1997). Moreover, this is an important finding as it suggests that female practitioners experience and are troubled by reminders of a client’s death to AIDS.

Conversely, the analyses revealed that interpersonal sensitivity is a reaction for male practitioners who lose a client to AIDS. Examining the demographic characteristics may assist in understanding this finding. Out of the 35 male participants, 25 identified themselves as being gay. With this in mind, the association between males and interpersonal sensitivity may become clearer. The Interpersonal Sensitivity subscale taps feelings of personal inadequacy and inferiority, especially in relation to others, in addition to self-deprecation and self-doubt (Derogatis, 1993). It is possible that negative feelings about self, and self in relation to others, stem from feelings and struggles about societal prejudice and non-acceptance of the gay community and lifestyle. Certainly, it would seem that feeling like a social outcast may affect how a gay man views himself and how he then relates to the world. AIDS-related bereavement may be seen to

exacerbate these feelings. The bereavement literature supports this finding as lowered self-esteem, feelings of worthlessness, and alterations in relationships were suggested as grief reactions (Lindemann, 1944; Worden, 1991). Perhaps, too, the items that denote personal inadequacy and self-doubt reflect the “helplessness” that practitioners experience in the face of client loss to AIDS (Bernstein & Klein, 1995; Dane, 1995; Farber, 1994; Gabriel, 1991; Namir & Sherman, 1989).

The analyses also revealed that phobic anxiety is associated with male practitioners. As stated earlier, the phobic anxiety dimension is defined as a persistent fear response, to a specific person, place, object, or situation, and the response is irrational and disproportionate to the stimulus (Derogatis, 1993). Again, demographic characteristics may help to explain this finding. While 25 out of 35 males were gay, the majority of respondents were HIV negative. These two factors seem key in understanding this finding. Thus, it seems likely that gay practitioners who are HIV negative may have fears about contracting HIV, and fears about death and dying that are educated with AIDS-related loss. Moreover, as a group, male practitioners apparently have fears that are grounded in working with the HIV/AIDS population and experiencing the deaths of clients.

Sexual orientation. This demographic assessed for sexual orientation as defined as heterosexual versus non-heterosexual. Sexual orientation was examined in relation to the measures of grief, trauma, psychological distress, and satisfaction with life. The results were quite surprising. Gay and lesbian mental health practitioners reported significantly higher past grief reactions, global psychological distress, somatization,

obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism symptoms than heterosexual practitioners. In addition, heterosexual participants reported experiencing a greater satisfaction with life than non-heterosexual participants. Examining the mean scores of these indices for non-heterosexuals indicated that the mean of Past Behavior met the cutoff score for grief and all other mean scores were slightly to moderately elevated but were not within the clinical range.

This finding seems to suggest that gay and lesbian mental health practitioners are suffering in a variety of ways from AIDS-related bereavement. It would appear that losing clients to AIDS is distressing for this group of practitioners. While this appears to be a major finding, the literature may assist in understanding and explaining the results, and may provide a context in which these findings can be interpreted. Specifically, the literature on gay men will be examined because the extent to which lesbian women have been affected by the AIDS epidemic is not known (Dean, 1995).

It has been stated that the gay community has faced and endured the AIDS epidemic the longest, while incurring the greatest losses (Lennon, Martin, & Dean, 1990; Neugebauer et al., 1992). Seemingly, it's "as if" the gay community has been held captive for the last twenty years by AIDS-related bereavement. Biller and Rice (1990) suggest that members of the gay community struggle to resolve grief because of society's inability and unwillingness to accept the gay identity, and due to the exacerbation of grief induced by repetitive loss over a brief period of time. Importantly, research has shown

that AIDS-related bereavement is distressing for gay men (Martin, 1988; Neugebauer et al., 1992; Summers et al., 1995; Viney et al., 1991-92).

Past grief reactions were associated with gay and lesbian participants. As discussed earlier, expressing grief at the time of the loss of a client may help to facilitate the grieving process. It seems likely that gay practitioners, in particular, have not only lost clients to AIDS, but have experienced the loss of friends and partners to AIDS as well. Grief, for gay practitioners, may be a part of their every day existence. Even though the results suggest that gay and lesbian practitioners experience grief reactions at the time of a client's death, other indices appear to suggest that they are a distressed group and are profoundly affected by AIDS-related bereavement. The elevated global severity of distress index seems to support this statement.

In addition to past grief reactions and a general psychological distress, gay and lesbian mental health practitioners experienced greater somatization, obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. This appears to be an important finding, with the implication that AIDS mental health work and more specifically, losing clients to AIDS, leaves gay and lesbian practitioners vulnerable for an array of psychological difficulties. In fact, it is this author's speculation that the numerous psychological distress outcomes comprise a current intractable grief.

Almost all of the aforementioned psychological distress outcomes are noted as grief reactions in the literature: somatization (Lindemann, 1944; Worden, 1991), obsessive-compulsive symptoms (Worden, 1991), interpersonal sensitivity (Lindemann,

1944; Worden, 1991), depression (Bowlby, 1980; Kubler-Ross, 1969; Rando, 1984; Worden, 1991), anxiety (Worden, 1991), hostility (Bowlby, 1980; Kubler-Ross, 1969; Lindemann, 1944; Rando, 1984; Worden, 1991), phobic anxiety (Worden, 1991), and psychoticism (Worden, 1991). It follows from this listing that gay and lesbian practitioners are exhibiting symptoms of grief. Lennon et al. (1990) suggested that caretakers of those with AIDS are vulnerable to pathological consequences of bereavement, prolonged or unresolved grief reactions, and high levels of distress due to the AIDS epidemic. As noted earlier, AIDS mental health work is tough, demanding, and takes a toll on some practitioners. Yet, apparently, nowhere near the toll it seems to take on gay and lesbian practitioners.

Studies have shown that gay men suffer consequences from AIDS-related bereavement such as: anxiety, anger, symptoms of traumatic stress, depression, hopelessness, helplessness, preoccupation and searching for the deceased, and panic disorder (Martin, 1988; Neugebauer et al., 1992; Summers et al., 1995; Viney et al., 1991-92). The findings from this investigation are consistent with the above psychological consequences, but seem to establish that gay, as well as lesbian practitioners, are touched deeply and are affected by the loss of clients to AIDS. In fact, it appears that they have a difficult time coping with AIDS-related losses. Bennett (1992; as cited in Sherr, 1995) found that identification with people with AIDS led to higher levels of grief. She suggested that gay professionals may be more vulnerable to overidentification and at emotional risk for more intense feelings of grief in

response to patients' death. Perhaps an overidentification with clients with HIV/AIDS accounts for gay and lesbian practitioners' bereavement and psychological distress.

Considering societal dimensions might also help to explain the apparent wide spread distress that gay and lesbian practitioners are reporting. Society, even prior to the AIDS epidemic, has not been accepting of the gay and lesbian communities. In general, gays and lesbians, even with the gay and lesbian liberation movement, aren't fully welcomed or accepted into society, and continue to fight against marginalization and discrimination, and for recognition and equality. Perhaps there are hurts and wounds exclusively from the experience of being a gay male or lesbian woman in the world. Perhaps, too, there is vulnerability carried over from this experience which might make a gay or lesbian mental health practitioner susceptible to distress, especially when faced with issues of loss and grief. Death may tap unresolved underlying issues of these practitioners. If these hypotheses are tenable, gay and lesbian practitioners may be at risk and vulnerable to psychological difficulties in response to AIDS-related bereavement, as this may help to explain the wide spread distress reported in this finding.

Although there is no research on lesbian practitioners working with the AIDS population, this finding is important and adds new information about this group of mental health providers. Importantly, AIDS mental health work appears to be stressful and distressing for lesbian as well as gay practitioners. The question arises whether this group of practitioners represents a "working-wounded": that is, practitioners that appear "okay" as they continue to provide AIDS-related services, but actually, are distressed as a result of AIDS mental health work and loss of clients to AIDS.

A 48 year-old, gay practitioner writes:

“Two lovers and hundreds of clients (18 years), I have not retained the joy of life I expected and think I lost many years ago.”

Summary and Implications of the Study

This study, although exploratory in nature, brings new information to the literature on AIDS-related bereavement among mental health professionals. Although some findings did not support pre-data collection assumptions other findings were important and informative.

Surprisingly, number of client deaths and recency of death were not found to be associated with bereavement or psychological distress. The absence of associations between greater number of deaths and all measures appears to disconfirm what Kastenbaum (1969) termed “bereavement overload” and the literature posed as problematic and distressing for AIDS mental health professionals: that is, multiple loss (Dane, 1995; Gabriel, 1991; Perreault, 1995). However, experiencing many client deaths was related to an avoidant response. It would seem that one way of handling multiple loss of clients to AIDS is to avoid reminders of the loss. Avoidance was posed by this author to represent a response set of denial, detachment, or minimization to the many deaths practitioners experience. If this speculation is correct, some practitioners may be at risk for personal and interpersonal difficulties brought on by delayed or unresolved grief. Some of these difficulties include: depression, lowered self-esteem, social isolation, hostility, and anxiety (Lindemann, 1944; Worden, 1991).

Interestingly, recency of a client's death was not associated with bereavement or psychological distress. Although recency of death does not appear to be a factor in AIDS-related bereavement, it is speculated, as was with number of deaths, that some practitioners deny, avoid, or minimize client deaths to AIDS, thus placing them at risk for distress.

The results appear to support Silverman's (1993) proposal of an HIV/AIDS caregivers' stress syndrome while this author proposed that an "HIV/AIDS traumatic-grief syndrome" exists for some AIDS mental health practitioners. This finding seems important and has implications for mental health professionals. It appears that some practitioners react to the death of clients with AIDS with symptoms of trauma, grief, and a general psychological distress. Visual examination of data revealed that working in an AIDS Center, having 75% to 100% caseload of clients with AIDS, and having a client commit suicide are features that may make a practitioner susceptible to an "HIV/AIDS traumatic-grief syndrome" (supplemental analyses appeared to confirm this). Importantly, the findings seem to identify a distress syndrome that may lead to impairment in mental health practitioners who lose clients to AIDS.

Interestingly however, individual or group therapy/support did not prove to be a mitigating factor with respondents. This was surprising but led to the speculation that other informal support systems may be helping and assisting practitioners to deal with their reactions to loss of clients. Further research needs to be conducted assessing social support and its relation with AIDS-related bereavement among mental health professionals.

Multiple regression analyses revealed important demographic characteristics associated with the indices of distress. Having a client with HIV/AIDS commit suicide, in addition to losing clients to AIDS, was related to grief and traumatic stress responses. Clearly, practitioners experiencing both types of client loss seem at risk for distress. It was also found that females seem susceptible to current grief, younger practitioners seem at risk for unresolved grief, and, gay and lesbian practitioners appear subject to a global psychological distress. These characteristics appear to highlight those at risk for bereavement and psychological distress. On the other hand, the results appear to show who is doing well and may be coping with client loss to AIDS. They are: practitioners with a smaller caseload of clients with HIV/AIDS (i.e., 2% to 50%), practitioners experiencing fewer client deaths, practitioners that are heterosexual, and practitioners with a higher academic degree.

Supplementary analyses revealed additional information concerning AIDS-related bereavement among mental health professionals. It was found that more years worked with persons with HIV/AIDS was also related to greater satisfaction with life. This finding supplements the previous finding and broadens the description of practitioners who apparently are “okay” and derive a satisfaction from their lives, even though losing clients to AIDS.

Importantly, analyses revealed that having a caseload primarily with clients with HIV/AIDS (i.e., 75% to 100%) is distressing. A heavy caseload was associated with depression, anxiety, and psychoticism. These distresses were noted as common grief reactions, yet their presence signals psychological difficulties for those working strictly

with clients with HIV and with AIDS. Other analyses showed that working exclusively at an AIDS Center or AIDS Project was related to past grief and a general psychological distress including symptoms of depression, anxiety, hostility, and paranoid ideation. This finding also seems important as it identifies distress reactions that practitioners working at an AIDS Center/Project may experience. Additionally, the analyses found that working in other types of non-AIDS agencies were related to satisfaction with life. Again, this last information is added to the list of demographic characteristics of practitioners presumably not reporting distress.

Gender, too, was shown to be an important variable. Females experienced greater intrusive symptoms while males reported greater symptoms of interpersonal sensitivity and phobic anxiety. In conjunction with an earlier finding, females seem at risk for intrusive symptoms and current grief in response to the death of clients with AIDS. Conversely, males seem at risk for feelings of inadequacy, self-doubt, and negative feeling about self and self in relation to others. Additionally, males appear at risk for a persistent fear response. It was hypothesized males may harbor fears about contagion and fears about death and dying. Importantly, this finding appears to highlight areas of psychological difficulty for each sex. Finally, the results revealed that gay and lesbian practitioners are distressed on multiple fronts. It seems that experiencing the death of clients to AIDS is very stressful and distressing for these practitioners.

Collectively, the results provide new and substantial information about AIDS-related bereavement. The findings seem to identify risk factors and susceptibilities for distress following loss of clients to AIDS. Perhaps, too, the findings may permit

speculation that some mental health professionals are impaired. Thus, the profile of those at risk or susceptible to distress appear to be gay and lesbian practitioners, practitioners working exclusively at an AIDS Center or AIDS Project, having a caseload with 75% to 100% of clients with HIV and with AIDS, and having a client commit suicide in addition to losing clients to AIDS. Furthermore, females seem to be at risk for current grief and intrusive symptoms, while males seem at risk for interpersonal sensitivity and a phobic reaction.

Moreover, these findings imply that help, be it psychological, social support, or otherwise, seems necessary for distressed practitioners working with the HIV/AIDS population. Death of clients with AIDS is distressing for some practitioners, yet apparently, they continue providing mental health services. It is hoped that the findings of this study will assist in identifying potentially distressed practitioners with the hope that those distressed will seek assistance.

Limitations of the Study

Although the present study represents one of the first investigations concerning AIDS-related bereavement among mental health professionals, certain limitations of the study must be acknowledged. Before proceeding, it bears mentioning that the face of AIDS has changed over the last twenty years. It seems that what mental health professionals encounter today with clients with HIV and AIDS is somewhat different than say five, ten, or fifteen years ago when prophylactic treatments consisted of only one or two drugs and new drugs were in trials or were not yet developed. Today, better medication treatments have assisted in prolonging the lives of individuals with HIV and

with AIDS. None the less, mental health practitioners continue to lose clients to AIDS-related diseases, and, according to the present findings, some appear to be distressed as a result. Some respondents echo what has been suggested.

A 51 year-old, female practitioner writes:

“A cure may be in the future, but not soon enough. I’ve been attempting to draw the happy parallel between now and the 80’s when there was no time to live. Now, thank God, we have that.”

A 45 year old, female practitioner comments:

“My reaction now is much different than years ago. After navigating with clients through their successes and relentless roller coaster falls, I have learned to rejoice in the good and ‘be there’ in the bad. Going through the entire process including funerals, is therapeutic for my resolution of a client death.”

And a 51 year old, female practitioner responds:

“By the same token, because fewer clients (and also friends) are dying now than in the mid-80’s, I don’t feel quite as desperate and depressed as during that period. For many years it seemed like everyone was dying.”

Potential limitations exist that may have bearing on the results of this investigation. Most notably, while the study investigated whether mental health professionals experience bereavement and psychological reactions following the death of a client(s) with AIDS, prior and existing mental health problems, not attributable to bereavement, may have influenced and contributed to the response set. This study is

grounded on the assumption that the identified psychological and bereavement reactions are rooted in the death of a client with AIDS. Caution is noted that mental health professionals may be practicing with pre-existing or current mental health difficulties or disorders.

Certain limitations surfaced concerning the demographic questionnaire. After completion of the study it appeared that additional information about participants was needed. For instance, a question inquiring about respondents' previous trauma history should have been included, as a trauma history could have confounded the results. A question assessing duration of symptoms would have assisted in differentiating normal from abnormal grief. Horowitz (1980) noted that abnormal or pathological grief reactions are more related to the duration or intensity of the reaction rather than to the simple presence or absence of a specific behavior. It would have been helpful to know how long practitioners experienced their bereavement and psychological reactions. Information about duration of distress would help to further advance the understanding of AIDS-related bereavement among mental health professionals.

In designing the demographic questionnaire item 18 inquired about the time period of most recent client death. Following this last demographic question respondents were asked to answer the subsequent questions with that person in mind. Written responses to the optional question at the end of the questionnaire provided valuable information concerning how participants responded to the measures.

A 40-year-old, female writes:

“Have changed dramatically since the past four deaths I have experienced,

especially the one involving my friend and co-worker. Answers to this survey would be much different if I had answered with that death in mind.”

A 32-year-old, male responds:

“How I react to the death of a client has as much to do with the individual and the type of life that was lead as with the actual death itself.”

And, a 57-year-old, male writes:

“I based my responses on the one most recent death, who happened to be a person who was alcoholic and a borderline personality – thus not one of many clients whom I loved dearly.”

It seems, based on these responses, that how a respondent “felt” about their most recent client that died from AIDS influenced their response set. Hindsight appears to suggest that asking respondents to keep in mind a client that was somehow important or that stood out for them while responding may have produced a different set of responses. The results are tempered by this knowledge.

Overall, the measures appeared to assess bereavement and psychological distress following the death of a client and provided valuable information. However, level of social support was not assessed as part of the study. Having information about this dimension may have helped to explain normative mean scores for the entire group of respondents. Knowing the relation between social support and all measures would have added to the understanding of AIDS-related bereavement among mental health professionals.

To repeat, the face of AIDS has changed as perhaps reflected in the number of questionnaires that were returned to the sender undeliverable. Forty-one questionnaires were not delivered for various reasons. This led to questions about the reliability of the source that was used to select research sites (of note, it was the most up-to-date and leading comprehensive resource of AIDS care), and questions about HIV/AIDS services that have closed because of funding problems or other difficulties. Interestingly, 108 respondents returned the questionnaire and 96 were usable. Although the response rate was good given the survey nature of the study, the question arose to why approximately 250 questionnaires were not completed and returned. It seems that the participants who returned the completed questionnaire may have differed in important ways from those who did not. Clearly, the majority of respondents were white, and, based on the written responses to the optional question, appeared motivated to express their experience of AIDS-related bereavement as some were thankful for the opportunity. More importantly, as an investigator, questions surfaced about the characteristics of those that didn't respond to the survey and about their mental health status related to the loss of clients to AIDS.

Finally, it must be noted that numerous statistical comparisons were carried out at the .05 significance level, increasing the probability of committing Type I error. As previously mentioned, setting alpha at .05 was done to permit the emergence of new information. However, all findings should be viewed with this knowledge in mind.

Future Directions

This was an important investigation and led to new information about AIDS-related bereavement among mental health professionals. While it represents ground floor research in this area of AIDS-bereavement, it also leads the way for future study. Some of the possibilities and directions for future research are presented.

Future study with this population needs to incorporate ethnic and racial diversity as minority groups were under represented. Also under represented were practitioners that are HIV positive and diagnosed with AIDS. Only five gay men with HIV and with AIDS participated in the study. Future research in this area should seek a larger sample of HIV positive practitioners and practitioners diagnosed with AIDS. Examining AIDS-related bereavement with this group of practitioners appears to be an extremely important area of investigation. Furthermore, it would also be helpful to consider ways of including and getting practitioners that are not likely to respond to AIDS-related bereavement research to participate in future research.

Further investigations examining AIDS mental health workers should assess for previous trauma history and level of social support. Additionally, religious or spiritual dimensions also seem important in understanding AIDS-related bereavement and may be assessed in future research. This study did not assess for behavioral problems resulting from AIDS-related bereavement (e.g., sleep problems, drug/ alcohol problems) and future research might address these issues. Again, measuring duration of distress would be helpful to better understand and assess the nature of AIDS-related bereavement.

It also appears important for future investigation to examine the experience of working with the HIV/AIDS population. While this study specifically examined AIDS-related bereavement, it seems likely that working with the dying, versus grieving over the loss of a client to AIDS, may represent different experiences.

Finally, as this investigation yielded profiles of practitioners that may be at risk or susceptible for bereavement and psychological distress, it seems important to further study those groups of practitioners (i.e., gay and lesbian practitioners, practitioners working at AIDS Centers, and practitioners with 75% to 100% of clients with HIV and with AIDS). It would seem important to examine why and what makes some practitioners at risk or susceptible for distress. And, conversely, to examine the factors that allow some practitioners to seemingly cope and report a satisfaction with life, even though losing clients to AIDS. Ultimately, it is hoped future research and interventions are aimed at decreasing distress and maximizing the opportunity for professionals experiencing AIDS-related bereavement to maintain a reasonable satisfaction with life.

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Appendices

Appendix A

Cover Letter

Dear Mental Health Professional,

As AIDS persists well into a second decade, research is vital to address the psychological and bereavement issues of those left in the wake of this deadly virus. Current AIDS-related bereavement research focuses on reactions of the gay community, physicians/nurses, family caretakers and volunteer AIDS caregivers to the death of persons with AIDS. Lacking, however, is empirical research that examines the reactions of mental health professionals when a client dies from AIDS.

Having worked as a counselor with the HIV/AIDS population and the affected community in South Florida for 3 years, I have witnessed and experienced the loss of clients to this horrific plague. My own experience and the lack of research on the reactions of mental health professionals to the death of a client with AIDS, led me to pursue this important and timely topic for my dissertation. This research project fulfills the requirements for a doctoral dissertation.

Moreover, I am conducting the present study to answer the question of what specific and unique reactions mental health professionals experience after the death of a client with AIDS. My plan is to use the results of this study to alert and inform mental health practitioners and the scientific community of the psychological and bereavement reactions to working with the AIDS population.

As director, would you distribute this questionnaire to the practitioner that is most representative of the counseling staff in terms of service provision to HIV/AIDS clientele. Importantly, participation in whole or in part in this research is voluntary. The respondent also has the right to not respond to every item and confidentiality and anonymity will be maintained.

As I know, it takes a genuine commitment and dedication to work with individuals with AIDS. I also believe those involved with mental health care of individuals with AIDS are deeply affected by their work. It is time to address the impact of loss for these special providers. I urge you to see that this questionnaire is completed and returned. Completion of the questionnaire will not only help to advance knowledge, but assist to identify consequences that may be adversely affecting mental health providers when a client dies from AIDS. You and/or a staff member can help further AIDS-related bereavement research. Thank you in advance. If you have questions or concerns about this study, please contact Joseph Kachik at (XXX) XXX-XXXX.

If you are not completing the questionnaire yourself, please pass along this letter, the questionnaire and the self-addressed return envelope to the appropriate staff member.

Sincerely,

Appendix B
Demographic Questionnaire

Mental Health Professionals Reactions to loss(s) of Clients with AIDS

Respondent:

Please begin by completing the following demographic questions and proceed with the remainder of the questionnaire. Time to complete the entire questionnaire will take approximately 20-30 minutes. When finished, place the completed materials in the self-addressed stamped envelope and mail. You have the right to not respond to every item, and confidentiality and anonymity will be maintained.

1. Gender: Male
 Female
2. Age: _____
3. Ethnic background: White Asian
 Black American Indian
 Hispanic Other (please indicate) _____
4. Sexual Orientation: Heterosexual
 Gay
 Lesbian
 Bisexual
 Trans-gender
5. Highest Degree Earned: Less than a Bachelor's
 Bachelor's
 Master's
 Doctorate
 Other (please indicate) _____
6. Academic Training: Counseling psychology
 Clinical psychology
 Social Work
 Mental health counseling
 Other (please indicate) _____

7. Theoretical Orientation: Humanistic (e.g., Rogerian, Existential, Gestalt)
 Behavioral
 Cognitive
 Psychoanalytic/Psychodynamic
 Family Systems
 Other (please indicate) _____
8. HIV Status: HIV positive Not known
 HIV negative Prefer not to indicate
 AIDS diagnosis
9. How many years have you worked with persons with HIV/AIDS? _____
10. Have any of your clients with HIV/AIDS died from AIDS?
 Yes No **If yes, how many?** _____ **(If no, skip items 14 and 18)**
11. Have any of your clients with HIV/AIDS committed suicide?
 Yes No **If yes, how many?** _____
12. Please indicate if you have had any **non-client** deaths during the last year:
 Family Members (including parents, siblings, children, relatives, spouse/
 significant other)
 Family Member with AIDS (including the above relations)
 Friends
 Friends with AIDS
 Other (please indicate) _____
14. Do you participate in individual therapy, group therapy or a support group to
 deal with **your** grief and loss issues?
 Yes No **If yes, how long?** _____ **how often?** _____

15. Type of work with HIV/AIDS clients: (check all that apply)
- Individual counseling/therapy
 - Group (e.g., support, counseling, psychoed.)
 - Couples counseling
 - Case management
 - Other (please indicate) _____
16. Type of setting:
- AIDS center/project
 - Health department
 - Community mental health center
 - Hospice/nursing home
 - Hospital
 - Other (please indicate) _____
17. Percentage of clients with HIV/AIDS _____%
18. Indicate the time period of most recent client death:
- 0-3 months
 - 4-6 months
 - 7-9 months
 - 10-12 months
 - greater than 12 months

Now please answer all of the following questions with that person in mind.

If you answered No to question 10, proceed to and complete the BSI and Scale #4.

(Remember you have the right to not respond to every item, and confidentiality and anonymity will be maintained.) Thank you for your help.

Appendix C
Reminder Postcard

Approximately one month ago you received a questionnaire concerning a research project regarding the reactions of mental health professionals to the death of clients with AIDS. As stated in the cover letter, this is an important area of research and your participation is vital to the project. Please complete the questionnaire as soon as possible and once again, thank you for your participation.

Joseph R. Kachik Jr., M.Ed.

Curriculum Vitae

Name: Joseph Robert Kachik Jr.

Date of Birth: October 27, 1955

Place of Birth: Johnstown, Pennsylvania

Education

West Virginia University, Morgantown, West Virginia

Degree: Ph.D. in Counseling Psychology (APA approved) - 1999

Florida Atlantic University, Boca Raton, Florida

Degree: M.Ed. in Counselor Education/Mental Health Counseling - 1992

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