Retrospectives From Three Counseling Psychology Predoctoral Interns: How Navigating the Challenges of Graduate School in the Face of Death and Debilitating Illness Influenced the Development of Clinical Practice

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Death and debilitating illness can have a significant impact on one’s understanding of self, others, and society. When a counseling or clinical psychology graduate student experiences such hardships during the course of his or her clinical training, there can be several potential implications. The stressors of graduate school may exacerbate the emotional responses to an already painful situation. Additionally, clinical skill development can be negatively affected if the student has difficulty acknowledging how hardship influences his or her capacity to be an effective therapist. However, the same tribulations can also help new therapists to realize their inner strength, develop beneficial coping skills, and apply this knowledge when working with clients. Highlighted in this article are three cases of loss and hardship that underscore the importance of supportive clinical supervision, psychological hardiness, humor, and optimism during times of personal crises.

Keywords: supervision, grief, training, clinical internship, counselor development

The experience of death or debilitating illness is a salient issue for most clinical and counseling psychologists. The presence of death or illness in our own lives can make navigating the day-to-day demands of life and work difficult. Yet, in the presence of such extraordinary difficulties, we can continue to learn and grow by reconciling and integrating these painful experiences. Considering such issues is a process that not only affects us on a deeply personal level but can also affect the therapeutic work we do. If our own struggles are dealt with appropriately, these experiences can actually make therapy more powerful and dynamic. However, learning to use painful personal experiences with clients/patients is a high-level clinical skill that requires substantial insight, intensive training, and strength-based clinical supervision. Moreover, the clinical training experiences that typify graduate training programs use a developmental process whereby psychologists-in-training treat clients/patients who are appropriate for their level of training and then are able to gradually move on to more complex cases as clinical skills are mastered.

An experience with death or debilitating illness at any point during the course of graduate-level clinical training presents both a potential obstacle and a source of tremendous growth, for it forces the novice psychologist to grapple with how personal issues affect his or her clinical work to a degree that is far beyond what is typically expected during the graduate training experience. We propose that it is the responsibility of students to identify how personal grief and loss impacts their clinical skills and to use the emotional pain to become better clinicians. This insight-oriented journey requires dialogue and introspection. These discussions should be facilitated by a supportive supervision process, peer support, and active self-reflection.

This article first broadly examines the stressors related to graduate school as well as the general impact of grief in people’s lives. Human resiliency provides the context for three case studies that
illustrate how three counseling psychology graduate students managed to succeed despite traumatic life events. Lastly, the protective psychological factors that were found in common across all three case studies are presented.

Stressors Related to Graduate School

The stressors of graduate school are evident in extraordinarily high attrition rates. Recent estimates of attrition rates of doctoral students hover between 40% and 50% (McAlpine & Norton, 2006; Smallwood, 2004). The high pressure associated with the sheer volume of work, anxiety-provoking lofty expectations, lateral professional comparisons, and continual academic evaluation can be quite overwhelming (Kilburg, 1986; Millon, Millon, and Antoni, 1986). In addition to this, graduate students in counseling or clinical psychology programs experience stressors related to the additional training they must undergo to become clinicians along with being scholars. Counseling and clinical psychology graduate students engage in diverse coursework—such as research design, statistics, assessment, psychotherapy, and ethics—while they simultaneously maintain a minimum of clinical and supervision hours. Dual professional roles can also be a source of stress. Often, psychology graduate students are confronted by professional dilemmas involving “multiple and overlapping roles” encountered during training, such as graduate assistant–student relationships, student therapist–student client relationships, and student–professor/advisor/clinical supervisor relationships (Oberlander & Barnett, 2005, p. 52).

Moreover, stressors outside of the academic arena can result in a substantial reduction of academic effort and interfere with therapists-in-training’s professionalism. For example, psychology graduate students who also juggle several other roles, such as spouse and parent, tend to have even higher stress levels (Dearing, Maddux, & Tangney, 2005). Financial hardships in light of full-time coursework, part-time practica, and concurrent thesis/dissertation time should not be overlooked (Millon et al., 1986). The transition from graduate school to predoctoral internship can generate turmoil, such as loss of significant relationships and renewed apprehension regarding clinical skills (Solway, 1985). Likewise, a graduate student who experiences a grief reaction or debilitating illness during graduate school must find the resources to manage this additional stressor.

Stressors Related to Grief

There are many physical and psychological consequences related to grief and bereavement. Researchers (Osterweis, Solomon, & Green, 1984; Stroebe & Stroebe, 1987) have suggested a decline in mental and physical health and general well-being in those who have suffered a loss. In addition, a growing body of research suggests that grief can have a negative impact on immune system functioning (Irwin & Pike, 1993; Kim & Jacobs, 1993). In regard to the relationship between grief and immune function, Irwin and Pike (1993) stated that “cell-mediated immunity may be altered in men and women undergoing severe, acute, psychological stress such as bereavement” (p. 166). Additionally, Jacobs, Hansen, Berkman, Kasl, and Ostfeld (1989) found five health conditions that may function to generate higher morbidity as a consequence of loss: (a) change in the health practices of the survivor, (b) neglect of early disease warnings, (c) inadequate management of chronic diseases such as diabetes or hypertension, (d) alcohol abuse, and (e) absence of care that used to be provided by the deceased.

Bereavement has also been connected to mental health issues. In a sample of 1,411 older adults (55 years of age or older), Murrell and Himmelfarb (1989) found that those who had lost an attachment relationship—such as with a parent, a spouse, or a child—had the strongest depressive reactions as compared with those with nonattachment bereavements such as from the loss of a sibling, friend, grandchild, house, pet, or job. Some research suggests that grief can contribute to physical illnesses. Ott (2003) found that 44% of 112 participants who had lost their spouse were currently being treated for a physical illness around the time of their partner’s death (e.g., hypertension, migraines, heart disease, gastrointestinal problems). At 33 months after the death of their partners, 26% of 112 participants reported a new physical illness since the death of their spouse, and 15% reported a new mental health problem since the death (e.g., depression, anxiety, suicide attempts).

Resiliency

The bright news is that the human spirit is resilient. Seligman and Czikszentmihalyi (2000) put forward their belief that all individuals possess strength and virtue. We believe that a therapist must remember to emphasize this resiliency when working through his or her own pain or with clients/patients who have experienced seemingly unbearable adversity. This strength-based paradigm allows both therapists and clients/patients to navigate the challenges in life and attempt to make sense of great loss. The following three stories highlight this struggle to maintain optimism, develop psychological strength, and sustain a sense of humor during times of personal challenge. The three novice psychologists also share their insights about how their experiences have enabled them to better work with individuals who may have similar grief, loss, or debilitating illness issues as their presenting concern.

Case Study One

Graduate school was a growth-filled experience for me. For many reasons, I felt immensely grateful to have gained entrance into an excellent graduate counseling psychology program at a Research I institution. My post–high school academic path was circuitous, and after several years of general vocational confusion, I returned to school. By the time I entered graduate school, I was a “nontraditional student” with a family. I was also the oldest student in my small cohort.

Learning the intricacies of counseling involved substantial personal growth that extended far beyond understanding how to manage my new professional role or identifying the theoretical orientation that best defined the way I operated as a therapist. I was a graduate student dealing with cancer. When my partner received the cancer diagnosis during my 2nd year in graduate school, I was profoundly affected. Not only did it affect me personally but this tragic news also affected my professional growth processes. I value privacy, and at that time in my life I was emotionally overdefended. Therefore, sharing personal tragedy, asking for help, and soliciting feedback from others regarding how I impacted
them was especially difficult. Yet becoming aware of how the way I managed my difficult personal circumstances affected my interactions with others was a crucial step in establishing my professional identity.

My 2nd year practicum was at a college counseling center, and as is the trend at other colleges, there was a noticeable increase in the level of pathology in the college population. While this was great experience for a nascent psychologist, it was also quite stressful managing a caseload of high-pathology clients. Beyond the extra readings of special treatment and diagnostic issues, I ruminated about client problems at night. Thesis research and academic coursework also occupied a significant portion of my time. In addition to this, my partner and I were doing cancer treatment research, examining the side effects and the costs. At that point in my life, the decisions I made at school, with high-needs clients, and at home felt particularly weighty. All of this took its toll on me mentally.

After some time, my partner and I finally decided to commit the next 2 years to cancer treatment. We were both graduate students, raising a child on graduate school stipends and student loans. Student health insurance only paid for portions of the outrageously expensive treatment regimens, leaving us with crushing debt. In addition to my other requirements, I took several extra side jobs.

Cancer treatments are known to cause fatigue; however, there was a time when my partner’s fatigue became very bad. One morning, the world began to crash around me. My partner began to have difficulty breathing and could barely get out of bed. We raced to the hospital, and my partner underwent emergency surgery and was given four units of blood in the intensive care unit (ICU). While my partner was recovering in the ICU, I was informed that my grandmother had died and that my brother, a helicopter pilot, was being deployed to Iraq. I could not reach my brother to say goodbye. I could not attend my grandmother’s funeral because my partner was too ill to watch our child. I felt guilty and angry.

During this very difficult time, my inclination to keep painful matters private did not serve me well in my clinical work. In an effort to stay in control of my emotions, I came across as unapproachable and uptight. I was told on a number of occasions that because I did not share my life circumstances, people did not ask me how I was doing or how they could help. My reactions to stress only served to further my sense of isolation. I continued to suffer emotionally and physically. I was exhausted, irritable, mildly depressed, anxious, and had embarrassing tearful episodes in class when issues hit too close to home (i.e., bereavement issues, cancer, and health psychology). I had difficulty explaining to others that, beyond the demands of parenting, relationship, and extra jobs, the role that cancer played in my life was enduring and profound.

I could not have retained my capacity to counsel others had it not been for my 2nd year practicum supervisor. My supervisor had just dealt with a protracted serious health issue with her partner. This fact was something I could not have known had I not opened up and shared my own story during supervision. She was able to understand my struggle unlike any other person in my life at that time. She helped me find the humor in the difficult circumstances we shared, such as how we clumsily answered our children’s questions about their fathers’ serious medical conditions or how we both nearly fainted when we received the first medical bill that was tens of thousands of dollars. She was also able to gently ask difficult questions pertaining to my clinical work in a way that was supportive and nonjudgmental. This supervisor helped me examine issues such as countertransference, discontinuing work with certain clients in light of my difficult life circumstances, and when to self-disclose appropriately. She helped me manage my emotions regarding my clients’ problems so that I did not excessively worry about them at the end of the day.

At the same time, she was humorous and emotionally available; when I expressed my appreciation for these characteristics in her, she pointed out the parallel process between my role as a supervisee and my role as a therapist. Disclosing my difficulties and emotions opened the door for this supervisor to share her similar life experiences, which in turn created an atmosphere of trust and support during supervision. In this way, this supervisor helped me to examine how overcontrolling my own emotions many times impeded my clients’ emotional growth and kept me isolated from others. This process allowed me to open up emotionally and to value the “here and now” with my clients.

Moreover, this supervisor gave me a strong clinical foundation and helped me use adversity to define further my professional identity. I gained more self-confidence, as I learned that I was capable of handling just about anything. Most important, I learned that finding meaning in adversity was imperative, as is finding strength in emotional vulnerability, asking for help, and maintaining a sense of humor. Under the guidance of a supportive clinical supervisor, my experiences with cancer and death let me fully acknowledge and feel others’ pain without becoming personally and professionally overwhelmed.

Case Study Two

My journey to becoming a counseling psychologist has been filled with bumps, bruises, uncertainties, challenges, and, most importantly, tremendous joys. Before graduate school, I assumed that therapy was a clear formulaic solution to use when helping others. Much of the best advice and supervision I received in those early years of graduate school involved listening to my own intuition, being comfortable with clients who were in tremendous psychological and physical pain, and becoming comfortable with not always knowing what to say. This is not to say that I am completely comfortable with the ambiguity that being a psychologist sometimes represents. However, as I learned to counsel others within the ambiguities of therapy, I also had to learn to deal with the ambiguities present in my own life.

During my master’s program, I developed an autoimmune disorder that caused much of my hair to fall out, a weight gain of more than 80 pounds in 6 months, incapacitating fatigue, and substantial slowing down of my metabolism. I tried on clothes in the morning that had fit me the previous week and found that they were now too small due to even more weight gain. I collapsed in tears. Early in this disease process, my doctors looked at my lab results and rising weight in puzzlement. There did not seem to be a cause, much less a cure, for this disorder. Coupled with my doctors’ uncertainty came diminished self-esteem, hopelessness,
and fear. Each morning my partner softly convinced me to go to classes, study for exams, and push myself to be a better therapist.

In total, I saw seven doctors in an attempt to figure out what was happening to my body. Many of these doctors did not listen to me when I told them what was happening. Many implied that I had become depressed and had overeaten to make myself feel better. One doctor even suggested I must have been eating massive amounts of kelp to account for my confusing blood results. He seemed unconvinced when I told him I was not a fan of seaweed, much less addicted to it.

Several months later, while I was in my doctoral practicum, a woman walked into my office for counseling. She began to describe ongoing physical problems such as weight gain, hair loss, and paralyzing fatigue. She went on to describe the medical community’s puzzlement regarding her symptoms and the accompanying emotional and psychological pain this disorder was causing her. I was immediately struck with a need to say something so profound as to fix her problems and make her pain go away. The words that I wanted to say to this client were the words I had longed for someone to say during my own health crisis. I considered self-disclosing and joining with her in her despair. I wanted to affirm the hopelessness she experienced within the medical community and her anger at her own body’s apparent dysfunction. Yet, despite these strong impulses, I held back and remained unconditional in my empathy and positive regard for this client.

During a discussion with my supervisor, I began to talk about my own struggles during my health crisis. She asked me to recall the things that kept me going. I knew that the humor and the hopefulness instilled by some medical doctors, friends, and family members were critical. I was reminded of moments of humor during my struggle with this autoimmune disorder. For instance, there was one time when I had gained so much weight that I didn’t have underwear to fit me. My partner and I went to a local discount store to purchase new ones. I was so frustrated by the new size of my body that I forgot that women’s underwear is sized differently than clothing. My partner balked at the size I chose (in lime green no less), but I snapped at him, “I know my size!” When I got to the parking lot, I unwrapped a lime green tent that was supposed to be underwear. Fold after fold after fold, I opened it. We both started laughing hysterically when we realized I had purchased underwear big enough to be a quilt for our queen-size bed.

Through additional discussions with my supervisor, I discovered that it was not just a “cure” that I longed for during this time. I desired the simple act of someone joining with me, validating my experience and frustrations, and instilling hope that I could feel better. I took this discovery with me into my therapy with this woman. Week after week, I encountered her pain and was reminded of my own during my experience. I appropriately disclosed small parts about my own situation, remaining careful to allow her to guide our time together and to not make her therapy sessions about me. As a result, I was able to join with her over a shared experience and was able to validate her frustrations and pain. I laughed with her as she shared her own stories of humor, and I tried to instill as much hope as I could. Through my work with her, along with supportive supervision, I learned that I do not have a formula to ease a client’s pain and suffering; however, I realized that as a psychologist, I have the ability and the power to help others find meaning in experiences that hold much pain and frustration.

Case Study Three

Graduate school has been tremendously fulfilling. I have been intellectually challenged, tired, poor, and grateful all in the same breath. Graduate school in counseling psychology presents its own complexities. Before graduate school, I believed that I had it all “figured out” and, for this reason, could provide a solid foundation for which others could work through their worries. As I learned how to be a therapist, I also learned that this self that was “figured out” was only a work in progress. Therapy invites a range of emotions and experiences not only for the client but surely for the therapist as well. It did not take long until I determined that being in graduate school to become a therapist initiated contemplation about my life, my priorities, my values, and how I deal with tragic loss and grief.

During college, my father unexpectedly passed away. He and I had a very close bond, and his absence left a tremendous void in my life. After he died, my family and I stood around the computer while writing his obituary. It was a beautiful and logical construction of words that we parsed and examined with care. I remember feeling simultaneously awestruck and inspired as we wrote down what he had accomplished and what talents he had contributed to the world. We talked about the giant impact he had on our lives, his many friends, and our community. I honestly felt humbled in that moment, to be one of his children. After we finished this final essay, I took 3 days off from school and then drove back to college, a far distance from any family. I excelled academically that semester, remained active in campus organizations, worked several jobs, and ran my fastest times during the track season. I wanted to make my dad proud. I wanted to live life to the fullest; just as he had lived his.

Several years later, during graduate school, my father-in-law, who I had known for over half of my life, also unexpectedly passed away. He was barely 50 years old; it did not seem to make sense. How had my husband and I suffered such a similar sadness? In response to my confusion, I similarly forged ahead—just as I had done in college. I turned in my papers on time and balanced practicum and two other jobs without a thought about taking time off from either. The problem was, my husband was mourning the loss of his father, and he and I differed in our coping styles. I avoided the practice of distancing myself from the world. We talked about the giant impact he had on our lives, his many friends, and our community. I honesty felt humbled in that moment, to be one of his children. After we finished this final essay, I took 3 days off from school and then drove back to college, a far distance from any family. I excelled academically that semester, remained active in campus organizations, worked several jobs, and ran my fastest times during the track season. I wanted to make my dad proud. I wanted to live life to the fullest; just as he had lived his.

Several months later while I was working as a practicum therapist at the university counseling center, a woman and her husband walked into my office for couple’s counseling. The woman had recently lost her mother to a long fight with cancer. The man’s father had died in an automobile accident several years earlier. The couple was arguing a lot, and the woman was frustrated by her partner’s seeming insensitivity to her loss. Her partner expressed that she should not be sad because her mother was “in a better place” and that there was a “reason for everything.” For the female partner, these words were unsatisfying platitudes.

I was immediately struck with a fascinating paradox. This couple had sought out treatment from me, since I specialize in couples’ issues, and I was the one person in the agency who had been through a very similar situation with my own spouse. However, my husband and I had actually gone through the situation
poorly. My partner and I had failed to understand and respect the disparate ways that we grieved.

So, there the three of us sat, week after week, and it was hard. Had I been a graduate student in literature or biology, I am not sure that this enigma would have presented itself to me. Further, I might not have been forced to actually sit still for 50 minutes a week and be reminded of my loss, my hurt, and my unresolved anger. I may not be expected to hold answers or insight. However, this was what I felt compelled to do, and it was brilliant.

During a discussion with my supervisor, I discovered that I was sympathizing more with the grief reaction of the male partner—we were optimists. The female client was mourning in a manner similar to my partner—they were realists. This realization allowed me to step back from the situation and objectively consider each of their reactions without judgment or emotional investment. It was this supervision that gave me clarity. I began to understand that each person in this dyad was “right,” and their reconciliation could be derived from mutual respect and understanding.

I found that in our common experience, I had empathy and compassion and respect for both partners’ deep suffering and grief. My eyes filled with tears when the wife talked about how she and her husband’s future children could not know either grandfather. I urged the husband to understand that she needed to see that this was moving, real, and sad for her. I was able to reframe his gift of tears, not as sadness in response to hopelessness but as congruent emotion alerting him that the person who was gone was important and influential in his life.

I validated his optimism and his deep love for life and for living it to the fullest, and I encouraged her to appreciate this aspect of his personality. She agreed that to a large extent, this is why she had fallen so deeply in love with him. She too was inspired by his inherent optimism. I valued our time together. We talked about how death has real impact and yields real emotion. We talked about how their disparate emotional responses to death were valid and important. I grew. She mourned. I grew. He developed skills. I grew. They flourished.

Sometimes clients present pain that exacerbates my own. When this happens, I try to remember that while sadness and loss should be embraced, I inherently find more personal value when I choose to look at situations in a positive light. One psychologist clearly stated that the psychological community has a history of researching only the negative implications of death and dying (and illness) because of the deficit-oriented approach that has been the dominant paradigm in the mental health field (Greeff & Human, 2004). However, a new paradigm reframes the ebb and flows in life as normative and considers that individuals can find great strength in sorrow and grief. Only when I could be still with my couple did I fully understand the power of empathy and understanding.

Protective Factors

In each of the case studies, we were able to learn about ourselves and how we embrace and manage our own grief reactions. The supervision process was invaluable to each of us, because we were able to verbalize our own emotional reactions to our clients’ lives and sort out which emotions were our own and which emotions were merely projections of our unresolved grief and loss experiences. Supervision enabled us to learn that our visceral reactions to clients can be useful and that sometimes even responsible self-disclosure can facilitate the therapeutic alliance. We also learned that there are times when our experiences can blind us to the differences between our clients and ourselves. Overidentifying with a client or an experience can actually impede or even damage the therapeutic alliance. These insights were prompted by positive supervision and personal introspection. Additionally, we believe that there are three inherent protective factors—psychological hardiness, humor, and optimism—that were critical forces during our emotional struggles. These factors emerged as powerful coping mechanisms for each of us. These protective factors were not only salient to us personally but informed us about how to recognize these strengths in clients when they cannot recognize their own resiliency and resources.

**Psychological Hardiness**

Hardiness refers to a personality construct that is thought to be a protective factor for individuals experiencing distress (e.g., anxiety, depressive disorders) or undergoing difficult life events (e.g., death, chronic illness). Hardiness is a “resilient response” to such stressors that allows an individual to continue participating in his or her daily life with “little or no loss of functioning” (Maddi, 2005, p. 261). The presence of hardiness in an individual’s personality is positively related to work satisfaction (McCalister, Dolbier, Webster, Mallon, & Steinhardt, 2006), increased personal health in the face of stressful events (Turnipseed, 2000), problem-focused responses rather than escape-avoidance responses (Conner, 2005), and lowered drug/alcohol usage (Maddi, 2002).

Hardiness is akin to “existential courage” or the blend of self-confidence with life acceptance (Maddi, 2002, p. 176). Research indicates that it comprises three attitudes: commitment, control, and challenge (Maddi, 2002). These “3Cs” of hardiness involve a strong commitment to the people and activities in a person’s life, a sense of personal control in managing life events, and the tendency to view life changes as positive challenges (Maddi, 2002, p. 175; McCalister et al., 2006). This definition is especially relevant in the first case study as the therapist-in-training struggled with the reality that sometimes the best definition of hardiness is having the discernment to ask for emotional and mental reinforcements from other caring persons.

**Humor**

The idea that humor has positive health benefits is not a new one. Martin (2002) suggested that there are four mechanisms of humor that have different implications for health. First, laughter may produce physiological changes, relaxing muscles, improving respiration, stimulating circulation, and increasing the production of pain-killing endorphins. Second, laughter and humor induce positive emotional states that may enhance immunity. Third, humor may moderate the adverse effects of stress on health. Finally, humor may also benefit health by increasing social support. Vaillant (2000) identified humor as an adaptive and health-promoting defense because “humor permits the expression of emotion without individual discomfort and without unpleasant effects on others” (p. 95). Vaillant went on to describe humor as such a sensible coping device that it surprises people because of the unconscious nature of it. This is perfectly illustrated by the second case study, in which the therapist-in-training was able to share a humorous...
moment in the parking lot over a pair of large lime green under-
wear.
Granick (1995) suggested that many therapists regard humor as a valuable and productive mechanism that enables clients to progress in dealing with personal, social, health, and emotional problems. Saper (1993) indicated that the use of humor can allow the therapist to draw attention to maladaptive behaviors while affirming the essential worth of the client.

**Optimism**

It is understood that therapists are actually inherently positive and emotionally strong. During school, optimism propels us further in our education. Scheier and Carver (1987) have studied how people pursue valuable goals. “Optimism leads to continued efforts to attain the goals, whereas pessimism leads to giving up” (Peterson, 2000, p. 47). It seems that optimism is advantageous in graduate school. We keep going to class, writing papers, and taking exams. Graduate students in counseling also possess a deep interest in the well-being of others and a deeply held belief that others can change and grow.

It is essential for a beginning therapist to consider whether optimism in times of grief is really a euphemism for denial. It is essential to challenge the assumption that an optimistic response to death is psychologically healthy. Even though looking at the positives rather than the negatives in any particular situation contributes to well-being (Peterson, 2000), maybe individuals who find strength in sorrow are “skipping” a step or two in the grieving process. Some theories have assumed that individuals who do not show overt signs of grieving will eventually manifest delayed grief symptoms (Bonanno & Field, 2001).

The third case study exemplified a situation in which optimism and denial were closely aligned. Did this therapist-in-training sufficiently embrace her sadness or did she simply “run” from her emotional discomfort? Did she “block out” pain by engaging in time-consuming activity in order to avoid the feelings? Did she, in fact, pathologize a client when she did not react in a similarly optimistic way when her own mother passed away? The assertion of optimism research is that an individual who displays relatively few negative grief symptoms can still mourn (Bonanno, Papa, Moskowitz, & Folkman, 2005).

Recent research has provided strong challenges to the views that optimism is a guise for denial. The relative absence of grief symptoms and the ability to function and flourish in day-to-day activities following a loss of a loved one appear to not reflect denial but an inherent and adaptive resilience in the face of loss (Bonanno et al., 2005). In one study, data from 323 bereaved adults who had lost a loved one 3 years earlier demonstrated that their positive thinking about the death was inversely related to measures of depression, anxiety, and traumatic grief symptomatology (Boelen, 2002). In fact, perhaps optimism is a positive coping skill that therapists can use in their own lives and teach to their own clients as well. The therapist in the case study was eventually able to use her optimism to realize that even the woman, with her more visible and emotional grieving style, could benefit from the therapy process and find a way to reconnect with her partner.

**Summary**

By reframing grief reactions as resiliency, we believe that individuals can flourish after tragedy. According to Fredrickson’s (1998) *broaden and build* theory, the lasting effects of positive emotions can transform people into more creative, resilient, and healthy individuals. In the first case study, the problem-focused response was an effective way to manage multiple stressors and forge ahead during a difficult time. In the second example, humor helped to lend levity and perspective to an experience that was seemingly desperate and beyond any personal control. In the last case study, optimism and a positive reframing process transformed two people who each believed the other “grieved wrong” into two people who respected the strengths they each brought to the relationship. In all three cases, supportive supervision had a direct role in helping us to transform personal crises into remarkable professional growth. Positive supervision provided a new lens through which to view our situations and the tools we needed to help our clients. In addition, this combination of internal strength and external support helped us reflect on our individual journeys toward becoming champions for all clients who seek to flourish and triumph through their personal struggles.

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