Middlesex University and Metanoia Institute

The Therapist in Crisis: Experiencing the Therapeutic Process After Personal Loss

Research Thesis

Amy Horwell

submitted in partial fulfillment of the degree of

Doctor of Counselling Psychology and Psychotherapy by Professional Studies (DCPsych)

Acknowledgements

Abstract

This research project explores the intersubjective world of the 'therapist in crisis' in an attempt to understand what it is like to be a psychological therapist following personal loss. Data gathered from nine semi-structured interviews with therapists who had experienced personal loss were analysed using a relational-centred approach to a heuristic inquiry research method. This incorporated an explicit use of my 'self-as-researcher' and careful attendance to the 'in-between' of researcher-participant in order to access the experiencing of the phenomenon under investigation.

Three core themes were identified and created from the data. The first concerns the ambiguity in the post-loss therapist's ability to connect in the therapeutic relationship, highlighting the sense of connection and disconnection that can happen on an intrapsychic and intersubjective level. The second concerns the experience of physical and psychic space in the bereaved therapist's world and the impact this has on their ability to continue clinical work. The third theme surrounds the meaning of their work to the post-loss therapist and the embodiment of their changing identity as a psychological therapist.

My findings suggest that there is a complex interplay in the dynamic processes involved in the intrapsychic and intersubjective world of the post-loss therapist. What is evident from this research, and is of central importance to this thesis, is the way in which loss inevitably enters the unconscious intersubjective domain of the bereaved therapist. This has important implications for the psychological therapist, for the therapeutic relationship, and for the practise of counselling psychology and psychotherapy.

Definition of Terms

The following terms are used throughout this thesis. From my reading of relevant literature in the field, I proffer my understanding and use of the terms.

Bereavement: the objective experience of losing someone or something, most commonly associated with the death of someone significant.

Loss: a broader experience that encapsulates a person being deprived of something important to which they are attached. This can include tangible losses such as death and divorce as well as less tangible losses such as identity. Loss can also refer to the subjective state of bereavement. I use these two terms interchangeably in this thesis given their interconnectedness and as a reflection of how my participants defined their experiences.

Grief: the personal experience of loss, and the emotional reaction or response to loss.

Mourning: the process which occurs following loss by way of actions and expression of grief.

Contents

Introduction

This research is concerned with the dynamic processes that occur both within the therapist-client dyad and within the therapist self structure, and the influence each has on the other, in the context of loss in the life of the therapist. Perhaps put more simply, I am interested in the interrelatedness between the impact of therapists' personal loss on their clinical practice and the impact of clinical practice on therapists' experience of personal loss. This concept of interrelatedness refers to a mutually interacting world of experience and interconnection between an individual and their environment. It brings to mind Trevarthen's (1979: 321) notion of 'primary intersubjectivity' where "human beings understand one another intimately and at many levels". The therapeutic process involves an interaction of the two subjectivities (Mitchell and Black, 1995) in which the client and therapist affect and are affected by one another (Aron, 1991). The result is a continuous co-creative dialogue between two minds in what Stern (2004) terms the intersubjective matrix.

Our understanding of intersubjectivity theory has shifted beyond Kohut's (1984) two-person psychology of selfobject needs, into Stolorow and Atwood's (1992) recognition of reciprocity and the interpersonal dimension, and moving to an emphasis on the significance of the relational unconscious (Gerson, 2004) or 'analytic third' (Ogden, 1994) that is the co-created ground between client and therapist. Developments from neuroscience and interpersonal neurobiology have provided a significant contribution to our knowledge of social relational exchange. The impact of one mind on another and the 'dance of connection' (Siegel, 1999) between two subjectivities are of central importance to this thesis. Ammaniti and Gallese (2013) point out that interest in intersubjectivity has continued to grow over the course of several decades in many scientific fields, including relational psychoanalysis (e.g. Mitchell, 2000), infant studies (e.g. Beebe and Lachmann, 1988; Stern, 1985; Tronick et al, 1978), social cognition (e.g. Lieberman, 2013) and interpersonal neurobiology (e.g. Cozolino, 2014; Damasio, 2000; LeDoux, 1996; Panksepp, 1998; Schore, 2003; Siegel, 1999). Infant research has demonstrated the "complex relational network of the individual self from the beginning of life" (Ammaniti

and Gallese, 2013: xv), evident in the 'still face' experiment (Tronick et al, 1978) and the implications this has had on understanding interactions between depressed mothers and their babies (Tronick and Weinberg, 1997), the development of attachment classifications (Ainsworth et al, 1978), and Beebe and Lachmann's (1988) observations of mother-infant mutual influence. Such work has demonstrable key parallels in psychotherapy and our understanding of the intersubjective field.

Stern's (1985) focus on affect attunement in his research with infants and their primary caregivers similarly informs the process of psychotherapy. His work on 'implicit knowing' in the mother-infant relationship led to the Boston Change Process Study Group to explore the workings of implicit knowing in psychotherapy, finding that "the expansion of implicit knowledge about the therapeutic relationship that becomes intersubjectivity shared between patient and therapist is a potent mechanism for therapeutic change" (Stern, 2002: 12). Just as the interactions at the micro-local level of the mother-infant relationship will be impacted by a mother's subjective state (such as her experiencing depression), so too will the nonverbal domain of implicit knowing be affected by the therapist's subjective state (i.e. at times of personal crisis).

In putting together this thesis, I have drawn on research carried out in the field of affective neuroscience and interpersonal neurobiology, which, while by no means conclusive, can provide a framework for thinking about this kind of communication and 'knowing'. It has been suggested that the right hemisphere, nonverbal 'firing' with another right hemisphere results in a resonance in the minds of the individuals. Siegel (2001: 84) argues "at this nonverbal, core-self level, the interaction of self with other becomes mapped in the brain in a manner that literally, neurologically, creates the mind of the other". This representational process is what Siegel (2001) describes as 'mindsight'. In his work on affect and consciousness, Panksepp (1998: 4) asserts that "internally experienced affective states do have an important function in determining how the brain generates behaviour". Taken together, I think one can start to see an argument for the neurological basis of intersubjectivity. Although there remain questions to be answered about connectivity and their functional role (Kilner and Lemon, 2013), the discovery of mirror neurons supports these ideas, providing insight into neurobiological mechanisms of establishing intersubjective connection and contact (Gallese, 2009).

It is through the theoretical lens of intersubjectivity that I make sense of my interactions with participants and the data we create together. Intersubjectivity theory allows us to understand *why* client material will inevitably be heard and experienced differently by different therapists (Bohart and Tallman, 1999) and *why*

personal factors in a therapist's life, such as pregnancy, death and illness, will impact upon the therapist and in turn, upon the therapeutic process (Gerson, 1996; Gold, 1999; Anastasopoulos, 2004).   My intention is to drill down deeply into the experience of the 'therapist in crisis' to illuminate what may be happening in the social relational exchange between therapist and client, and indeed between researcher and participant, in the context of this work. The research rests on the presumption that:

1) Therapeutic neutrality is an untenable aspect of clinical practice and that emotional engagement with a client is part of effective treatment (Mitchell, 2000). As such, I expect therapists to be affected by personal events and for that to be part of their 'self' in the therapy room;

2) Therapists, like all human beings, have the potential for change. Working with clients can lead to self-growth and healing in the therapist (Maroda, 2004; Wosket, 1999);

3) This is an ongoing, cyclical process. As a therapist's self structure and understanding of their loss changes, so too does their 'self' in the therapy room.

There is a fourth presumption on which this study is based, and it is drawn from the same arguments as the first three. That the research process itself can be a vehicle for growth and development (Etherington, 2004) for both the researcher and the participants. For participants who have experienced personal loss, the research interview may represent an interaction that challenges them to (further) examine their experience of loss amidst clinical practice, and, in doing so, to re-construct the meaning such experience has for them. There is, therefore, the recognition that the research process will impact upon the participant's personal life and their professional work. This is an important additional contribution of the research and underscores the value of clinical practitioners undertaking these kinds of projects.

As for the research process being a vehicle of growth for the researcher, this comes from the deep personal engagement I have with the research topic. During the third year of my training, I suffered two separate and significant losses, and found myself with a deep-seated curiosity of how I would manage them and how I could integrate them into my 'self', both personally and professionally. I found a dearth of literature pertaining to the questions going round my mind and this prompted my professional curiosity to examine the issues more closely.

In this regard, just as we cannot be objective therapists, I cannot approach this study as an objective researcher. This is a central premise of my work and will inform every aspect of the study from philosophical underpinning and epistemological

positioning to data analysis and write-up. The overall aim of this project is to get to the core of what it is like to be a psychological therapist post-loss. I brought together a heuristic inquiry research method with a relational-centred approach to research in order to get to the heart of what I was seeking to know. Immersing myself explicitly into the study meant ensuring I remained as transparent as possible. As such, in the chapters that follow, I intend to take the reader through my own process, the influencing factors behind the research, and to map out the unfolding journey that led to this final synthesis.

Chapter One sets out the rationale for the study by examining the relevant literature in the field of loss and bereavement, and exploring the research carried out to date on the bereaved therapist to identify the gaps in our current understanding. Chapter Two offers the reader an overview of the epistemological position that I take up and an examination of the methodological approaches that influence my role as a researcher, the processes involved in gathering data and my approach to analysis. Chapter Three is the presentation of my findings before moving into a discussion of these findings in Chapter Four and considering the implications to the wider field. I draw the strands of the project together as my 'creative synthesis' in Chapter Five, making my final conclusions and reflections.

Chapter I

The Research In Context

My research question was borne out of my own experience of loss and followed a personal quest of searching the literature to find an answer to my then consciously unformulated question. In this chapter, I provide the background and rationale to the conceptualisation of the study, clearly locating myself in the field of loss from both a personal and professional standpoint. I then offer the reader an overview of literature to date, stemming from mainstream bereavement theorising before turning my attention more specifically to the literature on the bereaved therapist. The chapter concludes by setting out the research aims and the value of the project to the field of counselling psychology and psychotherapy.

1.1. A personal approach to researching loss

1.1.1. Becoming and being a practitioner-researcher

Historically, the doing of 'practice' and the doing of 'research' have been viewed as very separate activities in the field of psychotherapy (Orlans, 2003). This separation can be understood, at least in part, by the different needs of practitioners and researchers (McLeod, 1999) as well as perhaps how each is perceived by the other. McLeod (1999), for instance, asks the question 'why are researchers not more interested in practice', and Orlans (2003) writes that practitioners often tend to see themselves as unskilled when it comes to research despite significant similarities. Finlay (2011) asks important questions about bridging the practice-research divide and highlights how the 'chasm' between practice and research may be less than it feels. She points to the directly transferable skills and qualities of the therapist to the research domain and vice versa, including the ability to 'interview' the other; to critically reflect; to make reflexive interpretations based on 'data'; and to demonstrate warmth, empathy and compassion. Surely as therapists, with our training in the importance of building the therapeutic relationship and our self-development of the intrapsychic and interpersonal foci in therapy, we are well placed to engage in

research in a way that purist academics might not. Cotter (2015) writes about the changes in psychotherapy research in recent years from an academic lifeworld culture to one of practice. Having started my career as an academic researcher, deciding that this was not what I solely wanted to do, and going on to train as a practitioner, I welcome a less dualistic position and consider this study to be an opportunity to further integrate the doing of practice and research for myself.

1.1.2. Values underpinning my approach as a practitioner-researcher

As an integrative psychotherapist, I see my approach to integration as being an evolving process; one in which I must hold the tension between 'change within a model', taking into account new experiences and learning, and 'commitment to ongoing consistent coherency within a model', where core values and principles provide a "containing boundary" (Orlans, 2008: 35) for a constantly developing framework. My approach to research starts with the same premise: that a set of core values provides a container for 'doing' research and informs my approach and identity as researcher.

The first value concerns my overriding (personal) approach to being a psychological therapist and being a researcher, which essentially rests on a relational-centred ideology. My belief in the **centrality of relationship** for human beings is evidenced by the now burgeoning research literature from the fields of attachment theory, infant observation studies, affective neuroscience and interpersonal neurobiology that support the human being's need to connect with an intersubjective world. A lot of the work in this area draws on the mother-infant dyad as well as the neurobiology of the developing social brain to make links with psychotherapy (Beebe et al, 2005; Fonagy et al, 2002; Schore, 2003; Stern, 1985; Trevarthan, 2001). In the context of adult psychotherapeutic treatment, the 'centrality of relationship' is translated into emphasising the therapeutic relationship as well as a 'commitment to the between' therapist and client (Evans and Gilbert, 2005). In research terms, I find myself influenced by the notion of relational-centred research, which highlights the significance of the researcher-participant relationship in which data are co-created, emerging from the intersubjective space between the two (Finley and Evans, 2009).

My second value concerns the emphasis I place on **subjective experience** and **meaning-making**. As such, I take the attitude espoused by the phenomenological method of enquiry (e.g. Joyce and Sills, 2001) of staying with the other's subjective experience of being-in-the-world (Spinelli, 1994). In clinical practice, this position allows me to be with a client in *their* experience while, as a researcher, it allows me

to adopt the 'phenomenological attitude' purported by Finlay (2011) with importance placed on practitioner-researcher subjectivity and how we go about making sense of, and attributing meaning to, phenomena. Kant (1724-1804) argued that our knowledge about the world could not be separated from our experience and perception; with the perceptual tools available to us, we construct, categorise and make sense of existence (Howard, 2000). Orlans (2009) points to the importance of these ideas in the field of counselling psychology and psychotherapy in terms of the nature of perceptual reality and the role of the one doing the perceiving. There is an implicit subjectivity to this wherein meaning is not necessarily a shared phenomenon. I shall return to this in my epistemology discussion as it has important connotations for the role of the researcher.

The third value that underpins my approach to research concerns the notion that **change is a constantly evolving process**. Through a constructivist lens, I see change as continuously occurring over the lifespan as we interact with new and emerging 'symbols', both within and outside of the immediate therapeutic or 'research' space. In the context of this project, the research encounter is a forum for 'change', both for researcher and participant. Drawing on the notion of the reflective practitioner (Schon, 1983) and the principle of researcher reflexivity (e.g. Etherington, 2004; Finlay, 2011; Rennie, 1992), in the same way that the therapeutic process may be a domain for (re)constructing meaning and self-growth in the therapist, so too may the research process be such a domain for the researcher and participants.

1.1.3. The story behind the study: locating myself in the field of loss

When I was four years old, my parents divorced and my American mother moved me to her home country. I returned to England to visit my father and his new family every summer. No doubt this arrangement would have continued if it weren't for my mother's sudden death during a mountaineering tragedy when I was 12. Uprooted from all that I knew in America, I was moved to live with my father in England. Despite a tumultuous few years, my father and I were close, but sadly, in my 20's, he lost a short battle to cancer.

So my relationship with 'loss' began long before I had conceptualised this study, stemming from the impact that my losses had on my sense of self and the way in which I constructed my identity. These pivotal experiences influenced my choice to train as a counselling psychologist and psychotherapist. Loss, for me, was very much 'in the field' but it was two further significant losses I experienced midway through my training that led to this research. The first was the violent suicide of my maternal aunt. She had, in so many ways, become my 'other mother' and her quick descent

into the depths of depression, culminating in her taking a gun to her head, left me reeling. The second loss, occurring just a few months later, was my confirmed infertility. On both a personal and a professional level, I needed to manage and integrate these experiences. Through immersing myself in this topic, I have found a way of bringing together the personal, the therapist and the researcher in a congruent and meaningful way.

1.2. A review of the literature

This section provides a review of the literature relevant to this study, starting with mainstream bereavement theories that have informed thought and practice over the last century as a way of locating myself specifically in the field of loss and grief. I then move into an examination of the scope of research undertaken to date on the bereaved therapist and a critical appraisal of the main themes to have emerged from the available research. Examining both the wider field as well as the particulars of personal loss for the psychological therapist provides a rationale for undertaking this research by identifying the gaps in the existing literature and offering a solid contribution to counselling psychology and psychotherapy.

1.2.1. The nature of grief

There has been a great deal written on the subject of loss, grief and the process of mourning. My research begins with the task of surveying the landscape of loss in a bid to identify the factors that impact on people's experiences of bereavement and to understand the grieving process. This will provide a backdrop to my exploration into the psychological therapist's experience of the therapeutic process post-loss. Although my research does not encompass the experience of grief *per se*, it is nevertheless bound up in the post-loss experience of the therapeutic process. It is therefore necessary to consider the development of grief studies over time and the contributions they have made to our understanding of the field. In this section, I shall provide a historical overview of grief studies, with particular attention being given to the influence of attachment theory in understanding loss and the more recent advances in the neuro-physiology of grief. I will consider what is understood by 'normal' grieving and what is meant by 'complicated' grieving as this may help illuminate the differences between therapists who are able to continue in clinical practice and those that may 'fragment'. Finally, I will consider the more recent interest in the field of posttraumatic growth and how this may apply to the bereaved psychological therapist.

Grief and attachment theory

Grief is a natural experience when faced with the loss of a loved one and will happen to most people on repeated occasions during their lifetimes. While grief is a universal phenomenon, research has shown that responses to loss can vary tremendously. Burke and Neimeyer (2013) write that grief-specific distress can be seen as a continuum of responses to loss, with resilience at one end (regaining psychological equilibrium fairly quickly), through moderate distress of shock and sadness, to complicated and protracted grieving (reflected in profound separation distress, intrusive memories, meaninglessness, and considerable difficulty in continuing life without the loved one). In an influential study by Lindemann (1944), the complications of grief were considered to be resolved if the bereaved expressed their grief and could 'do the grief work'. However, subsequent clinicians and researchers were finding that those individuals who sought psychiatric help following bereavement were more likely to not be able to stop grieving than to be repressing their grief, so encouraging such people to express their grief may do more harm than good (Parkes, 2011). Parkes and Prigerson (2009) point out that chronic, lasting grief is more common than grief that is delayed, inhibited or distorted. To understand more about the differences between those who navigate the journey of grief with no lasting problems and those for whom grief results in a myriad of psychiatric problems, we need to look to the studies on the development of human attachment.

Parkes and Weiss (1983) found in the Harvard Bereavement Study that lasting grief was associated with more dependent, clinging attachments to the deceased. Bowlby (1988: 29) terms attachment behaviour to be "any form of behaviour that results in a person attaining or maintaining proximity to some other clearly identified individual who is better able to cope with the world. It is most obvious whenever the person is frightened, fatigued, or sick, and is assuaged by comforting and caregiving." The fear aspect is particular salient in attachment theory, and Prior and Glaser (2006: 16) point out that "fear and attachment behaviour are often simultaneously activated". Fear is elicited by a threat or perceived threat to a child's sense of safety or security, and they seek contact with and proximity to the attachment figure. The fear of being cut off from or separated from one's attachment figure, or secure base, results in separation anxiety. Slade (1999) outlines the key notions to Bowlby's theory: (1) children are born with a predisposition to become attached to a caregiver; (2) children will organise their behaviour and thinking to maintain these attachment relationships, which are key to their physical and psychological survival; (3) children might maintain these relationships at a cost to

their own functioning; (4) the distortions in thinking and feeling that come from early disturbances in attachment usually occur as a result of the caregiver's inability to respond to the child's needs for comfort, security and emotional reassurance. In short, the attachment system is a motivational system designed to regulate the proximity to attachment figures. In bereavement, this system is activated precisely because of the loss of an attachment figure and we would expect our specific attachment style to be most strongly activated under conditions of stress or distress such as the loss of an attachment figure (Zech and Arnold, 2011).

It was the groundbreaking work of Mary Ainsworth and colleagues (Ainsworth et al, 1978) on the 'strange situation' that led to a classification system for organised attachments. She focused predominantly on the quality of maternal responsiveness and how this links with patterns of infantile behaviour. From the observations of infant behaviour patterns in separation and reunion in what became known as the 'strange situation', Ainsworth and colleagues differentiated between secure and insecure attachment styles, breaking the latter into three insecure attachment classifications: anxious-avoidant, anxious-resistant / ambivalent and, in subsequent investigations, disorganised attachment style. The category of 'anxious-ambivalent' applied to those infants who, in the 'strange situation', became intensely distressed at separation and responded to reunification with a mixture of angry resistance and clinging or other contact seeking behaviour, giving the impression of ambivalence. Parkes (2006) found that people who had an 'anxious-ambivalent' style of attachment in childhood responded to bereavement in later life with severe, protracted grief and a tendency to 'cling'.

Perhaps to a lesser degree but nevertheless important to consider, those with an avoidant attachment style are also at risk of pathological grieving but in the form of repression or denial. The infants in Ainsworth et al's (1978) 'strange situation' who were described as having an avoidant attachment pattern, displayed little distress upon the mother leaving and paid little attention to her upon her return. However, their physiological arousal was high, suggesting that their avoidance tactics did not alleviate the extent of their separation anxiety. The difficulty from a research point of view is that it is not easy to distinguish avoidance from genuine autonomy over grieving (Parkes and Prigerson, 2009).

In the theoretical and empirical literature on attachment, it is suggested that attachment style predicts how we handle stressful situations and manage emotions, and therefore that attachment style can predict psychopathology outcomes. In terms of grief, it is posited that attachment style predicts how we might cope with bereavement and our grief reactions (Zech and Arnold, 2011). Attachment theory

provides a way of understanding individuals' grieving processes, how we cope with loss and has implications for effective treatment interventions, particularly in terms of complicated grief reactions. Attachment theory forms a background against which concepts of grief have developed over the years. In the following section, I shall proffer the main theories that have been put forward to understand bereavement. This is not an exhaustive exploration; rather it is an overview to show the key trends in bereavement theorising.

Mainstream grief models

In setting out his early theory on mourning a century ago in 'Mourning and Melancholia', Freud (1917) posited that the work of grieving ends once the individual severs their emotional attachment to the deceased. Later, and in large part based on his personal experience, Freud (1953) revised his theory to take account of the endlessness of grieving. However, it is his early theory that seems to have dominated subsequent psychoanalytic thinking on appropriate grieving behaviour (Silverman and Klass, 1996) and the belief that grief was a process of disengaging from the deceased (Machin, 2014). The severing of bonds demonstrated the readiness to form new attachments and thus recovery had been achieved. This is reminiscent of a more medical concept of grieving (Averill and Nunley, 1993) in which grief is something to 'get over' and 'recover from'. This view has been challenged by the lack of empirical evidence and, in contrast, research and cross-cultural evidence has shown the process of reconciling the past with the present through integrating the memory of the deceased and the meaning of the bereaved relationship with them by way of maintaining a 'continuing bond' with the loved one (Klass et al, 1996).

Following from earlier psychoanalytic thinking, the second half of the 20th century saw a number of empirically-based theories of grief put forward that indicated the bereaved passed through a series of stages or phases in resolving their grief.   In her seminal work 'On Death and Dying', Kubler-Ross (1969) put forward the five stages of grieving as a model for helping dying patients cope with death and bereavement. Her stage model comprises: denial and isolation; anger; bargaining; depression; and acceptance. Her work was hugely influential in the field of grief studies and opening a dialogue about death, dying and terminal illness. The difficulty, it seems, was that while her stages were not intended to be a linear timetable for the grief process (Machin, 2014), critics nevertheless cited the fact that many people expected dying patients to quite literally pass through the sequence of stages (Worden, 2003).

In the 1970's, Parkes, along with various colleagues, solidified the dominant model of grieving of the time based on their analyses of studies of widows (Parkes, 1972) and, underpinned by attachment theory, he and Bowlby offered the idea of four phases that needed to be passed through during the mourning process: a period of numbness, which can help them disregard the death for a brief period of time; a phase of yearning for the lost one, which can incorporate denial and anger; a time of disorganisation and despair, making it hard to function; and finally a phase of reorganisation (Bowlby and Parkes, 1970).

An alternative to stage or phase models, Worden (1983) presented his notion of the tasks of mourning as a more useful concept to the clinician. His view was that stages and phases suggested a certain passivity while tasks implies that the bereaved can take action. Subsequent research has also cast doubt on the notion of a stage theory of grief (e.g. Maciejewski et al, 2007) and Parkes critiques his own work in writing that "we no longer consider the 'phases of grief' to be a very useful concept" (Parkes and Prigerson, 2009: 8). The value to 'stage theories' is that they have highlighted the fact that grief is a process that people generally pass through from a state of distress to one of understanding and acceptance. Prigerson and Maciejewski (2008: 437) suggest that 'stages' could instead be more accurately thought of as "multidimensional grief states that evolve and diminish in intensity over time", namely disbelief, yearning, anger and sadness, and that yearning was the predominant distress indicator throughout the acute bereavement period (1-23 months in this research).

In some contrast to the concept of 'grief states' that a bereaved individual moves through, Worden's (1983) tasks of mourning implies action on the part of the bereaved and thus is a powerful remedy for the helplessness many mourners experience. Taken together, his four tasks aim to enable the bereaved to adjust to a life without the deceased: to be interested in life, to feel hope and gratification, and to adapt to new roles. In later revisions of his work, Worden (2003) and Worden and Winokuer (2011) amended the fourth task from 'withdrawing emotional energy from the deceased and reinvesting it in another relationship', which was based on Freud's early theory of grieving, to 'emotionally relocating the deceased and memorialising the loved one'. His shift reflected the evidence that people do not decathect from the dead but remain connected to the loved one by developing 'continuing bonds' (Klass et al, 1996) with the deceased.

Moving away from stage or task theories, a divergent model proposed by Stroebe and Schut (1999) is the Dual Process Model in which the bereaved engage in a dynamic, regulatory coping process of oscillation between loss-oriented coping

and restoration-oriented coping. The model draws on attachment theory, cognitive stress theory and bereavement studies to show how people undertake tasks of coping within these two categories of stressor. Machin (2014) points out that this more contemporary model embraces the wider elements of grief and the diversity of grief expression, taking account of social and cultural dimensions in the lexicon of reactions to loss. Loss-oriented coping reflects the more classic notion of 'grief work' where the bereaved deals with processing some aspect of the loss itself, such as reminiscing about the deceased or powerful yearning for the deceased. Restoration-oriented coping refers to the adjustments needing to be made following bereavement, such as taking on new chores that the deceased used to do and having to attend functions alone. It also encompasses the development of a new identity, such as 'wife' to 'widow', and incorporates the necessity of taking time off from the pain of grief by way of distraction or avoidance. The central component of the model is the dynamic process of oscillation between the two, considered to be fundamental to successful coping. Exclusive use of either the loss-orientated strategies or restoration-orientated strategies would lead to pathological grief reactions such as chronic grief in the former and absent or inhibited grief in the latter case (Zech and Arnold, 2011). The Dual Process Model also predicted that factors such as attachment style influenced the extent to which individuals would engage in either loss- or restoration-orientated strategies for coping (Stroebe et al, 2005). Carr (2010) reviewed four recent research studies carried out to test and refine the Dual Process Model, demonstrating the strength of the model and its influence on innovative interventions to help treat the bereaved. The more constructivist thinking of Neimeyer (2000) complements the Dual Process Model in advocating the process of meaning reconstruction following significant loss.

'Normal' versus 'complicated' grief
Before looking further at complicated grieving, it would be prudent to consider what is meant by 'normal' grieving. Worden (2003) provides quite an exhaustive list of the manifestations of normal grief, covering feelings, physical sensations, thoughts and behaviours. He considers the question of whether grief is an illness, and goes on to make the distinctions between grief and depression, indicating that unlike depression, grief typically does not result in the loss of self-esteem or if it does, it tends to be more transient. Indeed, many of the 'normal' grief reactions and feelings associated with the loss may seem like manifestations of depression, so much so that the Diagnostic and Statistical Manual IV of the American Psychiatric Association did not allow for a diagnosis of 'major depression' to be made within two months of a

bereavement unless the symptoms are "characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation". Presumably because we recognise that as painful and traumatic as loss can be, the manifestation of grief (or the experience of acute grief) tends to improve for most people over time without psychiatric diagnosis or treatment intervention.

However, for a significant minority of bereaved people, grief is complicated and can become dysfunctional and debilitating. As a consequence, for many years Complicated Grief (CG), or Prolonged Grief Disorder (PGD), or Persistent Complex Bereavement-Related Disorder (PCBRD) were debated and considered for inclusion in the DSM-5 (Boelen and Prigerson, 2012). While opponents of the resultant changes to the DSM-5 seem to fear the over-medicalisation of grief (i.e. over-diagnosing depression, pathologising the experience of the depth and breadth of grieving the loss of a loved one, and over-medicating the bereaved), proponents of the changes argue that formal recognition of the complications of grief can lead to early identification of sufferers and appropriate treatment interventions.

Shear, Boelen and Neimeyer (2011), among others in the field, have set out the risk factors for developing complicated grief and they group them into several distinct categories. The first is 'personal psychological vulnerability', which would include an insecure attachment pattern, a history of trauma or multiple losses or a history of mood or anxiety disorders. The second concerns the 'circumstances of the death' itself, and Parkes and Prigerson (2009) suggest deaths such as unexpected deaths, multiple deaths, violent deaths and deaths involving human agency (homicide and suicide) represent a particular risk to a person's mental health even in the absence of prior vulnerability. And the third category of risk factors focus on the 'context in which the death occurred', such as the bereaved having a poor support network, going through a relationship breakdown or having just lost their job. In addition to this, there is perhaps a fourth category that can create difficulties for people and refers to losses that cannot be socially validated or publically acknowledged. Doka (1989) termed this 'disenfranchised grief' and divided them into: unrecognised relationships (such as extramarital affairs); unrecognised losses (such as perinatal deaths, abortion or the psychological loss without death as when a partner develops Alzheimer's disease); and unrecognised grief (such as children who are thought to be too young to grieve or people with learning difficulties).

Returning to the 'circumstances of the death', let us turn our attention to the literature on traumatic loss, thinking about the differences in the grief associated with traumatic forms of death and that associated with other types of bereavement. Burke

and Neimeyer (2013) conducted an empirical review of studies on risk factors to common grief and complicated grief, citing a number of studies in which violent deaths led to more severe grief responses than 'natural' deaths. This is perhaps the intertwining of trauma and grief where, following a traumatic loss, posttraumatic symptoms are present, such as intrusive images or avoidance behaviours. Parkes and Prigerson (2009) also cited various studies on violent deaths that show an increased risk to mental health in the bereaved. They suggest that oftentimes grief in these circumstances is complicated by intense feelings of anger and guilt. Neimeyer and Sands (2011) suggest that for losses that are more objectively traumatic, the data demonstrate that the bereaved person's search for sense and a 'crisis of meaning' is particularly acute.

As much as there are risk factors to developing complicated grief, there is resilience to loss and grief. Bonanno and colleagues (2002) found that resilience to bereavement was associated with pre-loss acceptance of death and a belief in a just world. In her framework for conceptualising grief (the Range of Response to Loss model), Machin (2014) outlines her three categories of response to loss, connecting each one to an attachment style. She highlights the notion of resilience as being central to the 'balanced' response to loss in her model, which is indicative of a securely attached individual who has the capacity to oscillate between loss and restoration in DPM terms.

Resilience seems to be a key factor not just in the protection against developing complicated grief but plays a significant role in the potential for growth following adversity. Although not specific to the field of bereavement and grief, Joseph (2011) writes extensively on posttraumatic growth, suggesting that such growth does not come as a result of resistance to trauma or even recovery from trauma. He posits that posttraumatic growth occurs in those people whose sense of self, views of life, future goals and their behaviours have been reconfigured positively in light of their adverse experiences. Posttraumatic growth implies a qualitative transformation of one's response to adversity. In other words, a process of growth through which a person develops beyond their pre-crisis level of functioning. This may be the result of the struggle with adversity or the result of their learning that has occurred through their efforts to cope with adversity. Research suggests that it is not the event itself that fosters posttraumatic growth but the struggling in the aftermath that leads to such growth (Tedeschi and Calhoun, 1995).

Moving onto reviewing the literature on the grieving therapist, I am mindful that the research in this narrower field does not reflect the full scale of human difficulties around loss and grief as discussed above. There is little mention of

complicated grief, traumatic reactions to loss, or notions of fragmentation, despair and collapse in the literature on the grieving therapist. I will return to this absence later in the thesis.

1.2.2. Research on the grieving therapist

When I first started this study in 2008, very little systematic research had been done on the psychological therapist's experience of personal loss and what information we seemed to have had been gleaned from anecdotal accounts. In the intervening years, it is heartening to note that further research has been undertaken, primarily in the form of qualitative studies (see Appendix 1). The purpose of this section is to map out the key themes that emerged from my evaluating the research literature to date. This 'mapping' enables me to identify existing gaps in the literature, to contextualise the need for my research and to provide a rationale for this project in the following section.

The wounded healer

This is not a concept exclusive to the grieving therapist. Increasingly we are confronted with the depiction of the psychological therapist as "impaired" (Wosket, 1999), "vulnerable" (Cozolino, 2004) and "making mistakes" (Casement, 2002). In their literature review of therapist bereavement and its impact on clinical work, Kouriatis and Brown (2011) cite evidence of some negative aspects of working with clients in the aftermath of loss, including impatience and irritability with clients (Rappoport, 2000); 'seeing loss' in everything a client brings (Balsam and Balsam, 1984); and losing the ability to be self-aware and self-reflective (Ulman, 2001). Chasen (1996) outlines her thoughts on returning to work in the aftermath of her son's death (one of the few examples of traumatic loss in the literature on bereaved therapists). She questions her ability to function but recognises both her practical and emotional need to work. These anecdotal, or single case, accounts point to the ethics involved in practicing therapy under personal difficult circumstances (Bond, 2000). The decisions taken by therapists regarding clinical practice are necessarily linked to the ethics of continued work in the face of possible emotional depletion or impaired emotional functioning, raising questions about the 'fitness to practise'. There is undoubtedly a limitation in the literature as to the nature of woundedness and the ability to function as a therapist. Anecdotal accounts and qualitative studies perhaps inevitably lean towards understanding the mechanisms for continued clinical work rather than the psychological collapse and withdrawal of the bereaved therapist. Thinking about the continuum of responses to loss discussed in the previous section,

the notion of the wounded healer as identified in the literature on bereaved therapists is not captured by the complicated grief end of the spectrum. And so based on data gathered from therapists willing to tell their stories, there seems reason to celebrate our woundedness (Martin, 2011). In Jungian terms, the therapist is considered effective because he or she is in touch with their 'shadow' side (Page, 1999), their own wounds. In an interview, Carl Rogers links the concept of the vulnerable or imperfect therapist with the potential for healing:

> "The therapist needs to recognise very clearly the fact that he or she is an imperfect person with flaws which make him vulnerable. I think it is only as the therapist views himself as imperfect and flawed that he can see himself as helping another person. Some people who call themselves therapists are not healers, because they are too busy defending themselves." (Baldwin, 1987: 51)

With an emphasis on the use of self in therapy from the humanistic and relational psychoanalytic traditions, understanding our vulnerabilities and imperfections is crucial in providing ethical and effective therapy. In discussing the notion of 'healing impairments', Wosket (1999: 118) writes:

> "All therapists bring imperfect selves to their practice of therapy. The therapist's personal struggle involves sorting out those impairments that may be damaging and therefore need to be kept away from clients and dealt with elsewhere, from those that can be legitimately incorporated into the therapist's repertoire of helping interventions, because they may actually benefit clients."

Research specifically undertaken on bereaved therapists takes account of this consideration. Since grief can be an overwhelming, disorientating experience (De Santis, 2015), the provision of support and self-care, including personal therapy and robust supervision was brought to the fore in the findings of several studies (Adams, 2014; Broadbent, 2013; Colao-Vitolo, 2006; Devilly, 2014). The grief-related issues of denial, anger, guilt, dependency and vulnerability that Morrison (1996) presents in his account of his wife's death, and the emotions expressed in the narratives of Millon's (1998) participants of numbness, dislocation, overwhelming sadness, changes to sense of self and world view, are all potent, visceral reminders of our human fragility. Is it any wonder that therapists experience impaired self-image in the aftermath of loss (Antonas, 2002), fears of being overwhelmed by their grief (Millon, 1998), avoidance of engaging with certain client material (Chasen, 1996), and fears of over-identifying with client issues (Kouriatis and Brown, 2013-14)?

Acknowledging these fears and admitting our vulnerabilities as bereaved therapists seems key in our quest to work in the therapy room in a way that is in the

benefit of clients. Martin (2011) argues that in order to make use of the Jungian 'wounded healer' archetype, the therapist must acquire a deep self-knowing. His research suggests the incursion of pain or distress is an essential part of the therapists' ability to be available to others. The next section examines what the available research tells us about the impact that the 'wound of grief' has on therapists' professional lives.

The impact of therapists' bereavement on their professional lives
The research studies on therapists' loss have all considered the impact on their therapeutic work and how they managed loss in the context of doing clinical work. An over-riding issue to come from the literature is the question of self-disclosure, both by way of anecdotal accounts (Chasen, 1996; Mendelsohn, 1996; Morrison, 1996; Vamos, 1993) and qualitative research studies (Boyden, 2006; Devilly, 2014; Millon, 1998). The narratives of therapists show the ambiguity involved in deciding whether and what to disclose to clients. Studies (Boyden, 2006; Devilly, 2014) suggest that a number of factors influence a therapist's decision to disclose, including a consideration of the benefits to clients, theoretical orientation and cultural factors. In some cases, self-disclosure was inevitable due to the circumstances of the loved one's death (Chasen, 1996) or terminal illness (Morrison, 1996). Anecdotally, Vamos (1993) reports that her disclosures were based more on her emotional state in sessions than on therapeutic considerations. The impact of self-disclosure on clients seems varied with some reports of abrupt termination of therapy (Chasen, 1996), anger levied towards the therapist (Morrison, 1996), but generally empathy, compassion and support were experienced by therapists who disclosed detail of their loss to clients.

In an article specifically on self-disclosure and therapist's grief, Tsai et al (2010) offer clinical guidelines on navigating the emotional territory of personal self-disclosure, suggesting assessing the strength of the therapeutic alliance, individual clients' histories and the circumstances of the loss in relation to their clinical work (e.g. having to suddenly cancel sessions) to decide how helpful disclosure might be. The authors of this article used data gathered from therapy surveys completed by one author's clients four months after she disclosed the death of her mother to her clients. She asked them about their experience of her disclosure, finding that thoughtful self-disclosure can be of great therapeutic value, becoming a "portal to emotions, themes and relationship factors previously unexplored" (Tsai et al, 2010: 9).

Casting my net more widely on issues of self-disclosure, I turn to the concept of relational self-disclosure where the therapist makes him or herself known within the therapeutic relationship (i.e. here-and-now feelings). This allows the therapist to be transparent to the client in a bid to invite them to see further into themselves by what the therapist reveals (Wosket, 1999). There is also the spectrum of unintentional or unconscious self-disclosure. Greenberg (1995) suggests that almost anything can and does reveal something of the therapist, including what questions are asked and what interpretations are made. This is very different to revealing personal details about one's life, but nevertheless these 'revelations' will impact upon the therapeutic process. It seems safe to assume that moments of immediacy, relational self-disclosure and unconscious self-disclosure will reflect the therapist's experience of loss and grief.

This leads into another theme depicted in the literature on grieving therapists; that of therapist preoccupation and altered presence in the therapy room. In her research on bereaved therapists, Millon (1998) reveals that some therapists who did not self-disclose their loss reported that their clients had nevertheless noticed instances of therapist inattentiveness and preoccupation, describing this as being "psychically detached" (p. 137). Similarly, Adams (2014: 2), who did not disclose to clients or supervisees her own personal crisis of facing a professional complaint, reflected on a comment made by a supervisee once it was over: "I knew something was wrong, I just didn't know what", leading Adams (2014) to question the therapeutic notion of 'bracketing'. Bracketing, a major component of the phenomenological attitude or method of enquiry as proposed by Husserl (1931), refers to the ability to remain open and present to the other in order to be with this unique client in this unique moment (Joyce and Sills, 2001). It requires an attempt on our part to identify the preconceptions and attitudes that we hold and put these to one side in the therapeutic (or research) relationship. Finlay (2011) writes that this phenomenon can be misunderstood in the field as a lesson in objectivity, a striving towards an unbiased position. Instead, it is to be seen as going hand-in-hand with the process of reflexivity; that we recognise our own subjectivity and understand how we impact on the relational dyad by remaining aware of our assumptions and judgements that we inevitably bring into the relationship. In her doctoral thesis, De Santis (2015) addresses the concept of 'bracketing', which her participants emphasised as an important part of self-protection and protecting their clients in the post-loss period. While De Santis cautions against the over-reliance on 'bracketing' and raises the question of 'leakage' and therefore the plausibility of 'bracketing', the notion of 'bracketing' seems to remain very separate to another theme she identifies;

that of how therapists' presence with clients is affected by their grief and vulnerability. I wonder whether there is more of a link between the two than is presented in her thesis.

De Santis' (2015) research findings point to an altered sense of presence for the bereaved therapist in the therapeutic dyad. She writes about the vulnerability and fragility felt by participants impacted their experience of their clients and their choices about moment-to-moment interventions. To me, this seems inextricably linked to her participants' emphasis on 'bracketing' and their need to lean on their professional identity in order to leave the therapist's vulnerability at the door. In other words, it seems that the literature tells us that, *despite* an absence of disclosure regarding bereavement and indeed perhaps *because of* fervent attempts to avoid unintentional disclosure, therapists' presence in the room is changed. De Santis (2015: 105) holds the tension between the positions, concluding:

> "For participants, working hard to bracket by leaning on their professional identity helped them find their way through an ambiguous landscape. This evokes a sense of dissonance between the idea of therapy as a job and the idea of therapy as a meeting of two minds… Overcoming such dissonance involves allowing one's therapeutic way of being to be informed by theory, rules and ethics whilst at the same time accessing one's emotional core so as to be able to engage with clients."

The third key theme to emerge from the existing literature regarding the impact of bereavement on therapists' professional lives is to do with what could be considered advancements in the therapeutic process. Without exception, all the studies I have come across that have explored the impact of loss on therapists' professional lives emphasise the positive implications of doing clinical work post-loss. The single most cited observation made by research participants is their enhanced ability to empathise and their increased capacity for connection with clients (Antonas, 2002; Bozenski, 2006; Broadbent, 2011; De Santis, 2015; Devilly, 2014; Kouriatis and Brown, 2013-14; Millon, 1998). The literature proffers the sense that the experience of a loved one's death and associated pain and grief can provide therapists with an increased understanding of mortality, loneliness, powerlessness and the felt timelessness of pain. Millon's (1998: 132) study suggests that the bereaved therapist's increased understanding of the pain associated with grief can translate into therapeutic practice through the capacity to "be there and help [clients] bear an intolerable reality" while De Santis (2015) writes about the moments of connection stemming from the bereaved therapist's ability to access their own feelings of loss in order to appreciate and attune to what the client was feeling.

Advancements in neuroscience, and in particular the discovery of mirror neurons by a group of Italian neurophysiologists in the 1990's, is one theory that may help us further understand this phenomena of heightened empathy as well as the experience of 'psychic detachment' and altered presence in the bereaved therapist. The concept of mirror neurons was first described by researchers who were conducting studies of monkeys and by chance found that when the researchers performed certain actions, parts of the monkeys' brains lit up as if they themselves were performing the action. Although questions remain unanswered regarding the nature and function of their role in neural processing, this discovery led to research into the human brain and the mirror neural system, revealing a significant change in the way we currently understand the way in which we understand, connect and learn (Rizzolatti et al, 2006). So beyond mimicry and imitating behaviour, it is posited that the mirror neural system is the basis for the ability to simulate actions, resulting in a shared body resonance known as embodied simulation, which mediates our capacity to share the meaning of action, intention, feeling and emotion with the other (Gallese, 2009). Embodied simulation, Gallese argues, is a crucial functional mechanism of intersubjectivity whereby the actions, emotions and sensations of others are mapped by the same neural mechanisms that are usually activated when we experience something similar. That is, neuronal activity is activated through the observation of the other, allowing one person to understand another on a bodily and emotional level. Our capacity to empathise is thus mediated by these embodied simulation mechanisms, and grounds our identification with and connectedness to others (Gallese, 2009). This supports the emphasis on the centrality of affect and implicit relational knowing involved in right hemispheric communication between therapist and client (Schore, 2007).

The heightened levels of empathy consistently reported in the literature on grieving therapists may be accounted for by such neuroscientific explanations as increased right brain activity, responsible for emotion and affective empathy, and the possibility that the mirror neural system is in some form of overdrive following bereavement. I wonder whether our heightened emotional state as a grieving therapist may mean an increased capacity to psychobiologically attune to an array of conscious and particularly unconscious affective states (Schore, 2007). Conversely, I wonder whether the mirror neuron system can shed light on the notion of 'psychic detachment' and inattentiveness in the grieving therapist. For this, I turn to Siegel's (2010) discussion of the neurobiology of attuning to another person. He hypothesises that starting with our mirror neurons firing, a complex process is initiated, stimulating changes in our subcortical limbic, brainstem and bodily areas.

At the phase of interoception, bodily data shapes the state of our reactivity or receptivity. The ability to relay the data on our bodily states to functions such as social relatedness and emotion regulation seems to be key to how we attune to the other. Presumably, if we are unable to tune into our own internal shifts (and being in the process of grieving may have an impact on this), we are not going to be able to attune to someone else and be clinically present.

Post-loss growth for the bereaved therapist

Earlier in this chapter, I outlined the key concepts in bereavement theorising, focusing on what the literature tells us about the process of grief. Research on bereavement indicates that the loss of a loved one can shatter our assumptive world and demands a revision of the inner representation of the beliefs one holds of security and safety that no longer fits the changed circumstances (Machin, 2014). From a constructivist perspective (Neimeyer, 2000; Neimeyer and Sands, 2011), the process of bereavement involves holding onto what is left of the pre-loss meaningful life view alongside revising the internal working models, assumptive world views and structures of meaning, to construct new meaning and new sense of self that fits more appropriately with the changes that have taken place. Being able to reconcile the old and new meaning, and reconstruct one's worldview, seems to be a central component in what Linley and Joseph (2004) call 'adversarial growth'.

Much of the literature on adversarial, or posttraumatic, growth has focused on an array of traumatic events, ranging from illness and injury to sexual assault and military combat. Although bereavement is included as a traumatic event in the literature, research exploring directly the relationship between posttraumatic growth and bereavement is sparse (Michael and Cooper, 2013). In a systematic review of the literature available on posttraumatic growth (PTG) and bereavement, Michael and Cooper (2013) found evidence for various mediators likely to foster growth after loss, including the bereaved age, religion and the time passed since death. Of particular significance, their analysis showed that the level and type of social support and the extent of their active cognitive coping strategies (i.e. meaning-making and positive re-appraisal) were both critical elements in nurturing positive growth. Identifying the factors involved in promoting PTG has implications for therapists working with bereaved individuals in facilitating such change.

The consistency of these findings in the PTG and bereavement literature suggests that one might expect to find similar outcomes in terms of the propensity for adversarial growth in bereaved therapists. This may be particular so in light of therapists' enhanced access to and emphasis on support systems (supervision and

personal therapy) as well as an assumption that therapists might be better able to engage with cognitive coping strategies, such as meaning-making, as a result of their sustained period of training and self-process in personal therapy. While Givelber and Simon (1981) comment that the professional role gives the false notion that therapists should manage better, they also reveal experiences of positive growth following loss. Adversarial growth is further evident in the anecdotal account of Chasen (1996) as well as the research findings from Broadbent (2011) and De Santis (2015). Broadbent (2011) discusses the personally transformative nature of loss for the bereaved therapist, reporting that her participants' experiences of positive growth are consistent with PTG research that identifies certain features of growth including changes to one's sense of self, relationships and life philosophy as well as her participants reporting the discovery of new strengths, greater self-awareness, confidence and self-esteem, a heightened sense of maturity, compassion and the ability to reflect upon their experience of grieving from a more comfortable place. Likewise, De Santis (2015) discusses the transformative effects of bereavement as a post-loss expansion of self, capturing participants' experiences of the emergence of latent parts of the self and the birth of previously absent parts of the self. In line with her locating herself within an existential theoretical frame, De Santis (2015) links the process of self-expansion with Yalom's (1980) assertion that loss is an 'existential opportunity' to uncover or get to the core of one's self and Heidegger's (1927) notion that one's sense of 'being-in-the-world' is inevitably changed with bereavement.

As I survey the landscape of grief and loss, and specifically therapists' experiences of post-loss growth, I find myself curious about the role that therapy has in the process of growth and change in the bereaved therapist. Michael and Cooper (2013) assert that personal growth after loss should be viewed as originating not from the event itself but from within the person experiencing it. When that person is a bereaved therapist working within a healing dyad with a client, it seems fair to assume that the therapeutic encounter has the potential to facilitate positive growth in the therapist and to impact upon, heal and change the therapist. If therapy is a process which impacts on both participants (the cornerstone of intersubjectivity theory and evidenced by interpersonal neurobiology), the therapist as well as the client will be affected and thus, subject to potential change. Kantrowitz (2004) writes that historically analysts have been resistant to discussing self-change and how such changes come about. Likewise, Maroda (2004) points to the ambivalence and controversy surrounding the notion of 'mutual healing' and the possibility of a therapist being healed by a client. With such emphasis on the power of the therapeutic relationship in the process of change, I cannot see how the potential for

change in the therapist can be avoided and I consider it part of being a reflective practitioner (Schön, 1983). This is underscored by Wosket's (1999) writing on the 'internal client' of the therapist – that is, the part of the self that grows, develops and can be healed by the work done with clients – as well as the role that this growth plays in the ongoing therapeutic process. Both Burton (1972) and Yalom (2002) have written on the notion that in the absence of therapist growth and healing, so too there is an absence of client healing and effective therapy.

1.3. The aim of this research study

When I conceptualised this study in 2008, there was a distinct absence of research on therapist loss and bereavement, and the bearing this would have on clinical work. In the intervening years, a small handful of studies have been carried out to explore this under-researched area. This represents significant inroads into opening a dialogue about therapists' personal lives; their trials and tribulations as well as the growth that comes from the pain and distress of bereavement. The small body of literature that has been gathered over the last five years taps into a number of important concepts for understanding the world of the grieving therapist and has highlighted issues for practitioners to take account of in their professional lives. However, despite recent advancements in this specific field of enquiry, there remains a paucity of research on therapist bereavement. In the face of continued interest in the role of the therapist in the therapeutic process and given the significant empirical evidence demonstrating the powerful effect of the therapy relationship on treatment outcomes (Norcross, 2010), the impact of grief and loss on the self as the therapist deservedly warrants further attention.

In reviewing the available literature, two key gaps stood out to me. The first is to do with the notion of mutual healing and the potential for the self-healing of the therapist. Although two studies (Broadbent, 2011; De Santis, 2015) found evidence of and discussed positive growth in the face of grief, there remains an absence of exploring the specific role that therapy can play in the therapist's healing.

The second gap comes from a methodological standpoint. The research studies carried out to date have utilised Grounded Theory, Consensual Qualitative Research, Thematic Analysis and Interpretative Phenomenological Analysis. Researchers' epistemological positions have varied in terms of clarity and relationship to the research. Despite the topic of therapist bereavement and loss having its roots in the emphasis on 'self-as-therapist', only two studies grappled with the issue of researcher subjectivity and made use of reflexivity as part of their work. To date, I have not come across a study in this field where the researcher became an explicit

part of the research itself. Previous research has elicited rich material on understanding the experience of the grieving therapist. I would like my research to go a step further by immersing my 'self-as-researcher' into the study and attending to the 'in-between' of researcher and participant in order to uncover and illuminate the essence of experience. The enlightening work of Broadbent (2011), Kouriatis and Brown (2013-14) and De Santis (2015) all utilised Interpretative Phenomenological Analysis to get to the experience of the phenomenon. I intend to use a relational-centred approach (Finlay and Evans, 2009) to Heuristic Inquiry (Moustakas, 1990) to go beyond the *experience* of the phenomenon and get to the *experiencing* of it (Sela-Smith, 2002).

It is with this mind that my research question was formulated and subtly shifted during the course of my research journey. I started with the question ***'how do therapists experience the therapeutic process after personal loss?'***. The process of formulating the research question encompassed having to define what I meant by 'therapeutic process' since this may be understood differently by individuals. Taking into account the issues I believe are salient to the research and the presumptions on which the research is based, I have borrowed from Orlinsky et al (1994) who distinguish between six aspects of the psychotherapeutic process and argue can be used as a generic conceptual system for all therapies. They are: a formal aspect; a technical aspect; an interpersonal aspect; an intrapersonal aspect; a clinical aspect; and a temporal aspect. The intrapersonal aspect encapsulates a cyclical process of change to the therapist's self-structure, leading to changes in their 'self' in the therapy room by highlighting the intrapsychic processes of how individuals formulate self-awareness, evaluate themselves and self-relate (O'Brien and Houston, 2007). Since this aspect applies to the therapist as well as to the client, this model for defining the therapeutic process seems an accurate one to utilise for the purposes of this research. This initial question captured the essence of what I was seeking to know from other therapists who had gone through personal loss during the course of their work. It drove the formulation of the interview schedule (see Appendix 4) and underpinned the dialogue between participants and myself. It captured the subsidiary questions such as 'how did therapists' loss impact upon their work?', 'how did they experience their loss in relation to their client's issues?' and 'what impact did 'doing therapy' have on their experience of loss?'.

The subtle shift to the research question came when I re-immersed myself back into the research and returned to my collected and analysed data to conduct a second round of analysis. As I started to work my way through my transcripts again, I found that I was 'seeing' things differently, there were new aspects to the

experiences being told, and I was experiencing different feelings as I looked back and explored the data as part of my phase of illumination. The aim, therefore, of this study is to explore the question *'what is it like to be a psychological therapist post-loss?'*.

1.4. The value of this research to the field of counselling psychology and psychotherapy

Following on from the aim of the project, I consider the key contributions the research will make to counselling psychology and psychotherapy to be as follows. In the first instance, and on both a theoretical and practice level, I anticipate this research contributing primarily to practitioners and supervisors in two main ways: firstly, relatively little has been written on the 'tragic' personal circumstances (i.e. loss) of the therapist and how this impacts on therapeutic process. Secondly, the research may provide a framework for thinking about these issues and offer a more overt understanding of how clinical decisions at times of personal loss are approached.

In the second instance, I hope that this work might offer something to researchers who value the use of reflexivity within the context of conducting research and who are seeking more illustrations of studies where the researcher uses their self quite explicitly in the data. I will build on and develop this idea further in the next chapter.

1.5. Concluding remarks

It has been the purpose of the opening section of this thesis to provide a backdrop to the project, demonstrating the need for further research in this field by identifying existing gaps in the literature, and contextualising the rationale for taking the approach I have done to carrying out this research. I shall now move into an examination of the specifics involved in my approach to the project through consideration of the methodological issues and providing an outline of my research design.

Chapter II

Methodological Considerations and Research Design

Having contextualised this research in the previous chapter and outlined the intentions and contribution of the study, it is now the purpose of this chapter to explore the specifics of carrying out this particular research. I start the chapter by setting out my epistemological position I adopt in relation to this research, providing the necessary foundation on which to base the rationale for my chosen method of enquiry. I then move into an overview of my research journey process; to understand what has been left in and left out of the study, to provide a transparent exploration of the adaptation to research questions, and to consider the rationale for preferring certain research methods to others. A discussion on the use of heuristic inquiry in this study follows, outlining Moustakas' (1990) phases of inquiry in accordance with my research tasks and reflections. The remaining sections of the chapter focus on the processes involved in gathering data, analysing data, evaluating the quality of the research and considering the ethics of the study.

2.1. My epistemological position

Epistemology is a philosophical concept concerned with theory of knowledge; how and what can be known (Willig, 2001). Slevin (2001: 144) defines it as "the study of what knowledge is, how we come to know, and the nature and forms that knowledge takes", going on to assert that the word is off-putting yet crucial to research. Both Willig and McLeod (2001) emphasise the need for an assumed epistemological position in research, with McLeod arguing that methodology should be based on our epistemological position. Perhaps there is some question as to how consciously thought out one's position is, with Salmon (2003) suggesting that rarely do researchers think through an epistemological position before choosing a method and that, more often than not, an adopted position is a retrospective rationalisation of what the researcher has done. My experience in the very early stages of carrying out this study was one of movement between choosing a possible method based on what I wanted to find out, re-evaluating this choice as I reflected further on the topic

at hand, and 'playing with' ways of working that best reflected the issues inherent in the research questions. The purpose then of this section is to make explicit my assumptions surrounding epistemology and the theoretical influences that underpin the position I take.

I started this research journey (consciously, in any case) desperately wanting to 'know' how therapists could be therapists in the face of significant loss. I will return to my research journey in a later sub-section; my focus here is on the concept of 'knowing'. In epistemological terms, how can I know the experience of the grieving therapist and what kind of understanding can I possibly come to? This brings to the fore epistemological questions asked of the research enterprise and ones I think it important to consider before moving into a discussion about methodology and methods. The epistemological questions that I have formulated here broadly reflect those purported by Willig (2001) and Finlay and Evans (2009).

What am I seeking to know?

This involves locating myself somewhere on the positivist-interpretivist continuum of gaining an understanding of research phenomena. Finlay and Evans (2009) describe a positivist epistemology as being the knowledge gained by an impartial researcher outside of the phenomenon under investigation and that such understandings can be replicated by another researcher. The knowledge is objective and 'truth' based. In contrast, and at the other end of the continuum, is the interpretivist tradition where multiple meaning, interpretation and situational context are recognised and valued. That objective knowledge is impossible as it depends on one's perspective (Finlay, 2011).

From the conception of my research, it was words like 'how', 'individual process', 'experience' and 'living with' that were in my mind. I intuitively knew that I wanted to know about individuals' subjective experiences and that I wouldn't be seeking out some form of objective 'truth' with my research. I was deeply genuinely curious about how therapists were being therapists in the face of personal loss and I knew I was seeking to engage with participants in order to 'know' more of their post-loss world. Consequently, my approach to this research fits into a more interpretive framework.

What is possible to know?

This question has more of an ontological feel to it; ontology being concerned with the nature of the world and what there is to know (Willig, 2001). Willig (2001) points to another epistemological continuum with naïve realism on one end and radical

relativism on the other. The 'realist' position is characterised by discovery-oriented research (Willig, 2001) where researchers seek to study and measure the 'real' world (Finlay and Evans, 2009). At the other end of the spectrum is the 'relativist' position where knowledge is seen as entirely a social construction, at odds with there being a measurable or observable reality.

Somewhere along this continuum lie the less naïve realist, the 'critical realist' and the less radical relativist. This position takes a more pragmatic stance than the radical relativist, accepting that there is a real and observable world out there but that it is subject to our own meaning-making processes and social constructions. It is the more 'critical realist' epistemological assumptions that underpin this study, having been historically influenced by symbolic interactionism as a researcher. Charmaz (2006) writes that symbolic interactionism is essentially dynamic and interpretive, and is about people creating, enacting and changing meanings and actions. With these concepts in mind, Etherington's (2004) work holds resonance with me when she proffers her belief that reality is socially constructed and is subjectively determined; as such, methods are needed that examine how these constructions come about and the meanings people give them. In this way, I take the position that reality is socially constructed and is subjectively determined and that we all engage in a process of making meaning of our experiences, while accepting that the individual experience is nevertheless 'real' to the person having it.

What is the role of the researcher in obtaining the knowledge?
The third epistemological question to consider is the extent to which I am part of and implicated in the research process. I have already alluded to, and at times been quite explicit, about how I locate myself in this research and what values underpin my approach to research. In line with this, I see my role as a researcher as a very involved one. I believe that I develop relationships with my participants (albeit temporary ones), that I influence their responses to me, that they impact upon me as the interviewer and so influencing the course of data collection, and that my subjectivity will be present in the meaning-making process of analysis. With all this in mind, I find myself influenced by three methodological positions or approaches that help me capture and understand my role as researcher.

The first is the concept of **relational-centred research** (Finlay and Evans, 2009) where the research relationship is explicitly examined and used as part of the findings and 'outcome'. It is the idea that data does not 'speak for itself', but instead emerges from the intersubjective space between researcher and co-researcher, which is a dynamic, co-created relational process (Finlay and Evans, 2009). A key

element of relational-centred research is the process of reflexivity where the researcher takes on the challenge of developing self-awareness through critical self-reflection at every stage of the research endeavour. Etherington (2004: 31) writes that her understanding of researcher reflexivity is "the capacity of the researcher to acknowledge how their own experiences and contexts (which might be fluid and changing) inform the process and outcomes of inquiry". In this study, reflexivity is an explicit part of the research itself, woven into the evolving tapestry from start to finish. This brings to mind the notion of hermeneutic reflexivity; a process of continually reflecting on our own interpretations of our experiences as well as of the phenomenon under investigation in order to go beyond previous understandings and our investment in certain research outcomes (Finlay, 2011). Finlay (2011) is clear that this is not just about reflecting upon one's initial positioning, expectations and presuppositions at the start of research, but is used throughout the research. Some of the stages of my reflexive process therefore, will be to consider such questions as:

- What was my relationship with loss before I commenced this study?
- What need was I trying to fulfil by carrying out this research?
- What ideas and preconceptions did I hold coming into this research?
- How did I select my readings on the topic?
- What was left out of the research, in terms of reading and formulating my research questions?
- Why and how did I decide on the participants to include? And the experiences of loss?
- How do I position myself as an interviewer?
- How much should I self-disclose in interviews? In write-up?
- How is one methodology chosen over another?
- How can I present my findings in a way that is true to the values I hold about psychotherapy and research?
- How best can I demonstrate transparency of my own process throughout the research journey?
- How will I use my own experiences (both in terms of personal history and dialoguing with participants) to make meaning of the data and to write my representation of my work?

These – and I suspect many other questions – have played on my mind at different times and in different ways during the research process. I have already begun to unpack the beginnings of the reflexive process so far and, in the chapters that follow, I shall explore these questions further.

An important aspect of reflexivity for me is its link with **feminist research**. This is the second methodological approach that influences how I conceptualise my role as a researcher. The transparency that comes with reflexivity speaks to the redressing of power imbalances inherent in both practice and research encounters. Reflexive feminist research encourages the explicit understanding of not just what we have discovered, but how it has been discovered (Etherington, 2004). Explicating the 'how' invites the researcher to dialogue with oneself, to look inward, to recognise the impact we have on the data collection and analysis – in short, to take account of our own subjectivity. To me, this means understanding our thoughts, feelings, personal histories and cultural contexts in relation to our research. Feminist research, for me, emphasises collaboration, closeness, mutuality, transparency and involvement. I have spent my entire adult life working for feminist organisations aimed at improving the lives of those affected by domestic violence and sexual violence, and these are values that are integral to this type of work. It would, therefore, seem incongruent to take up the role of a researcher that was not consistent with such values.

The third methodological approach that informs my understanding of my role as a researcher is **heuristic research**. Heuristics is one form of phenomenological research that brings to the fore the personal experience and insights of the researcher (Patton, 2002). Patton goes on to highlight the uniqueness of heuristic research with the researcher coming to understand the essence of the phenomenon through shared experience and reflection with co-researchers. There is an emphasis on connectedness and relationship. Finlay (2011: 163, original emphasis) writes that this type of research is "a way of engaging in scientific search using methods and processes aimed at **discovery** through engaging **self-inquiry** and **dialogue** with others to find underlying meanings of human experience". The role of self-disclosure is a pertinent one in heuristic research; Douglass and Moustakas (1985: 50) write "at the heart of heuristics lies an emphasis on disclosing the self as a way of facilitating disclosure from others". As well as self-disclosure with others, there seems to be an emphasis on one's relationship with the self and the role of self-dialogue. Moustakas (1990: 16) writes of the need for initial self-inquiry and that "one's own self-discoveries, awarenesses, and understandings are the initial steps in the process". This very much reflects my 'pre-research' experience with this study and it speaks to how I have located myself as a researcher in order to obtain the knowledge that I am seeking. Moreover, it is important to me that my methods allow for my – as the researcher – experiences to be explicit and to be able to draw on my relationship with the research topic over time in a transparent and reflexive manner. I am

interested in the dynamic process of the research, how I will change and develop as a result of conducting the work. As such, I view the role of the researcher as a 'participant' in the study who, along with the other participants, will construct an understanding of the phenomenon under investigation. Finlay and Evans (2009) discuss the role of the researcher in terms of being either a witness (faithfully recording what participants say and representing their perspectives in an unbiased way as possible) or an author (playing an active role in constructing the findings and authoring the final creative piece) or a bit of both. As a participant in the research, I see myself as author of what is to be finally presented and my role is very much *in* the research; part of the complexity, however, is to ensure that the other participants' voices are in it too. How much 'witnessing' I do of this process is an issue with which I continue to grapple.

2.2. Overview of the research journey

This is not intended to be a detailed chronology of the steps taken to produce this research; rather it is a reflexive account of some of the pivotal stages in navigating my way with this piece of research, offering the reader some insight and transparency into key decisions that I made along the way.

Initially engaging with the research

I was finding it hard to focus on the short breakfast menu that was resting on the Formica table in front of me, aware that our waitress would be returning momentarily to take our order. She had already brought us coffee and I wrapped my fingers around my mug, feeling the heat warm my hands, lost in thought. It was a Sunday morning in early January 2008. I was sat at this little train station café in Palmers Green with my husband, having decided to escape the mess and chaos of our flat which was in the process of being renovated. The mess and chaos was a reflection of life at that time. My aunt had killed herself at the end of November 2007, after which time I had travelled back to the States to be with my cousin and uncle as we tried and failed to make sense of the tragedy. When I returned home in December, I felt like I was in a fog, behind some kind of screen separating me from the rest of the world. I picked up aspects of my work but I could only manage a limited number of tasks in a day. The Christmas holidays came and went, and suddenly it was a new year. Life goes on. I wanted, needed, to feel normal again.

But how? Not 'how to feel normal'. But, I mused to my husband after the waitress had taken our order, how can this awfulness be part of who I am as a therapist? I was halfway through my training at Metanoia Institute. I was training to

be a psychologist, a psychotherapist. Surely there was something more I could do with this harrowing experience. Something that I could really learn, and understand, about loss and pain, and my capacity to meet others in their experiences of loss and pain.

Years later, I can see that it is as Hiles (2001) said – that in heuristic inquiry, the research question chooses you. And so I began my research process before I actively decided to formalise this into my research project. I set about reading therapy books and searching online for the articles, for the texts that would help me know how to be a grieving therapist. And I found surprisingly little written on the topic. Following one particular research seminar at Metanoia in the spring of 2008, the pieces of this particular puzzle came together and I chose to not move away from the tragic death of my aunt and 'put it behind me' but to embrace the messiness and complexity of what could come from making my personal life my research project.

Formulating the direction of the research

Looking back on my very early notes and reflections, it is apparent that my core question has not significantly shifted over time. On my first page of scribbled notes are the words "therapists' traumas and experience – what happens to this once in the therapy room?" and "coping and dealing with own life issues while being an effective therapist". In these early days of formulating a research direction, my relationships with training peers, tutors, and work colleagues as well as friends and family were all crucial to developing my thinking around the issues. Working through some of the issues that might present themselves during the research process came from some form of self-dialogue as well as from numerous conversations with others in my life. Since my chosen topic was one borne of my own experience, I found that I was talking about it with a much wider audience than had I been carrying out research on an area more detached from myself and my life. This I believe kept me immersed in the research as I lived my daily life, regardless of whether or not I was doing traditional 'research activities'.

When I first submitted my proposal, my over-riding research question was 'how do therapists' 'crises of loss' impact upon the therapeutic process?' and I broke this down into two key areas of examination within which I posed a series of sub-questions. The first area centred on the ethics of the 'fitness to practise' following personal loss, revolving around the questions contained in Box 1. The second area concerned the impact of the personal loss on the therapist and the therapeutic process, utilising the questions contained in Box 2.

Box 1. Sample sub-questions:
- o   What was the timeframe during which the therapist returned to work following their crisis?
- o   What contexts changed that decision?
- o   What factors influenced the decision?
- o   What social support networks were available to the therapist?
- o   How did the therapist know when to return to work?

Box 2. Sample sub-questions:
- o   Was the crisis growth promoting for the therapist?
- o   How did the therapist use their own crisis to further their work with clients?
- o   How did the crisis influence how they were with their clients?
- o   How does client work help or contain the therapists' crisis?
- o   What factors helped the therapist's effectiveness following their crisis?
- o   What were particularly difficult moments in the therapy?
- o   How was supervision used in this process?

Even at this early stage, it is apparent that my leaning is towards a sort of positive growth model of thinking in terms of loss and trauma. I think this, at least in part, stemmed from a deep-seated desire to create some positive meaning from my experiences of loss. Developing and refining my ideas on research through self-dialogue and encounters with peers and tutors meant having to think about the possibility of denial and fragmentation in the therapist's experience of loss. Although I held this in mind and my central research question was altered and the interview questions reflected this challenge, I suspect that I wasn't entirely comfortable with the idea that personal loss could result in such splits. After all, what would it mean for me if the therapists in this study were telling me that they were in fact *not* OK or even that their experience of personal loss had not had a growth-enhancing effect on them or their work? Indeed, I wonder now whether it was only the result of my break from the research that enabled me to experience the denial that must be inherent in the therapist post-loss in one form or another.

My re-immersion into the research
The above realisation came when I returned to and re-immersed myself back into the research project four years after completing interviews with participants and having done the first round of analysis. During those intervening years, I found that I moved towards and then away from the project as life disrupted the flow. I became a mother through the process of adopting first my daughter, and then my son. Notwithstanding the intense love and joy I experienced with this change to my life, loss and grief were in the mix too, becoming part of my 'self' as researcher. When I finally felt I had the capacity, I returned to the research project with renewed energy and excitement. It

was at this point, in 2015, that I undertook a second round of analysis, which took specific account of my felt experience of the data gathered and analysed in 2010/11. The process here was one of me observing my role and communications (verbal and unconscious) in the interviews and locating myself within the raw data as well as within the constructed meanings made four years previously. I was making sense of not only what the participants had told me, but of me making sense of my analysis four years earlier.   This layered interpretation and construction of meaning is characterised by a hermeneutical circle (Kvale, 1996: 50) where "the interpretation goes beyond the immediately given and enriches the understanding by bringing forth new differentiations and interrelations in the text, extending its meaning".   In a nutshell, I was getting a better sense of what it was like to be the post-loss therapist.

Rationale for choosing heuristic inquiry

My journey navigating the methodological terrain of the research involved some careful consideration and difficulty at times. When I first started thinking about the study and well into the data collection phase, I anticipated using an abbreviated form of grounded theory (Willig, 2001) for the process of analysis while retaining a heuristic inquiry approach for data collection. I considered that utilising a grounded theory method of analysis would provide a way of understanding and theorising peoples' actions, reflections and formulated meanings (Charmaz, 2003).   I had imagined constructing and developing a theory on the post-loss therapist in practice. In retrospect, I am aware that I was perhaps holding onto a methodology that felt more 'scientific', that would be seen as more rigorous, with an emphasis on ensuring validity and trustworthiness. In practice, however, as I engaged with participants and heard their stories, my desire to develop a theory from the generated data retreated from the research focus and I became increasingly preoccupied with the lived experiences of participants, which encompassed our relational experience of one another in interview. Reflecting on this now, it may have been the initial appeal of developing a theory or idea through grounded theory and heuristic inquiry that meant I didn't consider engaging the process of autoethnographic research – a methodology similar to heuristic inquiry in its creativity and immersion of researcher, but divergent in its objective to "seek…a point of illumination" (McLeod, 2011: 212).

Choosing the 'how' of the research study strikes me as bringing in another personal aspect to the work. I concur with Etherington (2004) who writes that the decision on how to undertake research is a personal one about what one needs to do to discover what one wants to know. She points out that a number of existing methodologies might suit her needs or she may need to create a new one specific to

her project. This is reminiscent of Feyerabend's (1975) observation that research can be playful and points to the 'anarchist scientist' who is not precious about methodology, recognising the limits of all methodologies. Similar to my view that practicing psychotherapy is not about having a set of techniques to use but is about developing a framework based on personal values and beliefs; my relationship with research is not a product of tools or methods to be followed formulaically, but rather a mindset based on a personal philosophy about the world and human beings.

By the time I returned to the project in 2015, and immersed myself back into the interview recordings and transcripts, I found I no longer had a desire to develop a theory. I could let go of what I had been holding on to as a form of security, and really embrace what felt like the right methodology for my project, despite my fears and discomfort over doing heuristic research where I would be right in the middle of it all.

2.3. Heuristic inquiry

Heuristic inquiry is a form of phenomenological research that brings to the fore the person of the researcher. The meaning of the word 'heuristic' comes from the Greek work *heuriskein*, which means to discover or to find. The primary developer of heuristic research was Clark Moustakas in his studies of loneliness (1961, 1972, 1975). He writes that heuristic research "refers to a process of internal search through which one discovers the nature and meaning of experience and develops methods and procedures for further investigation and analysis. The self of the researcher is present throughout the process and, while understanding the phenomenon with increasing depth, the researcher also experiences growing self awareness and self-knowledge." (Moustakas, 1990: 9). Moustakas (1990) elaborates on the other influences of heuristic methodology, pointing to its roots in humanistic psychology (Maslow 1956, 1966, 1971; Rogers 1951, 1961); Jourard's (1968, 1971) investigations of self-disclosure; Polanyi's (1962, 1967) emphasis on the tacit dimension, indwelling and personal knowledge; Buber's (1958, 1965) work on dialogue and mutuality; and Gendlin's (1962) analysis of meaning of experience. Douglass and Moustakas (1985) point out that heuristic inquiry can be differentiated from phenomenological research in several ways:

- Heuristics emphasise relationship and connectedness while phenomenology encourages more detachment from the investigated phenomenon;
- Heuristics lead to depictions of essential meanings, intrigue and personal significance that underpinned the research quest while phenomenology results in definitive descriptions of the structures of experience;

- Heuristic inquiry concludes with a synthesis of creative discovery that includes the researchers intuition and tacit knowledge whereas phenomenology concludes with a distillation of the structures of experience;

- In heuristic inquiry research participants remain visibly present in the investigated data (and I would include the researcher as participant here) whereas in phenomenology research participants are lost in the process of descriptive analysis. So, "phenomenology ends with the essence of experience; heuristics retains the essence of the person in experience" (Douglass and Moustakas, 1985: 43).

As I understand this, and what I take on board as I commit to the process of heuristic research rather than another descriptive phenomenological approach to inquiry is the implicit hermeneutic shift (Finlay, 2011) that comes from self-understanding and the *I-who-feels* (Sela-Smith, 2002); the emphasis and value placed on self-search and personal transformative potential; and the production of a creative synthesis that is underpinned by the tacit dimension, intuition and self-searching.

Moustakas (1990) distinguished between the concepts and processes that underscore heuristic research and the phases of carrying out heuristic research. I shall provide an overview of both and will subsequently refer back to these concepts and use the phase-approach to demonstrate my research process at work. The seven identified key concepts are:

- **Identifying with the focus of the inquiry**. This is about 'getting inside the question' through living it, open-ended inquiry and self-directed searching. *"Becoming one with what one is seeking to know."* (p. 16)

- **Self-dialogue**. This involves allowing the phenomenon to speak directly to one's own experience and to be questioned by it. It requires self-inquiry and an openness and receptivity to all facets of one's experience of a phenomenon. Arguably, this is the critical beginning: *"the recognition that if one is going to be able to discover the constituents and qualities that make up an experience, one must begin with oneself."* (p.16)

- **Tacit knowing**. Based on Polanyi's (1983: 4) notion that "we can know more than we can tell", Moustakas highlights the importance of knowledge that is implicit to our actions and experiences. He argues that without the tacit in research, we limit the possibilities for knowing and understanding. *"The tacit dimension underlies and precedes intuition and guides the researcher into untapped directions and sources of meaning."* (p.22)

- **Intuition**. This provides the bridge between the tacit and the explicit knowledge. Intuition provides the clues to patterns and relationships, which makes it possible to perceive things as wholes. *"Intuition guides the researcher in discovery of patterns and meanings that will lead to enhanced meanings, and deepened and extended knowledge."* (p.24)

- **Indwelling**. This involves a willingness to turn unwavering attention and concentration to some aspect of human experience. The process is conscious and deliberate where one dwells inside the 'clues' to expand meanings and association until insight in achieved. *"Through indwelling, the heuristic investigator finally turns the corner and moves toward the ultimate creative synthesis that portrays the essential qualities and meanings of an experience."* (p. 25)

- **Focusing**. Here Moustakas is referring to an inner attention, staying with the sustained process of being with the central meanings of an experience. He argues that it is about creating an inward space in order to identify the qualities of an experience that have previously remained out of conscious reach. *"Focusing enables one to see something as it is and to make whatever shifts are necessary to remove clutter and make contact with necessary awarenesses and insights into one's experiences."* (p. 25)

- **The internal frame of reference**. The knowledge derived from the heuristic inquiry must relate back to the experiencer's internal frame of reference in order to portray the experience. *"To know and understand the nature, meanings, and essences of any human experience, one depends on the internal frame of reference of the person who has had, is having, or will have the experience."* (p. 26)

The six interrelated phases put forward by Moustakas (1990) are:

- **Initial engagement**. The discovery of an intense interest that holds important social meaning and personal implications. It is the start of a process of self-dialogue and inner search, during which the researcher reaches inward for tacit awareness;

- **Immersion**. 'Staying with' their question of interest, allowing the researcher to come to be on intimate terms with the question. Almost anything connected with the question can become raw material for immersion, for maintaining a sustained focus and concentration. The concepts for facilitating this process include self-dialogue, pursuing intuitive clues and drawing on tacit knowledge;

- **Incubation**. The researcher retreats from the intense focus on the question to allow for new understandings and perspectives to emerge. During the process of

incubation, the inner workings of the tacit dimension and intuition can extend and clarify our understanding on levels outside of immediate awareness;

- **Illumination**. The researcher is receptive to tacit knowledge and intuition, resulting in a growing awareness of patterns or themes. This may include suddenly seeing new things in the experience, finding hidden meanings or adjusting distorted understandings;

- **Explication**. An examination of what has emerged and been awakened in consciousness in order to understand the various layers of meaning. The process of self-searching continues, and Moustakas considers that the key concepts at play in this phase are focusing and indwelling with the recognition that meanings depend upon internal frames of reference;

- **Creative synthesis**. The researcher puts together an integration of the data based on tacit knowledge, intuition and self-searching.

Moustakas (1990) also indicated a seventh phase although he did not name it as such. He spoke of the process of **validating the heuristic research**. This involves the validation of meaning through the researcher returning again and again to the data to ensure that the experience has been comprehensively, accurately and distinctively depicted in the final synthesis. This involves a process of 'checking and judging' by the researcher as well as seeking assessment from participants on the accuracy depicted of the meanings and essences of the phenomenon under investigation.

2.4. Methodological criticisms of heuristic inquiry

Sela-Smith (2002) provides a detailed critique of Moustakas's (1990) heuristic research method, carrying out a review of 28 research studies whose authors asserted they had followed Moustakas's method. She found that just three studies of the 28 successfully fulfilled the heuristic research process. The 25 that did not seem to have fallen down on what Sela-Smith considers to be key to the heuristic investigation – the *I-who-feels* aspect of the tacit dimension. Sela-Smith explores why so many studies seem to be missing this crucial part of heuristic inquiry and in so doing, she returns to Moustakas's own process of what she considers to be him moving away from his feelings by effectively becoming an observer of his experience as he would be to someone else's. This arguably means missing the tacit dimension. Sela-Smith distinguishes between the 'experience' of a phenomenon and 'experiencing' the phenomenon; the former has the more phenomenological flavour of researching others' lived experiences rather than staying with the self-in-experience, which Sela-Smith would suggest, is the essence of heuristics. *"When the*

focus is on another, what is learnt is from an observational perspective rather than from within experience." Sela-Smith (2002: 76)

Linked to this, is Sela-Smith's (2002) critique of Moustakas's (1990) notion of validity. She argues that checking one's personal experience against the experience of others does not validate the experience nor does it provide access to the tacit dimension; rather the experienced feeling is valid in its own right. She asserts that "validity of the research is established by surrendering to the process that is pushing itself into the consciousness of the researcher, allowing the process to unfold and then noticing results in expansion of self-awareness, deepening of self-understanding, and of self-transformation that others can experience in the 'story'." (p. 79). Sela-Smith suggests that the process of establishing validity through external observation was more an attempt to make his method acceptable to positivist science.

This seems to be what Loewenthal and Winter (2006) advocate when they posit the limitation to heuristic research of the researcher being at the centre of the meaning-making process. They suggest that the researcher should have support during the research phases in order to avoid 'blind spots' and that a deconstruction of the creative synthesis takes place so that the researcher is not at the centre of the meaning-making process but is subject to it. The issue at stake seems to concern the ways in which tacit knowledge can be uncovered in heuristic research and this involves grappling with how to balance the self and other experiences.

So what of the role of 'other' in heuristic research? Are research participants there to provide validation of the captured, or created, meanings of experience? Are they there to help elucidate one's own experiencing of the phenomenon? I find myself drawn to Sela-Smith's argument around the disconnections that can occur when the focus of heuristic inquiry become too much on the 'other' rather than on the self-in-experience, and yet I believe that to understand and make sense of the self-in-experience requires attending to the 'in-between' self and other. In other words, attending to and making explicit the relational dimension to researching the therapist's experience of personal loss.

2.5. Relational heuristic inquiry

With this in mind, I plan on bringing together a heuristic inquiry research method with a relational-centred approach to research. I aspire to remain mindful of the Upper Left quadrant (Wilber, 1995) and the *I-who-feels* aspect of experience put forward by Sela-Smith (2002). It is, however, my opinion that accessing the *I-who-feels* does not occur in isolation from the 'other' in this research and that to access another's

subjectivity and experience is through an examination of the relationship. For this, I have in mind Finlay and Evans' (2016) processes of **presence**, **embodied empathy**, **intersubjectivity** and **reflexivity**, which make up their relational-centred attitude to research. As I outline the application of Moustakas's six phases to this research project, these processes will become an explicit part of my methodology.

Initial engagement.

> *"All heuristic inquiry begins with the internal search to discover, with an encompassing puzzlement, a passionate desire to know, a devotion and commitment to pursue a question that is strongly connected to one's own identity and selfhood."* Clark Moustakas (1990: 40)

I presented the period of initial engagement at the start of this chapter; my struggle to know how to be, and how I could be, a therapist in the face of personal loss. I recall the moment in that Palmers Green café when I first consciously thought about making my deeply personal question about therapists facing loss into a formalised research project, and it felt right in a way that feels difficult – even now – to put into words.

Starting to formulate a question that encapsulated getting to the heart of what I wanted to know at that early stage meant delving into my own material more, which I did through my own personal therapy, discussing my thoughts with my training group during research seminars and with research tutors, and starting to investigate the literature for reference to therapists' experiences of personal loss. Looking back over my notes from this time shows an emphasis on the therapist's coping and meaning-making process. I have scrawled down questions and comments such as:

- What happens to the pain once the therapist is in the therapy room?
- 'Finding Meaning in Therapy Room Pain' – playing with possible titles...
- Think about the impact of the client on the therapist's experience of loss – changes to the therapist's narrative about loss.
- What about self-disclosure issues?
- Think about stuff to do with 'fitness to practise'.
- Can I look at what happens between therapist and client when parallel issues could be present? How?

It is apparent to me that this was not going to be research where I was going to be a detached observer or gatherer of data. My interest was on the therapist and on the relationship between the therapist and client. I remember taking this to my own therapy, exploring my fear that this could be just about meeting a need in me, especially as I was still amidst my losses. I questioned whether I would be able to

sustain my 'interest' in the topic once the immediacy of 'coping' with the loss(es) receded. These were important early 'initially engaging' discussions and ponderings that helped me hone the direction of my research as well as giving me a way of 'being with' my experience of loss.

Immersion

Moustakas's (1990) notion that during the immersion phase, the research question is lived in wake, sleep and dream states, became a reality for me. The fact that it centred around the *I-who-feels* (a retrospective term rather than a consciously thought-out position at the time), the topic was with me all the time. I found I was having numerous informal conversations with friends and family about my experience of loss, my thoughts, my struggles. These were the people who wanted to know about **me** and how I was doing – one thing that seemed to happen during this time was how the interchange of dialogue with another helped me clarify what was happening to me as a therapist (these people weren't asking this question) and at the same time, my readings and professional explorations were impacting on my experience of loss. I found that so much of what was going on around me and within me was connected to my research question. I discovered ways of self-searching through journaling, painting and walking. I wanted to know how to be a therapist in the face of another's pain and loss but so too I wanted to know how to be with the juxtaposition of another's happiness and joy. Through much of these struggles and searching, I was not the researcher in the true sense of the word but I am nevertheless reminded of Finlay and Evans' (2016) notion of presence. Being fully present and engaging in these dialogues with others was part of my immersion in the research.

Incubation

I find it very difficult to delineate between the immersion, incubation and illumination phases and set them out in a clear, linear order. For me, this reflects the problems inherent in the 'stage theories' of grief discussed in chapter 1. I think it more likely that I moved between these three phases at different times during the research journey. Keeping up the intense focus of inquiry is a challenge and oftentimes due to external pressures or commitments, I had to retreat from this focus. During the year that I carried out the participant interviews, I came in and out of the concentrated exploration when I had to attend to other things, such as writing and submitting the clinical dissertation and sitting the clinical viva. The most significant period of 'incubation' were the few years following the adoption of my first child. There were

significant periods of time when I felt disconnected from my research, wondering when and how I would find my way back to it. There were also meaningful moments during this time when I *felt* a new understanding develop in relation to my research. I reflected on these moments by maintaining my research journal, knowing on some level the salience of these experiences and the need to record my ongoing process.

Illumination

A key time for the process of illumination came in 2015 as I re-immersed myself into my data. There was a process of awakening during this second round of analysis in which I experienced the data quite differently. Listening to the recordings again and really being open to my bodily and emotional responses meant that I was able to 'hear' things in a way I didn't the first time round. Being receptive to this process required me to trust my intuition and tacit knowing, which led to a deeper awareness of what might have been happening in interviews and to new discoveries being made about the material. My journal entries at this time point to the questions I had about my own process in interview and what might have been enacted in the 'in-between'.

Explication

I remained focused on the concepts and new discoveries that were illuminated during the research process, and in particular what had occurred for me during the second round of analysis. I sought to capture the essence what my participants and I might have been experiencing by expanding the meaning of the data in line with what I understood about these concepts in the literature. I endeavoured to stay with the ambiguity and the contradictions that were inherent in the data in a bid to not 'miss' elements of the story. As part of this phase, I sought out external sources to help me explore the 'clues' and examine the layers of meaning in what I was constructing. This included research supervision discussions and using therapist colleagues to read sections of material. These conversations helped keep my focus and enabled me to hone in on particular understandings.

Creative synthesis

For me, there is a sense that this piece of work will never be 'complete' – perhaps mirroring the notion that grief itself is never 'completed'. I expect that the ideas this project has generated for me and my own process of self-searching will continue beyond the formal submission of the thesis. Nevertheless, it is the end product of this written document that sets out the essence of my understanding of the experiencing phenomenon that is my creative synthesis at this point in time. Integrating the

elements of this research into a comprehensive 'whole' brings this particular journey to a close.

2.6. The processes involved in collecting data

In this section, I shall take the reader through the main ways by which I generated my data. This includes an examination of the process involved in obtaining participants and my sampling strategy, an overview of the research interview, and my use of reflexive research notes.

2.6.1. Participants

The participants in this study consist of all those involved in the data collection. This includes myself as researcher / interviewer and participant; my interviewer; and my participants. All participants in this study were practising UKCP or BACP registered psychotherapists or HCPC registered / BPS chartered Counselling Psychologists save for three of us (including myself) who at the time of interview were senior trainees. All participants had experienced, in the course of their therapy work, a 'crisis of personal loss'. This is, of course, too broad a sample definition, and the following is an overview of the exploratory questions that I asked myself in determining the inclusion and exclusion criteria used in selecting participants:

- *What will count as a 'crisis of personal loss'?*

Particularly early on, I was concerned with the extent to which I impose my definition of 'loss' onto others yet equally recognising the need to not have too broad a definition that will make gathering data more arduous and time-consuming for this project. Initially I saw the definition as 'an event out of the ordinary, unexpected and sudden'. This would exclude, for instance, a therapist's bereavement to a protracted terminal illness. The rationale for excluding loss that was not sudden was the potential for encountering issues that may be present in this type of loss that might influence or impact on the therapeutic process differently than for sudden loss. In other words, how a therapist makes decisions to continue or return to work is likely to differ if a loved one is diagnosed with cancer than if a loved one has been killed in a car crash. The initial definition also would have excluded those losses that one can reasonably expect to experience in the course of their life, such as the passing of an elderly parent or grandparent. I took the view that how a therapist experiences this type of loss may be vastly different to how they would experience the loss, for instance, of a child. Again, the rationale was to focus the research on a more homogenous type of loss. My process of mulling and reflecting took me to a realisation that I didn't want to lose data from participants whose loss is not 'sudden'

– indeed there is a great deal of 'suddenness' in the diagnosis of a terminal illness. I also wondered about the extent to which excluding participants on the basis that their loss was not 'out of the ordinary' would narrow the focus. Moreover, I realised that rejecting this particular exclusion criterion would present more of a challenge to me as a reflexive researcher in terms of my own subjective biases by not colluding with the disenfranchisement of grief. Consequently, participants were implicitly asked to self-define their personal loss.

- *What type of therapist should be included?*

Before recruiting participants, I had to decide whether to focus on a particular modality or whether to include therapists belonging to any theoretical orientation. I decided against narrowing my sample to any one particular orientation, having been influenced by my training as an integrative practitioner, but I deemed it important to include participants who align themselves with a relational approach to psychotherapy due to the emphasis on 'self-in-relationship' within the context of the topic under investigation and the nature of the research process.

- *The recency of the loss.*

This is something that I played with during the development of the research proposal. I initially opted to exclude participants whose loss occurred less than two years prior to their point of data collection. The rationale for this was primarily due to ethical considerations wherein I wondered whether participants needed to have had an opportunity to gain some distance from the acuteness of their loss. The proposed timeframe would also take into account the practicalities involved in therapists potentially taking time off from work and returning to work, with space to have reflected on the impact of the loss on them and their work. In my own reflections on this study as well on my own personal losses (which did not meet that criteria), I believe there were sound arguments for not imposing such a rigid timeframe. The stipulation of 'more than two years' may have discounted those therapists who can offer a more 'in the moment' feel of the effect of loss on their work, which may have quite a different flavour to those who offer a more retrospective account. I was also conscious of the fact that grief does not follow a linear trajectory and that loss can be re-triggered despite the passage of time. Where this process took me was to a recognition of what I intuitively felt: that there are aspects of my exclusion / inclusion criteria that I would like to be more collaborative in nature and in keeping with the philosophy of the project. How people choose to become part of this project is in itself an interesting question to me. I therefore chose to have a *recommended* time

passage of 12 months rather than a stipulated time passage of two years. The recommended part of the criteria reflects the importance of the participant's judgement of where they are at with their loss and their work. If someone approached me whose loss was less than 12 months, I wanted to have a dialogue with them about participation rather than executing a rigid timeframe.

- *The need for supervision.*

I considered it important for participants to be in regular clinical supervision in order for them to be included in the study. Again this was an ethical consideration to allow them support for any issues that may have arisen as a result of participating in the research. A secondary factor in this inclusion criterion is what it will lend the research; part of the exploration with participants was around their reflexive process in terms of making sense of their loss in the context of their practice. Being in supervision seemed to me to be an important part of this processing.

The process of exploring what factors would be salient to this research consequently led to the following inclusion / exclusion criteria for participants:

- To have experienced personal loss during the time they have been in practice as a psychological therapist
- To be UKCP / BACP registered psychotherapists or HCPC registered / BPS chartered counselling psychologists
- To work relationally, though no stipulation as to specific therapeutic orientation
- Careful consideration is given to participating in the research if the loss is less than 12 months hence
- To be in clinical supervision

In addition to these prioritising criteria, I also aimed to involve both male and female therapists and hoped to recruit therapists with varying demographic profiles such as age and ethnicity. Having said that, I did not actively seek out differential characteristics in participants, mainly because I received a response from therapists who varied in terms of gender, age and experience. Five men and five women were interviewed, ranging in age from early 30's to late 60's. At the point of interview, participants had between two and 20 years' experience of client work since their initial therapeutic training, apart from three participants (including myself) who were in their final year of psychotherapy training at the time of interview. All participants were White British. **Table 1** shows the spread of participant characteristics.

Table 1. Participant Characteristics

Therapist	Gender	Theoretical orientation and training	Type of loss	Time since loss	Included in the analysis
A	Female	Integrative psychotherapist and counselling psychologist – senior trainee	Aunt – suicide Infertility	18 months	No
B	Female	Integrative psychotherapist and counselling psychologist – senior trainee	Family friend – cancer	Two years	Yes
C	Male	Integrative psychotherapist / EMDR	Brother – car accident	Five years	Yes
D	Male	Integrative psychotherapist – senior trainee	Mother – leukaemia	15 months	Yes
E	Male	Counsellor / Integrative psychotherapist / EMDR	Father – cancer	Two years	Yes
F	Male	GP / Counsellor / Integrative psychotherapist	Partner – lung cancer	Nine years	Yes
G	Male	Rational Emotive Behaviour / psychodynamic / systemic / couples psychotherapist	Partner – breast cancer	Four years	Yes
H	Female	Nurse / Counsellor / Humanistic psychotherapist / Hypnotherapist	Nephew – killed by van	Two years	Yes
I	Female	Psychodynamic psychotherapist and counselling psychologist	Multiple miscarriages over four-year duration	Five to nine years	Yes
J	Female	Humanistic – person-centred psychotherapist	Mother – vascular dementia / Brother – cancer	Three years / six months	Yes
K	Female	Arts psychotherapist / counsellor	Daughter – electrocution	Two and a half years	No

Participants were recruited through self-response to an advertisement (see Appendix) placed in BACP's *Therapy Today* noticeboard, British Psychological Society's newsletters and Metanoia Institute's newsletters. The data collected from participants formed the basis of the findings set out in chapter three, with the

exception of participant A (myself) and participant K. I shall discuss this further in subsequent sections.

2.6.2. The research interview

Participants were interviewed using a semi-structured interview protocol to allow for an in-depth exploration of their experience. During the process of formulating the research question, I wrote and modified the interview schedule before settling on a format that was more akin to an interview guide. It consisted of three main areas for exploration and prompt questions within each area to delve deeply into participants' experiences of loss and post-loss work (see Appendix 4). My intention was to create a space and open a dialogue with each participant to help them describe what it was like to be a therapist following personal loss. I endeavoured to balance my need to maintain some focus on the areas of inquiry with a desire to be flexible and present with what participants were telling me, using intuition to sometimes guide the direction of the 'research conversation' (Etherington, 2004). From the outset, I was influenced by the notion that the research interview can be a vehicle for growth and an enriching experience for both participant and interviewer (Etherington, 2004; Kvale, 1996), and I sought to make this an explicit aspect to the interview guide.

I carried out 10 interviews with participants that lasted between one hour and an hour-and-a-half. They were all recorded on an electronic audio device and subsequently transcribed for analysis. Each participant's transcription was sent to them and they were invited to provide comments and reflections if they so wished. Prior to these interviews, the first interview conducted was between myself as participant and a colleague as interviewer. Originally, the purpose of this interview was to pilot the interview style and guide, but as my methodology crystallised, the data from this interview became increasingly salient to the project as a whole, despite it not forming an explicit part of the overall analysis.

The majority of the interviews took place in the participants' homes or at their place of work. I arranged to hold two interviews in a room at Metanoia Institute due to these participants having travelled to London from elsewhere. The interviews took place between August 2009 and November 2010.

2.6.3. Reflexive research notes

In discussing my epistemological position at the start of this chapter, I indicated the influence that relational-centred research has on conceptualising my role as the researcher and that, central to this role, is my reflexive process as part of the research. Journaling and keeping research notes "can help us to focus on our

internal responses to being a researcher and to capture our changing and developing understanding of method and content" (Etherington, 2004: 127). From the outset, I was conscious that my research would impact on me personally and that I would need to pay close attention to my evolving thoughts and assumptions as the process unfolded. I began keeping notes early on in the process, partly as an uncensored way of tracking my developments, questions and curiosities as I thought through aspects of the research, and partly as a means of being transparent in my research journey. Bager-Charleson (2014) links journaling to assessing the validity of a research project, suggesting "it invites the outsider to follow the researcher's journey and decide for themselves where they consider different actions could be taken". I recorded my internal process from the point of conceptualising this study and continued throughout the data collection and analysis stages. My intention in keeping research notes was to continually reflect on my feelings, reactions and responses to the material and to my experience of being with the Other, keeping at the fore how this would impact upon the research process.

2.7. The process of analysing data

Moustakas (1995) considered heuristic research to be a process of internal search through which one discovers the nature and meaning of experience and one in which develops methods and procedures for investigation and analysis. As such, I consider that the process of investigation and 'analysis' was underway early on in my research journey through such informal means as self-dialogue, dialoguing with others and intuition. Alongside this, developing a more formalised process of data analysis enabled me to make sense of the collected data, to capture the essence of the experience under investigation, and to re-present the voice of the participants so that the phenomenon is opened up to the reader (Finlay, 2011). Making sense of the data, bringing some sort of order to the data, providing credible and meaningful answers to the research question is at the crux of this process. In this section, I aim to set out a transparent account of how I approached data analysis, both in terms of my attitude and approach to analysis as well as the mechanics of analysis.

Following each interview, I noted down my immediate reflections of the encounter, paying attention to the feelings that came up for me and any moments from the interview that had particularly stood out. I also used it as an opportunity to self-dialogue around what aspects of the interview had 'worked' better than others. Since, for practical reasons, I opted to not transcribe the interviews myself, I immersed myself back into each interview by listening to the recording again as well as reading each transcription before attempting to make sense of what I was being

told. This process is reminiscent of Giorgi's (1985) first step in analysing empirical phenomenological research of developing a **general sense of the whole** description given by a participant. I was also aware at this stage that I would remain mindful of my bodily intuitions to help guide my way with the data, noticing what moved me as I listened back to interviews and what became foreground versus what retreated from my immediate focus.

My next step in analysis was to create a template that would capture the meaningful elements of the participants' experiences and would allow for the tracking of my felt process in each interview. The template I put together contained the **transcribed material** in the first column; my **relational-reflexive process** in the second column; and the **emerging themes** in the third column. An anonymised extract of an interview is in Appendix 5. With Moustakas' (1990) concept of tacit knowing and Sela-Smith's (2002) notion of the *I-who-feels* in mind, I went through each transcript while listening to the recording, and noted down in the second column what I felt about the material and what I observed to be happening in the *in-between* myself and my participant. It felt important to do this step first since this would have an impact on my making meaning of the data. I knew that my experiences and self-understanding would inevitably guide the direction of my making sense of the material and that this kind of dialoguing with myself at this stage was a critical facet in remaining accountable in the overall process of analysis and subsequent construction of findings.

The next step in the process was to make sense of the content of the transcripts, to illuminate the meaning of participants' experiences and to explicate my understanding of what has evolved. In so doing, I was influenced by Braun and Clarke's (2006) writing on thematic analysis whereby they suggest a process of generating initial codes; identifying patterns, or themes, within the data; and reviewing, defining and naming key themes. While thematic analysis can be regarded as a relatively uncomplicated foundational method for analysing qualitative data, Braun and Clarke (2006) argue that the task in writing up a good thematic analysis is to provide a concise, coherent, convincing and interesting story that the data tell. In engaging with the process of identifying themes in my data, I had to remain mindful of two considerations. Firstly, having spent time reflecting on my own inner process, the context of the research and the relationship between myself and participant, I was able to notice what chunks of data held meaning for me and which segments of narrative elicited an emotional or bodily reaction within me. This process provided clues as to the choices I made in constructing meaning of the data. Finlay's (2011) writing on reflexive analysis impacted on my understanding how I

made sense of the data.

Secondly, I had to adopt a questioning position with regard to defining my themes in terms of their relevance. Taking up such a position reminds me of Rothschild's (1999) Dual Awareness process in trauma therapy where the client is helped to find a way to hold the 'experiencing self' and 'observing self' simultaneously. In my analysis, I endeavored to hold both of these positions in order to construct meaning of the data. Identifying my themes revolved around what Braun and Clarke (2006) describe as 'keyness' of a theme, which is about determining what should count as a theme. Here, they suggest it is not about quantifiable measures (i.e. how often a theme recurs); rather it is about whether it captures something important in relation to the research question itself. Therefore, throughout my analysis of transcripts, I strove to keep in mind the question: what is this person telling me about their experience as a therapist post-loss?

As the reader will be aware, I conducted the first round of analysis in 2010/11, interwoven into the continued phase then of data collection. Having taken time to dwell with the recordings and transcripts, and to reflect on my inner process in relation to my interactions with participants, I started making notes in my **emerging themes** column that indicated connections between parts of the narratives and reflected upon implicit meanings in the text. I was conscious of the double hermeneutic in doing this task; that these were my reflections and reactions to participant meanings rather than facts. I paid attention to the **relational-reflexive** notes I had made (and continued to make!), noticing what statements jumped out at me, what segments puzzled me and what interested me. During this first round, I knew that I was interested in knowing more about participants' decisions regarding returning (or not) to work, how their loss impacted on their clinical work and how they experienced being a grieving therapist impacted on their relationship to their loss. Using diagrammatical tables, I started grouping the data together in terms of these areas of inquiry, noting the commonalities across statements and what each theme seemed to be saying about these main areas of inquiry. As I moved through this process of analysis, I began writing my findings into a synthesised narrative.

When I returned to the project in 2015, I went back to the raw data in its entirety. I actively decided to re-experience the interviews by sustaining an intense focus on the material, taking my time once again to dwell with my data, listening to the original recordings and re-reading the transcripts. I then returned to my written account of the constructed themes and found myself interrogating the meaning that I had made, noticing a superficiality to the analysis. I drilled down into the deeper meanings of the themes I had identified as significant, drawing out what I felt was

being said about their experience as a grieving therapist. I created a new diagrammatical table that encompassed the original themes as well as the possible underlying meaning of each one (Appendix 7). I built on those themes that seemed key in harnessing the essence of experiencing grief as a therapist and I conducted this second round of analysis asking the question: how am I experiencing the *in-between* as a researcher post-loss? This signifies the subtle but important shift in my research question that I described in the last chapter.

2.8   Addressing issues of quality

One of the major challenges for qualitative researchers is the struggle over how to establish agreement over the criteria to be applied in assessing the quality of a piece of research (McLeod, 2011). The criteria that have traditionally been used to evaluate the scientific value of quantitative studies in psychology (such as validity, reliability and generalizability) become quite meaningless in assessing the quality and value of qualitative research (Willig, 2001). I find myself managing the tension between the notion that one's personal experience is valid in its own right (Sela-Smith, 2002) and the position that it is both personally and professionally important to me that what my findings convey can be held open to scrutiny and evaluation by readers. Managing this tension means finding the 'right fit' of criteria to assess this particular piece of research. Importantly, the criteria used needs to take account of what the research was trying to find out (i.e. the research question), the researcher's epistemological assumptions and the appropriateness and compatibility of the research methods involved (Willig, 2001).

With my ontological and epistemological assumptions in mind, I am looking to ensure that the following sort of questions can be answered: do the findings make sense to the reader? Is there sufficient transparency showing how I arrived at my findings? Have I clearly demonstrated the role of me-as-researcher in reaching my findings? Have I adequately shown how meanings were constructed in an intersubjective context? Do my findings resonate on an emotional as well as cognitive level for the reader? Are the findings useful to the field of counselling psychology? I looked at several frameworks for assessing the quality of my research. Lincoln and Guba (1985) set out the four criteria of credibility, transferability, dependability and confirmability. Elliott, Fischer and Rennie (1999) provide a set of guidelines for 'good practice' research and assessing the publishability of studies. Yardley (2000) suggests four criteria for assessing qualitative psychological research: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. These frameworks helped guide some of my practice as

a researcher. However, due to the my positioning within the research, I thought it important to use criteria that emphasised reflexivity in the research process and I was therefore influenced by Finlay and Evans' (2009) framework for assessing quality in relational-centred research. They suggest "that good qualitative and relational research is trustworthy and transparent in its process and impactful in its outcomes" (p. 59) and propose the 4 R's as criteria. These are **rigour**, **relevance**, **resonance** and **reflexivity**.

Rigour refers to how well the research has been managed and systematically worked through. It is suggested that researchers can demonstrate the rigour of their work by methodically showing critical reflection of the process, plausible interpretations and well-marshalled evidencing of the findings. Throughout the project planning and data collection phases of this research, I had the opportunity to discuss with peers and research tutors various aspects of my study, including draft interview guides and the formulation of research questions. This ensured that I remained in dialogue with others and kept myself open to having my thinking critiqued – a particularly important element of my research given its deeply personal nature. In the early stage of analysis, I involved my training group in 'testing out' my template for data analysis by asking my peers and tutor to read and code a short anonymised extract of a transcript. We then discussed this process and the usefulness of having the template in its current format. This helped me to reflect on how the template would work in practice. Specifically, the template I had constructed allowed for transparency in how I had made sense of my participants' accounts by simultaneously setting out my internal process as I went through each transcript. This formed part of the 'inquiry audit' (Lincoln and Guba, 1985) deemed important in qualitative studies. Also as part of this auditing process were my research notes and the two quite separate rounds of analysis.

Throughout the research, I have endeavoured to make clear and provide a rationale for the decisions that I have taken as a researcher, from setting out my epistemological position to the participants involved to the way in which I analysed my data. In making meaning of the participants' stories, I have ensured that the themes I arrived at were derived from the words of participants and that my analysis is supported by specific quotations that directly map the finding in question.

Relevance concerns the extent to which the research contributes to the field of counselling psychology and psychotherapy, and how much it might enrich our understanding of the phenomenon under investigation, or more widely, the human condition or psychotherapeutic process. I started this project from the premise that this was a significantly under researched area in counselling psychology and

psychotherapy, and in particular, there was a dearth of systematic investigations into the phenomenon. In the time since my project has been underway, several other studies have been produced, providing a richer body of knowledge within which my research sits well. My findings have added new understandings to how personal loss is experienced by the psychological therapist, particularly as a consequence of my differing method of inquiry. As well it has concurred with various elements of the findings from other investigations into this phenomenon.

Finlay and Evans (2009) suggest that relevant research can be growth-enhancing for either participants and/or readers. Without exception, the participants in this study reflected on the personally beneficial nature of having thought through and dialogued about the experience as a therapist post-loss and their feedback generally was that they had valued having the opportunity to reflect on and process how that time had been for them. Several spoke of new realisations and having come to new understandings of themselves as post-loss therapists as a result of participating in the interview. In terms of what this research can offer by way of relevance to readers, this is of course a subjective matter to some degree. I have endeavoured to keep my findings focused on the experience of the psychological therapist and the impact on the psychotherapeutic process. Since the research was borne out of a genuine 'need to know' on my part as a grieving therapist, I hope that my research can offer therapists some guidance and thoughtful reflection of the phenomenon.

Resonance refers to the emotional power that the research findings convey to readers. Finlay and Evans (2009) ask such questions as 'to what extent is the reader touched by the findings?' and 'can the reader enter into the research account emotionally?' to judge the trustworthiness of phenomenological research. Assessing resonance, therefore, is a deeply personal, subjective task – something that arguably can only be judged on an individual basis by readers. Nevertheless, I believe there is an onus on me to demonstrate steps taken to assess resonance as part of the research process. In a bid to judge both resonance and relevance, I enlisted the help of a peer-led supervision group that I had been part of for the previous year or so. The other three therapists had no prior knowledge of my research as our focus was always on current clinical work. With their agreement, I sent each member of the group an extract of my findings, and asked them to notice their emotional response as they read the piece and how it 'landed' with them. We met as a group a week later and used the session to discuss their reactions. We agreed that I would not take part in the discussion; rather, I would observe their interaction and engagement with the material. I was conscious that I did not want this to become a

process of giving me feedback and I felt it was important to see how my three colleagues engaged with the material. Listening to their discussion provided me the opportunity to see the material ignite an evocative and thoughtful dialogue about the phenomenon under investigation. I observed a wealth of emotional responses to the material, which in turn elicited personal stories of their own regarding loss and bereavement, tapping into their own experiences of grieving and having done client work at times of personal difficulty. This was a moving meeting for all of us. The content of the extract I sent them to read had the effect of inviting them to think about their own 'space' of the therapy room. It was a discussion that showed the in-the-moment complexity and ambiguity of the meaning this space has for the grieving therapist, where for one peer her home consulting room was a "sanctuary" while another peer felt it would be an "intrusion" or "distraction". The richness of the discussion content and the poignancy with which they engaged the material provided the sense that these research findings resonated with these readers. This process also allowed me to, in some small way, 'test out' the contribution of the research and to assess the relevance of my findings for an audience.

Reflexivity refers to the self-awareness and openness that the researcher shows towards the research process and their subjective positioning within it. It has been my intention to demonstrate explicit reflexivity throughout this research project. Since I placed myself at the centre of the study from the start, it was crucial that I was able to account for my own subjectivity and to demonstrate transparency as a researcher so close to the subject matter. I sought to do this in three main ways: to offer readers a clear and coherent account of how I locate myself in this research by reflecting on the personal and professional influences that gave rise to the study; making use of reflective note-keeping (journal entries, questions, musings, doodles) and an analysis template that allowed for personal reflection on collected data and encounters with participants; and giving space in the final synthesis for 'reflexive analysis'.

2.9. Ethical considerations

Using the professional guidelines set out by the British Psychological Society's *Code of Ethics and Conduct* (2009) and subsequent *Code of Human Research Ethics* (2014) as a framework, I operated on the basis of the *Code's* moral underlying principles to inform psychological research practice. This framework was applied at the different stages of the research project from inception to conclusion. In this section, I shall consider the steps I took during the research process to adhere to

these principles, keeping in mind the complexities of negotiating the ethical pathway through the research journey.

Respect for the autonomy and dignity of persons

I began addressing ethical issues from the point of first contact with potential participants by engaging in an initial dialogue with them (usually by email) about the research. If an individual continued to express an interest, I sent them an information sheet, setting out the scope of the research. This was then discussed at the start of the interview, along with reviewing a research contract. This ensured that they understood what the research was about, what their participation would involve, that the material discussed may be sensitive and could be uncomfortable or distressing, their right to withdraw at any time, the need for possible self-care measures to be taken (including not having to answer any questions they did not wish to), and confidentiality and anonymity issues. This latter point refers to not just my participants but to the client work that they discussed. To ensure anonymity of clients, participants did not disclose any identifying details, including names, and only disclosed their experience of working with particular clients rather than the specifics of client material.

Part of this principle speaks to the 'fair treatment' of participants. This brings to mind the importance of setting up and establishing the 'research relationship' with potential participants. Paying attention to power dynamics and interview techniques is crucial in building trust and rapport, and in keeping participants' safety paramount. This includes considering how to close the research relationship; a consideration that became an ethical challenge for me as I prematurely came out of the research for a protracted period of time due to my own family circumstances. Although I contacted my participants to let them know I was effectively 'pausing' the research, I was not able to provide them with a timeframe within which I would return to the project. In the event, four years passed before I re-immersed myself into the research. Given the uncertainty I experienced during this gap, I chose not to involve my participants in my 'on-off' relationship with the project, which I felt would not be fair. Instead I intend to let them know about the completion of the project and to offer some form of summing up should they wish.

Scientific value

Ethical approval was granted for this project, in part, on the basis that the objectives of the research were clearly laid out and the potential contribution of the research was outlined. I ensured that my original proposal and participant information was

transparent in terms of the aims of the research, the process and the intended outcomes.

Social responsibility

In the context of this study, this refers to my responsibility as a researcher to take seriously the implications of my research, to be open to challenges that may arise, and to ensure the quality and contribution of my research. This principle also emphasizes the importance of researchers engaging in a reflective process regarding the ethical challenges thrown up by the research. The specifics involved in my process of self-reflection and the steps taken to consider the contribution of the research are discussed in the preceding section entitled '*Addressing issues of quality*'.

Maximising benefit and minimising harm

Central to this principle is the, at times, difficult balance to strike between costs to the individual participant versus potential societal benefits. A primary consideration I had to hold in mind from the outset was the likelihood of participant distress given the nature of the research topic. I went into this research keenly aware that the material could trigger painful memories and material. I sought to minimise the risk through the following steps:

- Ensuring that all potential participants understand the nature of the research and what would be expected of them in terms of interview material.
- Ensuring that all participants understand that they do not have to answer questions with which they feel uncomfortable.
- Recommending that if a potential participant's loss occurred less than 12 months previously, taking part in the research may not be advisable.
- Stipulating that participants attend clinical supervision as part of their support system and, in addition, providing contact details for further support where relevant.
- Ensuring that there is appropriate 'debrief' space as part of the interview process.

In addition to this, I remained mindful of the need to 'check in' with participants during interview as to how they were doing and to attend to the 'space between' in the research encounter.

Despite taking care to minimise distress, I found that human error on my part has likely resulted in distress for one research participant. During the analysis, I discovered that the recording of my final interview was irretrievable on the recording

device. I remain uncertain as to whether I somehow failed to capture the interview (i.e. through a faulty socket or having not properly pressed 'record') or whether the recording was subsequently lost from the device. I will return to discussing this 'lost' material later; for now, it is a matter for reflecting upon my ethical conduct as a researcher. I pointed earlier to the question of closing the research relationship with participants and how to do this in the context of the time passage involved in the project. After exploring this particular issue and my feelings about it with my supervisor, I opted to contact the participant and explain what had transpired. I sought to be as transparent as possible whilst mindful of not overwhelming her with my own sense of guilt at 'losing' her story. I invited her to have any kind of further dialogue with me regarding this if she so wished. This has not been taken up.

And so this raises ethical questions for me that parallels the questions therapists have asked of themselves when working at times of personal difficulty. I held this final interview just days before meeting my new daughter through the adoption introductory process. It was a tumultuous time, and uncertainty, unknowing and loss were certainly 'in the field' for me. I have had to consider whether I was suitably 'fit' to interview a mother about the loss of her daughter at that time, much like my participants who have asked themselves whether they were 'fit to practise'. I thought I had accounted for the ethical challenges this research might raise and yet I have likely caused distress to a participant. To me, this speaks to the complexities involved in determining ethical issues and decisions, which go far beyond adhering to the rules of research, and bring into focus the unconscious world of the researcher in relation to the research.

2.10. Concluding remarks

The overriding aim of this chapter was to provide the reader with a clear explanation of the philosophical underpinnings to my methodological approach to carrying out the research. The 'how' as well as the 'why' behind the 'how'. I have set out the practical aspects of conducting the research, and addressed issues pertaining to quality and ethics. I have also sought to convey my role and involvement in these co-constructed processes. In the following chapter, I shall offer an account of the meaning I have made of the data as my Findings.

Chapter III

Research Findings

In this chapter, I shall set out the three core themes that I constructed from my engagement with the data. Contained within each theme are the associated sub-themes. Figure 1 depicts these themes in diagrammatic form. I shall take the reader through each theme as I made sense of my data, before concluding each superordinate theme section with a reflexive analysis narrative. Consistent with an idiographic approach, it should be noted that the themes I constructed from the data were based on what was figural to me in terms of answering my research question. In staying with the uniqueness of the individual participants' stories, each interview offers something different in their contribution to the creation of themes, with each sub-theme being supported by specific quotations from participants. The voices of all nine participants (B-J) are part of the analysis; however, I have had to decide at times whose voice to include and whose voice to leave out. I am conscious that some voices are 'louder' in my analysis; that some participant pseudonyms appear more frequently than others. Ultimately, inclusion was driven by what I felt was key to elucidating the experience of the post-loss therapist. This is not an attempt to assert facts about the bereaved therapist nor do I assume that the themes created from the data can be generalised to the experiencing of this phenomenon. The themes are offered tentatively as a way of understanding the key aspects of participants' experiences post-loss.

Theme 1:
Connection
with Self and
Other

Theme 2:
Sense of
Time / Space

Connecting through:
- vulnerability
- anger
- healing

Lived space of the therapy room

Lived experience of space

Disconnection through grief

Making meaning of one's work

Embodying the identity of the bereaved therapist

Theme 3:
Meaning and
Identity
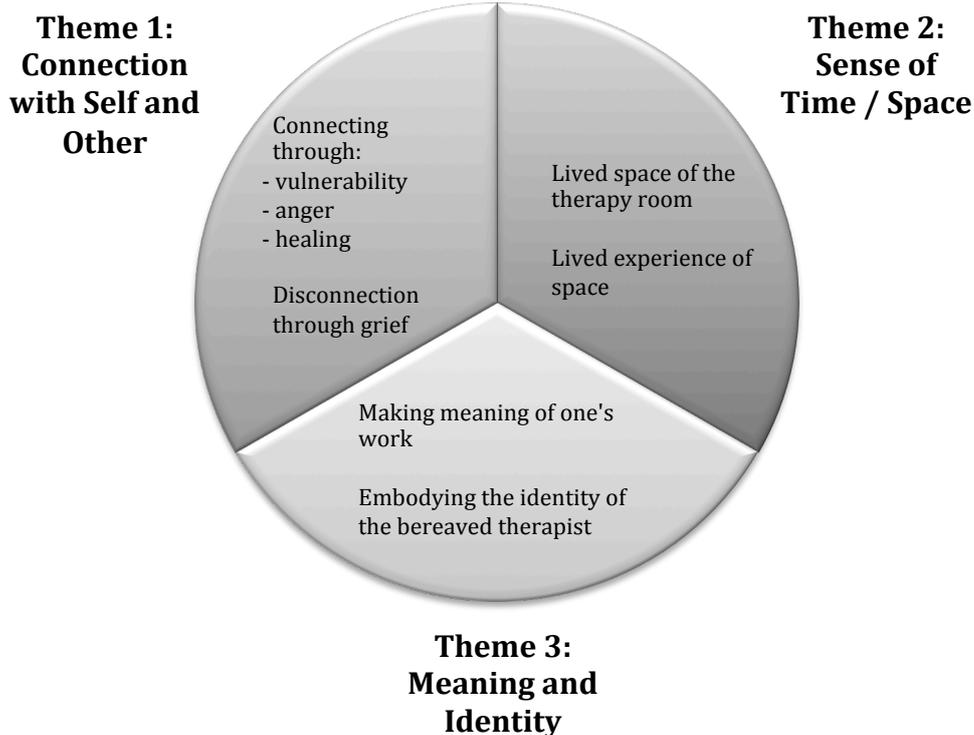
Figure 1: Overview of superordinate themes and sub-themes

3.1. An integrating statement of my findings

There is an ambiguity to the bereaved therapist's ability to connect with their client in the therapeutic relationship. Therapists can find themselves much more open, more receptive to the pain their client brings, stemming from the raw state they are in. Their emotions seem closer to the surface, more readily accessible to them in the therapeutic endeavour. Paradoxically, in either seeking such connection or being engulfed by their heightened emotions, they can experience disconnection within the relationship and 'shut down' can occur. Part of staying connected with the work is the way in which therapists might experience their physical surroundings. The safety of the therapy room can temper the chaos of our personal crises and provide a space where we feel competent, alive and present with the other. The vulnerability and rawness that comes with grief can mean having to reconfigure our space outside the therapy room. Taking our time and attending to our sense of overwhelm is an important part of the bereaved therapist's ability to manage their self-care. It undoubtedly helps that therapists create positive meaning of the work, finding it stimulating and rewarding, countering the oftentimes tendency for grief to leave us feeling powerless and ineffectual. Providing therapy can be a powerful, and healing, antidote. The transformative potential of this experience becomes apparent in their

embodiment of the identity of the bereaved therapist where the depth of feeling and tacit knowing seem to underpin their sense of who they have become in their professional world.

3.2 Connection with Self and Other

"No-one ever told me that grief felt so like fear. I am not afraid, but the sensation is like being afraid… There is a sort of invisible blanket between the world and me. I find it hard to take in what anyone says. Or perhaps, hard to want to take it in. It is so uninteresting. Yet I want the others to be about me." (*A Grief Observed,* C.S. Lewis, 1961)

To me, at least in part, this is about a need and a capacity for connection as well as the sense of disconnect that exists after loss and in our grieving. As therapists, we strive to connect with our clients as part of the therapeutic relationship and as part of the work we do with them. As I analysed my data, I became keenly aware that much of what the participants were telling me was to do with the connections that had been made with their clients in the aftermath of personal loss and as a result of their own grieving process. The first three sub-themes in this section are separated out as the descriptions of connections made through participants' felt sense of their own vulnerability, their anger and their process of healing. The fourth sub-theme came from a later stage of analysis as I pondered my own interactions with participants and began to notice a degree of disconnect that seemed to be present in the dyadic space, leading me to hypothesise that I had unconsciously retreated from the painful material at times and so re-visited the interviews to see whether this might be apparent in the other therapists' stories.

3.2.1. Connecting through vulnerability

Feeling vulnerable as a result of personal loss and what that vulnerability meant for them as psychological therapists were two interrelated concepts touched on by almost all the participants in the study. What came across to me in listening to their stories, was the nature of the work done by these therapists in their post-loss practice. That despite – or more aptly put, *because of* – their feelings of vulnerability, their sense of their practice was enhanced.

Several therapists spoke of the influence their own pain and grief had on how they felt and how they were with their clients. I have chosen to focus particularly on Greg and Joe's stories in this section. It should be noted that all names are

pseudonyms. Here, Greg talks about his heightened awareness and empathy for his clients as a result of being really in his own grief:

Greg: I was seeing all these other people [clients] who were bereaved as well, and what of course that meant was that at that moment, of course, my empathy was extraordinary. My ability to be understanding, be in contact with, really feel what they were going through because I was going through it myself, was very heightened, so in many ways, I think that I was in a very fit state to help them.

And further into the interview, he returns to this experience of being in contact with clients and elucidates on his sense of presentness:

Greg: There is a process, I think, especially when it's a fresh death, you know, when it's not happened too long ago, that in many ways you can be quite alert and quite present and very alive and very astute. In a way, it's almost like it kind of wakes you up in a particular way, so I was very awake…I can't explain it somehow, but your consciousness, the volume's turned up in a way.

Amy: You were very awake to things. I'm wondering whether there's something about the particular connection of being able to make contact in that way with someone who is in a similar place in terms of grieving.

Greg: Yeah, I think there's something about that. You're very – yeah, you can contact the client, you can really touch and feel and, you know, sense… in a way, your senses are heightened so, you know, I mean in some ways I may have been the best therapist there ever was just after that death.

Greg is describing the meeting place between two people where "fresh death" of client and therapist mingles in the relational space and words are insufficient to capture how being in this space is experienced. He uses what feels like rather evocative language to convey his felt experience of being in this meeting place with a bereaved client; alert, present, awake, alive. All of which have the flavour of being the antithesis of death. It is as if in his grief, Greg's experience of himself with another is to be particularly awake and alive to the other. I found myself especially struck by his statement "*I can't explain it somehow, but your consciousness, the volume's turned up in a way*" and in analysis, I wondered whether this referred to an ability to 'hear' (feel, sense, pick up on) things in a way that one might otherwise not.

This concept of being more present, of being 'with' a client in this way, was something that was repeated by other participants. Ann described feeling like she had had a protective layer of skin removed and felt things more acutely, which reminded me of Greg being 'very awake with the volume turned up'. Lyle described his ability to be present with someone else as being more able to "enter into their

world than ever I was before" and Sally pointed to her own sense of vulnerability as giving her "a heightened sense of people's vulnerability", putting her more in touch with clients' stories. I am reminded of Tronick's (1998) concept of 'expanded dyadic consciousness', which refers to the enlarged scope of the sharing between two people. So this feels to me that there is a particular moment of meeting and being with a client when we are in the vulnerable state of grieving that may lend itself to increased connection and has transformative potential.

Returning to Greg, he gave a clinical case example involving self-disclosure that seems to reflect this transformative potential:

Greg: *I was working with this woman and she was, before the death of my brother, she was very defended around her vulnerability… And after I'd shared that piece of information and clearly made myself very vulnerable, she started to become much more vulnerable and she softened, and she was much more able to share some of her pains. They weren't necessarily grief, but certainly pains and losses…and not just that actually, many things about her that were vulnerable, and it transformed our relationship. And her therapy sped up a bit because she wasn't so scared, she wasn't busy defending, she was much more able to go into her own vulnerability because I'd been vulnerable.*

Greg experienced his expression of vulnerability as a turning point in the therapy with this client and he feels something transform in the room, transform in their relationship and transform in her. This, Greg says later, was not the intention behind his disclosure but it ended up being the consequence.

The vulnerability of the grieving therapist is a paradoxical experience. In Joe's story of his post-loss work, he describes being less present with clients, a "bit more held back", and what this seemed to elicit in his clients:

Joe: *So after that [the night his father died] I didn't feel terribly… well, I was upset but I wasn't distressed, if that makes any sense. I was just sad really, and quiet and… I think in a way it might have actually aided some of my therapy clients.*

Amy: *Tell me about that.*

Joe: *Well, I'm not a sad person in general… I found [his father] to be a very warm man and I think that's probably my strength in therapy, that I can be engaging and I'm probably not as good at bringing out the kind of difficult stuff and I think maybe I felt more open to … open to other people's distress or …*

Amy: *What was that like before?*

Joe: *I'm not saying quite what I mean.*

Amy: *I was understanding from you that – I don't know, tell me if this isn't right – is that there was something about perhaps eliciting a more positive transference in terms of clients and being there and being very empathic and containing but somehow that can sometimes block, I guess, more of a difficulty or more of a vulnerability?*

Joe: *Or it may not always allow the kind of shitty, the kind of angry, the envious …*

Amy: *Yeah.*

Joe: *Absolutely.*

Like Greg, Joe seems to be describing a capacity to 'hear' or be open to something else in the other as a result of the vulnerability of grieving; in his case, it was an increased sense of receptivity to negative feelings in the client (or in the space between client and therapist). It seemed that for Joe, the effect that his sadness and grief had on him allowed his clients' more difficult feelings to emerge in the therapy. His experience of being "less present" in the therapy room had the potential for transformative moments in much the same way that Greg's heightened presence and 'awakeness' had. The complexity of being present and what this means when we are experiencing the vulnerability of grieving speaks to the power of connecting with our clients when we are in that authentic state of 'being with' our own grief.

The participants' stories illustrate the potential therapeutic value of a therapist who is vulnerable and who is grieving. This is a difficult and contentious concept since we are unlikely to want to think about the psychotherapist as vulnerable. It raises all sorts of questions about 'fitness to practise' and competence. What I found in these participants' stories was an acceptance of change within themselves and almost an embracing of their own pain and vulnerability in terms of the impact it had on their post-loss work. In intersubjective terms, these retrospective accounts show how the therapist's crisis changes something in the 'in-between' such that they are with their client on a deeper level (feeling more empathic, more present, more in touch) and, significantly, furthering the therapeutic trajectory.

3.2.2. Connecting through healing

This sub-theme focuses on therapists' experiences of the therapeutic process post-loss as being a way of helping them continue to process their own grief and continue their own healing. The psychological therapist is in a rather unique position insomuch as they are privy to others' losses and pain in a very intimate manner and one cannot help but wonder what this might mean for the therapist who is grieving. Several therapists in this study spoke of the beneficial nature that providing therapy had on their own journey of loss. It is Cara's story that particularly captured this process and

features in this section. Cara, having had an unsatisfying relationship with her mother and then losing a mother figure in the form of a close family friend, spoke of her work with a client who had been left motherless as a young child. The work she described took place in the months following Cara's bereavement of her friend, and despite the chronological difference in the occurrence of deaths, Cara's experience was one of parallel mourning and 'learning to mother oneself':

Cara: That's a good question. Have I taken anything from that? I think probably what I have taken is – because I'm not very good at, kind of…ordinarily I am very good at seeing this for myself, is the impact that it does have. And I guess the work that I've done with this client has been a lot around her… to sort of mother herself more. She is very critical of herself so just didn't know how to mother herself, she'd never had that shown to her, how to do that. So – and as I was saying that, I'm getting that tightness in my chest, so I think yeah, that's quite….definitely, definitely happening when I was talking about that, so I think for me….yeah, it's taking…being more…giving myself permission to see how it's impacted. (cries) Gosh, sorry! (pause)

Amy: What's going on for you now, as you're talking about it?

Cara: I don't know, it's… I don't know, just obviously when I started saying that, I just felt really overwhelmed really. Because I haven't been…I haven't been great at allowing myself to see what impact it's had, and I'm behind myself in that really, so….

Amy: I noticed you seem particularly moved when you mentioned about her needing to mother herself because she hadn't had that.

Cara: Yes.

Amy: And I was particularly struck by the fact that you've also talked about – because you didn't have that.

Cara: No.

Amy: And then Jen filled that role.

Cara: Yes, that's it, yeah. Definitely.

Amy: I'm wondering whether there's something about your work with this woman around her learning to mother herself that also resonates for you.

Cara: Yeah. Yeah, definitely. Yeah, absolutely. No, definitely. I think that's really my process of….kind of, yeah, running alongside hers really.

Cara was sensitive to her physiological responses as we spoke during interview, indicating when she felt a tightening in her chest, her heart beating faster or her breathing quickening, and she seemed to use these responses as a gauge for how powerful she was finding the process. What she hadn't necessarily recognised at the

time of doing the work was how much she also seemed to be taking from the sessions with her client:

Cara: Yeah. Yeah. I think that's it. More than being needed, it wasn't really about being needed, it was actually every time, you know, something would be going on for her [the client] and I'd support her through that – it was almost like I was giving a bit of therapy to myself, I guess. Yeah, my chest is happening again! (laughs) So that's probably it. Yeah.

And a moment later in the interview:

Amy: So it sounds like one of the threads of work you were doing with her was around being able to hold her where she was and encourage her, however that was done, to stay with her process and stay with her pain, and be able to work through that. And it sounds like, at the same time, you were doing that yourself.

Cara: Yeah. And I think there's definitely a sense of, I was able … I felt I was able to give her something that I felt was perhaps missing in my own therapy, which was obviously quite healing for me as well.

Since loss can evoke unfinished business, therapists can find themselves not just processing their immediate bereavement but confronted by and needing to address other issues that are subsequently triggered. I formed the impression from Cara that part of her healing was indeed the loss of her close friend, but that it also encompassed the legacy of 'losing' her mother.

The concept of mutual healing is also apparent in Lyle's story:

"Being present with the experience of other people talking about and working through their grief is something which I have found rewarding and therapeutic for myself… I would have to say that I have continued to work on my own grief, my own loss, as a result of being involved in therapy with people who have also experienced bereavement or loss… I am changed by the process of therapy as patients are changed by the process of therapy".

The ability to remain open to the impact our clients can have on us as therapists, and our capacity to learn and change as a result of these interactions, is illustrative of the intersubjective stance that characterises the psychotherapeutic relationship.

3.2.3. Connecting through anger

This sub-theme encapsulates the impact that personal loss had on therapists' capacity to challenge their clients. For some, their capacity to challenge their clients' choices stemmed from their anger at what they saw as oftentimes reckless behaviour.   I draw on Greg, Eleanor and Ann's interviews in this section. Greg

described himself as a therapist who believes in challenging self-harm and reckless actions that can place a client (or others) in danger. Post-loss, he considers this capacity to challenge to have been brought more sharply into focus directly as a result of his increased sense of life value and the consequent anger felt at clients who placed their lives at risk. It was this combination of anger and the sense that "life is precious" that led Greg to become explicitly challenging with clients.

The sense I had of Greg was of him treading a fine line between feeling anger at a client's recklessness and challenging that behaviour, and having his own anger towards his dead brother triggered and redirected towards clients. Greg candidly spoke of one occasion when he felt his anger at his client was "charged", identifying it as his rage against his brother's careless driving, and resulting in his feeling that it "leaked" into his intervention with the client. Other clinical material presented by Greg showed his ability to be in touch with his anger in such a way that it enabled him to appropriately confront and challenge clients:

Greg: *But you know, I think it kind of changed my practice in a good way because even though, at first, there was that charge, and I needed to be careful about it, what it did do was I was much more likely to bollock them, and I realised that I felt good about bollocking them sometimes because when I really looked and thought, what am I doing bollocking them, what do I mean by that, it's totally life supportive and I thought it's about challenging self harm and it was about deeply valuing them, valuing life, valuing their life.*

Eleanor similarly spoke of feelings of rage and anger towards clients who did not seem to value their lives. She gave a clinical example of a client who displayed parasuicidal behaviour; after one such occasion, Eleanor felt intense anger at the client and tape-recorded herself "giving voice" to her anger. She described this as a form of self-supervision that allowed her to move through the anger she felt towards her client to a place of understanding and acceptance. Significantly, her anger had seemed to sensitise her to the issues that needed addressing with the client. Eleanor's opinion was that had she not felt so angry and expressed it in the way she had done, some degree of anger would have stayed with her and kept her distanced from the client's needs.

Ann described herself as being more challenging with clients since the death of her brother as a result of feeling that her sense of mortality has been heightened. She gave a clinical example of challenging a particularly passive 40-year-old client who is essentially waiting to die. Listening to Ann's story, I had the sense that her brother's death had sharpened a philosophy around 'live life – it can be taken away so quickly', and as Ann vocalised to me "come on, it's now or never", I formed the

view that this belief underpinned some of her interventions and ways of being with clients. Anger, to varying degrees, appeared to have the result of empowering and enabling these participants to challenge their clients in ways that they might not otherwise have done.

3.2.4. Disconnecting through grief

Much of this section has focused on participants' stories of feeling connected: to their clients, to the clinical material, and to their own processes of grieving. During my second round of analysis, when I returned to the interview recordings and transcripts, and listened to them again, re-reading the dialogues I had had with therapists, I noticed a process within myself that had not been apparent during the first round of analysis. I noticed that I felt impatient and critical of the 'me as interviewer'. My interview transcripts began to be noticeably annotated with question marks and irritated comments as to why I had not stayed with something a participant was describing to me. I became interested in what was going on in the interview that meant I seemed engaged and connected with participants in one moment and then clinical and detached in another. As I started to re-read these passages again, a pattern began to emerge showing my tendency to retreat from the more potentially painful moments in interview (for me), creating a disconnect between myself and the other. Noticing this pattern led me to return to the data with a renewed perspective and a curiosity about the existence of this sort of disconnect in my participants' stories. My interviews with Hugh and Robert seemed particularly salient in this regard.

Hugh spoke of "retreating into a more person-centred mode of being" with clients following the death of his mother, meaning that he considered himself to be "more passive", less direct and "just let them talk more". He did not feel this particularly impacted his clients but he noticed that there were times when he "decided to let something go whereas [he] may have addressed it [before]". He goes on to talk about "choice moments" in therapy where he chose not to go further (or deeper) with a client:

Hugh: There may have been times when perhaps people were talking about quite painful things and … in fact, I can think of maybe two and I'm not even sure what they were … where I thought I could go deeper with this, but where I am, I don't want to go to that emotional place with them.

Now Hugh doesn't describe this as a disconnect; rather he sees it as one of many moments where therapists make a decision about how to respond to a client, recognising that his decision was based on feeling "emotionally exhausted in that

moment". It would seem that Hugh was making a conscious choice to protect himself in those moments of feeling particularly vulnerable. This next extract follows on directly from Hugh talking about these choice moments and shows how his vulnerability (this time as a result of being asked about his practice in interview) could lead to a disconnect between us:

Amy: And I wonder … a couple of times now you've mentioned the word 'mistake' and I wonder if there's also something – another process here – about … we're talking about your practice and I think it can feel a little bit..

Hugh: Vulnerable.

Amy: Yes, vulnerable. Or maybe some fear of judgement on my part, that …

Hugh: Yeah. I think that's come in the last couple of moments … but it's … it's quite unusual to – apart from supervision which is normally focused on a client – to talk about my practice in this depth in some ways. It is quite unusual, isn't it, really?

Amy: Yes.

Hugh: So maybe it is just a little bit exposing, but it feels okay. It's not horrible, it's just sort of like 'hmm' … strange to talk about that, although I rarely think in terms of mistakes.

Amy: I just had this sudden sense that maybe you'd sort of interrupted your process in this moment to make sure that, you know … make sure that perhaps you weren't too exposed.

Hugh: Yeah. Yes, I think I did. Yeah. Yeah. And I think as a background issue, it [grief] was probably affecting all the time, but maybe not … but not … but there weren't many concrete instances where it really showed up.

Since Hugh had made reference to 'mistakes' or 'doing something wrong' on several occasions when I hadn't asked him about this, I suspected that he was finding the interview at this point quite difficult and I thought it was important that I addressed this so that we could find a way to re-connect. Hugh was then able to reflect that his experience of loss was "probably affecting [client work] all the time".

In a previous sub-section, I examined therapists' experiences of the connection that came from feeling vulnerable when with clients. My own sense of disconnecting at times in interviews when I perhaps felt vulnerable with the material led me to look again at participants' stories for indications of possible disconnection. I returned to Robert's interview where he had talked to me about his decision to return to clinical work and his experience of disclosing his bereavement to clients:

Robert: One of the things I did find, which you know looking back I know was not

probably appropriate, was sometimes with clients I would tell them what – you know if they mentioned a bereavement – and I'd say, well actually I've just had a bereavement myself, so.. Now, whether that was a ... whether I was disclosing too much doing that ... it was a bit of a conundrum for me.

Amy: *What made you decide to disclose that?*

Robert: *I think looking back, I wanted people to know.*

Amy: *Okay. Do you know what you wanted from that?*

Robert: *You know, was I using the clients for support for myself? I don't know, but that was – sort of looking back, I may have been doing that, I don't know. But it was people who had had a loss of some kind and I needed to tell them about my own, which then I began to wonder if I was sort of – might have gone back a bit too soon, I don't know whether four months, three or four months was enough. I thought it was, but I'm just looking back now…*

Amy: *Of course … What sort of responses did you get? I mean what happened when you disclosed your bereavement?*

Robert: *Well there was one person particularly I can remember, I think he was gay and his partner had just gone or they'd broken up or something and you know I said that I'd lost my partner, she died and I don't think he came back again after that. So I think – again this is a recollection in hindsight because it was all nine years ago – but I think, I'm pretty sure he didn't come back and that maybe I was putting too much on him.*

When I listened again to the recording of the interview, I was struck by how lost and bereft Robert seemed to be even as he talked about this nine years on. My sense of being with Robert was that this 'lostness' was located in his rich descriptions of his experience and his in-the-moment processing of what had happened around the time of his loss, rather than it being a state of where he was currently at. In other words, I formed the view that he had been so terribly lost in his grief and once he returned to clinical practice, he perhaps sought a connection with others who were grieving. In the case he describes above, his disclosure (and possible desire for connection) seems to have led to a disconnect between him and his client instead.

3.2.5. Reflexive analysis

The participants' descriptions of their post-loss work with clients brought to the fore the ambiguity of (dis)connection between self and other. They conveyed this through their recollections of 'being with' their clients whilst in the midst of grieving, drawing on their felt sense that they had been able to connect in a particular way and that this had potentially transformed something in the therapy. On the other end of this

polarity, I became increasingly aware of the depth of disconnection that occurs in the relationship between self and other that may not be consciously accessible to us in the moment. The participants' accounts were, at times, laden with pain and sorrow, and it was through observing and analysing my process with this material that led me to experience their narratives in a more layered way.

During the first round of analysis, I paid attention to how I was feeling as I read the transcripts, noting down what was evoked for me and holding this in mind as I tried to make sense of what the participants were telling me. However, I found that when I returned to the analysis some four years later, I had cut off at times from what might have been happening in the space between us and I became interested in the fact that despite an awareness of the mutuality of pain in the dialogue, I seemed to guard against this vulnerability by asking rather head-level questions about their experience. This had the effect of yielding more cognitive, factual responses rather than emotional material. In retrospect, this may have felt safer for me, both in terms of protecting against my own exposure to pain and grief as well as being in the position of a 'trainee' (versus experienced) therapist. Noticing what happened to the *I-who-feels* during interview and during the earlier stage of analysis led me to ponder on what happens to those vulnerable feelings in the therapeutic dyad. I returned to the transcript of my own interview where I had talked about my work with a client where I wondered what I might have 'missed' with her as a result of the painful material she was bringing, and it strikes me that there is a process occurring where we, as therapists, may guard against our sense of vulnerability and exposure to pain by consciously or unconsciously disconnecting from the more evocative material or when we feel some sort of threat to our emotional well-being. This process seemed to play out in the interviews to some degree.

One way was the level of carefulness taken by several participants to guard against feeling 'too much' during interview. As they reflected on the research process, there were such comments as "I was carefully isolating my emotional responses [to you]" and "you can still get back in touch with that pain…I'm holding back". As a researcher, I appreciated the care they took of themselves and I felt that they still gave rich accounts of their experiences.

Another way this process was played out seemed to be around the care taken to avoid feeling judged by me as interviewer. This was explored in two of the interviews and I felt it had the potential for both disconnection and (re)connection in the relational space. It is difficult to know where this sense of judgement emanates from but as a relational researcher, I have to consider what I brought to the encounter and how this may have inadvertently set up the dynamic of perceived judgement and

defendedness. As I look back over the transcripts, it is apparent that some of my questions were very 'doing' based (which may have been more likely to have had the effect of eliciting a fear of being judged) – in part because that was something I was interested in but through analysis, I have come to realise that some of my more 'doing' or clinical questions may have had their roots in an avoidance of the more painful evoked material for me. This was something I was unaware of at the time and has since led me to wonder about the impact that our choice of interaction has on our clients when we unconsciously defend against our own feelings of vulnerability. There seems to me to be a challenge here about holding the 'in-between', raising questions about what I inadvertently set up, what I am or am not open to, and what gets 'kept out' by both of us. Being able to attend to the challenges of the 'in-between' at times of grief and vulnerability is perhaps a demanding task for both the researcher and psychological therapist.

3.3. Sense of Time / Space

The two sub-themes that make up this life-world concept are concerned with the notion of lived space in the therapist's world. The first sub-theme explores the way in which the space of the therapy room was experienced post-loss by the therapists in this study while the second sub-theme looks at the meaning of lived space in a wider context as well as the embodied experience of space. In the reflexive analysis section at the end, I take particular account of the concept of time in relation to how this allows us to create space for ourselves in the midst of grieving. This encapsulates the need to take 'time off', the process of 'taking time' with something or with ourselves, and the subjective sense of timelessness in grief.

3.3.1. The lived space of the therapy room

Back when I was initially engaging with (re)searching for 'answers' to my question on how to be a post-loss therapist, I remember struggling to comprehend how I could be with a client in the therapy room. Even doing it, I was still wondering how I was doing it. I felt as though it should be the hardest thing in the world. And yet, there was something about being in the room that felt really okay. That was my felt sense at that time. A tacit understanding of my experience in the therapy room, not formulated into language back then, and if anything, probably construed as being on 'automatic pilot'. Through my time with the research participants, I have been able to put words to this experience, constructing an understanding of the way in which the place of the therapy room is experienced by the grieving therapist.

In my interview with Sally, the lived space of the therapy room took on significance as we explored how she experienced client work amidst personal loss. Here is an extract about how she managed continuing with the work:

Amy: One of the things I was thinking about when you were talking about your training and that sort of determination in doing it; it sounded like perhaps the course or seeing clients gave you some structure in an otherwise quite uncertain, unknown world. I don't know if that's there for you…

Sally: I think it was an escape in terms of when you're thinking about something that's interesting and stimulating and you need to be very focused on your work, particularly in counselling practice. You had to be able to compartmentalise. Now how good was I at that actually? I'm not sure but I wasn't bad. I mean, is it ever as good as … I find it sometimes a real struggle getting there, getting into the room, the room bit, the therapy room, but once in it, the work began and my life, it did sort of shut the door on my life and that is a relief.

Amy: Yeah, I hear that. What was happening with the struggle getting into the room? What went on for you?

Sally: I think it was a general state of chaos and to be honest, it's mirrored a lot after having children as well when they're really young because my mind was full of me and my problems, or me and my tiredness, my concerns. It's like my physical and emotional exhaustion. I'm thinking post having children as well in some ways, in that feeling, you know, a real 'woe is me' and I don't know. I want to say how hard it was to go and focus on someone else's problems but I think that was part of what made … that the door was shut and it was about someone else.

The image of the shut therapy room door, separating what was going on outside from what was happening inside is striking for me, bringing to mind a sense of respite from one's experience of pain and loss. In this way, it is as if the therapy room becomes a place of safety, a cocoon away from the outside world that encompasses our loss. So the therapy room becomes the place (perhaps the only place) where our loss is not figural. And what a relief, to use Sally's word, to have such a place into which to retreat.

It seems to me in this extract that Sally is touching on the contradictions inherent in the meaning of the therapy room. She appears to be pulled towards wanting to tell me that it was difficult going into the room and focusing on someone else, as if there is an expectation or notion that it should be hard, that it should be something we are unable to do when in grief. I formed the sense that she was caught in a juxtaposition

of *feeling* that the act of sitting in the therapy room with someone else's problems should be hard for her and yet *experiencing* the act of sitting in the therapy room with someone else's problems as the very reason as to why it wasn't hard.

When I look back over my notes and the transcript of the interview, it seems that the image of the shut therapy room door stays with me and, as I write this now, I can quickly conjure up the feeling I have when I usher a client into the therapy room and close the door behind us. The room becomes something different to the outside world; it serves a purpose and has a function and requires the presence of 'me as therapist'. During my interview with Sally, this physical separation of space was not something of which I was consciously aware. Rather I regarded the separation as more of a mental escape. This can be seen later in the interview in my question that follows, and yet Sally again brings in the significance of the therapy room as a different space:

Amy: *You talked earlier about compartmentalising and I was also aware of how you talked of "escape", I think the word was. I wondered whether elements like that came into your thinking about continuing [work as a therapist], that sense of 'I can put this to one side' or 'this is important to maintain this particular structure for myself'?*

Sally: *I think sometimes my thinking was messier and there was something, as you say, structured once in the room. That ordered things in a way that was…I could use the other parts of myself.*

It seems that, for Sally, the structure of the therapy room was very important in keeping her going as a therapist. She picks up on my use of the word 'structure' and uses it to describe something of her experience of the therapy room and introduces the concept that this "ordered" things. I am struck by the stark contrast of the ordered place of the therapy room with the "state of chaos" that Sally refers to earlier in the interview to depict her life with her multiple pregnancy losses. This brings to mind the powerlessness and huge uncertainty that is involved in the quest to get pregnant. Being able to leave this "state of chaos" and immerse myself in the more "ordered" space of the therapy room was certainly a part of my experience of clinical work.

3.3.2. The lived experience of space

I remember in the early days after my aunt's suicide being asked at work to attend a funding meeting and give a short presentation on a particular part of our service provision. I was due to meet with a client that morning at our main office as part of a care proceedings assessment I was preparing. It would then mean taking the tube to

another venue for the meeting in the afternoon. There was nothing unusual about these events. Yet my bodily response to being asked to attend the meeting was very unusual. I recall a tightening in my chest, a light-headedness and I felt claustrophobic. The task felt monumental to me and I couldn't see my way to having my day filled with meetings and travel with no space amongst it all. In the years since, I have recollected this experience with great clarity, pondering on what made it feel so impossible to manage a day that felt very full in the aftermath of loss. My need to create psychological and physical space around myself was quite compelling and this need seems evident in the material with Joe.

In his interview, Joe refers at various points to his experience of space and his need to create space for himself following the death of his father. The following extract comes from a point in the interview after I have asked Joe about any difficult moments that he experienced in his clinical work. He gives this some careful consideration before telling me that he doesn't think he found being a therapist difficult following his loss and starting to unpack for himself why this might have been:

Joe: *There's something for me about, in a way, a short attention span helps me, aids me in my work because I'm completely there and then I'm… And vice versa. So I could have been thinking about my dad and then have a session, and I probably had a little ritual I think. I probably took a bit of extra care – I had a bit longer before sessions started to kind of think about the client. I think I did a bit more of that.*

Amy: *Okay.*

Joe: *And I remember… I remember, you know again something about a taxi, and luxuriously I took a taxi from West Hampstead to here because I didn't want to travel on the tube and be jolted about … I just wanted a bit of space. So there were a few little changes like that.*

Amy: *And were you aware of why you were doing that at the time?*

Joe: *Yes. There's a parental part of me thinking 'oh' … so I took a bit of extra care I think and… I remember…just giving myself a bit more space and a bit more time to reflect on sessions and how I was because normally I don't consciously do that kind of reflection on a session. I might reflect on the countertransference and my emotions but it was like an extra dynamic for me to think about. I remember doing that and actually the taxi ride was quite nice. A nice little space.*

In phenomenological terms, it would seem that Joe's felt sense of a jolting tube carriage took on a new meaning on this occasion. It became a place that perhaps

felt overwhelming, unsafe and jarring. As I write this now, it is not hard to conjure up the sensory experience of the tube; the piercing squeals of metal on metal, the repetitive announcements, the close proximity of fellow travellers, the involuntary jerking as the train lurches around bends, the constriction of grounding to a halt in a tunnel and the uncertainty of being on the move again. In contrast, I have in mind the safe, easy and "luxurious" place of the taxicab. Taking care of himself by attending to this temporary shift in lived space meant that Joe was able to create the psychological space he needed as a bereaved therapist.

In the previous sub-section, I highlighted how the place of the therapy room became a sort of ordered structure in contrast to the chaotic world of loss outside of it. This theme is mirrored in Joe's material when he reflects on the psychic space he experiences when in the therapy room. In this next extract, we are talking about how he managed continuing to see clients:

Joe: On the whole it was fine. I still don't really understand why but it's a bit like…(long pause). Why was it okay? There wasn't a lot of presenting issues that were close to the bone, which was fortunate really, but also it's funny... It's a different space for me… Therapy, giving therapy. It feels very different.

Amy: Can you say a bit more about that?

Joe: Yeah. So sometimes I go into a therapy session when something has happened before – I can't think of an example but, you know, something that is kind of shocking or – and I think 'oh I wish I didn't have to do this'. And then I do and I just kind of forget about what's happened because I'm in a different head space.

The ability to be in a "different head space" can provide bursts of relief from the pain of grieving and, according to the Dual Process Model (Stroebe and Schut, 1999), can be regarded as a necessary part of the oscillation between mourning loss and adjusting to loss. But perhaps more than this, there seems to be something about the very nature of being with another, of immersing ourselves into the world of another, that provides us with some emotional respite and space to be away from our outside world of loss. This next extract from my interview with Joe comes when we are talking about client work that might have been helpful to him in relation to his loss and he, again, and after much reflection in interview, brings in this notion of needing space to manage his loss, but this time he finds it inadvertently through his client work:

Joe: I don't know. I'm trying to think what else they [client interactions] would have given. I mean, nothing particular, obviously, just me enjoying the work and … yeah, nothing more than I'd normally get actually is the reality of it. So the

> *kind of insights, the perceptions, just the kind of stuff of life that I find*
> *fascinating and also I suppose because they didn't know.*

Amy: *I guess you saying that makes me think about the experience of loss and*
what it's like then to be in the presence of someone who doesn't know what
happened compared to when you're with that friend or family who do know.

Joe: *Yeah.*

Amy: *What was that like for you?*

Joe: *A bit odd. Yeah. Because – do you know what, that might have been what*
they gave me. It might have been somewhat of a relief. I don't know. It might
have been a bit of a psychic retreat maybe. I hadn't thought of that. Because
one way of me containing it all the time I think was not to get lots of people
saying [makes empathic sounds] and just … a bit of space probably.

My analysis notes point to my felt sense of being with someone who didn't know about the loss and of course this is the piece that I pick up with Joe and ask him more about. His in-the-moment processing of what that was like for him was very moving and there seemed to be a bit of a eureka moment when he suddenly stops and says to me "do you know what". His phrase "psychic retreat" and his need to have "a bit of space" from his experience of others in his world capture something of what intuitively drives the psychological therapist to be able to continue with client work, and brings to mind Bollas' (1987) 'unthought known' as a way of conceptualising this process.

3.3.3. Reflexive analysis

As I re-read and re-listened to the interview transcripts, I became aware of the noticeable and oftentimes subtle changes in tempo and pace as participants and I explored their experiences of loss. What they were saying and what we were doing together seemed to tell me something about the creation of space for oneself in the aftermath of loss and the ambiguous nature of time and timelessness in grief. The rounds of analysis brought into focus the ways in which the bereaved therapist manages their grief in the context of the lived space that they inhabited and brought to the fore the importance of how taking time and creating space has the potential to transform our ability to manage our experiences of loss as therapists.

At the start of this research, I was quite caught up in thinking about time: how much time should I take off; how do I know what is enough time to have off from client work; how do I fill the time outside of work, and so forth. But this concern was about chronological time. Something measurable. And asking these sort of questions to the therapists in this study was part of my interview format to some

degree. I think I was seeking something concrete – maybe there was an 'ideal' period of time to take off for a bereavement. This is, of course, naïve thinking but in grief, we sometimes need that concreteness, that structure. I remember first reading Barbara Chasen's (1996) first-hand account of the sudden death of her 12-year-old son and her return to her psychoanalytic practice two weeks afterwards. Until I had the privilege of interviewing the therapists in this study, I was unable to comprehend *how* Chasen was able to return to client work two weeks after this unutterably tragic loss. I now wonder whether some of what my participants communicated about the experience of the space of the therapy room can help me understand how it was possible.

It would seem then, that the concept of time is about the creation of a space in which the bereaved therapist can regain some equilibrium and some relief from the acute or overwhelming experience of loss. This 'creation of space' was apparent when I listened back to the interviews again, noticing the measured pace of certain interviews, feeling that together we had 'taken our time' in exploring the material and that I had 'given space' in interview to participants who had spoken of their need to create space for themselves following loss (i.e. Joe) or taken significant time out of practice (i.e. Robert). Prior to interviews, this was not something I had thought about in this way; rather the 'creation of space' was something that seemed to emerge in the 'in between' researcher and participant.

Returning to the sub-section on the 'lived space of the therapy room', I am struck by the significance that the physical space around us can have on our experience of loss and what different spaces can communicate for us. Looking back at the period of time following my aunt's suicide, I was living in the midst of chaos as a result of having our flat renovated. There was exposed brickwork, unplastered plasterboard and wires popping out between beams. There was not a room in the flat that was untouched by building work or packed to the gills with furniture from the other rooms. Each day saw a team of builders take over the flat with their tea mugs, boom box and equipment. The noise and the dust created on a daily basis were unbearable. Escaping this chaos to a space that felt safe and 'ordered' no doubt was part of my own ability to continue working in the midst of grief. Making sense of what my participants brought into the research room of their experience of spatiality was certainly influenced by my own intuitive sense that there is something in our implicit understanding of our lived space that impacts and influences our experience of the bereaved therapist.

As I worked my way through the transcripts, I found that I was engaging in a sort of layered meaning-making process with my data. During the first round of analysis,

I quickly noticed the resonance that references to 'the need for space' and the 'space of the therapy room' held for me and I understood such references as the creation of a juxtaposition with the experience of loss (i.e. chaos versus order). Returning to the recordings during the second round of analysis, I found myself moved (sometimes to tears) as I listened again to participants voice the transformative nature of physically shifting from one space to another. In their voices, I could sense the importance of being in the therapy room and the meaning of that space for them, and this is something that really touches me. Paralleling this, I find myself thinking about the potentially transformative space of the research room and how the concept of this lived space will have had different meanings for the therapists in this study. What was threatening and exposing to one therapist was containing and meaningful to another. I find myself longing to explore this concept further with therapists and find myself curious about the experience of physical space for those participants who did not mention it. How did they 'create their space' in the research room? Just as grief itself permeates beyond the bounds of lived time and space, I am left with the sense that how we reflect on and talk about what it is to be the bereaved therapist comes from the space between self and other.

3.4 Meaning and Identity

These two sub-themes both reflect something of the internal process of the bereaved therapist in their integration of loss into their sense of themselves as clinicians. The first sub-theme is concerned with participants' ability to 'do therapy' post-loss, at least in part, because of the meaning and significance that the work held for them. And conversely, what it would have meant to them and their experience of loss had they stepped away from the work. Closely linked to this is the way in which participants (re)constructed their identity as a psychological therapist post-loss, which forms the second sub-theme. I conclude with another reflexive analysis section

3.4.1. Making meaning of one's work as a therapist in the midst of grief

Notwithstanding the obvious practical implications of not returning to work, most notably financial (especially for the self-employed) and what to do with client caseloads, there seemed to be a drive towards continuing to work in the aftermath of loss because of something that the work held for the therapist. In this sub-section, I shall focus on the meaning that doing clinical work had for therapists in the context of their experience of loss. In elucidating this meaning for participants, I am conscious that I am engaging the process of hermeneutic reflexivity (Finlay, 2011) where I remain aware of my own experience of working after loss and the influence this has

on the way in which I explored this in interviews with participants and again in analysis when I have made sense of them making sense of their experiences. I went into the interviews with the tacit knowledge that continuing to 'do therapy' in the aftermath of loss was part of the process of healing but I am not sure this was something I had conceptualised at the time. Through exploring participants' reflections on their return to work after loss and then searching for clues in the analysis that might help me understand this phenomenon, I seem to have found some words to explain what I intuitively felt at the time of my own losses.

A salient feature of the post-loss return to work was the need for therapists to reclaim their lives and to recognise that grief is one part of that life. In my interview with Ann, who lost her brother to cancer, she referred several times to the idea of "getting back to life":

Amy: And how did it feel to go back?

Ann: I did think [about taking more time off], because that's what you're meant to do. But actually – relief is not quite the right word – but getting back to life seemed the right thing to do.

I found her repeated reference to 'life' to be a poignant polarisation with death. As I mulled over her words during analysis, I wondered whether the drive to 'get back to life' was an attempt to stave off the omnipresent presence of death. I formed the view from participants that, for many, they questioned their decision to keep working and yet there was a sense of knowing that the work held some significance in terms of staying with life. Greg, for instance, told me:

Greg: It was really important to stay in contact with my life and living. At the same time, not denying the fact that I was in a huge amount of grief and a huge amount of pain and sometimes shock.

Reminiscent of the Dual Process Model of grief (Stroebe and Schut, 1999), several therapists in this study indicated the ability to hold grief alongside life (for want of a better word), not just as a way of continuing with work but also as a necessity to continuing their lives as psychotherapists. Joe, whose father died of illness, spoke about putting grief "on the backburner" at times – being able to laugh and being able to be in clinical practice – without discounting the loss. In teasing out what enabled him to be able to go into a session and be with a client, Joe said:

Joe: I think I understood – just like the laughing – it didn't discount what had happened at all. It just meant it wasn't present in my head. It's okay to kind of weave in and out of it.

Similarly, Sally was able to continue clinical practice through a recognition that she was not all about loss, that she "could use the other parts of myself" when in the therapy room.

For some participants, 'getting back to life' was about the relief that came from the normality of working. In an earlier sub-section, I pointed to Joe who had spent some time reflecting in interview on what it was like to be with someone who did not know about the loss:

Joe: It might have been somewhat of a relief, I don't know. It might have been a bit of a psychic retreat maybe.

It strikes me that there is something profoundly comforting in returning to a 'normal life', a life where the loss is not at the fore and where we can, as Sally says, use the other parts of ourselves as therapists. This ability to access other parts of ourselves and 'get back to life' is arguably an integral facet of the grieving process.

Hugh also referred to the notion of 'relief', this time the relief that his work routine brought:

Hugh: It was a great relief just to be getting on with routine and just to be getting on with work and to feel that I was doing something … I was looking after myself and working, and it took my mind off those things.

My initial analysis notes indicate that I coded this as 'distraction', being particularly influenced by his phrase "it took my mind off those things". I think culturally we tend to equate the pull towards 'keeping busy' with the avoidance of experiencing grief (see, for instance, Neimeyer et al, 2011) and I wonder whether I unconsciously perceived Hugh's narrative through the lens of this prevailing social norm. While I cannot reject this out of hand, when I looked again at this during the second round of analysis, I made sense of it in quite a different way. This time, I found myself gravitating towards Hugh's phrases of "to feel that I was doing something" and "I was looking after myself". There seems to be a complexity here that suggests the meaning of the work for Hugh goes beyond it being a distracting activity. The oftentimes debilitating nature of grief can certainly leave one feeling powerless and ineffectual in their own lives, and I wonder whether Hugh's 'doing something' was in fact a reference to feeling in control of an area of his life. Likewise, 'looking after myself' brings to mind a needs-based theorising of human motivation where we seek to have our needs met, including self-esteem needs (Lapworth, Sills and Fish, 2001). If grief has the propensity to leave us feeling that we are lacking in confidence due to challenges to our assumptive world (e.g. Parkes and Prigerson, 2010), a return to the world in which we feel secure and competent would arguably be a huge relief.

The meaning of the work as something which stands to restore a sense of control and competence seems to be echoed by both Joe and Lyle, who pointed to having continued with work being about these self-esteem needs being met:

Joe: Just me enjoying the work…the kind of stuff of life that I find fascinating.

Lyle: I like to work. I missed the work very much. It's far and away the most satisfying thing I've ever done.

Sally too linked her feelings about working as a therapist with how she managed her multiple pregnancy losses:

Sally: I was and still am...involved and stimulated by the work so it was very much a part of my coping, part of the resilience that I could go in and carry on with it.

The descriptions that these participants use (enjoying, fascinating, satisfying, involved and stimulated) powerfully capture the essence of what their work means to them. The feelings that the work evokes will be in stark contrast to the experience of grief.

At the start of this sub-section, I pointed to the juxtaposition of experiencing death and needing to get back to life as part of therapists' drive to continue their work. I was similarly struck by an aspect of Sally's story wherein she talked about the need to keep going with work as being akin to needing to keep going with her quest to carry a pregnancy to full term:

Sally: It was really important to keep going. Because I had to keep going. Everything was mirroring each other in the sense that I was keeping going, I wanted a baby, I was keeping going, keeping going with the treatments to get pregnant, going to keep going with the pregnancies, I was going to keep going with the miscarriages…I'm going to get on with it.

What was striking as I read and re-read this during analysis was the possible meaning that stopping work had for Sally as she experienced these losses; if keeping going with work mirrored her determination to keep going with her pregnancy quest, would stopping work perhaps mirror stopping trying for a baby? Something she was not prepared to do.

3.4.2. Embodying the identity of the bereaved therapist

I have attempted to capture in this sub-section something of the tacit knowing conveyed by participants of their sense of themselves as therapists post-loss. All the participants in the study reflected on the impact that they felt their loss had on them as psychological therapists and it seems that their experiences of loss re-defined how they saw themselves as therapists and allowed them to construct an identity as a bereaved therapist. A process that Joe seemed to go through was his identification

with his father after he died in relation to a conscious recognition of the sort of traits they shared that would be considered characteristic of a 'good' psychotherapist:

Joe: There was something about my dad that then losing him made me really appreciate something in me as a therapist. And I wasn't expecting that at all.

Joe goes on to talk about the warmth and compassion evident in his father and how it was reading the eulogy at his father's funeral that led to people remarking on their similarity. Joe reflects in interview that he believes his father would have made a "brilliant psychotherapist" and I wonder whether his 'taking in' the goodness of his father is a way of not just identifying with him as lost love object but as a way of connecting the meaningful elements in his life.

Three participants made explicit reference to a "maturation" process they felt they had undergone in the intervening time since their loss and what this meant for them as therapists. Joe reflected in interview on his experience of losing a parent and the impact it has had on him as a therapist, struggling to convey in words what he seems to want to get across to me:

Joe: There is something about maturation here I think. Just growing up, losing a parent. … I find it quite intangible, I find it really hard to describe. I just… I've experienced something that has made me feel all kinds of emotions. Has made me feel sad, has made me feel lost, has made me feel lonely, and lots of elements which I think, you know, changed me and changed my work. So when someone talks about loneliness or being lost in sadness, I get it.

I discussed earlier the heightened sense of empathy that participants indicated experiencing. There is a flavour of this here, but it seems to me that there is a distinction between the experience of empathy and one's empathic response to another, and the process of 'taking on' the experience of loss as an integrated part of oneself. The powerful words "I get it" reveals something of Joe's sense of himself as a knowing, feeling, bereaved therapist that goes beyond empathic understanding and into the lived experience of what it is to be a bereaved therapist. This is echoed by Lyle who lost his partner to cancer:

Lyle: I've grown up. I believe this experience contributed an enormous amount to my own emotional maturity. … I do actually understand something of loss and pain. … I think I am a better therapist for being able to understand that feeling. Feel his pain, her pain. I can feel my pain and I can understand what they are saying in terms of what I have been through and at least have some human connection with the experience they are bringing.

This is a nuanced description of his own understanding of loss and pain. It is on a felt level and speaks to his process of embodying the 'form' of the bereaved therapist.

Robert, who also lost his partner to cancer, spoke of seeing himself as having matured and changed as a consequence of his experience of loss:

Robert: I think I've matured a lot. … I developed insight I think, sort of much more aware of myself, because I was much more – my own feelings were very stark and I guess that even with three years of therapy training, maybe I still hadn't really got very in touch with my own feelings. But I certainly did then and I have been ever since. … I think it makes me a better listener, insightful, intuitive. Intuitive particularly I think.

Robert's grief seems to have put him in touch with himself on a tacit level. His sense of himself as having come from a medical model background and theoretically embracing a converse position to medical thinking during his training, shifted implicitly only after he experienced the pain of loss:

Robert: I was actually able to break out of [medical model thinking] and I think that's something that maybe this whole experience has had for me, is I think I have been able to break away from it more. … I think because [loss] is such an overwhelmingly emotional experience. … I used to be able to give [breaking away from medical model thinking] lip service, but maybe I found it difficult to believe until I'd actually had that experience.

Training to be a psychotherapist from having been a GP had its challenges for Robert, and this implicit shift in how he aligns himself with medical model thinking has the flavour of him re-defining his identity as a psychological therapist and the pivotal experience of loss seems to have allowed him to 'become' a different sort of therapist in the room with clients. This process begs the question as to the role of right brain activity involved in grieving in the first instance, and then how we make sense of our changed emotional landscape thereafter. In many ways, I am asking participants to engage in a very challenging task of making explicit the felt experience of loss. Participants seem to be conveying their sense of themselves as changed, as different therapists post-loss. And this seems to be on an embodied, implicit level.

The changed, altered sense of themselves as bereaved therapists was captured by other participants and what is most striking in their narratives around this is the powerful, evocative words they use to describe that implicit shift. I have put these words in **bold**. Greg described this shift as going from the theory of death and bereavement to embodying its meaning:

*Greg: A lot of my stuff was theoretical. This is what I'd learnt through people I worked with, I'd worked with a lot of death, experts I'd worked with around death, I'd learnt a lot about it. I'd had some losses and stuff but not until I'd had this significant loss did **I actually really understand what that really, really meant**… It was shifting, I suppose, from theoretical to something much more embodied.*

Hugh's experience seemed to concur with this notion of tacit knowledge resulting from the experience of loss:

*Hugh: It's all material, it's all experience, it's all something I can use and that **I can know** what that's like, to be in that situation, having gone through that situation, experienced the losses, experienced the bereavement and known what's involved in that.*

Interestingly, returning to Robert, who had felt so disempowered after the death of his partner, spoke of his sense of feeling strengthened in the years after his loss and more effective as a therapist as a result of his experience of loss rather than other sources of knowledge:

*Robert: But that was the academic learning and then suddenly, a few months later, I was dropped into the deep end with the sort of emotional learning and what it really meant – not just sitting in a goldfish bowl in the middle of a room, but, you know, the **actual raw experience**. And not that I would want anybody to go through that in order to become a therapist, but I feel that as the years have gone by, it has sort of proved that I think helped me to be more effective in what I do.*

Following the death of her nephew, Eleanor spent her evenings talking to her grief-stricken sister on the telephone. She described these sessions as akin to training wherein she felt completely helpless and had to learn experientially that it was okay to feel helpless. This seemed to shift something within her in terms of being able to sit with feeling helpless with clients at times; something that was harder to do previously but, significantly, something that became real or possible as a result of experience rather than theoretical learning:

*Eleanor: It's a hell of a hard way to learn what you'd already learned in theory. I say to clients 'nobody ever learned to swim by reading a book'. And I keep saying 'Eleanor, nobody's ever learned to swim by reading a book'. It's all about being helpless, you know. **This is what it feels like**.*

I pointed previously to Joe's phrase "I get it" and I would draw attention to Lyle's earlier words "I do actually understand", poignantly similar to Greg's phrase "I actually really understand". These participants are trying to communicate to me their

experiencing of what it is to them to have become a bereaved therapist. The depth of feeling, tacit knowing and intuition seem to underpin the participants' sense of who they have become in their professional world.

3.4.3. Reflexive analysis

Even as I conceptualised this study and started exploring the literature on grief, the concepts of meaning and identity were already 'in the field' for me. This research came into being precisely because I wanted to know how I could integrate my experiences of loss into my 'self as therapist'. The participants' stories resonated with me, giving voice to some of the more unconscious aspects of my experience around the desire to work and my need to make something positive out of personal loss. Connecting with another person, being intellectually challenged with theory, and "using the other parts of myself" as Sally stated, can be an enlivening experience for the bereaved therapist – and one that is in quite stark contrast to the 'deadening' weightiness that grieving can have.

There also seems to me to be a paradox in the meaning that the work holds. Being a psychological therapist in the midst of grieving seems like it should invite speculation as to the person's 'readiness' to get back to work. Questions about our ability to be 'with' someone else's painful or distressing material, the ability to focus, or not become overwhelmed, understandably, are not asked of many other professions. There is perhaps an assumption made regarding the perceived need for the psychological therapist to take some time out because of the kind of work we do. Yet it is, in part, precisely *because* of the work we do that we are able and willing (perhaps unconsciously motivated) to return to the therapy room.

As I consider the meaning I have made of the (re)construction of identity for the bereaved therapist, I am forced to reflect upon the fact that much of my personal identity stems from my earlier experiences of loss. I notice the extent to which loss has moulded my sense of self and how I define myself. Bringing this process into awareness has no doubt influenced my understanding of my participants' stories and helped shape the notion of the 'embodied bereaved therapist'. I can see that the pull towards creating something positive post-loss and harnessing this into who I am as a therapist can be viewed in terms of 'growth following adversity'. This pull was something that I needed to remain mindful of as I made sense of my data. I was aware of the potential for other participants to have a similar pull towards positive growth and of the ways in which this became a co-created process in the research encounter.

3.5. Concluding remarks

In this chapter, I have provided a detailed analysis of the co-constructed themes of connection-disconnection, time and space, and meaning and identity. Using participants' words and rich examples from the raw data, I have given voice to the phenomenon of the bereaved therapist's experience in post-loss clinical work, drilling down to illuminate the tacit knowledge of therapists and the unconscious processes that can be at play in the bereaved therapist's consulting room. The meaning and consequences of my illustrated themes will be the subject of the next chapter, which forms the Discussion section of this thesis.

Chapter IV

Discussion: Thinking About the Meaning and Implications of my Findings

As I face the task of writing this chapter, I am aware of feeling a sense of anticipation as well as dread. There is something very exciting about making sense of my findings within the wider context of existing knowledge and being able to present my constructed understanding of what it is like to be the post-loss therapist to the reader. So too, however, is the dread of facing this part of the journey, with questions pertaining to how best to communicate my understanding to an audience. There is also my sense of anticipation and dread as this research draws nearer to a close, having been a part of my life for so long. Loss further echoes as I choose which aspects of the findings to highlight and discuss in this chapter as inevitably not everything can be captured within the confines of the study. The inclusion of one discussion point may mean the exclusion of another. In line with the research process as a whole, I am conscious that the construction of this chapter rests on my own subjectivity as a researcher and that this, once again, calls for transparency in highlighting the choices I have made over what to include in the discussion and how I have made sense of my findings may not be the interpretations made by other readers. Just as there is no one way to grieve, there is no one way to understand the world of the grieving therapist.

4.1. Overview of the discussion

The aim of this study was to explore what it is like to be a psychological therapist working post-loss. The central themes across the interviews were the process of connecting and disconnecting in grief, the experience of physical and psychic space in the bereaved therapist's world, and the creation of meaning and identity of bereaved therapists. In this chapter, I shall draw on the aspects of these themes that seem to particularly illuminate the experience of the post-loss therapist, linking them with the existing literature and addressing the gaps in our understanding and

knowledge about the experiencing of this phenomenon. I shall then consider the implications of this research for the practise of counselling psychology and psychotherapy, reflect on the limitations of this research and assess possible future directions for research in this field.

4.2. What my findings tell me about being the post-loss therapist

4.2.1. The potential for mutual healing and therapist self-change

References to the concept of mutual healing and the notion of the therapist being healed in some capacity by the client are scarce in the literature, and are not explicitly discussed within the studies carried out on bereaved therapists to date. Those studies (Broadbent, 2011; De Santis, 2015) that discuss therapist self-change focus on positive growth rather than 'mutual healing'. As I sit here and try to make sense of the therapist's healing potential, I am conscious of my own discomfort in discussing this. Does acknowledging the ability to be healed (to whatever degree) by our clients contravene our ethical standards? Does it make us appear selfish or needy, having not yet 'worked through' our own processes? Maroda (2004: 48) argues that "the concept of mutual healing is naturally a controversial one as it stimulates fears of needy therapists abusing their patients under the guise of providing something healthy for them". There is a question then, as to how we know that our own healing is not compromising the client's therapy.

This research did not seek to answer this question; no doubt readers of this thesis will have their own thoughts on the subject. What the research findings have pointed to is the capacity for bereaved therapists to experience the therapy dyad as a curative factor in their own process of grieving. The participants who were explicit around this indicated that it was their presence with their clients' grief and their ability to 'take in' their own interventions that formed part of their own healing process. This brings to mind the idea of a system of 'reciprocal mutual influence' (Stolorow and Atwood, 1992) being at play where both therapist and client are constantly contributing to the relationship, each influencing the other in a process of reciprocity. Taylor (2014: 207) offers this as a four-stage process: "(i) I support myself (ii) in order to support you (iii) in order to support yourself (iv) in order to support me" in her discussion of mutual regulation in trauma work. The emphasis here is on interconnectedness between self and other. Thinking back to my reflections on the mirror neural system in chapter one, I would argue that the bereaved therapist's observation of, and presence with, a client in a healing relationship offers the potential for the therapist to 'share' the experience on a bodily and emotional level. I think this process could quite aptly capture the bereaved therapist's experience of

self-healing in the therapy dyad. Viewed through a neuroscientific lens, the notion of 'mutual healing' in the bereaved therapist is normalised, understood as part of effective psychotherapy. This finding is significant in furthering our understanding of the bereaved therapist's capacity for self-healing, offering a unique perspective divergent from previous studies that emphasised therapists' enhanced ability to empathise and their increased capacity for connection with clients (Antonas, 2002; Bozenski, 2006; Broadbent, 2011; De Santis, 2015; Devilly, 2014; Kouriatis and Brown, 2013-14; Millon, 1998). In turn, this understanding may provide a challenge to our ambivalence around accepting the therapist's self-healing capacity and give us alternative ways to conceptualise issues of 'fitness to practise'.

4.2.2. Communication in the unconscious embodied domain

The findings from this research indicate the existence of a connection-disconnection polarity within the experience of the bereaved therapist. The extent to which the therapist can be present with and attune to their client will be impacted following personal loss, and this resonates with other research carried out on bereaved therapists (e.g. Bozenski, 2006; Broadbent, 2011; De Santis, 2015; Devilly, 2014; Kouriatis and Brown, 2013-14; Millon, 1998). A unique feature of this research, however, is the heuristic element to the investigation which brought to the fore the researcher's own process in the interview dynamic of connection-disconnection. Using myself in this way and drawing on the *I-who-feels* (Sela-Smith, 2002) has allowed me to understand the phenomenon of (dis)connection between client and bereaved therapist on a deeper, more experiential, level.

The participants in this study pointed to the experience of grieving as leaving them vulnerable and raw, which impacted both their sense of themselves as empathic and their capacity for therapeutic presence, arguably two critical outcome variables on the part of the therapist (Norcross, 2010). Looking at the descriptions given by participants to account for how they experienced themselves with clients, the language has the flavour of being quite bodily-based, almost as if there is a physicality to it. Being "very awake with the volume turned up", having "a protective layer of skin removed", "enter[ing] into their world", being "very alive", having a "heightened sense" are all states of being that communicate something of ourselves to clients on a somatic and affective level. This communication accords with Stern's (2004) view of implicit (nonconscious) knowing between therapist and client. Implicit relational exchanges and body-based communication are crucial to empathic attunement and the interactive state of resonance. Siegel (2010) writes of resonance as the experience of 'feeling felt' by the other, highlighting our need for intimate and

vulnerable connections in relationship. The bereaved therapist's vulnerable state has the potential to 'open up' moments of intersubjective creation or "special present moments" (Stern, 2004: 75) such that a mutual 'reading' of feeling takes place between the two. The mirror neuron system provides a way of understanding the neurobiological mechanisms involved in reading the other's state of mind, resonating with the other's state of emotion, and experiencing the other's experience (Damasio, 2000; Gallese, 2001). The rich descriptions participants in this research gave of their post-loss experience of themselves can be understood in terms of an 'ongoing intersubjective matrix' (Stern, 2004). In these terms, the implicit communication from the bereaved therapist will be 'felt' by the client on a non-conscious level. Likewise, the 'exposed, awake, alertness' of the therapist provides the potential to 'take in' the client's state of being and to meet them in that experience. This implicit relational process was made explicit by a number of participants in interview with me: "I get it", "I actually really understand", "I can know", "actual raw experience", "this is what it feels like". Schore (2007: 9) captures this phenomenon when he writes "Just as the left brain communicates its conscious states to other left brains via linguistic behaviours, so the right brain communicates its unconscious states to other right brains *that are tuned to receive its communications*" (original emphasis). Siegel (2010) posits the key to clinical presence is being open. I would argue that it is the vulnerable state of the bereaved therapist that can facilitate a special kind of openness and that this openness is communicated to clients within the unconscious embodied domain.

There appears to be a complexity to the bereaved therapist's capacity for presence and empathic attunement. On the one hand, we become more open, more receptive, more able to take in the other's internal state for interpersonal attunement. On the other hand, it is perhaps because of their state of vulnerability that the bereaved therapist retreats, withdraws, becomes "psychically detached" (Millon, 1998) or otherwise disconnects from their client. In this research, this seemed to happen at a conscious level (for instance, Hugh described retreating from "deeper…emotional places" with clients) and at an unconscious level (for instance, the possible motivation behind Robert's disclosure to a client leading to a disconnect between them). De Santis' (2015) findings suggest a similar dichotomy in terms of a tendency for the bereaved therapist to retreat by way of 'bracketing' and their resultant altered presence in the therapy room. What I am interested in is what this communicates to the client within the implicit relational exchange and what happens in the unconscious intersubjective domain.

Part of my reflexive analysis in the last chapter focused on my 'cut-off' at times in interviews as a possible defence against the evocation of painful material. I believe this had an inevitable impact on my capacity for presence and attunement with my participants, and will have directly altered the intricacies of gathering data within the intersubjective space. As I consider the nature of this implicit exchange, I return to the 'lost' interview in this research. I find myself wondering about the nature of the embodied communication that took place – what happened in my process that led to the loss of this participant's story? I raised this question in chapter two in relation to the complex ethics involved in researching at times of personal difficulty. This parallels how much we hold as psychological therapists of the pain our clients bring into the room and speaks to the misattunement that can occur. The loss of her story may serve as a clue to what was under the surface of the other disconnecting moments in interviews. Those moments of unconscious overwhelm, an implicit sense of the material perhaps being 'too much' to bear. It seems important to attend to this concept of lost or missed moments between the bereaved therapist and client as this finding has implications for understanding communication in the implicit domain and regulating the intersubjective field.

4.2.3. The creation of space

The findings highlight the importance of the bereaved therapist taking time and creating both psychological as well as physical space for themselves as a means of managing the experience of loss. We know from bereavement literature that grief symptoms can include confusion, lack of concentration, and a sense of overwhelm and disorientation (Machin, 2014; Parkes and Prigerson, 2009; Worden, 2003). Studies evaluating the neuroendocrine response during early bereavement have been carried out (Buckley et al, 2012), which show elevated cortisol for at least the first six months following bereavement. They suggest that cortisol elevation is associated with disturbed sleep, immune imbalance, cardiac risk and reduced quality of life. Such physiological associations offer an explanation as to the aforementioned grief symptoms. If we look at the literature on trauma, we can further understand the bereavement experience from a neurobiological standpoint in terms of the impact of stress on the activation of the nervous system. Rothschild (2011) points out that stress results from both negative as well as positive experiences but that a traumatised nervous system and mind cannot necessarily distinguish the difference between pleasant and unpleasant stress once the baseline level has reached a particular intensity. So even enjoyable activities may leave the individual with trauma unable to tolerate their fluctuating, often unconscious, modulating stress levels. An

unhelpful and ongoing increase in stress hormones, such as cortisol, can have an impact on the cortex (responsible for conscious thought) and the limbic system (particularly the hippocampus, which is central to learning and memory). Stress 'overload', then, can result in a dampened ability to think clearly, to access information that one otherwise could do in calmer circumstances, and increased forgetfulness. Although Rothschild (2011) focus is on posttraumatic stress disorder, the oftentimes debilitating experience of grief is likely to result in a similar neurophysiological process, which in turn has implications for the intersubjective matrix. It stands to reason that the neuroendocrine response and neurophysiological process that occurs during bereavement will impact upon the intrapsychic world of the therapist and consequently on the co-creative dialogue with the other mind in the dyad. It is this process that may account for the bereaved therapist's need to create an environment in which there are the optimal conditions for them to feel safe or contained in the midst of grief.

This finding also highlights the ambiguous nature of grieving. Notwithstanding the complications that can arise for some, there is no one 'right' way to grieve (Boerner et al, 2013). There is a sense of unchartered territory, an unpredictability that comes with each day, each task, each interaction. The participants who spoke about their experience of shifting into a different physical or psychological space had not consciously thought this through at the time. It emerged from the depths of the interview as they reflected on their post-loss work. Stories about the meaning of the therapy room (safe versus intrusive, engaging versus distracting) and the experience of the wider space we inhabit offers some insight into the world of the grieving therapist and what unconsciously drives the choices we make regarding continuing work, taking time out and mobilising self-care strategies.

4.2.4. Finding meaning in the work

This study highlighted the powerful presence of the work for the bereaved therapist in how they coped and managed following loss. An individual's relationship with their professional life has received scant attention in the bereavement literature, although a number of studies point to a lack of adequate social support being a risk factor in complicated grieving and generally people faring less well with bereavement (Burke and Neimeyer, 2013; Worden, 2003). While part of one's support network might include their work life, the significance of the bereaved person's relationship with their work does not appear to have been explored as a possible factor in the mourning process. The closest I have come to finding a link comes from Worden's (2003) notion that the tasks of mourning may be mediated by a number of variables

including 'social role involvements'. He suggests that engaging in multiple roles leads to better adjustment to loss and that one such role may be that of an employee. Arguably then, the social role of the psychological therapist is likely to affect adjustment to bereavement, although this role is not specifically investigated as part of determining the mediator. Furthermore, bereaved therapists' feelings about their work did not emerge as a discussion point in the qualitative studies cited in chapter one. This divergence might be accounted for by the nature of the inquiry made by different researchers. I was interested in the fundamental question of *how* it was possible to 'do therapy' following personal loss. My interview format reflected this direction of inquiry and I would have been looking for clues to help me make sense of this in analysis.

Therapists in this study indicated shifting between grieving and remaining in contact with 'life and living', of which client work was an integral part. Being able to hold these polarities and vacillate between them is the central principle of the Dual Process Model (Stroebe and Schut, 1999). Going to work, maintaining a 'normal' routine, is illustrative of the restoration-oriented oscillation where one's energy is channelled into activity – described by Martin and Doka (2000) as instrumental grieving. The DPM can help us understand the process of oscillation and balance in the bereaved therapist's life; however, this model alone does not capture the significance in the meaning of the therapist's work to them.

To understand something of this particular phenomenon, I turn to theories of human motivation. In their text on integrative psychotherapy, Lapworth, Sills and Fish (2001) provide an answer to Elton Wilson's (1993) question 'what do most people search for in their lives?' by highlighting six needs that we seek to meet: basic physical needs; social / relationship needs; need for structure; self-esteem needs; need for stimulus; and need for meaning. This needs-based theorising came to mind as I worked through my second round of analysis, noticing the bereaved therapist's (unconscious) motivation to return to work or "get back to life" as meeting these fundamental needs.

Under the premise that adult attachment is guided by the assumption that the same motivational system that is at play in the emotional bond between caregiver and child is also responsible for the bond that develops between adults in emotionally intimate relationships, it is easy to see that the therapists in this study experienced bereavement as the loss of an attachment figure. The loss of a significant other is therefore likely to activate the attachment behavioural system (Bowlby, 1969; Hazan and Shaver, 1990). In the face of the threat, or challenge, to the bereaved therapist's attachment system, I question what this may mean for our

other motivation systems. Lichtenberg (1989) proposes his theory of motivation drawn from infant observation and adult clinical work, which highlights key aspects of the development of the self. He originally suggested five motivational systems, each being built around a fundamental need; if those needs are met, the result is a self-object experience (defined as a mutual relationship of self-regulation and regulation between self and environment) whereas if the needs are not met, the result is disturbed cohesion. The five systems are: the need for psychic regulation of physiological requirements; the need for attachment and affiliation; the need for exploration and assertion; the need to react aversively through antagonism or withdrawal (or both); and the need for sensual enjoyment and sexual excitement. These motivational-need systems are subject to shifts in dominance, depending on what motivational needs are currently primary in relation to our development and changing circumstances. Kets de Vries et al (2005) use the motivational-needs systems theory to understand life in organisations and I think this is of particular interest to understanding conceptually the meaning of the work to the bereaved therapist. Specifically, our need for interpersonal relatedness and belonging (affiliation) may be met through our engagement with our clients and our role as a psychological therapist. Moreover, our motivational-need system of 'exploration and assertion' may become primary following loss as we (unconsciously) search for autonomy, competency and purpose in our lives. Pansksepp's (1998) work on affective neuroscience and mammalian behaviour underscores this idea with his identification of the SEEKING emotional operating system. This system is the neuronal network that makes animals interested, excited and curious in the world around them. While in animals this could be seen as foraging behaviour, Panksepp (1998) suggests that in humans it generates and sustains curiosity and promotes learning.

In a revision to the earlier theory, Lichtenberg, Lachmann and Fossage (2011) posited a further motivational system; that of caregiving across the lifespan, including an early caregiving system. They cite evidence from functional neuroimaging to support their recognition of the separate caregiving system and see it, as with the other motivational systems, as a co-created phenomenon. I would theorise that "the distinctive characteristic of caregiving – focusing primarily on the intentions, needs, desires and mind states of another with relative suppression of self-interest" (Lichtenberg, Lachmann and Fossage, 2011: 20) is evident in the post-loss world of the bereaved therapist.

Evidence from motivational and emotional operating systems provides a way of understanding the tacit knowledge apparent in the bereaved therapist's relationship

with their work and may offer an insight into our capacity to 'do therapy' in the midst of grief.

4.2.5. Becoming the post-loss therapist

The findings in this study are illustrative of the re-definition of self and the construction of a post-loss identity as a psychological therapist. This reflects one aspect of the grieving process captured by researchers in the bereavement literature (Stroebe and Schut, 1999; Worden, 1983) such that the (re) construction of identity is considered one of the integral tenets of the 'resolution' of grief. Worden and Winokuer (2011) discuss this as part of the third task of grieving – making internal adjustments to the bereaved individual's world without the deceased, which includes adapting one's social self-definition. In the case of the bereaved therapist, I would hypothesise that not only is there an adjustment to be made to one's social self-definition (e.g. becoming a widower) and sense of who they are without the loved one, there is an adjustment to be made to their sense of themselves as a psychological therapist who has experienced significant personal loss. As I write this now, I am conscious of my own sense-making process following loss where I questioned what this meant for me *as a therapist*.

This is borne out in the findings from previous researchers where post-loss growth and transformation is evident in the narratives of bereaved therapists in relation to their changed sense of themselves as therapists (Antonas, 2002; Bozenski, 2006; Broadbent, 2011; De Santis, 2015; Devilly, 2014; Kouriatis and Brown, 2013-14; Millon, 1998). Previous research suggests that the bereaved therapist becomes aware of an enhanced ability to empathise with and attune to clients, and an increased capacity for connection with clients. This represents an internal shift within the therapist as a way of 'being' (an unconscious attitude rather than a change in technique). Broadbent (2011) pointed to changes in self-esteem, self-awareness and self-confidence, and – as reflected in my findings – a heightened sense of maturity for the bereaved therapist. This suggests an altered sense of self, captured by De Santis (2015) as 'an expansion of self'.

The findings illustrated another aspect in how the bereaved therapist seeks to re-define their 'self', which is through the identification with the lost loved one. This is a phenomenon that has been widely acknowledged in the psychoanalytic literature as the process by which people who have suffered a loss sometimes "take into themselves certain aspects of the lost person" (Parkes and Prigerson, 2009: 101). This process was apparent in Joe's narrative of his late father, and it seems that his

identification with particular qualities his father possessed gave rise to his experience and definition of himself as a therapist.

The process of becoming the post-loss therapist seems to involve the integration of various elements of the grieving trajectory – such as the identification with the deceased, making sense of the loss and engaging in meaning-making of life, death and self – as well as the significance that the work holds and the desire (conscious or unconscious) to create growth as a psychological therapist.

4.3. Implications for the practise of counselling psychology and psychotherapy

4.3.1. Attending to the unconscious intersubjective domain of the bereaved therapist

Applying the theoretical contributions made by advancements in neuroscience to my research findings from the participant narratives around connection-disconnection in the implicit relational exchange has given me a way of thinking about what it might be like to be the bereaved therapist. Making sense of my data through the lens of right brain activity offers an understanding of the experience of heightened empathy, altered presence, attunement and (dis)connection that seems characteristic of the bereaved therapist. Considering something of the science underpinning these concepts highlights the need for therapists to be mindful of, and bring into conscious awareness, their patterns of affect regulation and non-verbal behaviour in how they impact upon the client's conscious and unconscious experience in therapy. Applying neuroscientific theory to the intrapsychic world of the bereaved therapist can have a normalising effect and allow the bereaved therapist to contextualise their experience of grieving and of their post-loss client work (anticipated or actual). But it is the emphasis on unconscious process and communication that paves the way for understanding what it is like to be the bereaved therapist and in turn, what that means for their clients.

From a practical perspective, the findings suggest that particular attention is given to the unfolding of unconscious process at times of significant loss and life crises. I am specifically thinking about how this is located within the supervisory remit and within counselling psychology and psychotherapy training programmes. Many training programmes and clinical supervisors will already be keenly aware of, and integrate in, a philosophy around personal development and the merging of the personal and the professional. It seems to me that a crucial part of our training as psychological therapists and our continued development as practitioners is having an ongoing space in which to reflect upon the interface between the personal and professional. This could take form in the following ways:

- Counselling psychology and psychotherapy training programmes incorporating a module on 'the personal life of the therapist' that builds on the evidence from neuroscience, attachment theory, intersubjectivity and communication in the unconscious embodied domain. Many programmes do place emphasis on understanding our motivations for becoming psychological therapists and unpacking the influences underpinning our particular choices; however, there seems to be less weight given to subsequent experiences of loss and trauma, and how therapists might navigate the terrain of their post-loss work.

- Supervisors to take account of supervisees' difficult personal circumstances when exploring clinical material. There may be a role for supervisors to take on a more 'psychotherapeutic' element in supervision as and when loss and bereavement occurs. The importance of the provision of supervision has been cited as a necessary support by participants in this research. The task for supervisors to contain both client and therapist process becomes arguably more challenging in the face of therapist personal loss; as such, supervisor training programmes could similarly integrate a specific focus on 'supervising the bereaved therapist', encompassing the neurobiology of loss and trauma, and how this manifests in the therapist's decision-making process and clinical work. This seems especially important given the propensity for the psychological therapist to experience bereavement at some point in their career and the likelihood that – particularly post-training – the psychological therapist's support network may include clinical supervision rather than personal therapy.

- The inclusion of the impact of personal life events and significant loss in Continued Professional Development events, and an emphasis on attending to one's personal development needs across the lifespan of the psychological therapist (Bager-Charleson, 2012).

These concretised thoughts reflect the need for illustrating, on a practical level, the 'how to' attend to the unconscious, intersubjective domain in the psychotherapeutic dyad.

4.3.2. A challenge to bracketing

The research findings, in shedding some light on the unconscious, intersubjective domain, present a challenge to the therapeutic notion of bracketing. This concept emerged as a significant theme in De Santis' (2015) research, where her participants stressed the importance of setting aside or shutting out the emotions and thoughts linked to their experiences of loss. While De Santis (2015) discusses this at length, drawing attention to the potential for 'leakage' and questioning the impact of

maintaining an unquestioning resolve to bracket at times of personal vulnerability, she does not consider this as part of the unconscious relational exchange between client and therapist. Perhaps in part because the unconscious domain has not been explicitly accounted for, De Santis (2015) tends to regard bracketing as a therapeutic technique that can sometimes be helpful to the bereaved therapist but can also come at a cost in how it impacts upon therapeutic presence. I concur with De Santis' (2015) thoughts on 'leakage' and altered presence in the therapeutic dyad but I would go a step further and question whether this is about so-called bracketing (or inability to bracket) or whether this is inevitably what happens in the unconscious relational exchange. This may be what is implicitly offered by Adams (2014) when she suggests that bracketing is an illusion.

The implication for practise is twofold. Firstly, we approach our work as therapists with the conscious knowledge that we will be communicating something of ourselves to our clients at an unconscious level. Understanding more about the neuroscience of trauma and loss can help normalise the idea that our wounds cannot be left at the therapy room door and opens the possibility that bereaved therapists can better support themselves in that knowledge. There is something here for me about the potential for 'counsellor shame' (Sanderson, 2015) coming into the work if we are inevitably unable to 'bracket' our loss. Arguably, the potential for shame is heightened at times of personal vulnerability and yet it is precisely these times that can activate the bereaved therapist's need to 'split off' from the loss experience. Understanding this dynamic as something other than 'bracketing' seems crucial to the therapist's well-being and development. Secondly, and following on from this, if we approach our work with the attitude that it is not **if** our loss enters the unconscious intersubjective domain but **how** it manifests, we open up the possibility of harnessing our vulnerability for greater connection and healing potential.

4.3.3. Assessing 'fitness to practise'

I am aware of a sense of ambivalence as I think about how to frame this issue. My findings do not indicate a need to focus on the bereaved therapist's fitness to practise nor is it evident in previous research on this topic. Certainly not in terms of formal Fitness to Practise (FtP) proceedings within the Health and Care Profession's Council (HCPC). Figures for 2013-14 showed that 157 cases were referred to the FtP process, which was the equivalent of 0.79% of practitioner psychologist registrants being subject to a FtP concern (Barwick, 2015). In many ways, this procedure is perhaps not the framework within which to gauge 'fitness to practise' questions regarding the bereaved therapist. The British Psychological Society's

(2009) *Code of Ethics and Conduct* stipulate that practitioners monitor their personal lives for signs of impairment and that they seek professional assistance for difficulties that may impair their professional competence. Again though, I wonder how we measure 'impairment' in the bereaved therapist and who it is doing the assessing of any impairment.

The findings of this research point to the potential for effective, healing therapy to occur in the context of therapist vulnerability. This tells me that it is not so much about being 'impaired' as it is about our awareness of, and ability to reflect upon, our 'impairment' and vulnerability. There is a need for the bereaved therapist to engage in a relational process of enquiry into their self-state, their needs and their motivations as a way of reflecting on the choices to be made. It is important that a space can be opened up for the bereaved therapist to draw on his or her intuition and embodied sense of 'being with' a client in their own pain and loss in order that they may make informed, shame-free decisions about working as an 'impaired' therapist.

4.3.4. Offering a model for understanding and integration

It was not my intention to put together a theoretical model based on my findings. Yet, as I began the process of bringing together the meaning of my findings, I noticed that I was seeing the various elements as a 'whole', with each 'part' impacting on another. I have long believed in the cyclical nature of grief – not that it is repetitive in its impact but that there are recurrences as we move forward in life. The image that comes to mind is that of a stretched-out coiled spring. Thirty years on from my mother's death and she is rarely forefront in my mind, but something can 'touch' that vulnerable part of me and I can experience overwhelming pain momentarily again. And so it goes on.

From the inception of this research, I had a sense that my personal loss would impact on me as a person and as 'the person of the therapist'. Influenced theoretically by a seminar I attended during my training on the Comparative Script System (Sills and Salter, 1991), I doodled my own version of the cycle in my research journal and I incorporated it into my Programme Approval Panel (PAP) back in 2009 as a way of conceptualising my process as a therapist and researcher. During the intervening years, I 'forgot' about this cycle, only returning to it as I found myself seeing the interconnectedness of the findings in cyclical form.
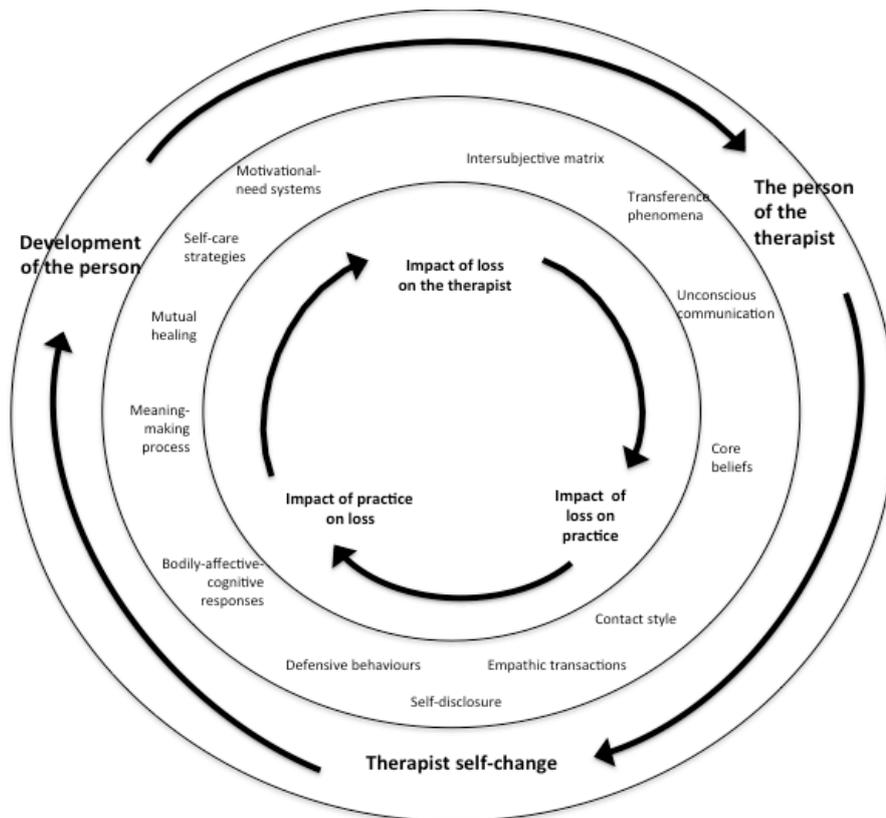
Figure 2: The Bereaved Therapist Process Model

Figure 2 depicts the process of the bereaved therapist as I have made sense of my findings. I should point out that the model sits within the confines of these research parameters, drawn from the social, cultural and environmental context within which the participants are embedded. In particular, issues of race and culture as they pertain to varying grief responses have not been captured and accounted for in this framework. The model offers a way of understanding how the bereaved therapist experiences personal loss and how personal loss becomes integrated into our personal and professional world. The inner circle shows the potential timelessness of the impactful nature of loss on the individual, on their practise as a psychological therapist, and culminates in the loss itself being impacted by our work as therapists. This in turn does something to our experience of loss, which impacts on the individual, which impacts on their practise, and so forth. The outer circle demonstrates the evolving nature of development and change, interfacing the personal and professional. In between the two circles are the psychological components identified by this research as integral to the bereaved therapist's experience.

I have not tested out the resonance of this model. Putting it together as part of a creative synthesis forms a pictorial way of thinking about the bereaved therapist's

process, something that previous research in this field has not done. Importantly, it has allowed me to understand how the process of integrating loss into the 'self-as-therapist' can occur.

4.4. Limitations of this research

As I reflect back on the journey of this research, I am aware of just how long it has been part of my life. A substantial portion of this time was spent with the research on hold during which I was not actively engaged in the process. There is a question as to how this 'pause' might have impacted on the research process and final outcome in two main ways. The first is to do with changes in the external field. Conceptualisation of the project and the collection of data took place before a number of other studies on therapist bereavement were available for me to review (most are dated after 2011). Yet, my analysis and write-up was done after these studies were available. I wonder how the findings of those studies impacted on the way in which I made sense of my originally collected data and what difference it might have made to my project, taking account of and incorporating others' findings that emerged in the midst of this research. The second potential limitation resulting from having 'paused' my research comes from the involvement of my participants. The passage of time between data collection / initial analysis and second analysis / write-up felt too great to be able to return to participants and invite them back into the research process. While I remain unconvinced that this would have been a route to take in terms of seeking some form of validation of findings, I cannot help but wonder whether the 'pause' effectively precluded any further collaboration with the project and what impact such preclusion might have had on the research.

Taking further account of the possible impact of having 'paused' the research, I have found myself questioning the extent of my own expertise as a psychological therapist and how this has changed over the intervening years. I have placed great emphasis on being able to engage at relational depth with participants and the need to attend to the 'in-between' researcher and participant. When I look back at the stage of my professional development during the data collection phase, I am conscious that I was a novice therapist (and novice relational researcher!), still very much embedded in training and finding my way of working as a therapist. I wonder what 'form' the interviews would take if I had done them as a more experienced therapist. Would I have taken more 'risks' in interview? Would I have deepened the process somehow? Would I have been different in 'setting the scene' of the interview or building the research relationship? How 'relational-centred' was I in the early phase of the project compared with the later phase of second round analysis? I

would naturally expect the development of my professional self to impact upon the research process, particularly in light of the weight given to my own role and involvement in the research.

There is a question too about the participants involved. In line with other research in this field, participants were recruited through self-selection and perhaps implicitly recruited on the basis that they were currently practising psychological therapists. This meant that all participants had continued to practise post-loss. It was unlikely that a therapist who had subsequently not returned to practise was going to take part in the research. Of course the focus of the research was on how the therapist continues post-loss, which perhaps dictates the necessary inclusion of practising therapists. Notwithstanding this, I would expect that we are unlikely to have a full and robust understanding of the bereaved therapist's process in the absence of having a voice from those therapists who may have 'fragmented' in some way, chose a different career or life path, or otherwise felt unable to continue to practise as a psychological therapist following personal loss.

Finally, looking at the characteristics of my participants suggests that something may have been missed in the research as a consequence of the lack of participating therapists from ethnic minorities or different cultural backgrounds. We know from the grief literature that culture is significant in shaping the experience of loss, in constructing the meaning of loss, and in the expression of grief (Machin, 2014). Our cultural rituals around mourning and our attitudes regarding life and death will have been part of the field within which this phenomenon was investigated. I would, therefore, expect narratives of therapists from different ethnicities or cultures to differ in some respects to my findings. Undoubtedly, this would influence both the process of gathering data as well as analysing data, raising further questions of holding and managing the 'in-between' in the context of cultural differences and the construction of findings. The implications of having a non-diverse sample surround the limits to the relevance and resonance of these research findings to a wider audience of bereaved therapists.

4.5. Future directions for research

My suggestions for further research naturally flow from recognising the limitations of this project. What might be missing from the 'type' of participant involved would include redressing the cultural component in a sample and focusing research on those therapists who did not continue to practise post-loss (or continued and then stopped). Adjusting the sample might yield a more robust understanding of the bereaved therapist's process and their experience.

It has not escaped my attention that in illuminating the unconscious intersubjective domain, I have missed the other subjectivity present in the dyad – that of the client. It would be interesting to think about the issues highlighted by this research from the perspective of the client. Adams (2014) gave an anecdotal account of a remark made by a supervisee after her crisis had passed: "I thought something was wrong". I would be curious to know more about clients' perceptions of the unconscious communication at times of therapists' crises. There may of course be significant obstacles in practically managing such a piece of work.

4.6. Concluding remarks

In this fourth chapter, I have brought the key findings of my research into the context of the current literature on the bereaved therapist, addressing the gaps that I highlighted in chapter one and reflecting on what my findings mean, and the implications they have, to the wider field. I shall now bring together the strands of the research to offer some form of cohesive end to this 'creative synthesis'.

Chapter V

Conclusion: Reflections of a Researcher

My journey in reaching this point has been at times an arduous one, and yet immeasurably rewarding in many ways. The research process has enabled me to formulate my own understanding of what it means to be the bereaved therapist, allowing me to develop this identity and integrate my experiences of loss into my 'self' both personally and professionally. What is evident from this study is the inescapable impact that personal loss has on the psychological therapist and the complexities involved in how that impact manifests in the therapeutic process. I started this research with a keen desire to know how the psychological therapist manages the experience of loss in the therapy room. What I of course hadn't foreseen was the direction that the research would take me in uncovering and co-constructing an understanding of the less conscious aspects of 'managing' loss.

The findings highlight the intrapsychic process of the bereaved therapist in the implicit relational exchange, demonstrating how both mutual healing can occur as well as disconnection and 'shut down'. This suggests that careful attention should be given to understanding individual therapists' trajectories of grief in relation to their contact style, defensive patterns and need for self-care strategies in managing their post-loss work.

Consequently, this study offers a divergent way of conceptualising the complex myriad of factors at play in the process of the bereaved therapist, what emerges in the space 'in-between', and what enables the bereaved therapist to effectively continue 'doing' therapy.

Epilogue

In a final nod to the stories shared by participants, I have used their voices to create a piece that captures and portrays my sense of what it is to be the therapist in crisis.

Loss In The Therapy Room

Grief. It's overwhelming.
I feel lost.
At sea, bobbing alone.
No anchor. Exposed to the elements.
A protective layer of skin is gone.
Eyes on me. Sympathetic looks.
They know about the loss that devastates me.

So I go into a world that doesn't know.
It's a relief. I can breathe.
A psychic retreat. A bit of space.
I shut the door on my life. My loss.

And I may be in pain but

                I see you,

                    I hear you.

I'm in your world now.
But mine is here too.
Unspoken to you.
Loss retreats. But never goes.

I take care. I make space.
I sit here, listening to your story.

Listening. Not like before.

Listening. As if the volume's turned up.

I'm very awake. Alive in here.

    I touch.

                  I feel.

                          I sense.

I get it. Your pain.

I can know. Your loss.

This is what it feels like.

My grief. Your pain. Together here in this room.

This heals me.

And I am changed.

I am the bereaved therapist.

References

Adams, M. (2014) *The Myth of the Untroubled Therapist. Private Life, Professional Practice*, London: Routledge

Ainsworth, M., Blehar, M., Waters, E. and Wall, S. (1978) *Patterns of Attachment: A Psychological Study of the Strange Situation*, Hillsdale NJ: Lawrence Erlbaum

American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR (4th ed.)*, APA: Washington DC

American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)*, APA: Arlington, VA

Ammaniti, M. and Gallese, V. (2013) *The Birth of Intersubjectivity: Psychodynamics, Neurobiology and the Self*, New York: W.W. Norton and Co.

Anastasopoulos, D. (2004) 'Introduction' in D. Anastasopoulos and E.

Papanicolaou's (eds) *The Therapist At Work: Personal Factors Affecting the Analytic Process*, London: Karnac

Antonas, V. (2002) 'Death in the Life and Work of a Therapist', *Self and Society*, 30(3), 17-23

Antonas, V. (2003) *The Effects of Bereavement on Psychotherapists and their Client Work*, Paper presented at the AHPP Conference, Regent's College, London

Aron, L. (1991) 'The Patient's Experience of the Analyst's Subjectivity', in S. Mitchell and L. Aron's (eds) *Relational Psychoanalysis*, Hillsdale NJ: Analytic Press

Averill, J.R. and Nunlet, E.P. (1993) 'Grief as an Emotion and as a Disease: A Social Constructivist Perspective' in M.S. Stroebe, W. Stroebe and R.O. Hansson (eds) *Handbook of Bereavement: Theory, Research and Intervention*, Cambridge: Cambridge University Press

Bager-Charleson, S. (2012) *Personal Development in Counselling and Psychotherapy*, London: Sage

Bager-Charleson, S. (2014) *Doing Practice-Based Research in Therapy: A Reflexive Approach*, London: Sage

Baldwin, M. (1987) 'Interview with Carl Rogers on The Use of Self in Therapy' in M. Baldwin and V. Satir (eds.) *The Use of Self in Therapy*, Binghamton, NY: Haworth Press

Balsam, R.M. and Balsam, A. (1984) *Becoming a Psychotherapist: A Clinical Primer (2nd ed.)*, Chicago: University of Chicago Press

Barwick, J. (2015) 'The Fitness of the Fitness to Practise Process' in Letters, *The Psychologist*, 28, p. 172-181

Beebe, B. and Lachmann, F. M. (1988) 'The Contribution of Mother-Infant Mutual Influence to the Origins of Self- and Other-Representations', *Psychoanalytic Psychology*, 5, 305-337

Beebe, B., Knoblauch, S., Rustin, J., Sorter, D., Jacobs, T.J. and Pally, R. (2005) *Forms of Intersubjectivity in Infant Research and Adult Treatment*, New York: Other Press

Berne, E. (1961) *Transactional Analysis in Psychotherapy: A Systematic Individual and Social Psychiatry*, New York: Grove Press

Blumer, H. (1969) *Symbolic Interactionism, Perspective and Method*, New Jersey: Prentice Hall, Inc.

Boelen, P. and Prigerson, H. (2012) 'Commentary on the Inclusion of Persistent Complex Bereavement-Related Disorder in DSM-V', *Death Studies, 36: 771-794*

Boerner, K., Mancini, A.D. and Bonanno, G. (2013) 'On the Nature and Prevalence of Uncomplicated and Complicated Patterns of Grief' in M. Stroebe, Henk Schut and Jan Van Den Bout (eds) *Complicated Grief: Scientific Foundations for Health Care Professionals*

Bohart, A. C. and Tallman, K. (1999) *How Clients Make Therapy Work: The Process of Active Self-Healing*, Washington DC: American Psychological Association

Bollas, C. (1987) *The Shadow of the Object: Psychoanalysis of the Unthought Known*, New York: Columbia University Press

Bond, T. (2000) *Standards and Ethics for Counselling in Action (2nd ed)*, London: Sage

Bonanno, G.A., Wortman, C.B., Lehman, D.R., Tweed, R.G., Haring, M., Sonnega, J., Carr, D. and Nesse, R.M. (2002) 'Resilience to Loss and Chronic Grief: A Prospective Study from Pre-loss to 18 Months Post-loss', *Journal of Personality and Social Psychology*, 83, 1150-1164

Bowlby, J. (1969) *Attachment and Loss: Vol. 1. Attachment*, London: Hogarth Press

Bowlby, J. (1980) *Attachment and Loss: Vol. 3. Loss, Sadness and Depression,* London: Pimlico

Bowlby, J. (1988) *A Secure Base: Clinical Applications of Attachment Theory*, Oxon: Routledge

Bowlby, J. and Parkes, C.M. (1970) 'Separation and Loss Within the Family' in E.J. Anthony and C.M. Koupernil (eds) *The Child in his Family*, New York: Wiley

Boyden, S. (2006) *Psychologist Bereavement and Self-disclosure: Impact on the Therapeutic Process*, Unpublished Ph.D. Thesis. Cited in K. Kouriatis and D. Brown (2011) 'Therapists' Bereavement and Loss Experiences: A Literature Review', *Journal of Loss and Trauma*, 16, 205-228

Bozenski, J. (2006) *The Impact of Bereavement on Empathy in Psychotherapy*, Unpublished Ph.D. Thesis. Cited in K. Kouriatis and D. Brown (2011) 'Therapists' Bereavement and Loss Experiences: A Literature Review', *Journal of Loss and Trauma*, 16, 205-228

Braud, W. (1998) 'An Expanded View of Validity' in W. Braud and R. Anderson's (eds) *Transpersonal Research Methods for the Social Sciences*, Thousand Oaks: Sage

Braun, V. and Clarke, V. (2006) 'Using Thematic Analysis in Psychology', *Qualitative Research in Psychology,* 3, 77-101

British Psychological Society (2009) *Code of Ethics and Conduct*, Leicester: British Psychological Society

British Psychological Society (2014) *Code of Human Research Ethics*, Leicester: British Psychological Society

Broadbent, J.R. (2011) *The Bereaved Therapist Speaks: An Exploration of Humanistic Therapists' Experiences of Significant Personal Bereavement and Its Impact on their Therapeutic Practice. A Qualitative Study Using Interpretative Phenomenological Analysis*, (Unpublished Masters Thesis) University of Chester

Buber, M. (1958) *I and Thou,* New York: Scribners

Buber, M. (1965) *The Knowledge of Man,* New York: Harper and Row

Buckley, T., Sunari, D., Marshall, A., Bartrop, R., McKinley, S. and Tofler, G. (2012) 'Physiological Correlates of Bereavement and the Impact of Bereavement Interventions', *Dialogues in Clinical Neuroscience*, 14(2): 129-139

Burke, L.A. and Neimeyer, R.A. (2013) 'Prospective Risk Factors for Complicated Grief. A Review of the Empirical Literature' in M. Stroebe, Henk Schut and Jan Van Den Bout (eds) *Complicated Grief: Scientific Foundations for Health Care Professionals*

Burton, A. (1972) *Twelve Therapists: How They Live and Actualise Themselves*, San Francisco: Jossey: Bass

Carr, D. (2010) 'New Perspectives On The Dual Process Model (DPM): What Have We Learned? What Questions Remain?', *Omega*, 61(4): 371-380

Casement, P. (2002) *Learning From Our Mistakes: Beyond Dogma in Psychoanalysis and Psychotherapy*, London: The Guilford Press

Charmaz, K. (2003) 'Grounded Theory' in J. A. Smith's (ed) *Qualitative Psychology: A Practical Guide to Research Methods*, London: Sage

Charmaz, K. (2006) *Constructing Grounded Theory*, London: Sage

Chasen, B. (1996) 'Death of a Psychoanalyst's Child' in B. Gerson's (ed) *The Therapist as a Person: Life Crises, Life Choices, Life Experiences and Their*

Effects on Treatment, Hillsdale, NJ: Analytic Press

Colao-Vitolo, N. (2006) *Coping and Bereaved Psychologists: Impact on the Psychotherapeutic Process*, Unpublished Ph.D. Thesis. Cited in K. Kouriatis and D. Brown (2011) 'Therapists' Bereavement and Loss Experiences: A Literature Review', *Journal of Loss and Trauma*, 16, 205-228

Cotter, A. (2015) 'Humanising Psychotherapy Research and Training in Research: Intersubjectivity and Beyond', *The Psychotherapist*, 61: 21-23

Cozolino, L. (2004) *The Making of a Therapist*, New York: W.W. Norton and Co.

Cozolino, L. (2014) *The Neuroscience of Human relationships: Attachment and the Developing Brain* (2nd ed.), New York: W.W. Norton and Co.

Damasio, A. (2000) *The Feeling of What Happens: Body, Emotion and the Making of Consciousness*, London: Vintage

Davis, D. (2012) 'DSM-V Controversy Rages On in the Bereavement Community', *Psychology Today*, March 2012

Devilly, S. (2014) *An Exploration of Therapists' Experiences of Bereavement and Personal Illness*, (Unpublished Masters Thesis) Dublin Business School

Doka, K. (1989) *Disenfranchised Grief: Recognizing Hidden Sorrow*, Lexington, MA: Lexington Books

Douglass, B. and Moustakas, C. (1985) 'Heuristic Inquiry: The Internal Search to Know', *Journal of Humanistic Psychology*, 25 (3): 39-55

Elton Wilson, J. (1993) 'Towards a Personal Model of Counselling' in W. Dryden (ed) *Questions and Answers in Counselling in Action*, London: Sage

Etherington, K. (2004) *Becoming a Reflexive Researcher: Using Our Selves in Research*, London: Jessica Kingsley

Evans, K. and Gilbert, M. (2005) *An Introduction to Integrative Psychotherapy*, New York: Palgrave Macmillan

Feyerabend, P (1975) *Against Method*, London: Versa

Finlay, L. (2011) *Phenomenology For Therapists: Researching the Lived World,* Chichester: Wiley-Blackwell

Finlay, L. and Evans, K. (2009) *Relational-centred Research for Psychotherapists: Exploring Meanings and Experience*, Chichester: Wiley-Blackwell

Finlay, L. and Evans, K. (2016) 'An Invitation to Engage in Relational-centred Phenomenological Research' in J. Roubal, P. Brownell, G. Francesetti, J. Melnick and J. Zeleskov-Djoric (eds.) *Towards a Research Tradition in Gestalt Therapy*, Gestalt Research Press

Fonagy, P., Gergely, G., Jurist, E.L. and Target, M. (2002) *Affect Regulation, Mentalization, and the Development of the Self*, London: Karnac

Gallese, V. (2001) 'The "Shared Manifold" Hypothesis: From Mirror Neurons to Empathy', *Journal of Consciousness Studies*, 8 (5-7): 33-50

Gallese, V. (2009) 'Mirror Neurons, Embodied Simulation and the Neural Basis of Social Identification', *Psychoanalytic Dialogues*, 19: 519-536

Gendlin, E. (1962) *Experiencing and the Creation of Meaning,* Chicago: Free Press

Gerson, B. (1996) *The Therapist as a Person: Life Crises, Life Choices, Life Experiences and Their Effects on Treatment*, Hillsdale, NJ: Analytic Press

Gerson, S. (2004) 'The Relational Unconscious: A Core Element of Intersubjectivity, Thirdness, and Clinical Process', *Psychoanalytic Quarterly*, 73, 63-97

Giorgi, A. (1985) *Phenomenology and Psychological Research*, Pittsburgh, PA: Duquesne University Press

Givelber, F. and Simon, B. (1981) 'A Death in the Life of a Therapist and its Impact on the Therapy', *Psychiatry*, 44(2), 141-149

Glaser, B. G. and Strauss, A. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research,* Chicago: Aldine Pub. Co.

Gold, J. (1999) 'Events in the Life of the Therapist: The Effects of Transference and Countertransference', *Harvard Review of Psychiatry*, 6 (5): 263-269

Greenberg, J. (1995) 'Self-Disclosure: Is It Psychoanalytic?', *Contemporary Psychoanalysis*, 31, 193-205

Guy, J.D. (1987) *The Personal Life of the Psychotherapist*, New York: John Wiley and Sons

Hazan, C. and Shaver, P.R. (1990) 'Love and Work: An Attachment-theoretical Perspective', *Journal of Personality and Social Psychology*, 59, 270-280

Heidegger, M. (1927) *Being and Time*, Oxford: Blackwell Publishing Ltd.

Hiles, D. (2001) *Heuristic Inquiry and Transpersonal Research*, paper presented to CCPE, London in October 2001

Hill, C., Thompson, B. and Williams, E. (1997) "A Guide to Conducting Consensual Qualitative Research', *Counseling Psychologist,* 25, 517-572

Husserl, E. (1931) *Ideas: General Introduction to Pure Phenomenology, Vol 1*, New York: Macmillan

Joseph, S. (2011) *What Doesn't Kill Us: The New Psychology of Posttraumatic Growth*, New York: Basic Books

Jourard, S. (1968) *Disclosing Man To Himself,* New York: Van Nostrand

Jourard, S. (1971) *Self-disclosure: An Experimental Analysis of the Transparent Self,* New York: Wiley Interscience

Joyce, P. and Sills, C. (2001) *Skills in Gestalt Counselling and Psychotherapy*, London: Sage

Kantrowitz, J. L. (2004) 'A Different Perspective on the Analytic Process: the Impact of the Patient on the Analyst' in D. Anastasopoulos and E. Papanicolaou's (eds) *The Therapist At Work: Personal Factors Affecting the Analytic Process*, London: Karnac

Kets de Vries, M., Vrigaud, P., Korotov, K., Engellau, E. and Florent-Treacy, E. (2005) *The Development of 'The Personality Audit': A Psychodynamic Multiple Feedback Assessment Instrument*, Working Paper Series

Kilner, J.M. and Lemon, R.N. (2013) 'What We Know Currently About Mirror Neurons', *Current Biology*, 23(23), 1057-1062

Klass, D., Silverman, P.R. and Nickman S.L. (1996) *Continuing Bonds: New Understandings of Grief,* Washington DC: Taylor and Francis

Kouriatis, K. and Brown, D. (2011) 'Therapists' Bereavement and Loss Experiences: A Literature Review', *Journal of Loss and Trauma*, 16, 205-228

Kouriatis, K. and Brown, D. (2013-14) 'Therapists' Experiences of Loss: An Interpretative Phenomenological Analysis', *Omega: Journal of Death and Dying*, 68(2), 89-109

Kvale, S. (1996) *Interviews. An Introduction to Qualitative Research Interviewing*, London: Sage

Lapworth, P., Sills, C. and Fish, S. (2001) *Integration in Counselling and Psychotherapy: Developing a Personal Approach*, London: Sage

LeDoux, J. E. (1996) *The Emotional Brain*, New York: Touchstone

Lewis, C. S. (1961) *A Grief Observed*, London: Faber and Faber Ltd.

Lichtenberg, J.D. (1989) *Psychoanalysis and Motivation*, Hillsdate, N.J.: The Analytic Press

Lichtenberg, J.D., Lachmann, F.M. and Fossage, J.L. (2011) *Psychoanalysis and Motivational Systems: A New Look*, New York: Routledge

Lieberman, M. D. (2013) *Social: Why Our Brains Are Wired to Connect*, Oxford: Oxford University Press

Lindemann, E. (1944) 'The Symptomology and Management of Acute Grief', *American Journal of Psychiatry, 101: 141-148*

Linley, P.A. and Joseph, S. (2004) 'Positive Change Following Trauma and Adversity: A Review', *Journal of Traumatic Stress*, 17, 11-21

Loewenthal, D. and Winter, D. (2006) *What is Psychotherapeutic Research?*, London: Karnac Books

Luca, M. (2009) 'A Therapist's Portrait of a Clinical Encounter with a Somatizer' in L. Finlay and K. Evans (eds) *Relational-Centred Research for*

Psychotherapists, Chichester: John Wiley and Sons

Maciejewski, P. K., Zhang, B., Block, S. D. and Prigerson, H. G. (2007) 'An Empirical Examination of the Stage Theory of Grief', *Journal of the American Medical Association,* 297 (7), 716-723

Maroda, K. (2004) *The Power of Counter-transference*, London: The Analytic Press

Martin, P. (2005) *The Effect of Personal Life Events on the Practice of Therapists*, Ph.D. Thesis: Bristol University

Martin, P. (2011) 'Celebrating the Wounded Healer', *Counselling Psychology Review*, 26(1), 10-19

Martin, T.L. and Doka, K.L. (2000) *Men Don't Cry…Women Do*, Philadelphia: Brunner/Mazel

Maslow, A. H. (1954) *Motivation and Personality*, New York: Harper and Row

Maslow, A. (1956) 'Self-actualizing People: A Study of Psychological Health' in C. Moustakas (ed.) *The Self*, New York: Harper and Brothers

Maslow, A. (1966) *The Psychology of Science*, New York: Harper and Row

McLeod, J. (1994) *Doing Counselling Research*, London: Sage

McLeod, J. (2001) *Qualitative Research in Counselling and Psychotherapy*, London: Sage

McLeod, J. (2003) 'Qualitative Research Methods in Counselling Psychology' in R. Woolfe, W. Dryden and S. Strawbridge's (eds) *Handbook of Counselling Psychology (2nd ed)*, London: Sage

McLeod, J. (2011) *Qualitative Research in Counselling and Psychotherapy 2nd ed.*, London: Sage

Michael, C. and Cooper, M. (2013) 'Post-traumatic Growth Following Bereavement', *Counselling Psychology Review*, 28(4), 18-32

Millon, M.L. (1998) *Death in Life: the Impact of Major Loss on the Therapist's Work*, Ph.D. Thesis. Cited in K. Kouriatis and D. Brown (2011) 'Therapists' Bereavement and Loss Experiences: A Literature Review', *Journal of Loss and Trauma*, 16, 205-228

Mitchell, S. A. and Black, M. J. (1995) *Freud and Beyond*, New York: Basic Books

Morse, J. (2000) 'Determining Sample Size', *Qualitative Health Research*, 10 (1): 3-5

Moustakas, C. (1961) *Loneliness*. Englewood Cliffs, NJ: Prentice Hall

Moustakas, C. (1972) *Loneliness and Love*, Englewood Cliffs, NJ: Prentice Hall

Moustakas, C. (1975) *The Touch of Loneliness,* Englewood Cliffs, NJ: Prentice Hall

Moustakas, C. (1990) *Heuristic Research: Design, Methodology and Applications*, London: Sage

Moustakas, C. (1995) *Being-in, Being-for, Being-with*, Northvale, NJ: Jason Aronson

Neimeyer, R.A. (2000) 'Searching For The Meaning Of Meaning: Grief Therapy And The Process Of Reconstruction', *Death Studies*, 24: 541-558

Neimeyer, R.A. and Sands, D.C. (2011) 'Meaning Reconstruction in Bereavement' in R.A. Neimeyer, D.L. Harris, H.R. Winokuer and G.F. Thornton's *Grief and Bereavement in Contemporary Society: Bridging Research and Practice*, London: Routledge

Neimeyer, R.A., Harris, D.L., Winokuer, H.R. and Thornton, G.F. (2011) *Grief and Bereavement in Contemporary Society: Bridging Research and Practice*, London: Routledge

Norcross, J.C. (2010) 'The Therapeutic Relationship' in B.L. Duncan, S.D. Miller, B.E. Wampold and M.A. Hubble's (eds.) *The Heart and Soul of Change (2nd ed.)*, Washington D.C.: APA

Ogden, T. H. (1994) 'The Analytic Third: Working with Intersubjective Clinical Facts', *The International Journal of Psychoanalysis,* 75, 3-19

Orlans, V. (2003) Research in Counselling and Psychotherapy: The Case for Practitioner Involvement, *Eisteach* (*Journal of the Irish Association for Counselling and Psychotherapy)*, Vol. 2, No. 26, 2-4.

Orlans, V. (2008) 'The Interplay of the Intrapsychic, the Intersubjective and the Contextual: Integration In Action', *The British Journal of Psychotherapy Integration*, 5(2)

Orlans, V. with Van Scoyoc, S. (2009) *A Short Introduction To Counselling Psychology*, London: Sage

Orlinsky, D.E., Graw, K. and Parks, B. (1994) 'Process and Outcome in Psychotherapy-noch einmal' in A.E. Bergin and S.L. Garfield (eds) *Handbook of Psychotherapy and Behavior Change*, (4th ed.) New York: John Wiley

Page, S. (1999) *The Shadow and the Counsellor*, London: Routledge

Panksepp, J. (1998) *Affective Neuroscience: The Foundations of Human and Animal Emotions*, New York: Oxford University Press

Parkes, C. M. (1972) *Bereavement: Studies of Grief in Adulthood* , New York: International Universities Press

Parkes, C. M. (2006) *Love and Loss: The Roots of Grief and its Complications*, London: Routledge

Parkes, C. M. (2011) 'The Historical Landscape of Loss: Development of Bereavement Studies' in R. A. Neimeyer, D. L. Harris, H. R. Winokuer and G. F. Thornton (eds.) *Grief and Bereavement in Contemporary Society: Bridging Research and Practice* New York: Routledge

Parkes, C. M. and Weiss, R. S. (1983) *Recovery From Bereavement*, New York:

Basic Books

Parkes, C. M. and Prigerson, H. G. (2009) *Bereavement. Studies of Grief in Adulthood (4th ed.)*, London: Penguin

Patton, M.Q. (2002) *Qualitative Research and Evaluation Methods (3rd ed)*, London: Sage

Persons, R. (1990) 'Psychotherapist and Widower' in E.M. Stern's (ed) *Psychotherapy and the Widowed Patient,* Hawarth Press

Polanyi, M. (1962) *Personal Knowledge,* Chicago: University of Chicago Press

Polanyi, M. (1966) *The Tacit Dimension,* Garden City, NY: Doubleday

Polanyi, M. (1983) *The Tacit Dimension,* Gloucester, MA: Peter Smith

Prior, V. and Glaser, D. (2006) *Understanding Attachment and Attachment Disorders. Theory, Evidence and Practice*, London: Jessica Kingsley

Rappoport, J. (2000) 'Traumatic Time: The Therapist's Mourning'*, Psychoanalysis and Psychotherapy: The Journal of the Postgraduate Center for Mental Health*, 17, 55-64

Rennie, D. L. (1992) 'Qualitative Analysis of the Client's Experience of Psychotherapy: The Unfolding of Reflexivity' in S. G. Toukmanian and D. L. Rennie (eds) *Psychotherapy Process Research: Paradigmatic and Narrative Approaches*, Newbury Park: Sage

Rizzolatti, G., Fogassi, L. and Gallese, V. (2006) 'Mirrors in the Mind', *Scientific American*, 295(5), 54-61

Rogers, C. (1951) *Client-centred Therapy,* Boston, MA: Houghton-Mifflin

Rogers, C. (1961) *On Becoming a Person,* London: Constable and Robinson

Rowan J. and Jacobs, M. (2002) *The Therapist's Use of Self*, Maidenhead: OU Press

Rowe, J. (2010) *The Effects of Transitions on the Therapeutic Practice of Psychologists*, Psych.D. Thesis: Roehampton University

Salmon, P. (2003) 'How Do We Recognise Good Research?' *The Psychologist*, 16 (1): 24-27

Sanderson, C. (2015) *Counselling Skills for Working with Shame*, London: Jessica Kingsley

Schon, D.A. (1983) *The Reflective Practitioner*, United States: Basic Books

Schore, A.N. (2003) *Affect Regulation and the Repair of the Self*, New York: Norton

Schore, A.N. (2007) 'Psychoanalytic Research: Progress and Process. Developmental Affective Neuroscience and Clinical Practice', *Psychologist-Psychoanalyst*, Summer, 6-15

Sela-Smith, S. (2002) 'Heuristic Research: A Review and Critique of Moustakas's

Method', *Journal of Humanistic Psychology,* 42 (3): 53-88

Shapiro, R.E. (1985) 'A Case Study: the Terminal Illness and Death of the Analyst's Mother: Its Effect on her Treatment of a Severely Regressed Patient', *Modern Psychoanalysis, 10(1), 31-46*

Shear, M.K., Boelen, P.A. and Neimeyer, R.A. (2011) 'Treating Complicated Grief: Converging Approaches' in R.A. Neimeyer, D.L. Harris, H.R. Winokuer and G.F. Thornton's *Grief and Bereavement in Contemporary Society: Bridging Research and Practice*, London: Routledge

Siegel, D.J. (1999) *The Developing Mind*, New York: Guilford Press

Siegel, D.J. (2001) 'Toward and Interpersonal Neurobiology of the Developing Mind: Attachment Relationships, 'Mindsight' and Neural Integration', *Infant Mental Health Journal*, 22(1-2), 67-94

Siegel, D.J. (2010) *The Mindful Therapist. A Clinician's Guide to Mindsight and Neural Integration*, New York: W.W. Norton and Co.

Sills, C. and Salter, D. (1991) 'The Comparative Script System', *ITA News*, 31: 1-15

Silverman, P.R. and Klass, D. (1996) 'What's the Problem?' in D. Klass, P.R. Silverman and S.L. Nickman (eds) *Continuing Bonds: New Understandings of Grief,* Washington DC: Taylor and Francis

Slade, A. (1999) 'Attachment Theory and Research: Implications for the Theory and Practice of Individual Psychotherapy with Adults' in J. Cassidy and P.R. Shaver (eds.) *Handbook of Attachment: Theory, Research and Clinical Applications*, New York: Guilford Press

Slevin, O. (2001) 'An Epistemology of Nursing: Ways of Knowing and Being' in L. Basford and O. Slevin *Theory and Practice of Nursing: An Integrative Approach to Caring Practice*, Cheltenham: Nelson Thorne

Spinelli, E. (1994) *Demystifying Therapy*, Ross-on-Wye: PCCS Books

Stern, D. (1985) *The Interpersonal World of the Human Infant: A View from Psychoanalysis and Developmental Psychology*, New York: Basic Books

Stern, D. (2002) *The First Relationship* (2nd ed.), Cambridge, Massachusetts: Harvard University Press

Stern, D. (2004) *The Present Moment*, New York: W.W. Norton and Co.

Stolorow, R. D. and Atwood, G. E. (1992) *Contexts of Being*, Hillsdale, NJ: The Analytic Press

Stroebe, M.S., & Schut, H. (1999) 'The Dual Process Model of Coping with Bereavement: Rationale and Description', *Death Studies*, 23(3): 197-224

Stroebe, M.S., Schut, H. and Stroebe, W. (2005) 'Attachment in Coping with

Bereavement: A Theoretical Integration', *Review of General Psychology*, 9, 48-60

Taylor, M. (2014) *Trauma Therapy and Clinical Practice: Neuroscience, Gestalt and the Body*, London: Open University Press

Tedeschi, R.G. and Calhoun, L.G. (1995) *Trauma and Transformation: Growing in the Aftermath of Suffering*, Thousand Oaks, CA: Sage

Trevarthan, C. (1979) 'Communication and Co-operation in Early Infancy. A Description of Primary Intersubjectivity' in M. Bullowa (ed.) *Before Speech: The Beginning of Human Communication*, London: Cambridge University Press

Trevarthan, C. (2001) 'Intrinsic Motives for Companionship in Understanding: the Origin, Development and Significance for Infant Mental Health', *Infant Mental Health Journal*, 22(1-2), 95-131

Trevarthan, C. and Aitken, K. J. (2001) 'Infant Intersubjectivity: Research, Theory and Clinical Applications', *Journal of Child Psychology and Psychiatry,* 42(1), 3-48

Tronick, E. Z. (1998) 'Dyadically Expanded States of Consciousness and the Process of Therapeutic Change', *Infant Mental Health Journal*, 19(3), 290-299

Tronick, E. Z., Als, H., Adamson, L., Wise, S. and Brazelton, T.B. (1978) 'The Infant's Response to Entrapment Between Contradictory Messages in Face-to-Face Interaction', *Journal of the American Academy of Child Psychiatry,* 17, 1-13

Tronick, E. Z. and Weinberg, M. K. (1997) 'Depressed Mothers and Infants: Failure to Form Dyadic States of Consciousness, in L. Murray and P.J. Cooper (eds.) *Postpartum Depression and Child Development*, New York: Guilford Press

Tsai, M., Plummer, M.D., Kanter, J.W., Newring, R.W. and Kohlenberg, R.J. (2010) 'Therapist Grief and Functional Analytic Psychotherapy: Strategic Self-Disclosure of Personal Loss', *Journal of Contemporary Psychotherapy*, 40, 1-10

Ulman, K. (2001) 'Unwitting Exposure of the Therapist: Transferential and Countertransferential Dilemmas', *The Journal of Psychotherapy Practi*se and Research*, 10(1), 14-22*

Vamos, M. (1993) 'The Bereaved Therapist and her Patients', *American Journal of Psychotherapy*, Spring 47(2), 296-305

Wilber, K. (1995) *Sex, Ecology and Spirituality*, Boston: Shambala

Willig, C. (2001) *Introducing Qualitative Research in Psychology; Adventures in Theory and Method*, Buckingham: OU Press

Worden, J. W. (2003) *Grief Counselling and Grief Therapy (3rd ed.)*, Hove:

Routledge

Worden, J. W. and Winokuer, H. (2011) 'A Task-Based Approach for Counselling the Bereaved' in R.A. Neimeyer, D.L. Harris, H.R. Winokuer and G.F. Thornton's *Grief and Bereavement in Contemporary Society: Bridging Research and Practice*, London: Routledge

Wosket, V. (1999) *The Therapeutic Use of Self*, London: Routledge

Yalom, I. (1980) *Existential Psychotherapy*, New York: Basic Books

Yalom, I. (2002) *The Gift of Therapy*, New York: HarperCollins

Zech, E. and Arnold, C. (2011) 'Attachment and Coping with Bereavement. Implications for Therapeutic Interventions with the Insecurely Attached' in R.A. Neimeyer, D.L. Harris, H.R. Winokuer and G.F. Thornton's *Grief and Bereavement in Contemporary Society: Bridging Research and Practice*, London: Routledge

Appendices

Appendix 1

Overview of the literature on therapist loss and bereavement

Anecdotal accounts

- **Givelber and Simon** (1981): a compilation of anecdotal experiences of the two bereaved therapist authors and their various colleagues. They discuss the effects of grief on therapeutic practice and aspects of professional functioning. They address the question of self-disclosure, suggesting that the issue is more to do with the meaning that revealing or not revealing the loss will have on the patient.

- **Shapiro** (1985): she offers an account of her experience of client work during and after her mother's illness and death from cancer. She presents the case of a depressed client to illustrate the development of parallel emotional states between the client and analyst as she herself became increasingly depressed over her mother's terminal cancer.

- **Persons** (1990): he writes about his grieving process as a psychotherapist and widower following the murder of his wife. His account focuses almost exclusively on the personal experience rather than any professional implications for his work as a therapist.

- **Vamos** (1993): she explores the impact of her own bereavement on her work with four clients (presented as case vignettes), focusing in particular on issues of self-disclosure. She points to the lack of research in this area and indicates that this contributed to her sense of loneliness and uncertainty on how to provide clients with information while protecting one's own vulnerability at times of personal crises.

- **Chasen** (1996: 3): she describes the "utterly unthinkable" of her 12-year-old son being killed by a car. She takes the reader through her choice to return to work two weeks after his death, her decision to be more transparent rather than taking up her more 'neutral' analytic stance, and the impact on her patients.

- **Mendelsohn** (1996): he focuses on his baby daughter's illness and eventual death at the age of eleven months in the context of repeatedly cancelling sessions and issues around self-disclosure. He considers his patients' reactions and the clinical work that followed, concluding that such tragic circumstances in the therapist's life may well lend themselves to the deepening of the analytic collaboration and that there can be something very positive about the patient experiencing the analyst in "ordinary, de-idealised terms" (1996: 39).

- **Morrison** (1996: 42): he examines issues pertaining to what he terms "enforced disclosure" of his particular loss. He and his analyst wife continued to practice in

their home-based offices during her lengthy battle with cancer, such that neither he nor his patients could escape the reality of her terminal illness. Following her death, Morrison reflects on the process involved in monitoring his self-state as he continues his work with patients. What these accounts seem to share, other than the impact of self-disclosure on the work, was the therapists' ability to engage with case material despite being "preoccupied and grieving" (Mendelsohn, 1996: 38) or experiencing "destabilisation of the self-state" (Morrison, 1996: 44).

- **Gerson** (1996) discusses her second trimester miscarriage (20 weeks) where the loss was visible to clients and very much 'in the room'. Such was the nature of this loss, it could not be kept out of the therapeutic space and Gerson offers many clinical examples of how the loss became a focal issue around which central themes were confronted in analysis.

Qualitative research studies

- **Antonas** (2002): he found that therapist bereavement led to shorter term negative effects, such as impaired self-image, but longer term positive effects, such as increased empathy and greater reciprocity in the therapeutic relationship. Since he analysed his data using a Grounded Theory approach, Antonas' research findings have been critiqued as potentially losing some of the richness and uniqueness of the participants' stories (Rowe, 2010). Nonetheless, the research signifies an important contribution to an under-researched area, having found its way into the literature reviews of various doctoral theses on therapists' personal crises in the last 10 years (e.g. De Santis, 2015; Martin, 2005; Rowe, 2010).

- **Millon** (1998): an unpublished doctoral thesis, this research has been cited by Kouriatis and Brown (2011) in their literature review on therapist bereavement as the first study to address the issue of therapist loss and their resultant professional lives. Her research was criticised by them as being limited by her inclusion criteria of participants who had lost a family member (thus excluding death of other significant persons). They further pointed to methodological weaknesses in her work, indicating that a clear epistemological position was lacking, the analysis process was unclear and that Millon did not examine how her own experience of loss and bereavement affected her as a researcher or the findings of her study.

- A second study cited by Kouriatis and Brown (2011) involved three researchers who conducted collaborative qualitative research, each then writing up a doctoral thesis focusing on a specific area of analysis. The study involved 12 psychologists, interviewed over the telephone by researchers, and the data then

analysed using Consensual Qualitative Research (Hill, Thompson and Williams, 1997). **Boyden** (2006) focused on the impact of bereavement on therapists' self-disclosure, reporting that disclosure was affected by client loss issues, therapist theoretical orientation, cultural factors and client initiating questions of therapist absence. **Bozenski** (2006) focused on therapist empathy in the aftermath of loss, reporting that participants described greater connection with clients and increased sensitivity, and that increased empathy seemed to inform their therapeutic interventions. **Colao-Vitolo** (2006) focused on coping strategies for the bereaved psychologists, demonstrating the reported significance of supervision, personal therapy and social support systems. This is something that Adams (2014) talks about in her study on therapists in 'crisis', citing the difficulty for therapists to acknowledge their own vulnerability and seek help. Kouriatis and Brown (2011) point out that notwithstanding the notable contribution the study made to this particular field, criticisms are levied against it by way of the type of loss experienced (namely, parental death rather than non-kin deaths) and the methodology used. They question whether an alternative qualitative method, such as Interpretative Phenomenological Analysis, would have given space for more interpretation of the findings. They also point to the method of data collection, challenging the suitability of telephone interviews for such a personal and sensitive topic and what might have been lost in non-verbal communication.

- **Broadbent** (2011): undertaking research for her master's thesis, she utilises Interpretative Phenomenological Analysis in which four master themes emerged from the data. The findings showed the uniqueness of the bereavement experience and the challenges it has to one's sense of self and social identity. It also has implications for personal growth and renewal in the reconstruction of identity. A significant finding was the interface between the personal and professional, and how supervision in particular was central to participants' development as therapists. Broadbent also found that grief had a considerable impact on therapists' practice by enhancing their capacity to empathise and connect with clients, reflecting Bozenski's (2006) findings. Appropriate to an IPA study, Broadbent's sample size of four participants provided a rich, detailed narrative of experience. A person-centred counsellor herself, Broadbent strove to redress the imbalance in the (largely anecdotal) psychoanalytic accounts of therapist bereavement by focusing solely on humanistic practitioners, which gives greater breadth to the available literature. She acknowledges, however, that her sample size was not representative in terms of gender, ethnicity or social class. She also points out that, since her study was a master's thesis, some of the

richness of data would inevitably have been lost through the process of selectivity. Perhaps also the consequence of word limitations in her thesis, Broadbent demonstrated reflexivity by laying bare her process with the research in her appendix rather than giving her own subjectivity a place in the main body of the write-up.

- **Kouriatis and Brown** (2013-14): following on from their literature review (2011), they undertook their own empirical research into therapists' experiences of loss. They sought to provide participants with the space to define their losses of personal significance rather than assuming the importance that a particular loss might have for them, which was a purposeful divergent feature from the few studies on therapists' grief that they had critiqued. Kouriatis and Brown asked the question 'how do therapists experience loss?' as the focus of their research, recruiting six psychotherapists to take part in semi-structured interviews and then analysed the data using Interpretative Phenomenological Analysis (IPA). Three master themes emerged from the analysis: i) the grieving therapist; ii) hindrances in grieving; and iii) the impact of loss on therapeutic work. It is the third theme that holds the most significance for my research, indicating the concerns participants' had about the dangers of over-identifying with clients and left them grappling with what was 'theirs' and what was not. Kouriatis and Brown suggest that the capacity for self-reflection and the role of supervision become paramount in the provision of therapy, mirroring Broadbent's (2011) finding. In terms of enhancing therapeutic work, the researchers point to increased empathy with clients, the "ability to walk alongside" (p. 105) clients by providing an attentive space and bear witness to pain, and the capacity to be bolder in the therapy room with clients. This study makes a notable contribution to the literature on therapists' personal loss and it is a clear strength of the research that it provided rich, detailed accounts of therapists' experiences and in a way that allowed participants to define their own significance of loss. There were, however, two key things that struck me as I read through their study. (1) the authors' own acknowledgement that, since they knew the six participants in a professional capacity prior to the research being carried out, the extent of participants' disclosures and self-exploration may have been restricted and curtailed. I think there is a question about the role of judgement (perceived, felt or actual), and who is doing the judging, when talking with therapists about their practice. Interviewing unknown participants might have ameliorated this to some degree. (2) the absence of any discussion on researcher reflexivity. Kouriatis and Brown (2013-14: 89), in providing a rationale for their research, argue "psychologists serve a profession on

which their own personal experiences greatly affect the therapeutic work, since their self acts as a 'filter' through which all communication – conscious or unconscious – between therapist and client takes place". I wholeheartedly agree with this contention and find myself wondering what happened to this stance in the researcher-participant relationship in their study. They go on to state their preferred method of data analysis (IPA), chosen in part for its emphasis on the active role of the researcher in the meaning-making process. Despite acknowledging their ontological and epistemological positioning in relation to IPA, it seems that the 'active role' of the researcher was not borne out in a transparent exploration of the intersubjective context. In short, I was left with questions about the impact of their own subjectivity on the research process and how their own experiences and 'self' acted as a filter through which researcher-participant communication occurred.

- **Devilly** (2014): another master's thesis, this one explored therapists' experiences of bereavement and personal illness, employing thematic analysis to make sense of the data collected. Devilly interviewed six psychotherapists who had either been bereaved or had suffered chronic, acute or life-threatening illness, and set out to ask about self-disclosure, support systems and self-care, the impact of the loss on the therapist, and the experience of therapeutic relationships at the time of bereavement or loss. Again, this is a study that contributed to an under-researched field, highlighting the importance of self-care practices and personal therapy at times of crisis. Her findings mirror previous studies on therapists' sense of heightened empathy following loss. Devilly also discusses the issue of self-disclosure, demonstrating the ambiguous nature of disclosure and the implications for the client. While these are useful discussions with which to engage, I found that her findings held less weight given she sought to incorporate the experiences of both bereavement as well as personal illness. Arguably, these experiences may feature quite differently in terms of issues around self-disclosure and self-care – two areas Devilly specifically aimed to explore with participants. Other limitations of this study include the lack of the researcher's epistemological position and any account of her own subjectivity that will have had an impact on her findings. The absence of the 'self-as-researcher' in the thesis seems to be in stark contrast to her acknowledgement and emphasis of the 'self-as-therapist'.

- **De Santis** (2015): this is a doctoral thesis on the lived experience of the bereaved therapist. Influenced by existential thinking, De Santis interviewed seven humanistic therapists who had been bereaved during the course of their work, analysing the data using Interpretative Phenomenological Analysis. She identified

four main themes: i) the experience of feeling overwhelmed and disorientated by grief; ii) how participants sought to manage the therapeutic encounter by relying on technique and professional identity; iii) the altered sense of presence that participants felt with clients post-loss; and iv) the expansion of the self post-loss.

De Santis (2015) provides a deep, rich analysis of the lived experience of the bereaved therapist. Her use of IPA was appropriate in achieving a layered, fine-grained analysis of the data collected, although she acknowledges the limitations of the methodology and the fact that a different method (or different researcher) would have produced different results. Her explicit reflexive exploration throughout the thesis lends the reader a good understanding of how she positions herself in relation to the research and demonstrates her clear commitment to the intersubjective context of the work.

Appendix 2

Ethics approval letter

13 North Common Road
Ealing, London W5 2QB
Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

Amy Horwell
DCPsych programme
Metanoia Institute

19th May 2017 (ethical approval was given in 2009)

Dear Amy,

Re: The Therapist in Crisis: A Qualitative Analysis of the Impact of Personal Loss on the Therapeutic Process

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as research ethics representative for the DCPsych programme.

Yours sincerely,

Prof Vanja Orlans
Senior Director of Studies & Programme Leader DCPsych
Faculty of Post-Qualification and Professional Doctorates

On behalf of Metanoia Research Ethics Committee

Appendix 3

Ethics attachment to original research proposal

By participating in my research, there is a realistic risk that participants may experience some upset or distress relating to the nature of the material, i.e. their personal loss. I reasonably expect, however, to be able to minimise the risk through the following steps:

1. Ensuring that all potential participants understand the nature of the research and what would be expected of them in terms of interview material.
2. Ensuring that all participants understand that they do not have to answer questions they are uncomfortable with.
3. Recommending that a potential participant's loss occurred less than 12 months previously, taking part in the research may not be appropriate.
4. Stipulating that participants attend clinical supervision as part of their support system and, in addition, providing contact details for further support where relevant.
5. Ensuring that there is appropriate 'debrief' space as part of the interview process.

Interview guide

The Therapist

Name:

Qualifications:

Length of time practising:

Theoretical orientation:

Practice context (e.g. client groups, specialisms, statutory/voluntary/private):

Type of supervision:

The Loss

Can you tell me a bit about what happened?

How long ago?

How did you cope? What support did you have?

Experience in the Immediate Aftermath

When did you go back to work?

Why then? What influenced that decision for you?

Did you feel ready to return to work? How did you know (if yes)? Why return (if no)?

What were your clients told (in your absence)?

What did you tell your clients? Why?

Looking back, how do you feel about having returned to work at that point? Did it help you? What was hard?

Experience of the Continued Clinical Work

Tell me about doing client work after (your loss).

What stands out for you when you think of the client work you've done since (your loss)?

What were the particularly difficult moments?

How did you feel doing the work?

Were there particular clients or issues that you found harder or more painful?

What did you do with these feelings outside of the sessions?

How did you manage your feelings in sessions? Did you share what was going on for you with your client(s)?

Did client work help you? How, in what way?

Have you changed as a therapist? How, in what way?

Do you think (your loss) impacted on your work as a therapist, either positively or negatively, and in what way?

Did you experience particular responses from your clients? What was that like and how did you manage them?

The Interview

What has been your experience of participating in this interview?

Appendix 5

Extract of analysed transcript

This excerpt comes from my interview with Hugh, the third person I interviewed for the research. The piece here is during the second half of the interview. I have included my analysis from 2011 and 2015.

'Meaning Unit' in text	Relational / Reflexive Process	Themes
Interviewer: So I'm thinking as well, you know, again, on-going work – you're continuing to work as a therapist and I'm very interested in the relationship between your experience of life and your experience of client work, and I'm wondering how generally and in other specifics, how perhaps you feel you might have changed. You might not have but aspects of your practice, or aspects of you might have changed as a result of the death of your mother. Respondent: Yeah. It took really ….it's not an easy question to answer in some ways because, probably as you've experienced, psychotherapy training is so thorough and robust, and all sorts of changes happen that sometimes, it's difficult to say well, it's actually that that's made the change and of course one's own psychotherapy has been…you know, that's been going on, my own psychotherapy. So how's impacted the work, how's it impacted me? I feel older. I feel 2008 kind of aged me by six or seven years rather than one, it felt like, in all sorts of ways – some quite good ways as well, because I was thrown back on my own resources and had to cope with quite difficult situations, and just do it. And sometimes, again looking at the parent and the child, also the adult and the child, certainly my teenage self was looking at me and thinking, 'I don't believe you're doing this, you know, so grown up, how do you manage?' Really, really grown up and so that's…there's something that came out of it, I thought actually, well I am grown up, not completely but I am grown up and I can deal with these things and….	Feels like a wisdom or maturity that comes with grief.	Feeling older. Aged. Self reliance. Coping. Grown up. Growth.

Interviewer: Your recognition.		Grown up.
Respondent: Your recognition.		
Interviewer: That's what it sounds like.		
Respondent: A recognition, yes, yeah. Because I don't have children of my own, that's the sort of …a marker that I haven't passed, if you follow me. So the bereavement was something, and actually multiple bereavements in a sense, because, yeah, my Mum, my aunt and my uncle…my brother's….sorry, my mother's sister's husband had died a couple of years before and suddenly, there's only one of that generation left now, so now I'm in the generation that is closest to death, in a sense. And there's two generations below me now, because my nephew's had a baby, his wife. So it really just took me forward in terms of feeling like a youngish man to suddenly feeling like I kind of got the hallmarks of middle age somehow. So that kind of put me forward a little more.	There's a connection here between us. I feel moved by what he says and his sense of change. Do I feel more grown up??	
Interviewer: And what did that mean for you as a therapist?		
Respondent: Thought you were going to say as a person, oooh! I really don't like it at all! In fact, middle-aged is not something I kind of think of myself as, I really don't. But as a therapist, I thought this is all…it's all material, it's all experience, it's all something that I can use and that I can know what that's like, to be in that situation, having gone through that situation, experienced the losses, experienced the bereavement and known what's involved in that.		
Interviewer: And when would you say that kicked in? Was that there in 08, or is this very retrospective?	I really feel this! This was how I felt in the Palmers Green café after Tara's suicide – it's almost like these are my words.	
Respondent: This is very retrospective, although at the time, I also thought, well….I knew that this would be material.		Change as a therapist. A more embodied sense of the world through experience of loss.
Interviewer: At the time?		

Respondent: ==At the time==. I had the awareness but of course, anything that happens is going to be useful, so I can empathise with clients, I can know what they might be going through. Yeah, but it's only in retrospect that I really feel it has made a difference. In some ways, I'm not sure that it has made a tremendous difference. I'm not sure that my integrative model, for example, has changed particularly as a result of it. Interviewer: And I take your point about doing that training as well, you were at such a point where you gain so much information, on such a learning curve that it is very difficult to separate…. Respondent: Quite. Yeah. Interviewer: …some of that out. Respondent: Yeah. Yeah, really difficult. Interviewer: I mean, on a….I guess, in the therapy room - and again I know this is going to potentially fall under the same umbrella that we've just been talking about in terms of separating these things out – but do you have a sense of maybe things you'd now do differently, or you did do differently immediately after her death? Respondent: In the therapy room? Interviewer: Yes. Actually with your clients. Respondent: Not especially, actually. I also knew that I was going to ==take it easy==. I wasn't going to…yeah, but….I mean, because my integrative model has a sort of person centred part to it, ==I allowed myself to kind of retreat maybe a little bit into that and just not be quite so proactive with them at times and not be…and just allow them to be more passive, to just let them talk more.== And so I consciously decided to do that. I consciously thought, well that just has to be ok because I'm a person, they	Feel excited by this. Hugely resonates with my experience of knowing (or hoping?) at the time that it's material.	Knowledge at the time that loss can be 'grist for the mill'.

don't have a computer as a therapist and…so…and I don't think I would've done that differently, I think that I have to be how I am. I'm thinking, did that….that either sounds terribly arrogant or it seems terribly self-accepting. I think it's just self-accepting really, that I just think, well….==I don't feel like I made any huge mistakes as a result of it==. I think I just felt robust enough to go back into the therapy room. Could have been a bit more robust, but I don't think it particularly impacted the clients, except they may not have had the full….==I may have decided to just sort of let something go, whereas I may have addressed it.==		Looking after self. Less proactive with clients.
Interviewer: Ok, I guess….		
Respondent: Yeah, so ==being more passive==.	Judgement piece may be present here with us.	
Interviewer: Right. And I guess what I was….and I'm kind of wondering whether there maybe – ==you said something about a mistake and that wasn't really something that's come into my mind at all==, you know, I think that ==what I was interested in then is maybe moments where you feel you might have either missed something, or not been available in a capacity, whatever that is – not maybe heard something because you weren't in a particular place, or you were having to manage your own process==. Can you think of any times when that might've been going on?	A different presence I wonder.	Different choices as a bereaved therapist. Letting something go. More passive.
Respondent: I'm sure it did, but it goes on anyway (laughing).	Responding to him possibly feeling judged?	
Interviewer: Yep!		
Respondent: I think I, quite a few times, had to ==block it out of my mind because it kind of impinged and I thought, no, I'm just not going to think about that==. Because there are some clients, as you probably know yourself, there are some clients…well, there's one client…in fact, it's the same client, strangely enough, that I was just speaking about, the Australian one,	How much am I thinking about my own experience with clients? Am I looking for something in particular?	

where he can be quite <mark>boring</mark>. His voice is quite monotonous and I find myself thinking about the shopping and I think, nope, I've got to concentrate. And I think about holidays – nope, I've got to concentrate, and that happens quite a lot. So I know with him and with similar clients who perhaps are a little bit kind of monotone, and just <mark>not very engaged with their emotions</mark>, I find myself drifting off and inevitably, I would drift off towards those sorts of thoughts, so I had to really concentrate. And there were a couple of moments when I thought, am I looking like I'm overly concentrating on them, are they going to feel like – ok….are they noticing that I'm just really holding on, sort of….I don't think so. I mean, I think there must've been impacts, but I don't think that they were huge, or that there were big differences in my responses. There may have been times when perhaps people were talking about quite painful things and…in fact, I can think of maybe two and I'm not even sure what they were…where I thought <mark>I could go deeper with this, but where I am, I don't want to go to that emotional place with them.</mark>		Block it out.
	How interesting, given what he said earlier about his connection with this client.	
	Knowing that I feel disconnection in these kind of moments.	
Interviewer: Right.

Respondent: So…

Interviewer: So there was quite a choice moment then for you..

Respondent: There was a choice moment of just not going down there….letting them go where they wanted to go, but <mark>not consciously furthering the process</mark>, not taking them to…yeah, not following through on the Gestalt cycle, if you like, letting them just be where they are but not furthering them….

Interviewer: And that being because of where you were at?

Respondent: Because of where I was at, when I thought <mark>I felt actually a bit emotionally exhausted at this moment</mark>, and so therefore I'm not going | | Self protection. Managing difficult moments by choosing not to go to deeper, more emotional place with clients. |
| | I'm interested in my choice in this particular moment of giving | |

to go down that route, but there are so many choice points anyway, again it's not….it doesn't feel wrong or a mistake, it just feels like – well, that's where I was and there are two of us here. If you've co-created, it's got to be ok.	what feels like a 'heady' response. Disconnection? (2015)	
Interviewer: And I wonder really…a couple of times you've now mentioned the word 'mistake' and I wonder if there's also something, just another process here, about….we're talking about your practice and, you know, I think it's maybe…can feel a little bit….I don't know….		Not furthering the process.
Respondent: Vulnerable.		Looking after self.
Interviewer: Yeah, vulnerability or fear of judgement maybe on my part, that….		
Respondent: Yeah. I think that's come in the last couple of moments, I think….and then…but it's….it's quite unusual to, apart from supervision which is normally focused on a client, to talk about my practice in this depth in some ways. It is quite unusual, isn't it, really?	Something is happening here between us around judgement. Making a mistake.	
Interviewer: Yes.	I feel exposed (he must do!) by bringing this in, but it feels important to name this.	
Respondent: So maybe it is just a little bit exposing, but it feels ok, it's not horrible, it's just sort of like, 'Hmm…' strange to talk about that, although I rarely think in terms of mistakes. Although I do sometimes, think 'Oh, I just knew that was…I could've said something differently there,' quite easily, but….	How exposing and vulnerable the research process is. This has such a different feel to the last interview!	Research process as exposing.
Interviewer: Yeah, I mean I just…I was interested in you talking about this particular choice moment, of it being very clear and actually there's plenty, and of course what I'm interested in is those moments that are linked to the loss, as opposed to lots and lots of other ones that do go on all the time.		
Respondent: Right.	Feels important that this sense of exposure is normalised, contextualised.	
Interviewer: I just had this sudden sense that maybe you'd sort of		

interrupted your process in this moment to make sure that, you know….make sure perhaps that you weren't too exposed.		
Respondent: Yeah. Yes, I think I did, yeah, yeah. And there were a couple of those that stick out, and I think as a background issue, <mark>I think it was probably at some level affecting all the time</mark>, but maybe not….but not…but there weren't many concrete instances where it really showed up.		
Interviewer: Right.		
Respondent: But I think at some level, it was always….that <mark>I was taking it easy</mark>, I wasn't kind of going fully…as fully as I do, sometimes, so yeah…		
Interviewer: And again, you know, and it sounds like part of that was around finding a way of taking care of yourself, you know, and looking after the….the adult looking after the child in you, which is very much where you started from as well.	My worry that I'm being the 'good enough' researcher. Don't want him to feel this is too much. Attempting to re-connect with him.	
Respondent: Yes. Yes, it was. Yeah, yeah.		
Interviewer: Just to kind of reverse that a little bit, thinking about how being….being a therapist and you've already talked a little bit about how your view that even at the time, this is all material, this is all going to kind of add to stuff, which really resonates with me you know, and <mark>I really remember feeling that with one of the losses I had during the training and feeling like, you know, I need to find a way of being able to make this part of me and integrate this somehow</mark>. And so I guess I do have a particular interest, then, in how being a therapist, doing therapy, impacts on our experience of loss. And I don't know if that's something you've thought much about, or how much that rings true for you, because it might not.	I went back with him to focusing on clients rather than staying with what was happening between us. What does this mean about protecting oneself in the research room?? (2015)	Grief as the backdrop – always present. Self care. Protecting oneself in the therapy room.
Respondent: Yeah, it's…it's become clearer, that loss is happening all the time to me, that sometimes we don't		

know we've had them. You know, sometimes somebody doesn't contact you, for instance, for a long time and you think – oh, perhaps, they want to be a friend and then…..this morning, for example, they send you an email saying, 'Hello, how are you? Haven't seen you for a long time' and so yeah, it has made me thing about ==loss as a continual process==, and it makes me reflect on how I've very much in life reflected on gains…..not reflected, focused on gains, like what am I going to get for myself next? What am I going to….what new friendships am I going to make? What new courses am I going to do? What am I going to add to my skills level? You know, without thinking actually, fifty per cent of the process of life is losing things as well.	Self-disclosure came more easily for me in this interview. I wonder if I was trying to connect with him.	
Interviewer: So what would you do with that, then? What happened to it, historically before?		
Respondent: Well, I suppose it just went, didn't it? I mean, I have been aware of it but it's just all really brought it home again that actually, it's everything that I have, I will lose one day and that's quite…that's quite difficult, really, to think that actually everything – including life – I'll lose one day, so….		
Interviewer: As you said that, I was thinking about your partner and what happened in March, and how that was a very different kind of loss, how that uncertainty of losing who he was, or…you know, I just…I realise that's been kind of absent from thinking about, I guess, what impact that had at that time.		Ongoingness of loss. Always there.
Respondent: Yeah. Well, I think it was just….it meant that kind of chaos and fear were all around, it seemed, and there were just some other things going on as well, all at the same time, it all seemed really chaotic because a really good friend of mine is from Georgia, Russia, and that was exactly the time that that last war was going on as well, so I was quite concerned about		

that, when he still lived there, his mother lived there and it just all seemed….just like everything sort of went horrible! For a bit…and so it did bring home to me the precariousness of certain things. Things may seem very solid and things may seem like they're all ok and everything's fine, but actually, these things can happen and they can happen quite quickly. I mean, I haven't thought of this before but actually, if those two things had happened pretty much simultaneously, I don't know what I'd have done. I really don't know what I'd have done, I would've been…God, what a horrible thought….	Other losses feel present. I bring in the earlier loss that he spoke about.	
Interviewer: If your partner…		
Respondent: And the death had happened at around the same time, if they'd happened really close together.		
Interviewer: They were fairly close together actually, weren't they?		
Respondent: Yes.		
Interviewer: A matter of months?		
Respondent: Yeah, yeah. But I'd managed to get….pretty much get over one before the other one.		
Interviewer: Right, ok. You were through the uncertainty and things had kind of recovered, I guess?		
Respondent: Yeah, yeah, pretty much, yeah. So yeah, I think it's just left me with a feeling of precariousness but also, a kind of experience of my own solidity and that ability to deal with things, so there's that phrase which says 'If it doesn't kill you, it makes you stronger' which I think does seem to be true, so…it can't really do anything else really, can it, like if it doesn't kill you then….well! You don't have a lot of choice! I suppose it could make you more….depends how you deal with it.	Sense of overwhelm. I feel fearful. Something here about the unbearable. Did I feel helpless? (2015) I seem to seek clarity here but I don't know why… (2015)	Concurrent losses. Relational disconnection. (2015)
Interviewer: And in terms of – again, I'm just thinking, I tend to take the perspective that all of this is very on-		

going, you know, and it maybe that you have a client in ten years' time that might make quite an impact on you in terms of your own death, for instance. So I'm just thinking of whether there's any recent examples that you have that did touch on you in a particular way, or did makes things difficult, or impacted on how you make sense of the loss? Respondent: Not that I can think of. I've had experience with a couple of friends whose issues with their ageing or dead parents are still quite massive for them, and I feel really grateful that mine aren't because there was a real concern about ten or fifteen years ago that I would be left with a whole mass of confused, difficult feelings and that hasn't really happened. There's some confused and difficult feelings, but not many, and…. Interviewer: Confused and difficult feelings as a result of….? Respondent: Earlier stuff. Interviewer: Right, ok. The things that may be not resolved? Respondent: Yeah, age three, age thirteen, that kind of thing. But not a lot. Interviewer: Ok. Respondent: So I can't really think of any…and I haven't had any clients with bereavement issues since that one who just brought that massive one, quite odd really! Interviewer: And that was fairly soon after, is that right? Respondent: Yeah, it was about six weeks later. Interviewer: Six weeks later. Right. Respondent: If it had come perhaps three weeks after I started work…so it's probably about nine weeks after the actual bereavement, but if it had come sooner than that, I think I would	What is happening in my process here? Why am I asking these questions? It seems to have the consequence of moving him away from the 'horrible thought' – was this for my own sake? (2015) I feel like I missed him at this point of interview. That I somehow disconnected from being with his experience and his here-and-now processing (2015) He seems to change in interview (2015) I seem to be very much in my head at this point. Seems to have resulted in a 'bittiness' to the interview at this point (2015)	Getting over loss. Precariousness after loss. Own ability to cope.

possibly have struggled. I don't know. <mark>I think something that's helped me – I don't think it helps me as a therapist – is that I can cut off, I can compartmentalise</mark>, that's what I did way too much if we go back in history. Interviewer: Right, ok.	Such a clunky feel to this! What's happening?? (2015)	
	This resonates hugely with me! Is this exactly what happened here in this process?? Did I just cut off when I felt overwhelmed, scared, helpless? (2015)	Cutting off. Compartmentalising. Parallel research process.

Appendix 6

Emerging themes from interviews

<u>**Emerging themes – Cara**</u>

Going back into practice:

- Fear of client material and ability to hold it.
- Fear of over-identifying with material.

Clinical practice:

- Having a strong physiological counter transference response (p.3) to a client.
- Usefulness of supervision to work through feelings evoked.
- Therapist journey of loss as a vehicle for understanding the client – and vice versa (p.5).
- Using own experience of loss to further the work with the client – and vice versa (p.6).
- Counter transference response: offering the client something the therapist would have liked, in this case an additional session a week (p.9) or to be held (p.11).

Retrospective observations of self:

- Being more aware of own grief and loss, and drawing on the experience to support clients.
- For self, allowing own therapist in more after the loss (p.6).
- Being ready to have that experience with that client at that time (p.15).

The impact of client work on own grieving process and personal/professional growth:

- Speaking to own grief as well as client's in these sessions – the therapist did gain from these sessions. Mutual healing – p.10.

Research process:

- Some disconnection in the research encounter on my part. Being with vs. distancing from.
- Grappling together to understand the phenomena. Transformative potential.

<u>**Emerging themes – Greg**</u>

Time off vs. continuing clinical practice:

- Bereavement agency policy – no loss in last 1-2 years; he disagrees. More about negotiating, discussing with therapists rather than set rules as it otherwise excludes. Challenges the notion that people cannot function or do the work if they are recently bereaved (p.26).
- Time off – max 2 weeks.
- The need to work (p.4), work was normal (p.5) – *reflective piece on the normality of working for myself.*
- Supervision for monitoring self (p.4) and exploring transferential feelings (p.14).

Retrospective observations of self:

- Heightened empathy, more contactful (p.4), therapist's own grief heightening his awareness of client's projections and transferences (being "very awake" with "the volume turned up" p.10).
- Holding both death / grief and life (p.4), holding both the ability to function and the ability to grieve – Dual Process Model (p.6).

Therapist disclosure about loss:

- Telling clients – what and why.
- Possible client responses to therapist bereavement.

Clinical practice:

- 1st specific client: therapist increased vulnerability 'allowed' the client's vulnerability into the room (p.7).
- Modelling 'managing' grief for clients (p.8).
- Deepening the therapeutic relationship with emphasis on gender and trust.
- Impact of deeper relationship on therapist – positive.
- 2nd specific client: therapist's bereavement highlighted the client's repetitive patterns of not allowing himself his own experience (grief). Led to "breakthrough" and furthering of the work (p.9).
- Generally: therapist not busy with or drawn into getting people 'over' their grief due to own process (p.23).

Difficulties:

- Feeling misunderstood or unfairly accused of not understanding (p.11) – *reflective piece on my desire for my interviewee to know my own experience of grief (p.13) as a parallel process within the interview itself. Towards end of interview, I return to this, disclosing T's suicide but not anything else. Why?*
- Experience of managing clients anger or acting out from grief – led to recognising the need to step back from specific telephone grief work.
- Clients recklessness with their own lives and the anger felt by the therapist (p.13/14) which reinforced how the therapist challenged clients. *Reflective piece on what this meant for my loss of T to suicide.* For specific example of positive intervention, see p. 16.
- Bereavement clarifying therapist's ethics and way of practicing on such issues as self-harm and contracting (p.16)

The impact of client work on own grieving process and personal/professional growth:
- Connecting with another's pain helps with your own pain. Not alone, shared (p.17). Can be a humbling experience.
- Gaining expertise (becoming an expert) by going through loss yourself, and working through it (p.19) – "inner knowledge" (p.20), moving from the theoretical to the embodied experience of significant loss (p.23).
- Increased resilience to pain and fear (p.21) – and how this resilience may enable the therapist to recognise it in clients, i.e. using own process of grief and resilience to help others' processes of drawing out health and resilience (p.22).
- Therapist being reminded that grief is not something to 'get over', that being in touch with grief serves as a connection with the deceased. *Reflective piece on my re-grieving' my mother (and the positive aspect of doing so!) during this analysis phase due to becoming a mother myself.*

Research process:
- Overwhelmingly positive feel – something shifted for me between two rounds of analysis.
- The teaching feel at times.

Emerging themes – Hugh

Time off vs continuing clinical practice:

- Adult vs Child split in self in response / reaction to bereavement – looking after the Child self through normality (p.3)
- Time off: 3 weeks which was a compromise between 2 weeks and a month (p.5)
- Fear of not coping and not being able to contain Adult self (p.7)
- Helpfulness of supervisor's comment (p.9)

Post-loss work:
- The relief of routine, work, 'doing something' (p.7)

Clinical practice:
- Using own loss as a clinician (p.8) and knowing this at the time of the loss (p.13)

Therapist disclosure about loss:
- Extent of disclosure through statement 'yes, isn't it' (p.9) – this started out as a discussion around deepened empathy due to experience of loss and in one respect was an example of actively bringing in that experience, and in another respect was a question mark for the participant around self-disclosure.

Difficulties:
- Felt he was going to cry in a session – knew it was own stuff as was incongruent with what the client was bringing (p.10). Reality of pre-therapy fears?
- Client material triggering own feelings linked to loss (p.11) – could be information about client?
- Choosing not to go to deeper, "that emotional place" with clients at times (p.15) – managing difficult moments by protecting oneself in the therapy room (p.16).

The impact of client work on own grieving process and personal/professional growth:
- Feeling older, grown up – now in the generation closest to death (p.13) – cf Yalom's death anxiety.
- As a therapist? A more embodied sense of the world through experience of loss (p.13). Otherwise felt that the loss has little impact on work (p.21)

Parallel process with research:

- The vulnerability of opening up to the researcher (p.15)
- Feeling exposed by research process (p.16)

Retrospective observations of self:

- Ability to compartmentalise – helps on a personal level but not necessarily as a therapist. Didn't check why not. (p.19)

Research process:

- More fluidity with my own disclosures.
- My disconnection from his here-and-now experience – the impact of this on the interview. Participant retreats – we're not being open.

Emerging themes – Joe

Time off vs continuing clinical practice:

- Therapy as a different space, allowing the therapist to be in a different headspace (p.4).
- Assessing self as OK to continue (p.5)
- Not experiencing psychotherapy as stressful or overwhelming (p12) therefore not feeling a need to stop work.
- Had the ability to laugh and be sad (Dual Process) – permission to be wherever he was at and to assess how he was (p.13). Ability to put grief "on the backburner" and that this did not discount it (p.13).
- Was in no doubt that he could continue work (p.14).

Retrospective observations of self:

- Change as a therapist – becoming more open to pain and distress post loss (p.7)
- Deepened sense of empathy that results from loss (p.10)
- Loss (and a post loss identification with his father) heightened his sense of self as a therapist (p.10) – this seems to be a theme throughout this interview. See p.23-24 also.

Therapist disclosure about loss:

- Reason for non self-disclosure was his narcissistic pull towards own needs rather than others, led to a need for putting up a boundary (p.20).

Clinical practice:
- Experience of losing a parent – could enrich his work as a therapist (p.9).
- Being able to be completely there with a client for the session and then being able to "cut off" (p.16) – why client work was not particularly difficult.

Difficulties:
- Managing a hard moment by keeping momentarily quiet (p.15)
- Taking extra care around sessions – giving self more space and time to reflect (p.16).

The impact of client work on own grieving process and personal/professional growth:
- Enjoyment of the work as helping during grief (p.18)
- Being with people who don't know about the loss (p.18)
- Some difficulty with separating out what impacted what (i.e. therapy training vs loss on client work, etc) – made identifying this area hard during analysis.

Research process:
- I did not pull away / retreat despite hugely resonating with the nature of his loss. Did not retreat into theory or 'less experienced'. Much more connected and togetherness here.
- My being able to sit back and give him space in interview to reflect and process – a very different quality to preceding interviews. Parallels his self care around giving himself space post-loss.

Emerging themes – Robert

Time off vs continuing clinical practice:
- Returned to locum GP practice after 3-4 weeks; therapy clients after four months.
- Returned due to financial pressures – feels, in retrospect, it was too soon (p.8).

Therapist disclosure about loss:

- Self disclosed about bereavement when clients spoke of bereavement.
- Why? He "wanted people to know" (p.7).
- Lost one client through this and feels he put too much of self into client issues.
- Has a continued desire / is drawn to letting clients know he has 'been there' (p.10)
- And to the present where he has disclosed as a way of providing a 'meeting place'.

Retrospective observations of self:
- Made inappropriate interventions at times (p.9)

Difficulties in clinical practice:
- Bereavement draining him of confidence (p.13).
- Feeling that he could have been disempowered very easily by a client (p.14).
- Finding it hard to challenge and be effective (p.14).
- **All this was without concrete examples but experience and recall was on a tacit level / was in the moment processing during interview. All this seems to have led him to NOW think that he went back too soon.**

The impact of client work on own grieving process and personal/professional growth (and the impact of loss on personal and professional growth):
- Increased insight and self awareness.
- Put him in touch with feelings much more (p.15).
- Better listener and more intuitive.
- Loss as such an emotional experience, feeling strengthened by it, and then feeling more able and empowered to deal with deeper issues – and for him, being able to "break out of" a medical model way of thinking (p19).

Research process:
- Slow paced interview – the need to give oneself time / psychic space to reflect and process.

- My sadness – moved to tears upon re-listening to the interview when he speaks of his "moment of horror" and the lost dream.

Emerging themes – Lyle

Time off vs continuing clinical practice:
- Work was a way of "keeping busy" (p.3).
- No issues of loss in client load (p.3).
- Cont to work during cancer; stopped when it became terminal; returned after 6 months.
- Going back was a "huge relief" – provided a distraction and a focus on other peoples' problems (p.6).
- The enjoyment / satisfaction of working (p.8).
- Used social interactions to gauge readiness to return – needed to feel present with others, contactful and focused (p.9).

Retrospective observations of self:
- Whilst cont work during illness: started to have difficulty focusing and memory was less good (p.5).

Therapist disclosure about loss:
- Took account of specific patients' needs and felt more appropriate to be candid rather than being vague or untruthful (p.4)
- Example of self-disclosure as a way of normalising grief for client (p13).

Clinical practice:
- Loss enhanced practice (p.9).
- Ability to connect with clients due to shared experiences – knowing / understanding the feelings (p.11).

Difficulties:
- Experienced strong responses to clients / couples wanting to separate – wanted them to stay together having just lost partner to cancer (p.7).
- The delicate balance of being in touch with own pain but the focus remaining on client's pain (p.11).

The impact of client work on own grieving process and personal/professional growth – post-loss growth:
- Gained a sense of emotional maturity / grown up (p.9).

- More empathic, less judgemental, more present and able to enter others' worlds (p.9).
- Being present with others' losses is therapeutic for self (p.12). Continued processing of loss through providing therapy (p12). – process of change.

Research process:

There was the theme of 'judgment' throughout this interview, referred to in different ways through the narrative, and discussed openly towards the end of the interview.

Emerging themes – Eleanor

Fewer theme clusters as this loss was different in that participant did not know her nephew well and the loss stemmed more from supporting her sister through that loss.

Disclosure about loss:
- Disclosed as a way of sharing experience (p.7).

Difficulties:
- Feeling anger towards clients – example of a client parasuiciding (p.8).

Post-loss growth (professionally or personally):
- The time spent with sister on phone was experienced as 'training' – learning to sit with feeling helpless and that being ok (p.15).

Research process:
- My struggle with this interview – her incongruent presentation (laughter, silly voice) to the nature of material. What happened with this between us?

Emerging themes – Sally

Time off vs continuing clinical practice:
- Work as a way of coping with the loss (p.6), work as an escape and provides another focus (p.7).
- The need to keep going, both with training and with treatment – the parallel in both (p.6). See also p.12.
- Had to be able to compartmentalize (p.7)

- Importance of own therapy, supervision and good training (p.8).

- Feeling that continuing work was the "right thing to do" (p.10).

- Felt manageable to continue with that particular caseload (p.10).

- Chaos vs order – perhaps being in the therapy room was a more ordered place to be in an otherwise chaotic, uncertain world (p.10).

- The therapist is not just about their own loss – "I could use the other parts of myself" (p.10).

Retrospective observations of self:
- Own loss creating a stronger intensity or vulnerability (on a felt level) – more in touch with clients' stories and traumas (p.10).

- Own vulnerability gave a heightened sense of others' vulnerabilities (p.11) – similar to heightened empathy?

Difficulties:
- How hard it was to get into the room, to focus on someone else's problems but what a relief it then was to be in that space (p.7-8).

- A client presenting with miscarriage but participant remembers little about it (p.11).

Clinical practice:
- Hard to identify ways in which loss impacted on practice. Participant spoke of possible hindrances but that her feeling was the work was "good enough" (p.16).

- Own loss giving her a greater understanding of others' processes (p.19).

The impact of client work on own grieving process and personal/professional growth:
- An understanding of resilience, a better understanding of self (p.19).

- The mirroring of continuing work and continuing her pregnancy quest.

- Doesn't quite fit here, but that sense of not 'getting over' loss – learning to live with it (p.20). Is this intertwined with having trained and being a therapist?

Research process:
- Her holding back, not wanting to get 'too close' to the material. This reflects my experience of painful material as well. She refers to clients 'knowing' things – the collective unconscious – parallel process in interview about pain

and not being 'too much' in touch with it on my part. Something we created together.

<u>Emerging themes – Ann</u>

Time off vs continuing clinical practice:
- Initial time out was after mother's death – texted clients – cited "family commitments" (p.2).
- Returning to work after brother's death was about "getting back to life" (p.11). Life was a poignant word on several occasions given we were talking about death.
- Being able to, or needing to, integrate loss into self (p.12).

Retrospective observations of self:
- Feeling exposed – a protective layer of skin is gone (she refers to skin a few times in interview) and felt this more acutely (p.3).
- More focused, more challenging – a sense of 'you have a life you can live' (p.13/14).

Therapist disclosure about loss:
- Told clients about brother's death after discussion with supervisor (p.11)

Clinical practice:
- Does more 'checking out' to avoid misunderstanding or confusing her issues with the client's (p.5).
- Therapist's intense feeling of loss led to "the depth of feeling that I had communicated to her" – use of own experience to connect with client's experience (p.13).
- Being acutely aware of pain / hurt in a client because of own pain / hurt – heightened empathy (p.15).
- Awareness of own pain when with clients but that pain being "at the side" (p.15).

Difficulties:
- Feeling entangled with one particular client, leading to stopping the work with her (p.9).

The impact of client work on own grieving process and personal/professional growth:

- An area that participant had not considered, citing it as "an interesting thing to think about" (p.15).

Research process:

- The impact of the recency of her brother's death on me. Change to my demeanour / response to her – did I fear that it could become 'too much'?

Appendix 7

Development of themes

Analysis Round 1 (2011)	Analysis Round 2 (2015)
Returning to work:	
Factors in deciding to continue or take time off.	The **meaning** of clinical work.
Getting back to life (normality).	The **meaning** of clinical work.
Therapy as a different space.	Sense of **space** or **time**.
Impact of loss on clinical practice:	
Decisions around disclosure.	**Connection-Disconnection**.
Therapist vulnerability.	**Connection** – Vulnerability.
Therapist anger.	**Connection –** Anger.
Doing something different / offering something new to clients.	**Healing**.
Post-loss growth:	
Theoretical knowledge to embodied experience.	Embodying the **identity**.
Mutuality of healing.	**Connection** – Healing.
Ongoingness of grief and connection with the lost person.	**Connection** – **Time**lessness of grief.

Appendix 8

Superordinate themes with illustrative quotes

Superordinate theme	Interview	Quote
Connection - Disconnection Connecting through vulnerability	Greg	I was seeing all these other people [clients] who were bereaved as well, and what of course that meant was that at that moment, of course, my empathy was extraordinary. My ability to be understanding, be in contact with, really feel what they were going through because I was going through it myself, was very heightened. You can contact the client, you can really touch and feel and, you know, sense… in a way, your senses are heightened so, you know, I mean in some ways I may have been the best therapist there ever was just after that death. [The client] was much more able to go into her own vulnerability because I'd been vulnerable.
	Joe	I was just sad really, and quiet and… I think in a way it might have actually aided some of my therapy clients… that I can be engaging and I'm probably not as good at bringing out the kind of difficult stuff and I think maybe I felt more open to … open to other people's distress.
	Lyle	I am more able to be present with somebody else, to enter their world than ever I was before. I find it easier to work empathetically with clients. It is easier to connect and engage with them if my experience has something in common with theirs. I find it easier to share their world when we have some shared experience. Enrich that connection is useful. Feel his pain, her pain. I can feel my pain and I can understand what they are saying in terms of what I have been through and at least have some human connection with the

			experience they are bringing.
	Sally		It put me in touch with loss more…I felt a vulnerability…I wonder if I felt a stronger intensity.
			A heightened sense of people's vulnerability.
	Ann		The protective layer of skin [exposed]. Not that I felt I was fragile but that you just felt things more acutely.
			I think the depth of feeling that I had communicated to her was far more than most of the other things I've done with her!
			It's that feeling that when they're saying something hurts, you are acutely aware of what that hurt is.
			Because you've had that layer of skin taken away so you do feel pain slightly differently.
	Cara		Something would be going on for her [the client] and I'd support her through that – it was almost like I was giving a bit of therapy to myself.
			I was able to give her something that I felt was perhaps missing in my own therapy, which was obviously quite healing for me as well.
Connecting through healing	Greg		Being in touch with that kind of humanity does help you with your own grief…It helps you with your own bereavement because you see other people going through these pains. You're not alone. You're all connected.
	Lyle		A continuing healing for me too.
			I have continued to work on my own grief, my own loss as a result of being involved in therapy with people who have also experienced bereavement and loss.
			I am changed by the process of therapy as patients are changed by the process of therapy.

Connecting through anger	Greg	If anybody was doing anything slightly risky with their life, I noticed I'd get angry.	
		This was my anger, my rage against my brother for being so stupid as to kill himself…I found it leaked and I needed to be really careful.	
		I think it's good to challenge self-harm but it was charged.	
	Eleanor	I can remember being just so, so cross with her. I thought 'what right have you got to take your bloody life?'	
	Ann	I think the impact it's had is for me to become more focused, a bit more challenging actually.	
		I won't say I've allowed her to be passive but it's quite difficult when someone is passive, how do you get them to engage in the work? I think I've kind of gone 'no. no, I'm not going to let you wriggle out of this in any way'.	
		I think it's kind of like 'come on, it's now or never'.	
		You just kind of go 'Jesus, how can you sit there and still be…' I suppose it's accentuated.	
Disconnecting through grief	Hugh	I could go deeper with this, but where I am, I don't want to go to that emotional place with them.	
		I felt actually a bit emotionally exhausted at this moment.	
	Robert	I'm pretty sure he didn't come back and that maybe I was putting too much on him.	
	Sally	There's enough distance that's gone past but I could burst into tears at any moment…I'm holding back, I'm thinking it through.	
	Joe	I had a sense of somehow being able to switch off.	

Sense of Time / Space Lived space of the therapy room	Hugh	I think I just felt robust enough to go back into the therapy room.
	Robert	I moved out of those rooms in [town]…and decided to work from home. I had the conservatory built so now I'm working in a very different environment, much more peaceful, much more relaxing.
	Lyle	It was almost a matter of distraction for me in psychotherapy, to be in a room and paying attention to other people.
	Sally	I find it sometimes a real struggle getting there, getting into the room, the room bit, the therapy room, but once in it, the work began and my life, it did sort of shut the door on my life and that is a relief. …the door was shut and it was about someone else. I think sometimes my thinking was messier and there was something, as you say, 'structured' once in the room.
Lived experience of space	Joe	Luxuriously I took a taxi from West Hampstead to here because I didn't want to travel on the tube and be jolted about … I just wanted a bit of space. I took a bit of extra care I think and… I remember…just giving myself a bit more space and a bit more time to reflect on sessions. I remember doing that and actually the taxi ride was quite nice. A nice little space. It's a different space for me… Therapy, giving therapy. I just kind of forget about what's happened because I'm in a different head space. It might have been a bit of a psychic retreat maybe. I hadn't thought of that. Because one way of me containing it all the time I think was not to get lots of people saying [makes empathic sounds] and just [pause] a bit of space probably.

Meaning and Identity		
The meaning of one's work as a therapist	Greg	It was really important to stay in contact with my life and living.
	Ann	But actually – relief is not quite the right word – but getting back to life seemed the right thing to do.
	Joe	I think I understood – just like the laughing – it didn't discount what had happened at all. It just meant it wasn't present in my head. It's okay to kind of weave in and out of it.
		It might have been somewhat of a relief, I don't know. It might have been a bit of a psychic retreat maybe.
		Just me enjoying the work…the kind of stuff of life that I find fascinating.
	Hugh	It was a great relief just to be getting on with routine and just to be getting on with work and to feel that I was doing something … I was looking after myself and working, and it took my mind off those things.
	Lyle	I like to work. I missed the work very much. It's far and away the most satisfying thing I've ever done.
	Sally	I was and still am...involved and stimulated by the work so it was very much a part of my coping, part of the resilience that I could go in and carry on with it.
		It was really important to keep going. Because I had to keep going.
Embodying the identity	Joe	There was something about my dad that then losing him made me really appreciate something in me as a therapist.
		I think my dad was very good at relating to people and I think that's where my strength lies.
		Dad would have made a brilliant psychotherapist.
		There is something about maturation here I think. Just growing up, losing a parent. … I

166

		find it quite intangible, I find it really hard to describe. I just… I've experienced something that has made me feel all kinds of emotions. Has made me feel sad, has made me feel lost, has made me feel lonely, and lots of elements which I think, you know, changed me and changed my work. So when someone talks about loneliness or being lost in sadness, I get it.
	Lyle	I've grown up. I believe this experience contributed an enormous amount to my own emotional maturity. … I do actually understand something of loss and pain. … I think I am a better therapist for being able to understand that feeling.
	Robert	I think I've matured a lot. … I developed insight I think, sort of much more aware of myself, because I was much more – my own feelings were very stark and I guess that even with three years of therapy training, maybe I still hadn't really got very in touch with my own feelings. But I certainly did then and I have been ever since. … I think it makes me a better listener, insightful, intuitive. Intuitive particularly I think. I think because [loss] is such an overwhelmingly emotional experience. [pause] I used to be able to give [breaking away from medical model thinking] lip service, but maybe I found it difficult to believe until I'd actually had that experience. I was dropped into the deep end with the sort of emotional learning and what it really meant – not just sitting in a goldfish bowl in the middle of a room, but, you know, the actual raw experience.
	Greg	Not until I'd had this significant loss did I actually really understand what that really, really meant… It was shifting, I suppose, from theoretical to something much more embodied.
	Hugh	It's all something I can use and that I can know what that's like.

	Eleanor	It's all about being helpless, you know. This is what it feels like.