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**Alyson Coleman**

**A study into the experience of dramatherapists working with  
children with life-limiting or life-threatening conditions**

**Student number: M00244479**

**Doctorate in Psychotherapy by Professional Studies**

**Metanoia Institute. Middlesex University, London. School of Health and  
Education**

**Module code: 5360**

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For Ray Coleman  
1931 – 2000

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## **Abstract**

### **A study into the experience of dramatherapists working with children with life-limiting or life-threatening conditions.**

In order capture the tacit knowledge which dramatherapists bring to their complex work, this qualitative study explores their experience in the specific context of their work with children who have life-limiting or life-threatening conditions. Understanding this experience has implications for practice and is relevant to the particular needs of the clients. The study has resulted in the emergence of several products, including a play, bereavement Special Interest Group and a chapter in a book.

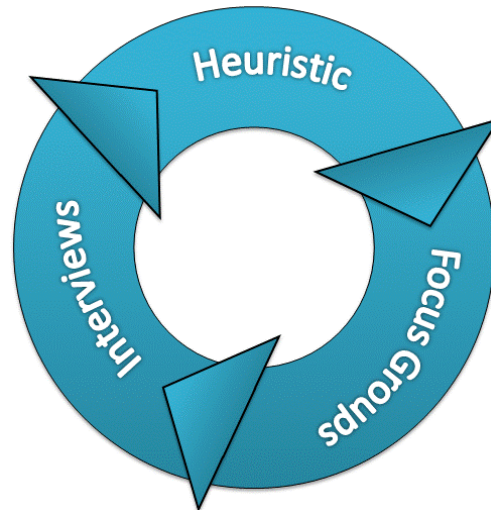
This three-phase project adopts a phenomenological practitioner-researcher approach through two key lenses: dramatherapy, and theories of children's bereavement. Heuristic inquiry in Phase One captures the researcher's personal experience of her practice, explored through creative methods, with themes being identified using Moustakas' (1990) six phases of data-gathering. Children with life-limiting and life-threatening conditions are supported by multi-disciplinary teams in a range of contexts; the themes identified in Phase One of the project were thus used in Phase Two to explore the experiences of school staff working in special education, of paediatric nurses, and of dramatherapists. Three focus groups were held to gain an understanding of the broader inter-disciplinary experience of these professionals, and thematic analysis (Silverman, 2011) was used to discover prevalent themes, which were then drawn down into the final phase. Phase Three involved in-depth interviews with four dramatherapists who work with this client group in different settings, with a view to gaining a richer understanding of their tacit knowledge.

Interpretative Phenomenological Analysis (Smith, 2009) was utilised to synthesise the themes from all three phases of the project, informing and shaping the development of a range of products for different audiences. The

devising, performance and evaluation of the play *How Do You Think I Feel?* is documented; the British Association of Dramatherapists (BADth) Bereavement Special Interest Group is discussed; and the co-authored book chapter 'Beginning, Middle, End, Beginning' is commented on. Finally, implications for future practice and training are explored and elaborated.

## Project Summary

A study into the experience of dramatherapists working with children with life-limiting or life-threatening conditions



Three phases of research design



## Products



Book Chapter



The Play



Article



Special  
Interest  
Group

## Project Timeline

	Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov	Dec
2008							Interview for programme			Start programme		
2009				RPPL ✓		Dyslexia/ dyspraxia diagnosis	Research Challenges ✓					
2010												
2011	PK 1: Maria Gilbert								Production 1: the play	PEP ✓	LA Present- ation	
2012			PK 2: Jeannie Wright	Special Interest Group 1  Programme Planning ✓		PK 3: Virginia Eatough  Research Presentation Badth/Sesame		Chapter published in book	Production 2: the play	PK 4: Holiday /Thomas  Focus Group 1	Focus Group 2	Focus Group 3
2013		PK 5: Souter Anderson	PK 6: Mona Livholts	Lecture given in Colin Murray Parkes series		Production 3: the play.		Interview 1	Interview 2	Interview 3	PK ✓	
2014	Interview 4									Submit large project		
	Phase One	Phase Two	Phase Three									

## **Chapter 1 – Introduction**

### **1. The researcher and the research theme**

Two birth certificates exist: the first bearing the name Alyson Jane Coleman, the second bearing Alyson Jane Victoria Coleman. As the family story goes, a swift baptism soon after my birth was carried out for fear that I would not survive. The matron at the hospital remarked that I had been ‘victorious over death’, so my parents added the middle name Victoria, and so began my life – and in a sense also my lifetime’s work. This project draws together the many influences that led me into this research, and which have contributed to my own story. It investigates dramatherapy with children who have life-limiting and life-threatening conditions.

Prior to this project, while working in a Pupil Referral Unit (PRU) for children excluded from mainstream education, I had noticed that invisible losses were often hidden behind acting out, destructive behaviour. It troubled me to see that such emotional distress, communicated through aggressive actions, frequently resulted in children hurtling towards punitive consequences and entering young adulthood with little education, a police record and a precarious, uncertain future. Often, as workers, we could only watch these events unfold, and I became uncomfortable with what Moustakas (1990) might refer to as a problem that will not go away. My process of being drawn to the issue of these children’s losses is reflected in the myth of Chiron, *Wounded Healer* (Pearson, 2013 – for the full story see Appendix 1), which describes the pull towards a wound we constantly try to heal in ourselves.

My experience led me to seek opportunities to put myself in positions where I was able to be more proactive, and to accompany children in their process of

loss and bereavement, offering something of myself and perhaps human compassion, and bearing witness – the importance of which is reflected in Frank's *Wounded Storyteller*:

What makes an illness story good is the act of witness that says, implicitly or explicitly, "I will tell you not what you want to hear but what I know to be true because I have lived it. This truth will trouble you, but in the end, you cannot be free without it because you know it already; your body knows it already". (Frank, 2013: 63)

Frank identifies an aspect of illness and death, perhaps echoing with my work, that is not easy or is 'too much' to articulate. Drama can offer a container to shake these stories out so as to view them from a different angle. This is illustrated in *The Story Bag* (Gersie, 1990 – for the full story see Disc 2, Track 1), which describes a boy who is told many stories but who does not share them with anyone else. The spirits of these stories are kept in a leather bag on a hook in his room, and as more and more stories arrive they become increasingly unhappy as they're squashed very tightly, eventually struggling to breathe. As time passes, the story spirits become angry and they plot to kill the boy, who has now grown into a young man. An old servant – who told the boy many of the stories over the years – overhears the story spirits whispering but is afraid that no-one will believe him if he raises the alarm, so he tries to protect the young man from the various attempts on his life. The old man's endeavours to save the young man are finally revealed and he is richly rewarded for having done a great service.

Nowhere is the 'shadow' – described by Jung as 'the thing a person has no wish to be' (Samuels, Shorter & Plaut, 1986) – more present than when faced with one's own mortality. Here, Jung provides guidance on how to engage symbolically with the prospect of death:

The mythic side of man is given short shrift [...] He can no longer create fables. As a result, a great deal escapes him; for it is important

and salutary to speak also of incomprehensible things. Such talk is like the telling of a ghost story, as we sit by the fireside and smoke a pipe. (Jung, 1983: 331)

The dramatherapist's work enables the client to speak about the unspeakable through the medium of drama. Not only does this give the client the opportunity to tell their story, but it also touches on mine: Jung suggests that 'between doctor and patient [...] there are imponderable factors which bring about a mutual transformation' (Jung: 1980). Practically and philosophically, the question "What will I leave behind?" is important both to the children I work with and to me personally. Legacy, therefore, is a significant aspect of bereavement work, and by contributing to this research both myself and those involved have created a form of legacy.

My interest in creativity and bereavement is longstanding, both personally and professionally. After spending my early adulthood training at stage school and then working within performing arts, I gained my Equity card by working with drama and elderly people in nursing home settings, and thought I had actually discovered something akin to dramatherapy as a result of the therapeutic impact the drama was having. After this organic discovery, and then being thrilled to discover that a method of using drama as therapy already existed, in 1995 I trained as a drama and movement therapist at the Royal Central School of Speech and Drama in London, and following 10 years as a dramatherapist in education, social services, educational psychology and health settings, I began work within the NHS in 2004, developing a Children's Bereavement Service for children with life-limiting or life-threatening conditions and/or their siblings.

Since 1999 I've also worked as a lecturer at the Royal Central School of Speech and Drama, where I'm involved with the Drama and Movement



Therapy (Sesame) MA course<sup>1</sup>. The combination of my ongoing NHS practical work and my lecturing post means I'm well placed to bring together both clinical and academic work within this project. Furthermore, I sit on two panels, the Fitness to Practice panel and the Continued Professional Development panel, and am also a registration assessor for the Health and Care Professions Council (HCPC – previously Health Professions Council), which ensures that the standards of conduct, performance and ethics (2008; see Appendix 2) are adhered to by arts therapist registrants.

In 2001, during my MA research at a Pupil Referral Unit into the use of story and role with children with emotional and behavioural difficulties<sup>2</sup>, I was struck by the high incidence of bereavement and loss among the boys referred to the arts therapy department, which was typically presented as acting out, aggressive behaviour and serious attachment difficulties (as discussed by Bowlby, 1980). In 2006 I completed the Postgraduate Certificate in Childhood Bereavement run by St Christopher's Hospice and Help the Hospices; as a result of this training I began to develop my practice, based on leading research such as Worden's Harvard Bereavement Study (1996), Colin Murray Parkes' psychosocial model (1971) and Klass, Silverman & Nickman's (1996) innovative ideas around forming continuing bonds. My final dissertation documented the new knowledge I had created through the integration of dramatherapy theory and child bereavement theory, and resulted in my first article on the topic being published in *The Sesame Journal* – entitled 'The Forgotten Mourners' (Coleman, 2006: 32 – see Appendix 3).

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<sup>1</sup> For course outline see [www.cssd.ac.uk/study/postgraduate/masters/](http://www.cssd.ac.uk/study/postgraduate/masters/) and for my staff profile see [www.cssd.ac.uk/staff/academic-staff](http://www.cssd.ac.uk/staff/academic-staff)

<sup>2</sup> MA dissertation entitled '*The Hidden Thing – Does Dramatherapy in a Pupil Referral Unit, focusing on story and role, offer children an opportunity to explore their personal issues?*'

In 2000, just before I took up my post at the PRU, my father had died suddenly and instantly from a heart attack<sup>3</sup>. There is without doubt an aspect of making sense of this event that remains present in my professional and personal life, and which remains embedded within my research influences and bias. Understanding these personal processes formed the key aim of my Practice Evaluation Project, which is explored in Chapter 5 of this project.

## **2. Context of study**

### **2.1. Dramatherapy**

Dramatherapy is defined as ‘a unique form of psychotherapy in which creativity, play, movement, voice, storytelling, dramatisation, and the performance arts have a central position within the therapeutic relationship.’ (HCPC, 2014)

In dramatherapy the drama gives voice to the therapeutic process. It’s an action-based intervention, employing movement (Laban, 1988), play (Slade, 1995), drama, myth (Campbell, 1993) and creative techniques. Relationships are formed within a therapeutic framework, facilitating change within the client’s inner world, which may then reflect and transform life experiences outside of the therapy space. The reflexive self is employed, with an emphasis on action and physical meeting being vital to personal identity and personal change. The dramatherapist works with the transference processes that inform the creative interventions; they may take on a role within myth enactment to enable the client to interact and challenge

---

<sup>3</sup> *Writing* about this event could not capture the enormity of my story. I would need to *tell* you what happened. Frank (2013: 159) stresses the importance of ‘what a listener becomes in the course of listening to the story. Repetition is the art of becoming. Professional culture has little space for personal becoming.’ This resonates with the art of storytelling and enactment within dramatherapy.

the role they themselves have been drawn to. This dynamic interaction enables the client and the therapist to meet through the symbol and archetype (Jung, 1983), allowing unconscious discovery and change to take place.

Jung emphasises the intuitive, creative aspects of the human being – the parts that participate in internal dramatizations found in fantasy, reflections and dreams. Arts therapies offer structures in which the client may translate the images of the unconscious into expressive forms, enabling dialogue with various parts of the psyche. Jones identifies three prime philosophical aspects that are key to dramatherapy: the connection with others; awareness of the roles we take in relation to others; and the embodied self (Jones, 2008). The way role works within my dramatherapy practice is illustrated in the chapter co-written with my job-share partner, Ali Kelly, in *Dramatherapy with Children, Young People and Schools* (2012), in which our co-facilitation of individual and siblings groups is documented (see Appendix 4).

Dramatherapy sits alongside art, music and dance movement therapies, and has existed as a profession since the 1930s (Jones, 1996). John Casson (1997) records its evolution from the 18th century through to 1989, when, in a significant development, the Whitley Council recognised dramatherapists within the NHS. Research within the arts therapies has grown, with training progressing from postgraduate diplomas to Masters qualifications and the development of research. Part of a survey conducted for the British Association of Dramatherapists (BADth) (Dokter & Winn, 2009) looked at the employment patterns of dramatherapists and found that 4.3% worked within the area of bereavement and palliative care, with nearly 25% working within Adult Mental Health settings. Since this research was carried out, interest in arts therapies and bereavement has increased, as indicated by well-attended workshops offered by BADth on the subject – including several that I have facilitated on the topic of child bereavement.

The professional landscape for dramatherapists in the UK encompasses employers, professional bodies and legislation. Employers include the National Health Service (hospitals, community services); the Department for Education (schools, universities); social services (learning disability day centres, adoption and fostering departments); the voluntary sector (hospices, charities for children); the private sector (private hospitals, corporate workplace); and the independent sector (private practice). The key professional body, which it is mandatory to join in order to practice as a dramatherapist in the UK, is the Health and Care Professions Council (HCPC). This body monitors codes of practice (see Appendix 2) and Continuing Professional Development (CPD), and maintains standards of education, training and proficiency (see Appendix 5).

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care through the development of evidence-based data, which informs professional practice. BADth disseminates good practice through an annual conference and through training events; it also supports forums for research and Special Interest Groups (SIG), and contributes to development through liaison with HCPC and other arts therapies professional bodies. The profession is also supported by the Sesame Institute – a registered charity that promotes the use of drama and movement in therapy – and by the European Consortium of Arts Therapies Education (ECArTE), which, with a membership of 36 universities in Europe, develops standards of education and training in the arts therapies through conferences and publications.

A range of legislation, frameworks and initiatives underpin dramatherapy practice: the Children Act (2004) is central as it provides a framework for ensuring the welfare and well-being of children (such as in Every Child

Matters), while the Health and Social Care Act (2012) places clinicians and practitioners at the centre of the commissioning and shaping of services.

## **2.2. The Sesame model**

There are several models of dramatherapy, but this research refers to a specific way of working – the Sesame Approach – in which I was trained and to which I contribute in many ways as a trainer and lecturer. The key features of this approach are captured in Kharis Dekker's summary:

Sesame's method is to engage the body creatively and allow the emotions spontaneous expression within the freedom and protection of role and metaphor. We do not go into personal material at a factual or literal level but rather find the symbolic equivalent or metaphor for the emotion. To approach issues through metaphor, where images stand figuratively in the imagination, allows for privacy of personal interpretation. It is possible to recognise and come to terms with inner problems through this indirect method, which is less exposing than a more confrontational approach and more likely, for this reason, to catch the hidden thing. (Pearson, 1996: 40)

## **2.3. Children with life-limiting or life-threatening conditions**

This project specifically concerns pre- and post-bereavement support for children with life-limiting and life-threatening conditions, and for their siblings. These conditions are defined by Chambers as follows:

Children are usually said to have a 'life-limiting condition' where there is no reasonable hope of cure, and a 'life-threatening condition' where the possibility of cure exists. The term 'life-limiting' is also used to describe the fact that the child or young person's life can be limited in scope. There is further complexity in that the term 'life-threatening' is the more inclusive of the two as it encapsulates all children who may die, but it is also used to describe a very precise point in the illness trajectory when a child has a 'life-threatening' episode and there is an immediate threat of death. (Chambers, 2013: 4)

The current trend in bereavement support is generally based on a community model where support can be gained from existing networks, such as school, church and so on (Stokes et al., 2004). The majority of children's bereavement services in the UK offer support to children and young people who have experienced the death of a family member or someone they have a strong attachment to, and tends to take place in community settings with the aim of facilitating support for bereaved children from within their existing networks. This support does not necessarily work with the symbolic nature of unconscious material that a child may present, and contrasts directly with an arts therapies approach, which emphasises psychodynamic processes within the therapeutic relationship.

By contrast, children's hospices offer a comprehensive range of pre- and post-bereavement support to siblings and families. This support is often in the form of play therapy with the child who is unwell and then, after they have died, irregular contact might be maintained for many years if the family wishes, through sibling days, social activities and memorial events often held around Christmas – The Candle Project<sup>4</sup>, for example.

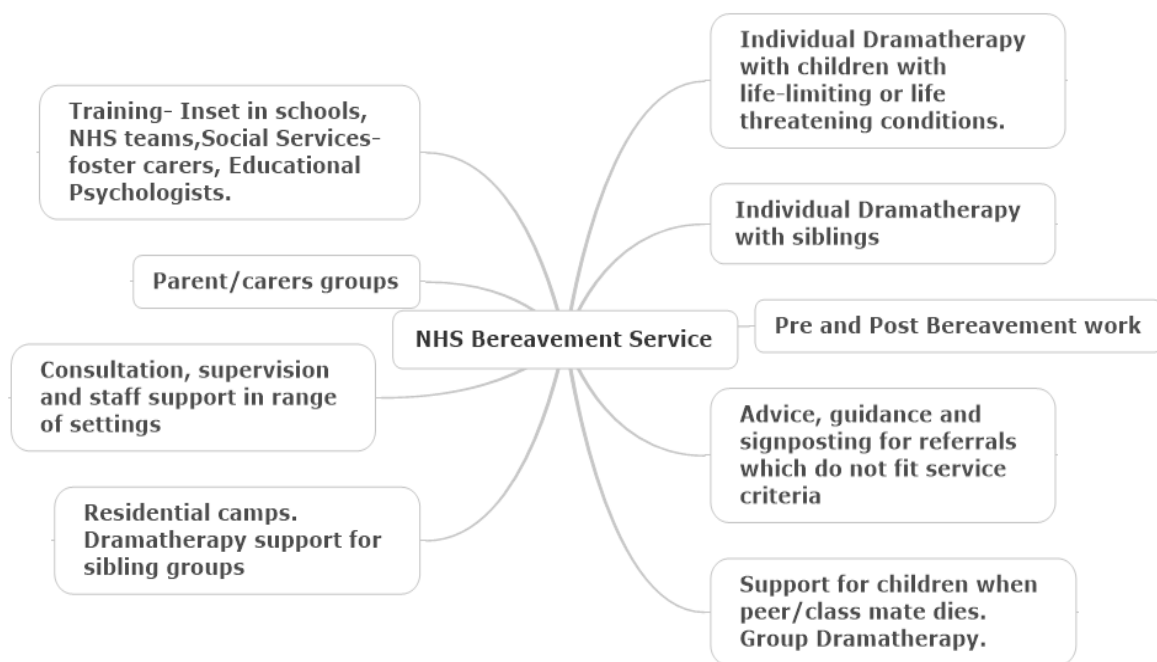
In my view, the arts therapies are particularly suited to the complex grief issues of children with life-limiting and life-threatening conditions as they work at a symbolic level, enabling the child to process the enormity and the often overwhelming aspects of serious illness.

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<sup>4</sup> For more information, see [www.stchristophers.org.uk/candle](http://www.stchristophers.org.uk/candle)

## **2.4. NHS Children's Bereavement Service**

In 2004, Ali Kelly (a dramatherapy colleague) and myself responded to a call for initiatives from the clinical team leader of a paediatric community service. The call invited ideas for setting up support for children and young people up to the age of 19 years with life-limiting and life-threatening conditions, and for their siblings. We proposed a series of dramatherapy projects, which were selected and then implemented. As a result of this, core funding from the NHS was provided for the establishment of a permanent service, integral to the community team. Central to the ethos of this service is the notion that dramatherapy forms part of a holistic approach to children's palliative care within a community health service. The therapy fits with the ethos of palliative care defined by the Association for Children with Life-Threatening or Terminal Conditions and Their Families (2003) as it 'embraces physical, emotional, social and spiritual elements and focuses on enhancement of quality of life for the child/young person' (ACT, 2003) (Kelly & Coleman, 2012).



**Figure 1: NHS Children's Bereavement Service**

The service has evolved around the needs of the children, offering individual, sibling group and whole-class dramatherapy sessions as illustrated above. The team also offers a programme of Bereavement, Loss and Change training within education and health settings. For certain conditions – such as neuro disabilities, leukaemia, juvenile Huntington's disease and progressive brain tumour, among others – the clinical work may be pre-bereavement (or post-bereavement with siblings). Other conditions can result in profound physical and learning disabilities, which can mean clients not using speech as a primary form of communication. Children may have been born with these conditions (such as cystic fibrosis), and obviously this affects the nature of the dramatherapy intervention. Therapy with these children can involve maintaining good mental health and moving through child development stages; this contrasts with dramatherapy interventions with children who *develop* an illness, such as cancer, with whom the work may be of short duration. Here, the beginning of the work often concerns trauma and



shock, and where there is time, work might include processing the illness and its impact.

Fig. 2, below, illustrates a typical case within the context of my bereavement service work, including the unique method of combining co-facilitation with siblings, as well as the individual work, which has developed organically within the service. Jason – a boy with a life-limiting illness – and his sister Sophie is a constructed case. The method of representation is used effectively by Yalom (1980), and the vignettes contain patterns and themes that have emerged from actual sessions (Kelly & Coleman, 2012). The service developed a new model of work – that of integrating dramatherapy with child bereavement theories – as explored in the dissertation submitted as part of my Postgraduate Certificate in Childhood Bereavement.<sup>5</sup>

### ***Examples of referrals within one family\****

*\*commentary provided in bracketed text*

***Name:*** Jason Smith

***Age:*** 11

***Referrer:*** Head of Year, Special Educational Needs school

***Reason for referral:***

*‘Jason seems very unhappy at school. He gets frustrated and angry with staff and other children. He has deteriorated physically, and is finding writing, computers, anything to do with his hands, very difficult. His mobility in general has become significantly impaired. He seems isolated and withdrawn. The staff are concerned that he is keeping his fears and questions about dying to himself.’*

***Background information:***

*Jason was diagnosed with a life-limiting, degenerative condition at a young age. The dramatherapy took place at the Special Educational Needs school*

<sup>5</sup> I was on the first postgraduate-level course in the UK to focus on child bereavement.

*that he attends, after he transferred from mainstream school because of his medical needs. He lives at home with regular short breaks at the children's hospice.*

**Name:** *Sophie Smith*

**Age:** *9*

**Referrer:** *Head of Year, Special Educational Needs school*

**Reason for referral:**

*'Mrs Smith mentioned to the nurses that she is worried about Sophie, who is complaining of tummy aches in the mornings and not wanting to go to school. She has become very clingy to her mum.'*

**Background information:**

*Sophie has grown up knowing that Jason has special medical needs. Nurses and hospitals have always been a part of family life. She has seen his health deteriorate and notices his loss of mobility and changing body.*

**Family information**

*The Smith family are Church of England, white British, with no underlying physical or mental health difficulties. Grandparents and an aunt live nearby and there are no major difficulties in the respective families of origin. The family home has been adapted for Jason's needs. They have a good collaborative working relationship with health, education and social services. Mr Smith is in full-time work; Mrs Smith works part-time.*

**Dramatherapy support**

*(Rhythms of sessions within the service vary according to the specific circumstances of the children. Initially there may be weekly sessions, followed by less frequent appointments and then a return to a more intense intervention at times of crisis or change. A child may be affected by their condition for a long period of time – often years – so the service has developed sustainable ways of 'holding' the therapeutic process with the*

child or young person. The child is then able to draw upon this work when needed, knowing that there will be more sessions on specific dates in the future.)

*Following an initial assessment with the Smith family, and information-gathering from the health and education professionals involved, dramatherapy sessions commenced within two weeks. A working alliance was established (Hawkins & Shohet, 1989). The dramatherapists were involved with the family for a two-year period in total, before and after Jason's death.*

*Jason had a combination of weekly and fortnightly sessions at school, at the hospice and at home, including three joint sessions with Sophie several months before he died. The children worked with the Japanese story of The Chestnut Tree in shared and individual sessions (Singh and Cann, 2003 – see CD 2, Track 2), which is a story about a young girl whose father dies at sea. In order to support her ageing mother the girl has to find work in a town far away, and during the daily journey she befriends a beautiful chestnut tree, which offers her comfort and strength over many years. When the tree tells her it is to be cut down and made into a boat for the prince, and that it is time for them to part, she tells herself it was just a bad dream. But the tree instructs her to come and find the boat, which it says will not move until she is reunited with it. One day, during a big storm, the girl runs for shelter – only to discover that her beloved tree is indeed gone and it had spoken the truth. The girl weeps and collects chestnut leaves to remind her of her friendship with the tree, but life was never the same again. One day, in the town, she sees the prince attempting in vain to launch his fine new boat in front of the entire town's people. As the tree had predicted, the boat would not be moved until the young girl came and whispered words of greeting, and touched the chestnut wood. The crowd fell silent as they witnessed this moment.*

### ***Individual dramatherapy with Jason***

*Jason was particularly drawn to the part of the story where the girl discovers the tree has gone. He objected strongly to the fact that the story didn't give the detail of what had happened to the tree. Where had it gone? He accused the therapist of 'forgetting' that part, of getting it 'wrong' and 'not telling that bit on purpose'. Over many sessions Jason brought several contrasting versions of what may have happened to the tree, which were enacted with the therapist. (Worden, 1996, suggests that children will fantasize about illness and death if they are not given age-appropriate information.) Enactments enabled Jason to explore his thoughts and fear, which previously he had felt unable to share verbally.*

### ***Vignette***

*Jason becomes the prince. The prince is very powerful and arrogant. He treats his servants very badly, calling them useless and stupid. The dramatherapist is directed to become one of the servants, who is humiliated by the prince. Jason directs the therapist in this role to become more and more incapable: the servant drops the food and drink he's serving; he doesn't get the jokes the prince tells him; he's too slow to catch the prince's very expensive horse that runs off and is lost.*

*The session seemed to be about actual loss of bodily function and independence in the present. This aspect of the condition was incredibly difficult for Jason to deal with. It affected each and every relationship. His family, friends and school staff responded in different ways – from obvious distress to denial. Observing him daily losing the ability to grip objects, speak and move was so difficult for him and others that he became very isolated. The child's emotional and spiritual maturity may contrast sharply with their physical limitations and lack of independence. As a toddler, Jason ran,*

*moved and played. He remembers this somatically, cognitively and emotionally.*

*The part of the story Jason chose to create and enact enabled him to explore being the master and the servant. The prince may have represented his illness, which is often 'in charge', and the servant represented the functioning part that endeavours to carry on and get things done. The servant is capable but restricted by the prince's demands and limitations.*

(Dramatherapy has the potential to move and change quickly; through the spontaneity of drama, the therapist can attempt to keep up with and accompany the child through the rapid changes of feeling and perspective that emerge from their process.)

'A child can soar like a bird to experience a freedom she'll never know, or a child can become death itself in order to face her darkest fears.' (Bouzoukis, 2001: 229)

*Dramatherapy enabled Jason to embody a range of conflicting archetypes (Jung, 1968). Within Jason's solo journey, he was able to create a landscape where friends and foe could battle and engage in dialogue. This appeared to lessen his isolation at a meaningful level, as his impossible-to-voice fears and questions were brought into the creative work. On several occasions this included directly talking about his death, his life and his legacy.*

### ***Individual dramatherapy with Sophie***

*Sophie was in Year 5 at the local primary school. Jason also attended this school until he transferred to a Special Educational Needs school that could accommodate his physical and medical condition. Both dramatherapists met with Sophie's teacher and Special Educational Needs Co-Ordinator (SENCO). (Rowling (2003) acknowledges the importance of school as a*

community that provides security and continuity, and as a place that can offer comfort and healing during times of emotional change.)

*The dramatherapy work with Sophie offered her support with the actual daily experience of Jason's deteriorating health, and it also looked towards the phases of Sophie's experience. Dramatherapy sessions can provide an opportunity to explore the theme of maximising life in the face of death; in Sophie's individual pre-bereavement dramatherapy sessions she had been able to express her feelings of anger, embarrassment and confusion about her brother's condition, and her worries and questions about his increasing disability. In their joint sessions, Sophie had been able to share some of her questions and fears with Jason. Over time, in her post-bereavement sessions, she was able to explore the theme of developing a new relationship with Jason (Klass et al., 1996).*

*After Jason's death the school requested staff training from the bereavement service. (Silverman (2000) suggests that effective support strategies can increase resilience in the grieving school community.) There was anxiety amongst staff about what to say to Sophie and how to respond to questions from her peers, so the therapists delivered the training before Sophie's return to school. (Teachers and school staff can be a valuable resource for children when death affects a school community (Dyregrov 2008).)*

*The session offered practical ways to support the children, and was an opportunity for the entire staff – teaching and non-teaching members, many of whom had known Jason since his first day at primary school – to share their memories and grief. The therapists spoke to the head teacher about risk assessment in terms of other children and staff for whom Jason's death might have a significant impact. (Both Capewell (2004) and Yule (1993) emphasize how previous deaths are relevant to our responses to current losses.)*

*During Sophie's first session after her return to school, Jason's death was acknowledged by the dramatherapist. They also discussed Jason's death at the hospice and when the funeral would be. (For many children it can be a relief to know what information the adults have about their situation; clarity around communication forms an essential part of the working alliance. Gersie (1987) supports the idea that children need to know how the therapist will liaise with other significant people in their life.)*

### ***Vignette***

*'Jason knew he was going to die.'*

*Sophie told the therapist that her parents had explained to her that sometimes Jason had been very ill and got better, but this time the doctors and nurses could not make him better. She said that sometimes when she woke up in the mornings before he died she used to tell herself that she had imagined it or made it up.*

*The therapists reminded her of the story of The Chestnut Tree that they'd worked with in several joint sessions with Jason towards the end of his life – specifically the part where the tree tells the young girl that it's going to be cut down and warns her that they will be parted. The girl tells the tree, 'I had a bad dream; I dreamed that the prince had given orders to cut you down.'*

*Sophie said that she didn't remember that part, and asked the therapist to tell her the story again. She wrapped some fabrics around herself, put a large piece of lycra over her head and was very still as she listened to the story. Then together they retold the story using the parts that Sophie remembered. The therapist invited her to enact some of the story; she chose the part where the prince gives his orders for the tree to be cut down, but said, 'I don't want to hear the words.'*

*The therapist was directed to be the prince and Sophie chose to be a guard. They enacted that moment from the story, then the therapist asked if Sophie wanted to swap roles; she did not want to. She requested to repeat that part three times; she gave the therapist instructions on how much emotion the prince was to show. The first two attempts were 'not angry enough!' She was able to use her body for the therapist to mirror the movements of the prince and the look on his face (Jones, 1996).*

*Sophie then wanted to enact the same part, but this time she asked to be the girl sleeping and the therapist to be the prince, again giving the order to cut the tree down using words and sounds. They repeated this several times and then she got up from her 'sleeping' position and started to bang the drum and shake the rain stick, getting louder and louder until the prince's voice could not be heard. She put all the drums in the middle of the room and told the therapist, 'You aren't the prince anymore, you're the forest, we are the forest and we hate the prince! We have to make the storm so loud that no one can hear the prince!'*

*There followed a lengthy period of banging and crashing of drums, cymbals and rain sticks. Sophie was able to articulate strong emotions with the use of sound, percussion and embodiment. (Using sound can enable children to access emotions, and embody them, where words are inadequate or hard to find (Pearson, 1996).)*

*'The tree was trying to warn her. That's the end for today,' said Sophie, as she was putting on her shoes to go back to class.*

*During this session Sophie had found a way to embody her anger and to symbolically pose philosophical questions: Why does this have to happen? Why did Jason die? The story provided a container for her overwhelming range of emotions, and supported her to integrate the healthy process of*



*oscillating* (Stroebe & Schut, 1993) *between restoration and loss*. (As Stokes (2004) observes, this may happen more rapidly for children than for adults.

The Dual Process Model (Stroebe & Schut, 1999) introduces the concept of oscillation between those coping behaviours that focus on the loss and those that focus on the future, with both being important for adaptation and finding new meaning in the loss. It's a framework that forms an important part of the theoretical underpinning within dramatherapy bereavement work; it's also used as part of an assessment for a healthy, self-regulating bereavement process. It's derived from empirical research whose conclusion is that avoiding grief may be both helpful and detrimental. To manage daily life, Sophie needed to take time off from the emotions of grief, which may otherwise have been too overwhelming (Worden, 1996).)

*Sophie returned to the weekly pattern of dramatherapy sessions for a term at school, and at the end of this period a dramatherapy report was written for the school. Several follow-up visits with Sophie and her family were then booked in advance over the next few months, and regular telephone conversations took place with her teacher to offer information, support and guidance.*

**Figure 2: Extract from book chapter**

### **3. Value of the research**

The core aim of this research is to improve the care given to children experiencing life-limiting and life-threatening illness, and to their siblings who may be experiencing loss. Future research may foreground the child's experience; during the design of this project I considered a similar, secondary or possibly parallel research project, such as 'What is the experience of

**children** with life-limiting or life-threatening conditions working with a **dramatherapist?** However, I considered it essential to develop further research skills and be part of the process myself before foregrounding potentially vulnerable clients.

To experience loss is to be human. It is also painful. Bowlby (1980) identifies the pain of witnessing such loss in another:

The loss of a loved person is one of the most intensely painful experiences any human being can suffer, and not only is it painful to experience, but also painful to witness, if only because we're so impotent to help. (Bowlby, 1980: 7)

Yet what of the unconscious, emotional and somatic experience of the therapist? If death is present in all therapy (Yalom, 1980) then close attention to the experience of the therapist may deepen and enrich the therapeutic work, and may support the therapist to remain healthy and alive whilst working so intimately with loss. By investigating the experience of dramatherapists working with children with life-limiting or life-threatening conditions, this study will offer insight into the therapist's process and encourage reflective thinking amongst the spectrum of professionals involved in this work. Its aim is to explicate therapists' specialist tacit knowledge in order to enrich therapeutic work by addressing the needs and interests of therapeutic practitioners.

In McLeod's research (2003: 2) in the field of counselling, he argues that there are five important reasons for doing research, all of which are directly relevant to this project. Firstly, 'gaining a wider perspective' – I recognised that in order to make a valid contribution to professional knowledge I would need to use an interdisciplinary approach to deepen my understanding of my professional context. Secondly, 'accountability' – I constantly questioned my own accountability for the work, and this research is a proactive endeavour to

express my sense of responsibility to myself, to the clients and to my profession. Thirdly, I'm at my happiest when 'developing new ideas' – using my creativity, my organisational and communication skills and my ability to drive projects forward on a daily basis to tackle unpredictable problems.

McLeod further argues the importance of applying research findings 'in new areas' – I've used professionals outside of dramatherapy to develop my products; for example, Adult Mental Health practitioners in a psychiatric setting. Finally, as a 'senior practitioner [...] seeking to consolidate [my] professional identity' – dissemination of the research through the opening up of its products for critical scrutiny by stakeholders both inside and outside the immediate professional field has attracted interest and dialogue, and has raised my profile in the profession. What McLeod omits as an important reason for research is its contribution to closing the gaps in existing knowledge, and the literature search for this project revealed that there is little published work in this complex area.

#### **4. Research framework**

As a senior practitioner in the field, I've aimed to spotlight the research aspect of my practice. Practice and research are inseparable; I therefore view this research through a dramatherapy lens. This qualitative, phenomenological research focuses on the dramatherapist's experience through hermeneutic and feminist lenses, using a reflexive, practitioner-based approach. The rationale for the choice of this framework is given in Chapter 3 (Research Design), and the methodologies and approaches used at each phase of the project are explained as they occur throughout the project.

## 5. Conclusion

‘New knowledge always begins with the individual.’ (Nonaka, 2008: 10)

This project began with an exploration of myself as an individual therapist, but its legacy is for the dramatherapy community. An intended outcome of the research is to make a contribution to the theory and practice of dramatherapy. As McLeod points out:

“Experiential knowing’, or ‘knowing how’, can be a valuable outcome of an inquiry process, but research always involves communication with others. Learning can occur at an individual, intuitive level, but research requires the symbolization and transmission of these understandings in the public domain.’ (McLeod, 2003: 4)

While the focus of the research is on the specific client group of children with life-limiting or life-threatening conditions, it has value for wider definitions of loss (such as the impact of separation from parents through divorce, prison or adoption). The main stakeholder, therefore, is the dramatherapy community.

The diversity of outcome and impact of this research is reflected in the products that emerged during its phases. The direct impact for the dramatherapy community can be seen in all of the products, but particularly in the Dramatherapy Special Interest Group and in the play; these products have all rippled out into wider contexts, such as European arts therapies, adult psychiatric professionals and religious communities (which are discussed in Chapter 8).

The book *Dramatherapy with Children, Young People and Schools – Enabling Creativity, Sociability, Communication and Learning*, in which Chapter 12 is co-written by myself and my job-share partner Ali Kelly, is

aimed at a multi-disciplinary readership of therapy, education, social care and health care professionals. Telling or hearing any story has an impact – on the teller and on the listener. We are inevitably changed in some way when we engage with others. After much investigation into how to develop my research interests and skills, I carefully selected the Doctorate in Psychotherapy by Professional Studies at Metanoia Institute in order to create a framework within which I could develop, house and share my dramatherapy practice.

Dissemination is not necessarily a concept that sits with this project, as it implies (by my interpretation, at least) a final stage – something to be done after the project is finished, when the research findings are ‘put out there’. In contrast, my research findings have been constantly woven back through the dramatherapy community. The final products, as such, are a true synthesis of my discoveries. As an audience member fed back after witnessing the performance of the play: ‘It was alchemy. Hardened alchemy.’ (ECArTE conference, Lucca, 2011 – see Appendix 6). This comment resonated with me as it captured the transformation that occurred when research participants’ experiences were brought together through the research process, and a change in understanding occurred for me and for them. An impact occurs and something new is created.

Chapter 2 contains a review of the literature that is pertinent to this research, and contextualises it around the themes of bereavement, the Sesame Approach, dramatherapy with children with life-limiting and life-threatening conditions, and dramatherapy and bereavement more generally. It continues with play therapy literature in children’s hospice settings and arts therapies in adult hospices. Creativity and death, and finally psychotherapy and death, are also reviewed. The research design is detailed in Chapter 3, including the methodology, resources, the project team and signatories; and Chapter 4 contains an overview of the ethical considerations of the project as whole.

Chapters 5, 6 and 7 elaborate on different phases of the research: Chapter 5 offers an in-depth record of Phase One and my heuristic process; Chapter 6 details Phase Two with the focus groups, and Chapter 7 features Phase Three individual interviews with four dramatherapists. In Chapter 8 I discuss the products that emerged from this research and analyse the ways in which the findings and dissemination of these products (a play, a published chapter and the Dramatherapy Bereavement Special Interest Group) have impacted on my practice and on the profession as a whole; and finally Chapter 9 draws together the project and contextualises it within future activity.



**Figure 1: *By The Moon***

6

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<sup>6</sup> I worked with *By the Moon*, painted by Lindsey Kerr, in supervision (January 2014) during the final few months of my project. Amongst many things I see qualities of wonderment, adventure, future, companionship and vastness, and I link these with core experiences within the research process.

## **Chapter 2 – Literature Review**

### **1. Scope and context**

To contextualise this project in existing literature is also to contextualise myself. Drawing together the influences of others' voices, heard in articles and books, seen in theatre and image, I am acutely aware of the true meaning of the researcher being at the centre of the project. The key themes in my Professional Knowledge (PK) paper (2013) continue to resonate through this literature review: explication of tacit knowledge and making the research my own; and how, throughout the project, I am constantly in the process of bringing this to the page. This chapter contextualises my existing knowledge in relation to others' knowledge. The shape of this project is influenced by my relationships with, and the ideas and theories of, others. As I connect and disconnect with these influences, the research develops as my own.

Writing a linear academic literature review within a reflexive project feels ill-fitting and difficult, like Cinderella's ugly sister cutting off her own heel and toes to make the shoe. My relationship with many of the following texts has evolved and deepened; they've been walked around and viewed from different angles with the passing of five years of engagement. I engaged with this 'literature review as literary research' (du Plock, 2013: 64) partly following my instincts and partly carrying out a systematic search, which resulted in the identification of several themes of relevance. This chapter is organised into categories that reflect these themes: my research lens; dramatherapy and life-limiting and life-threatening conditions; dramatherapy and bereavement; play therapy and children with life-limiting and life-threatening conditions; arts therapies in adult hospice settings; creativity and death; and psychotherapy and death. Specific literature on heuristic research, focus group research

and interviews, and the themes that emerged, can be found at the start of Chapters 5, 6 and 7 respectively.

Death is a highly personal matter and I therefore compile this review from an insider's perspective, using the parts that go to assemble myself as a practitioner-researcher: dramatherapist, lecturer, supervisor, family member, friend, and a bereaved person.

## **2. Themes**

### **2.1. Bereavement**

This literature review will not cover the full extent of bereavement theories, as the research is about *dramatherapists'* responses to and experience of the client's bereavement. However, my practice – and therefore this research – is inevitably underpinned by the work on theories of children's bereavement by Stroebe & Schut (1993), Klass, Silverman & Nickman (1996) and others (see bibliography in book chapter in Appendix 4); and these form one of the lenses for this research.

The Dual Process Model (DPM) of Stroebe & Schut (1993) is based on the recognition that isolation of the pain of grieving from the restorative tasks of getting on with life is necessary during the grief process, and Stroebe (1993) suggests that the arts can regulate this oscillation between the two aspects of grieving. Particularly in the first, heuristic phase of this research, I experienced oscillation between complete emotional immersion in the process and the detachment needed to carry on with day-to-day life; in this sense it mirrored the client's grieving process, as outlined by Stroebe. McGuinness & Finucane (2011) include this model in their design and evaluation of a creative arts bereavement support group run at an adult



hospice, offering a relevant example of how useful the DPM can be as a framework for thinking, noticing and facilitating practical work.

Klass, Silverman & Nickman's (1996) term 'continuing bonds' describes the development of the relationship with the deceased. Dramatherapy is grounded in the exploration of the texture and experience of relationship (Clarkson, 2003); this directly contrasts with Freud's (1917) concept of breaking all ties with the person who has died in order to move on with life. Summarising all of these developments, Parkes (2010) offers a thorough review of the evolution of research, theory and practice of bereavement support, which has provided an invaluable contextualisation of my practice.

## **2.2. The Sesame Approach**

Key aspects of the Sesame Approach, which is central to my work, are threaded through this project, and thus it warrants some reference as a key research lens.

Marian R. Lindkvist, known affectionately within the dramatherapy community as 'Billy', is founder of the Sesame Approach to Drama and Movement Therapy. Having read *Bring White Beads* (Lindkvist, 1998), I now return to it with a new curiosity and deepened respect. Billy, now in her 90s, describes her early research – funded by *The Readers Digest* (!) – with the Zulu people of South Africa, and her visit to a traditional healer who called upon the 'shades' during rituals. This prompted me to further research Ubuntu Psychology (Washington, 2010), which acknowledges the spiritual essence of self and others. The holistic approach that Lindkvist went on to develop has at its core exploration of the body and mind through movement, ritual and stories. It also incorporates the philosophies and theories of certain key psychologists and practitioners, including Jung (1983), Laban (1988) and

Campbell (1993). Those aspects of their philosophies and practices that contribute to this research are discussed below.

At its most basic, this project is about the polarities of life and death and the therapist's encounters with the healing symbols between those two opposites. Jungian analysis aims to bring about transformation through the 'transcendent function', consisting of a slow process of growing self-awareness whereby a number of polarities (expressed unconsciously by the conflicts that tear us apart) become conscious and are reconciled by a 'third' which transcends them – that is, the healing symbol. The word 'symbol' comes from the Greek word *symbolon*, meaning 'that which has been thrown'. It describes the two halves of an object that two parties broke between them as a pledge to prove their identity when they meet at a later date. The symbol therefore is the missing piece of an object that corresponds exactly to the psychological function of a symbol (Tuby, 1996).

Jung led the way in encouraging his patients to paint or dance in order to explore the images that emerged from their unconscious. Dramatherapy, contained by the therapist's creation of therapeutic space, activates and encourages work with symbols. There may be conscious elements or unconscious dialogue between the therapist and client. Jung devised a method, called 'active imagination', of cultivating the symbol, and this influences arts therapies methods. Jung developed the idea that below the layer of personal unconsciousness there exists a layer of human experience that is common to all, timeless and universal, expressing itself through myths, fairytales and rituals. These are the dramatherapist's toolkit, and they form the archetypal motifs of the collective unconscious described by the early poets, artists and mystics. Dramatherapists facilitate these expressions intuitively, travelling alongside the client and facilitating the material of the collective unconscious through the metaphors contained within aspects of drama.

Laban's techniques enable dramatherapists to observe and respond therapeutically to clients as the body bridges the internal and external worlds:

Each phase of a movement, every small transference of weight, every single gesture of any part of the body reveals some feature of our inner life. (Laban, 1988: 19)

Movement connects the outer bodily process with an inner psychological process. Laban's fundamental idea is that the body speaks its own language; his approach to movement observation and analysis enables the exploration and development of each client's unique movement vocabulary. The Sesame Approach engages the body in a dramatic context through play, improvisation, character work, and story and myth enactment. Myth, fairytale and story enactment, as illustrated by the practice vignettes in Chapter 1, are especially effective tools in therapeutic contexts.

Campbell develops Jung's ideas of the psychological importance of myths, and explores the concept of the indirect, oblique approach, whereby rather than focusing on a person's immediate behaviours and symptoms, working with the unconscious can offer a creative and metaphorical context to a problem:

Through our dreams and through a study of myths, we can learn to know and come to terms with the greater horizon of our own deeper and wiser, inward self. (Campbell, 1993: 15).

Not only can dramatic work help to catalyse individual creativity, but it also offers a means to explore culturally specific experience through the symbolic images contained in mythology. Cultural sensitivity is crucial to the work of dramatherapists in general, and in particular to the research participants and to myself in a place as culturally diverse as London.

The Sesame Approach enables the dramatherapist to work with clients who may not be able to speak and are thus unable to access other types of counselling and therapy, as well as to work with children who have life-limiting or life-threatening conditions, with whom it is not always possible to talk directly about the enormity of death.

### **2.3. Dramatherapy with children with life-limiting and life-threatening conditions**

There is a wide literature dealing generally with the topics of bereavement, child bereavement and arts therapy. There is, however, limited literature exploring dramatherapy with children who have life-limiting or life-threatening conditions. There is only one text on pre-bereavement work with chronically ill children: Carol E. Bouzoukis' *Paediatric Dramatherapy* (2001). Through case study and the use of Landy's Taxonomy of Roles (1993), Bouzoukis documents the children's participation within sessions. She does not document her own experience, focusing only on the children's engagement. This is very useful to the research as it offers insight into the client process and details therapeutic material selected for sessions; but it contrasts with the path I have chosen. My research therefore offers a unique perspective on this work for the dramatherapy community, and is a new and important contribution to understanding in the field.

### **2.4. Dramatherapy and bereavement**

While there is limited literature on dramatherapy with bereaved children, I have found valuable insights in the literature on dramatherapy with bereaved *adults*.

Alida Gersie is a dramatherapist with decades of clinical and research experience. She has a social work background and is a former dramatherapy training course leader, a consultant to the NHS bereavement service that I developed, and an important signatory to this project. Her extensive contribution to the field of dramatherapy includes the key text *Storymaking in Bereavement: Dragons Fight in the Meadow* (1991), which contains a rich resource of folk tales, myths and story-making structures relevant to aspects of adult dramatherapeutic work with regard to mourning and grief. Gersie's impact can also be seen in her contribution to stories and story-making (1987; 1990). The influence of Gersie's research into brief intervention within dramatherapy practice (1996) can be seen in much of the literature on dramatherapy. She highlights how, with limited time, the dramatherapist can adapt her approach by careful structuring to guide the client's process; this is valuable for some sibling work within my service – although due to the circumstances of the children, the majority of my work is longer-term.

Dramatherapist, psychologist and former psychiatric chaplain Roger Grainger (2008) has written several texts on the subject of bereavement. Particularly relevant to this project is his collation of symbols and rituals found in the process of grief and mourning throughout the world. He brings culture, ritual and death together within the following themes: refusal to die; fear of the dead; the unburied; the shape of death; and rite of passage. Personal ritual can be developed within dramatherapy sessions that are culturally specific to each client. Grainger offers me a deeper personal understanding of the recurrent shipwreck image that came to find me in art therapy, in galleries, in news items, and then through the sociologist Frank's (2013) teachings. I specifically use the word *teachings* here, as Frank's work taught me about narrative wreckage: 'Repair begins by taking stock of what survives the storm' (Frank, 2013: 55).



**Figure 2: *Draw Me a Shipwreck***

Noelle Blackman's *Loss and Learning Disability* (2003) is the book I wish I had written. I recommend it to students and have revisited it many times during this project as it is groundbreaking in its acknowledgment of the often cumulative grieving process of people with learning disabilities. This links strongly to the theme of loss being hidden or not understood, which emerges in my research and which unsettles me into continuing to advocate and raise the importance of support for vulnerable, life-limited or life-threatened clients. As Blackman herself articulates so clearly:

The knowledge of our mortality is often held as a secret. We hardly dare think of it ourselves, and we do not speak of it to others. This innate secrecy, born of fear, makes it difficult for certain sections of society to make sense of mortality and death. This is particularly true of children and people with learning disabilities who are both often excluded from conversations, rituals and plans surrounding this taboo subject. For many of us however, the positive side of thinking about our own death is that it enables us to reflect upon our life in the present. It is through the relationships that we make and the impact

we have on the world that we will be remembered. Daring to think about death enables us to consider and revise our choices.  
(Blackman, 2003: 137)

This research has found that the therapist often needs to risk 'daring to think about death' in order to work alongside a client nearing the end of his or her life.

Ann Cattanach (1996) draws on dramatherapy and play therapy in her work but does not mention bereavement directly. However, she offers a highly relevant chapter on working with clients with physical disabilities, and includes the story *Children of Wax* (see Disc 2, Track 3). Cattanach identifies the themes of difference and sameness in the story, which are common themes for clients with disabilities, but the theme of bereavement is so evident to me that I've brought this story countless times to clients and during staff training, as it offers the opportunity to explore the themes of family experiences of death and transformation.

Neta Dor-Bahar (1996) discusses the possible benefits of dramatherapy with adult clients experiencing 'abnormal' grief reactions. Placing dramatherapy in the context of Bowlby's (1980) attachment theories, Dor-Bahar focuses on brief intervention within group dramatherapy and explores dramatic concepts in relation to bereavement, including catharsis and distancing. The notion of distancing with dramatherapy is implicit within the Sesame Approach, whereas the specific aim of catharsis is not – although this may occur naturally through enactment, movement or voice. Dor-Bahar explores the concepts of over- or under-distancing in relation to working with abnormal grief reactions, suggesting that a client who becomes stuck in intense grief can be seen as 'under-distanced', whereas a client who experiences difficulty expressing emotions about the loss might be assessed as 'over-distanced'. Landy (1993) states that through 'aesthetic distance the two extreme states are in balance.'

The concept of dramatic distancing within bereavement work is further developed by my linking it with the Dual Process Model (Strobe & Schut, 1999) while setting up the NHS Children's Bereavement Service, and this is documented in the dissertation for my Childhood Bereavement Post Graduate Certificate. Pertinent to this study is the need, identified by Dor-Bahar, for the therapist to have an awareness of his or her own process of grief, and of his or her feelings around death, in order to understand possible countertransference – although she does not expand on this in her work discussed above.

Also grappling with brief intervention, Zografou (2002) describes dramatherapeutic work over 10 sessions with Lucy – a bereaved adolescent girl with learning disabilities. Zografou illustrates a familiar issue for therapists in bereavement work with children: that of complex systemic circumstances which impact the child's life in addition to the bereavement. In my clinical experience, children who have complex family situations are less resilient and thus less likely to cope with bereavement, and they are therefore more likely to be referred for or need specialist input. In the case of Lucy – the oldest of 10 children whose parents both have a learning disability, and who was expected to take on much of the childcare and household tasks – the death of her father contributed to her already complex emotional life. Zografou shares some of her own process, touching on the transference that occurred and including her frustration at the short duration of intervention due to funding constraints.

Bar-Yitzchak (2002) offers a case study of a client suffering from prolonged grief following fertility treatment and stillbirth, identifying the most valuable aspect of the 20-session dramatherapy intervention as the emphasis on 'grief work as an active process' (2002: 9). Projective techniques such as working with clay, spectrograms, drawing and painting were employed throughout. A



similar theme to Zografou's work with Lucy emerges as Bar-Yitzchak refers to a talking session where she identified that the client was working 'toward emotional equilibrium' (Bar-Yitzchak, 2002; 11).

Bar-Yitzchak details a personal disclosure to her client, near the beginning of the intervention, of a 'similar tragedy' 25 years previously, and I'm left wondering about the therapist's process and the impact this disclosure may have had on the therapeutic relationship. It's easy to slip to a place of judgement about other therapists' work when reading off the page. This may well have been an inspired intervention in the overall therapeutic process, and the work – as documented – certainly appears to have proved of benefit to the client. There have been many occasions where I've considered in the moment sharing something of my own bereavement experiences with clients, but to date I have never done so. Sharing professional knowledge through a seminar, Professor Maria Gilbert (2011) used the phrase 'promiscuous disclosure' to describe the sharing of personal information that has not been thought through before it is divulged to clients. Perhaps a key difference might be that my role is predominantly with children, whereas Bar-Yitzchak describes an adult client.

My personal therapist told me recently that her sibling had died the previous year – something I was completely unaware of. I experienced this as a very powerful and helpful disclosure, which enabled me to view something of my own loss, which we had been working with, in a different way and challenged my professional, self-imposed rule of non-disclosure with clients. I conclude that my therapist's intervention was effective due to her skilled timing and the context of trust built over our long therapeutic relationship. However, it's also important for me to acknowledge that I later got tangled up with my need to offer something to her, which resulted in me sending her a thank you card for all her support over the years – but I did not and could not name the death of her brother. Similar dilemmas occur within Yalom's (1999) explorations of

sharing of oneself with clients, but I still find it hard to make sense of why I could not send a sympathy card to my therapist.

## **2.5. Play therapy with children with life-limiting or life-threatening conditions**

Of all therapeutic practitioners, play therapists are the most likely to work with children with life-limiting or life-threatening conditions. Golden (1983) suggests that 'play intervention for children in hospital settings is an unqualified necessity. The play therapist's puppets are every bit as important as the surgeon's knife' (Golden, 1983: 213). Willis (1990), Axline (1947) and Siegel (1993) write about the suitability of play therapy with seriously ill children, although they do not comment on the emotional process of the therapist involved with this client group – even though many models of play therapy utilise psychodynamic elements to inform interventions within the work.

## **2.6. Art therapies in adult hospice settings**

One of the key figures in the adult hospice context, Nigel Hartley – himself an experienced music therapist – considers the therapeutic aspect of the arts secondary to their co-incidental benefits (Hartley and Payne<sup>7</sup>, 2008). More recently, Hartley states that 'experience has taught me more of the value of the act of creating and being together with others rather than interpreting the psychological meaning of what is happening,' but he does go on to add that 'there is a place to support some people at the end of their lives through intensive therapeutic support and intervention' (Hartley, 2013: 25). What Hartley fails to take into account are the differing models of arts therapies: the Sesame Approach to working with clients focuses on strengthening the

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<sup>7</sup> Nigel Hartley is Director of Supportive Care, and Malcolm Payne the Director of Psycho-Social and Spiritual Care, at St Christopher's Hospice

healthy parts of the psyche rather than pathologizing the dying process (as is the case in the medical model).

My personal encounters with Hartley over the last 10 years have been full of debate about the value of arts therapies and their non-medical model, which he wrongly assumes can disempower the client rather than strengthening him or her. A helpful contribution from Hartley and Tasker (Hartley, 2013) for creative therapists and artists working in end-of-life care concerns self-care whilst working in adult hospice settings. Tasker – a community artist and person-centred counsellor – identifies and discusses key areas in sustaining well-being, such as finding appropriate support; utilising existing support systems and structures; formal and informal supervision and support; developing self-awareness; annual appraisals; CPD; boundaries; understanding our own relationship to death, dying and loss; and recognising and coping with stress (Hartley, 2013: 205).

## **2.7. Creativity and death**

As a reflexive researcher, moments from the work of several artists have had a significant impact on my thinking, and have contributed to the living literature search of this project. As an *inside* researcher, my project design creates opportunities to experience and learn from inside the narrative of the research participants. I'm 'thinking with' (Frank, 2013) the story. Reflecting on Mona Livholts' seminar (2013), my PK paper recorded an important development in my research understanding, whereby:

The emphasis has tended to be on synthesis or pulling everything together. Fragmentation, however, is also a way of pulling everything together in that it allows for the reality that aspects of experience, research – or indeed thinking – may be messy and fragmented, and acknowledges the value of accepting that this is how things are. (Coleman, 2013: 10)

A particular fragment in a complex theatre piece, *The Drowned Man*, resonated with my experience of this project. In *The Drowned Man*<sup>8</sup> the audience is inside the performance and is free to wonder around the set as they choose, following a number of overlapping scenes. The award-winning theatre company Punchdrunk<sup>9</sup> offers an embodied experience of the narratives of individuals within a collective presentation. The individual characters may come together for some aspects of the whole story, but we can view their personal story throughout; they might go home, or to work, and we're free to follow and watch. This is exciting and sometimes challenging. Stumbling across a funeral scene (pews of a church, an empty coffin trestle at the front) where the 'action' (I could only assume) had been a funeral service and the mourners (audience members and actors) had moved on, I was left alone within the fragment of the scene. This resonated with my experience of bereavement work, where the death of the person ripples out and one experiences that death in a multitude of different ways.

In direct contrast is the beautifully simple account of bereavement in the play *The Year of Magical Thinking* (2006), with Vanessa Redgrave holding the stage alone and giving one person's account of grief. I sobbed all the way through this as she described her excruciating pain. In bereavement work, 'magical thinking' can describe the period of time when it's possible to imagine the dead person is still alive; framing death in such a way as to make it tolerable is a core aspect of dramatherapy work, and the use of metaphor – which provides distance – is central to this. As the character in *The Year of Magical Thinking* states: 'Grief has no distance' (Didion, 2006: 27).

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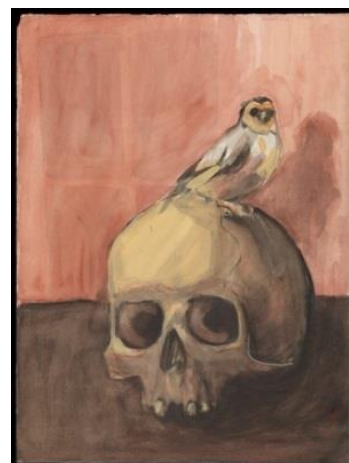
<sup>8</sup> I attended a performance of *The Drowned Man* in July 2013, at 31 London Street – a large building that was previously the Royal Mail sorting office next to Paddington station, central London

<sup>9</sup> Punchdrunk specialises in immersive and interactive theatre. This production played with the idea of following more than one lead narrative. <http://punchdrunk.com>

A wealth of creative works have wrapped the project in stories and metaphor – offering the distance needed to make the research tolerable for me – including such work as *Golden Mothers Driving West* by Paul Durcan (2007), concerning his mother's dementia and death. His metaphorical thinking within this short story allows him and me both to contain overwhelming feelings of loss (see Appendix 7).

The Professional Knowledge seminars I've attended as part of the doctoral programme can be viewed as a living literature review: I recall my resonance with Carol Holiday and Val Thomas during their seminar *Using Images In Qualitative Research* (2012), where I recalled in my PK paper that 'the reading list alone was an object of desire' (Coleman, 2013: 7). Lakoff & Johnson (2003), in particular, underpin this project as they argue that 'metaphor is pervasive in everyday life, not just in language but in thought and action' (Lakoff & Johnson, 2003: 3).

*What Makes a Good Death?* (2013), hosted by the Wellcome Collection, was an unusual conference and exhibition of artwork and artefacts. The diverse range of delegates enabled me to chat to and network with a funeral director; a recently bereaved woman who intelligently and simply told me that she was using the conference to pass the time with people who might understand what she was going through; philosophers; and lawyers concerned with the legalisation of euthanasia. It was chaired by Claudia Hammond of BBC Radio 4's *All in the Mind*. In the collection of artwork I came across Ricky Swallow's painting *Perched Bird*<sup>10</sup> (1974, see Fig. 5) – significant to me for its representation of the fragility of existence.



**Figure 5: *Perched Bird*, by  
Ricky Swallow**

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<sup>10</sup> This painting was part of Richard Harris' art and artefact collection called 'Death – a Self Portrait' at the Wellcome Collection. [www.richardharrisartcollection.com](http://www.richardharrisartcollection.com)

## **2.8. Psychotherapy and death**

With regard to the literature on psychotherapy and death, the sociologist Frank is included for several aspects of his work, including his own experience of illness, the narrative of illness, and narrative analysis. Key psychotherapists include Yalom (for his commentary on death in psychotherapy); Levine (on the creative process and its value to the exploration of life and death in psychotherapy); Romanynshyn (important in terms of research from a Jungian analyst's perspective); and Oaklander (for her work with children).

Frank recounts his own relationship with the experience of life-threatening illness:

Illness taught me that beyond anything I can do, the body simply is. In the wisdom of my body's being I find myself, over and over again.  
(Frank, 2002: 63)

Movement in dramatherapy allows the body's wisdom to be revealed to the conscious mind, reminding me once again of the potency of movement in this work, as framed by Laban. An example of how movement work allows for the symbolic exploration of grief emerged during a movement therapy workshop at an early stage of this research project. As part of the workshop's process, I found myself symbolically washing the feet of another participant; she had covered herself in black cloth and I sat bathing her feet with red cloth, and our bodies found their own ways of engaging in therapeutic movements of value to our processes. The humility and servant-like nature of my work connected to her need for care; she said she felt I knew what she needed even though we didn't know anything about each other outside of the movement work. Later, she shared that she was in confusing and deeply private mourning for – as she described it – 'the love of

my life', who she had not seen for over 30 years, having just read in a newspaper that he had recently died.

Irvin D. Yalom is an American existential psychotherapist and psychiatrist. Yalom's work – in particular *Staring at the Sun*, a profound book offering examples of client bereavement work and Yalom's personal reflections on his own mortality – acknowledges that 'everyone is destined to experience both the exhilaration of life and the fear of mortality' (Yalom, 2008: 273). In my work, death is part of the everyday routine, so speaking about it matter-of-factly is both familiar to me and useful with clients in order to normalise the topic, which can otherwise be overwhelming. In acknowledging that everyone experiences death, Yalom states that 'I prefer to speak about death directly and matter of factly' (Yalom, 2002: 130). However, at times I feel uncomfortable with Yalom's dismissive treatment of religious faith having any place in bereavement psychotherapy. It contrasts directly with my work with clients who come from a range of faith backgrounds, including practising Muslims, Sikhs, Christians and Jehovah's Witnesses. In addition, my own faith background enables me to have an understanding of the significance of faith in the dying process. Through ritual and symbol (Roose-Evans, 1994) the dramatherapist works with the client's beliefs, acknowledging these as part of their unique make-up and as resources for being with life and death.

Yalom's other work (1999), and recordings of his teachings and discussions, includes a number of statements that resonate with my own work and with this project. For example, he states that 'patients don't voice concerns about death if they sense the therapist's discomfort. What's more, therapists do not hear it if they do not wish to hear it' (2011). This was an important part of the original drive to do this research – namely to investigate my own engagement with discomfort. In my work I often hear things I would rather not hear, but my duty is to keep listening.

A further example of the relevance of Yalom to my work, and to that of the research participants, is that I work creatively with the dying process, and working well with this process can be transformative for both the client and for the therapist. Finally, Yalom (1999: 117) acknowledges the systemic, relational element of bereavement work, and he illustrates the careful investigations of the surrounding layers of emotional influence. This echoes with my NHS work and how death often impacts – sometimes destructively – on a whole family system, and leads me to ask myself the question, “Does any therapist work only with the client in the room?”. This theme emerged in all of the phases of this research.

Levine is a Canadian expressive arts therapist and educator. In his book *Poiesis* (1997), he offers a clear articulation of the theoretical underpinning of creative therapies. ‘Poiesis’, the creative act, is at the heart of dramatherapy and of my project. Levine considers that the ‘death and re-birth of the soul’ (1997: xvi) comes out of despair and the creative process, which allows us to re-form. I attempted to capture this, moment-to-moment, re-forming my inner, private world within the heuristic phase of the research process. Levine explores the connections between psychology and forms of creative expression, and in doing so reinforces the links between arts and psychotherapy. In *Who Dies? An Investigation of Conscious Living and Conscious Dying* (1986), Levine devotes a chapter to his work with children who are dying. He articulates an important element of reflective practice for the bereavement worker – that the practitioner must be self-aware, without fear and pity:

When you meet the pain of another with fear, it is often called pity. When you’re motivated by pity, you’re motivated by a dense self-interest. You want to alleviate their discomfort by alleviating your own. Pity creates more fear and separation. When love touches the pain of another, it is called compassion. Compassion is just space. (Levine, 1986: 168)



This research is an attempt to understand more deeply the emotions or experiences of the practitioner in order to respond more fully – more *compassionately* – to the client.

In his most recent book, *Trauma, Tragedy, Therapy: The Arts and Human Suffering* (2009), Levine articulates the intricacy of working creatively with human pain. He challenges the ‘what is?’ of this entire research project – ‘What is the experience of a dramatherapist...?’ – by stating that ‘what is?’ is a ‘philosophical question’ and ‘it cannot be answered by giving examples of the thing being asked about’ (Levine, 2009: 154). On reflection, asking ‘what is?’ imposes a boundary on the enquiry – simply ‘exploring the experience’ of a dramatherapist might have allowed for a more fluid and expressive response, and this has been an important consideration in the design of my project. Indeed, a common dilemma addressed by McNiff (1998), Romanyshyn (2007) and Etherington (2004) is that of how to balance the scientific and the creative within research. The essence of the art must be preserved, as Levine writes:

Art-based research, then, needs to pay attention to both dimensions of our work. I must honour the demand for clarity, order, form, meaning, logic, and all the other dimensions of the Apollonian, but it must also embody the passionate, erotic, vital basis of the arts. (Levine, 2009: 157)

Levine highlights the need for order and chaos, light and shadow, science and art to engage in dialogue and be present within imaginative research. I’ve built this theoretical underpinning into my project by incorporating art-based research into a heuristic methodology (Moustakas, 1990).

Robert Romanyshyn (2007), an American psychotherapist trained in phenomenology and Jungian psychology, teaches about the soul in research:

Research with soul in mind is re-search, a process of re-turning to and re-membering what has already made its claim upon the researcher through his or her complex relations to the topic. (Romanyshyn, 2007: xi)

At a Sesame Institute and C.G. Jung Club workshop entitled *Soul and Body: Lingering with the Poets On The Margins of Psychology* (2014), Romanyshyn commented that 'we are not so at home in our interpreted world,' and looking back at the footprints of my project, I experienced feelings of near-impossibility at the task of representing my creative work in a way that would make any sense to the reader. I treasure my copy of Romanyshyn's *The Soul in Grief* (1999), signed by the author, for its metaphorical ability to capture the transformational aspects of bereavement – the beauty as well as the despair. Its poetic language is truly a phenomenological inspiration to me.

Violet Oaklander, an American psychologist and Gestalt psychotherapist trained in family and child counselling, does not focus on bereavement directly in her writing (1998) but describes frequent presenting issues experienced by children referred for psychotherapy for a range of reasons including anger, hyperactivity, being withdrawn, traumatic experiences, insecurity, excessive pleasing, and bed-wetting. This is helpful for bereavement work as such feelings and resulting behaviours are all common reactions to loss, communicated through behaviour. In addition, Oaklander highlights that the circumstantial and environmental context (the outer world) is likely to impact the child's inner world. For example, in Moustakas' (1959) writing on aggression in children, he describes a disturbed child as often motivated by interchangeable and blurred feelings of anger and fear. Parents often assume that a disturbance springs from an inner cause, but it's the *environment* that bothers the child, who is unable to communicate his feelings in any other way. In my experience, age-appropriate information

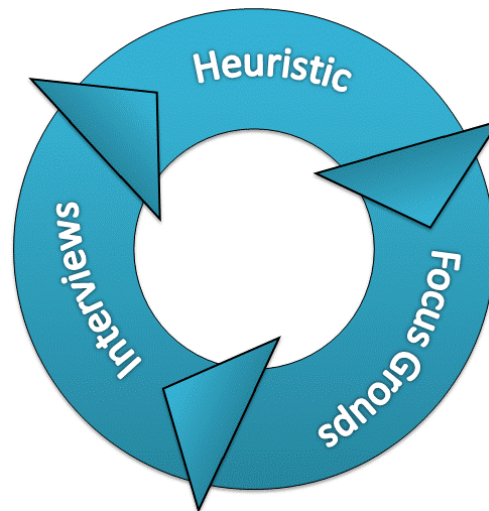
goes a long way in helping a child to understand a close loss, preventing anger and fear from escalating.

### **3. Conclusion**

This literature review constitutes the first contribution to the field of practice on the specific topic of the dramatherapist's experience of, and response to, children with life-limiting and life-threatening conditions. I have taken stock of the influences of the written word in books and articles, and of the living literature in the performances and Professional Knowledge seminars I've attended. I've identified several themes of relevance to the research topic, and organised the literature review into the following sections for analysis and discussion: my research lens; dramatherapy and life-limiting and life-threatening conditions; dramatherapy and bereavement; play therapy and children with life-limiting and life-threatening conditions; arts therapies in adult hospice settings; creativity and death; and psychotherapy and death. Throughout this review I have borne in mind the two main threads identified within my reflections on my professional knowledge and written up in my PK paper; that is, explication of tacit knowledge and making the research my own. These threads continue to be present in my work and in this research project.

In returning to the original version of *Cinderella*, as referred to in the introduction to this chapter, I find that transformations are prompted not by the fairy godmother (who only appears in later versions) but by Cinderella's visits to her mother's grave, where she is nourished and receives wisdom. It is truly a story of death and transformation. Literature can make the idea of death more tolerable and allow deeper understanding from different perspectives – whether through theory that helps us understand patterns or through creative material containing metaphor. The Cinderella symbolism

has supported me in abiding with the large amount of time spent engaging with the literature, and has prompted small transformations within my knowledge and practice.



**Figure 6: Research Design – whole**

## **Chapter 3 – Research Design**

### **1. Introduction**

This is a qualitative, phenomenological project employing heuristic enquiry, focus groups and individual interviews to explore the experience of dramatherapists working with children who have life-limiting or life-threatening conditions. The study adopts a phenomenological epistemological orientation and a pluralist approach in order to accommodate my assumption that the lived experience of dramatherapists working with this client group is 'complex, multi-layered and multifaceted, and that therefore a methodology which is equally complex, multi-layered and multifaceted is perhaps the most suitable way to find out more about it' (Willig, 2013: 17) and to create new knowledge. The research design is circular in nature, with three phases flowing into each other – as illustrated in Fig. 6, above. The distinct methodology utilised in each of the three phases is described in detail at the beginning of each relevant chapter. An ethical overview is given in

Chapter 4, while specific ethical considerations are detailed within each phase.

This is a qualitative project in that it is 'orientated to discovery rather than verification' (McLeod, 2003: 192). However, this project recognises that 'research that generates ideas about what is possible is equally as valuable as research that tests or verifies what is known or believed to be 'factually' true' (Strauss & Corbin, 1990). Denzin & Lincoln (1998: 19) have identified a 'crisis of representation' in reflexive research where the personal responses of the researcher are acknowledged as an important part of the study. As Etherington suggests:

This crisis has been created in response to the falling away of traditional notions of truth, reality and knowledge that previously provided us with familiar structures for presenting our 'findings'. If there is no objective truth to be found, then there can be no findings. What we have are the voices and experiences of our participants and ourselves, and a need to find new ways of re-presenting them. (Etherington, 2004: 83)

The key aim of this project is to use representation to create a bridge between the individual (my own) and the collective (arts therapies community) experience in order to improve practice. The research places me at the centre in order to explore inner and outer experience when relating to others. The research lens, therefore, is a composite of my training, work history and personal life experience; it acknowledges and is influenced by the process in my relationship with the research participants in order to inform the research products. The research design is pertinent to psychotherapy as it captures the phenomena of the experience of myself as a therapist in relationship to others.



**Figure 7: Ouroboros**

The diagram at the beginning of this chapter (Fig. 6), illustrating the circular nature of my research design, is similar to the Ouroboros (Fig. 7) – the snake eating its own tail. Having first emerged in ancient Egypt, the symbol is frequently used in alchemical illustrations, where it symbolizes the circular nature of the alchemist's opus. This image often symbolizes self-reflexivity, and like the flow of my project it carries the sense of something constantly recreating itself – as in the eternal return<sup>11</sup>. Phase One, the deeply personal heuristic inquiry, ended with the creative synthesis of the writing of a play, which in turn created the beginning of the next cycle of performance and transformation of the themes through the audience experience, and the beginning anew as soon as the first had ended. It also often associated with Hermeticism, which links strongly to the life cycle and therefore resonates with the day-to-day experience of work within a palliative care setting.

This chapter is organised according to McLeod's (2011: 71) recommendation for discussion and elaboration of a complex research project. While his work is based in counselling, I have found this to be an appropriate means for analysis of my own research design. The discussion below is organised into

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<sup>11</sup> The concept of 'eternal recurrence', developed by Friedrich Nietzsche, is the idea that with infinite time and a finite number of events, events will recur again and again infinitely.

three sections, according to McLeod's (2011: 70–71) three layers of activity within research design. He proposes, firstly, that 'there is an underlying philosophical dimension to all research – the domain of core assumptions about epistemology and ontology.' Secondly, at the level of methodology, he proposes that there are 'ideas and principles about different ways that the research process can be organised in order to achieve different kinds of knowledge and understanding.' Thirdly there is the method layer, which he suggests comprises of 'the concrete practical tasks that researchers need to carry out in order to collect and analyse research information (data/texts).' The overarching ethical considerations of the project, which are an essential element within the design of the research, are detailed in Chapter 4, with specific detail of each phase discussed in the relevant chapters.

## **2. Level One – Philosophical dimension**

### **2.1. Phenomenology**

Within this project, phenomenology has been identified as the most appropriate principle in illuminating the lived world of dramatherapists. Phenomenological principles and methods are utilised to create what Reeder calls the 'crucial link' in understanding the experience of dramatherapists working with children with life-limiting or life-threatening conditions:

Phenomenology is a self-critical methodology for reflexively examining and describing the lived experience (the phenomena) which provides a crucial link in our philosophical and scientific understanding of the world. (Reeder, 1986: 1)

The methods used include a heuristic framework to synthesise personal inquiry (Phase One); focus groups to capture the collective experience of professionals (Phase Two); and interviews to capture individual experience (Phase Three).



Langdridge (2007) offers a critical summary of the fundamentals of phenomenology, including a description of Edmund Husserl's development of phenomenological philosophy, which describes a 'return to the things themselves'. There are many variations on these early ideas, and different phenomenological approaches inform different methodologies. What they all have in common is that they disagree with the subject-object dualism that is central to positivism and the scientific project, where we see the separation of the world as it really is and the world as it appears to us in our perception. An object enters the world only when we perceive it and when it is presented to our consciousness; and our perception will vary according to the context, the position of the perceiver in relation to the object and the mood of the perceiver. There is, therefore, no once-and-for-all knowledge to be found in a real, knowable world.

Heidegger's development of Husserl's philosophy incorporated the notion of 'person in context':

Heidegger's view is that the person is always a person in context. Intersubjectivity refers to the shared, overlapping and relational nature of our engagement in the world. Heidegger believed we cannot occasionally choose to move outwards from some inner world to take up a relationship with the various somatic and semantic objects that make up our world, because relatedness to the world is a fundamental part of our constitution. Intersubjectivity is the concept which aims to describe this relatedness and to account for our ability to communicate with, and make sense of each other. (Smith, 2009: 17)

Merleau-Ponty provides the notion of the embodied nature of our relationship with the world, and discusses how this leads to 'the primacy of our own individual situation perspective on the world' (Smith, 2009: 18). He proposes that our bodies are vital in our relationships with others and the world – a notion that is central within dramatherapy – and he claims that the body is 'no

longer conceived as an object in the world, but as our means of communication with it' (Merleau-Ponty, 1962: 106).

In addition to these underpinning philosophical dimensions, other philosophical principles are woven through the project and these are discussed in the relevant chapters.

## **2.2. Pluralism**

Research pluralism is a way of integrating different approaches to knowledge-generation within the same study. I therefore employed pluralism as a means of capturing and expressing my understanding of the complex, multifaceted and multi-layered phenomena experienced by dramatherapists working with children with life-limiting and life-threatening conditions. I have integrated the themes from each of the three phases of analysis by allowing each to flow through into the subsequent phase – thus enabling an integration of all findings. In this sense the aim of the design is to produce a rich summary of findings from the range of participants, thus doing as Willig (2013: 17) suggests, which is to 'integrate the results from the various cycles (or layers) of analysis in some way, thus presenting a coherent narrative which includes all of the aspects of 'reality' uncovered by the research.'

The heuristic reflexive process used in Phase One generates phenomenological knowledge of my lived experience as a dramatherapist working with children with life-limiting and life-threatening conditions. Thematic analysis, as utilised to analyse the data generated by focus groups in Phase Two of this project, can be said to reflect a 'realist epistemology': the themes that emerged are believed to represent an underlying truth about the experience of working with this client group, and the data is seen as a window onto the participant's reality – or in this case the differently situated

realities of the participants in the focus groups (educators, dramatherapists and nurses).

The project utilised an Interpretative Phenomenological Analysis of the data generated by semi-structured interviews with dramatherapists in Phase Three. IPA is pluralist in the sense that its key principles are phenomenology, hermeneutics and ideography – enabling a ‘plural vision’ (Smith, 2009) through varying layers of analysis. This project, in its use of ‘interpretative phenomenological research’, as suggested by Willig (2013: 16), ‘seeks to generate knowledge about the quality and texture of experience as well as about its meaning within a particular social and cultural context.’ Knowledge from these different sources (in this case the three phases of research) is seen as having ‘the potential to be mutually enhancing: corroborating, triangulating and elaborating each other, with the possibility of an active, continual process of interpretation and re-interpretation (Goss & Mearns in Cooper, 1997: 120).

Adopting a pluralist design also enabled specific limitations of each method to be overcome, as detailed in each relevant chapter. Professional Knowledge seminars within the doctorate programme (Souter-Anderson: 2010b; Livholts: 2013) stressed the importance of creating a design that would support the inquiry rather than the other way around. It is specifically through the pluralist approach that I endeavour to ‘amplify rather than pin down meaning’ (Willig, 2012: 163).

This research privileges a professional point of view in that the client voice is heard indirectly through the people working with them. Further research would aim to integrate this by gathering client and family experiences of dramatherapy, therefore developing the knowledge gained from the project.

### 3. Level Two – Methodology

In terms of this project, the beautiful Chinese painting below – *Court Ladies*, attributed to Emperor Huizong (1082–1135) – represents members of my project community involved in the making of different kinds of knowledge and understanding. The co-researchers, signatories, research participants, academic team, colleagues and supervisors are folding, looking, talking, close together or some distance apart, working at different tasks, resting, laughing, concentrating, making... and central to this community of people and resources is the notion of practitioner-researcher in practice-based research.

#### 3.1. The project community



Figure 8: *Court Ladies*

#### 3.2. Co-researchers

Two co-researchers have been active members of the project community. In the interest of full transparency I will now describe their participation.

Ali Kelly and myself set up the NHS Children's Bereavement Service together. In this role we co-facilitate sessions with individual clients with

complex issues, sibling groups and classes of children within school settings. An element of this work is described in the book chapter 'Dramatherapy with Children, Young People and Schools' (2012 – see Appendix 4, product 1), an extract of which is in the introduction to this project (Chapter 1). We have developed and offer training sessions in educational, health and social services settings, in addition to running training days for arts therapists on bereavement work. We often facilitate workshops and make presentations at conferences – such as the closing workshop at the BADth conference in 2013. These joint experiences are woven through the fabric of the project. More directly, Ali Kelly was a natural choice as a signatory to the project and has consistently taken the role of critical friend, reading drafts and engaging in ethical discussions. In addition she agreed to be interviewed, and she filmed the focus groups.

Catherine (Kate) McCormack and I trained together as dramatherapists and have worked together many times since qualifying in 1997. We share a particular interest in the *drama* part of dramatherapy, and she brings a specific expertise in this area to the project. Kate has directly contributed through the devising and performances of the play *How Do You Think I Feel?* (Product 2), which is detailed in Chapter 8. We founded the White Dog Theatre Company with the aim of further developing therapy-based performance pieces. Kate also agreed to participate in a pilot interview and has taken the role of critical friend throughout. In addition to her creative input in the play, her guidance and creativity is knitted through the project – particularly in the oral presentation of the Learning Agreement and in preparation for the final viva.

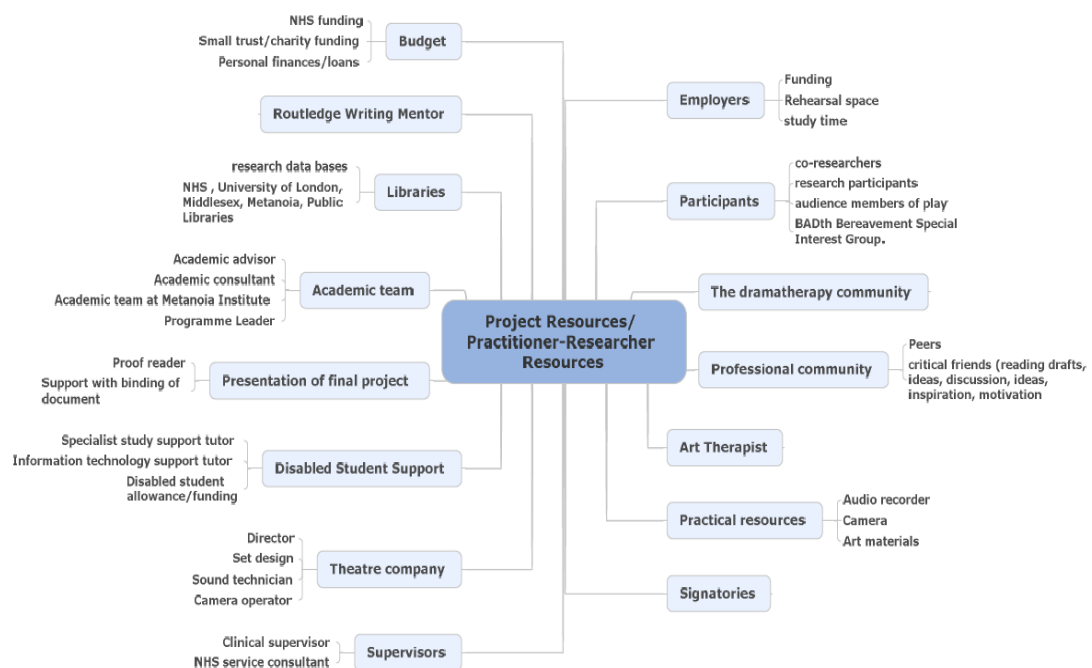
### **3.3. Signatories**

The signatories 'endorse the significance, originality and importance' (Metanoia handbook, 2011: 95) of the project through their range of expertise, ongoing guidance and support.

The signatories to this project are:

- Dr. Alida Gersie – dramatherapist and author of *Storymaking in Bereavement* (1991), and a leading expert in the field of dramatherapy and bereavement
- Professor David Olivier – former Head of Education at St Christopher's Hospice
- Mary Smail – Director of The Sesame Institute, Drama and Movement Therapy
- Alison Kelly – dramatherapist, supervisor, lecturer and NHS Bereavement Service job-share partner

Fig. 9, below, demonstrates how the people involved and the resources came together to form the project.



**Figure 9: Project/practitioner-researcher resources**

### **3.4. Practice-based research**

‘Practice-based research takes place on a grassroots level and involves practitioners and clients in a real-life setting.’ (Bager-Charlson, 2014: 2)

This definition directly reflects how I see and wish to carry out my research; it is real, and it is directly relevant – and of value to – my clients, to myself and to the research participants.

An important methodological question in the design of this practice-based research was how to offer structures that would provide a potential benefit to the participants and to myself as the researcher. Kvale (1996) suggests that well-thought-through qualitative research can be an enriching experience. The personal, heuristic phase – although emotionally demanding – resulted in great personal and professional development for me. McLeod (2003) identifies a key aspect of job satisfaction for counsellors and therapists as ‘the sense of continually learning about human nature in response to the lives and personal worlds that clients allow them to enter’ (McLeod, 2003: 2). He also suggests that research can allow the senior practitioner to ‘consolidate their professional identity’ (2003: 2). As I began to understand myself in relation to the work at a far deeper level, this consolidation or synthesis is ongoing throughout the project and is demonstrated by career progression and teaching invitations in the wider field.

An aspect of the rationale for selecting focus groups – even though I had no direct experience of running them – was my sense that discussing the experience of working with children who are known to be dying would be of great value to the school staff, providing a much-needed opportunity for members of the team to get together and share their experiences with

colleagues through speaking about an issue which, inevitably, does not get aired during the very busy working day. Despite the challenging topic, meetings with each of the three groups of professionals (educators, nurses and dramatherapists) were enjoyable occasions, with laughter, 'team spirit' and a feeling of sharing. Many months later they are still mentioned and considered useful. I was recently invited to facilitate a series of focus groups to find out parents' views on aspects of the school that was involved in the project, which evidences the value of the model. This is encapsulated by Josselson:

Thus the 'I-thou' exchange of narrative research is not only ethical but life enhancing for both the participant and the researcher. (Josselson, 1996: xvii)

### **3.5. Practitioner-researcher**

I consider a strength of this research methodology to be my 'insider' status (Styles, 1979), in that this research is carried out by me, a dramatherapist, primarily *for* dramatherapists – although the products have been demonstrated to have wider value. Without research, practice 'becomes sterile'; the book chapter illustrates why I describe myself as a practitioner-researcher, according to Barber's definition:

A researcher systematically explores experience with a view to refining knowledge; a practitioner applies knowledge skilfully with a view to improving practice. As both must be integrated in real-life situations to affect excellence, we arrive at the notion of the practitioner-researcher. Without research, practice becomes sterile. Likewise, if practitioner-researchers in such professions as counselling and teaching fail to illuminate new knowledge with those involved, then something is drastically wrong. (Barber, 2006: 24)

### **3.6. Application of philosophical approach**



The research participants and co-researchers are witnesses that I have sought out and asked, through interview, about the phenomena of working with children with life-limiting and life-threatening conditions. They are not themselves the focus of the research – it is their *experience* of the work that's being studied, and thus methodology of this project is guided by the philosophy of phenomenology, which is 'a philosophical approach to the study of experience' (Smith, 2009: 11). As the researcher I aim to gain an understanding of how they've experienced this work, what it means to them and how they themselves have made sense of the experience, with a view to better understanding the phenomenon of the experience of being a dramatherapist working with children with life-limiting and life-threatening conditions.

Husserl (1931) identified 'bracketing' as an important aspect of the phenomenological attitude. This requires the researcher to endeavour to approach the data with an open mind and attempt to put to one side, or 'bracket', his or her own assumptions about the phenomenon under investigation. As Willig suggests:

Bracketing assumptions however, does not mean erasing them. Rather, it involves a process of recognizing their effects, or interrogating them, of being suspicious of them and, as a result, being able to hold them more lightly and more flexibly. (Willig, 2012: 97)

Phenomenological bracketing calls for a deliberate and disciplined return to the subjective – a reflexive approach. This interrogation of my subjective responses has taken place mostly through artwork, poetry and creative writing. My process is shared directly in this document only when it impacts or illuminates the research, and when it can be included in such a way that it may be relevant to the reader. However, my personal process informs each word within the project, which is written with a reflexive tone. An invaluable piece of feedback on my earlier research was that 'that which is meaningful

to the author needs to be rendered in a form that is equally meaningful for the reader or it cannot be properly understood, credited or critiqued' (Goss, 2011). Responding to this comment, I developed a checklist to help decipher an item's usefulness in relation to the research and to its relevance for inclusion within the main document (see Appendix 8).

My inclusion criteria and rationale were informed by Etherington's description of the purpose of reflexivity:

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. If we can be aware of how our own thoughts, feelings, culture, environment and social and personal history inform us as we dialogue with participants, transcribe their conversations with us and write our representations of the work then perhaps we can come close to the rigour that is required of good qualitative research. (Etherington, 2004: 32)

Early in the project I identified a need for a confidential space, in addition to clinical supervision and personal therapy, for the processing of the material and to 'capture moments of insight' (Nelson, 2013: 29) specifically linked to the research. I engaged in art therapy – a form of psychotherapy that uses aspects of art as its primary form of communication – with sessions on average once a month during the six-year duration of the project. I considered dramatherapy but decided to use a different form of creative expression other than my own medium; this would provide a further layer of distance as I was mostly working with dramatherapist research participants. The art therapy sessions also offered me a much-needed layer of emotional support with feelings connected to the actual process of being a candidate on the doctoral programme.

Josselson (1996) describes very similar feelings to those I've experienced frequently throughout the project, and the necessity of working *with* rather than against them:

Yet I would worry most if I ever stopped worrying, stopped suffering for the disjunction that occurs when we try to tell an Other's story. To be uncomfortable with this work, I think, protects us from going too far. It is with our anxiety, dread, guilt, and shame that we honour our participants. To do this work, we must contain these feelings rather than deny, suppress, or rationalise them. We must at least try to be fully aware of what we are doing. (Josselson, 1996: 71)

Ethically, I considered the art therapy space an important addition of containment to ensure safety of the clients, the research participants and myself when experiencing these difficult feelings.

### **3.7. Imagined reader**

Multiple audiences exist for any text (Fetterman, 1989), and one of my aims within the project has also been to create products for different audiences. This document is a unique blend of written text and living products. Naturally, knowing that the text will be assessed by an academic panel also plays a part in the style, structure and language selected. I'm reminded of the editing process for an article prior to submission to *The Journal of Bereavement Care*, when the potential reader had a significant influence on what I included. For example, I decided that several of the poems (seen in full in Chapter 5) were not appropriate for parents or carers of people who were acutely unwell, as it is not helpful for them to be aware of the difficult aspects of the job of the therapist. Smith reminds us of the 'imagined reader of our eventual write up' (Smith, 2009: 41) being the third hermeneutic layer; with this in mind I imagined, as I was writing, members of the BADth Special Interest Group trying to make sense of the researcher (me) making sense of the research participants making sense of the phenomena of the experience of working as a dramatherapist with children with life-limiting or life-threatening conditions!

Another helpful notion is the concept discussed at length in Mona Livholts' Professional Knowledge seminar (Livholts, 2013) of 'only one reader', which focused my writing on the intended multiple readership and lessened overwhelming feelings. Keeping an imagined reader in mind – reading my writing through someone else's eyes – supports Yardley's (2000) notion of coherence and adds to the validity and quality of the project. Despite thinking my material might be suitable, this article was not accepted and I learned that I had not fully imagined my reader while writing. I also learned the need to research a journal's readership more thoroughly before submission of material.

### **3.8. Research bias**

The reflexive exploration and awareness of my research bias is the core of the study itself. I've been aware for some time that quick, sudden death is more familiar to me (following the death of my father, as mentioned in Chapter 1), and long-term, pre-bereavement processes do not match my personal, embodied rhythm of the life cycle. My responses continue to be carefully attended to in clinical supervision, peer supervision and personal therapy.

Further exploring my research bias, I was prompted by Barber's (2006) invitation to 'illuminate your own research shadow', based on Jung's psychological typology (Jung: 1971), and I concluded that I fall somewhere between the intuitive-feeling and the intuitive-thinking domains, and it is probable that I'm more likely to integrate theoretical concepts through practice rather than at a thinking/analytical level. I'm mindful of this shadow aspect, and I balance this by raising my own awareness through discussions with my clinical supervisor and academic and project team. Inevitably, my cultural background – that of a white British female in her forties with a

Christian upbringing – is present within both the research focus and my findings.

### **3.9. Validity**

Langdrige (2007: 156) brings together several writers' views on how to assess validity within phenomenological research. Langdrige concludes that Yardley's four broad topics are most likely to be of concern to qualitative researchers seeking validity in their research: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. These topics resonated directly with my beliefs about and commitment to integrity within the project.

Taking into account Yardley's principles, I ensured sensitivity to the context of the project through a detailed literature review – hence situating the research in a wider setting. I was also influenced by Nelson, a theatre practitioner and researcher, who recommends that within a summary of adjustments from practitioner to practitioner-researcher, one 'locate[s] [one's] praxis in a lineage of similar practices,' and 'relate[s] the specific inquiry to broader contemporary debate (through reading and exploration of ideas with references)' (Nelson, 2013: 29).

Langdrige (2007) identifies that descriptive phenomenological studies often contain features that are expected in traditional scientific reports, such as a literature review, but they tend to depart from the traditional scientific report in the presentation of findings, and there's less attempt to link findings with the extant literature. In this study, the findings are firmly rooted in existing literature in order to contextualise the experiences described, ensuring the research does not exist in isolation. I also identified a need to take my own 'inward'-looking heuristic research 'outwards', and therefore presented this

work at research events and brought the themes from Phase One into multi-disciplinary focus groups. In addition, I employed my therapist skills throughout, ensuring participants were comfortable at all stages of their engagement.

A firm commitment throughout the six-year project has been to participant involvement on issues such as representation, anonymity and transparency of communication. Rigour is continuously demonstrated in the thoroughness of preparation, engagement with participants, the systematic approach to analysis and the ongoing checking of quality in research supervision and with the academic team. I have extended Smith's (2009) recommendation for IPA methodology to all three phases of the project – that transparency and coherence is supported by the detailed description of the research process in the write-up of the study. This has been achieved in the project by allowing considerable time for this particular task. Diagrams and tables have been included, where helpful, to demonstrate the rigour of the process.

In contrast to this project and the to aim of the Professional Doctorate, with an emphasis firmly on the usefulness of the research through the production of robust and evaluated products, Langdridge expresses concern at the increase in the 'commodification of knowledge and pressure for findings to have practical, unfortunately often monetary, value [which] leads to an unwanted and unnecessary emphasis on applied research' (Langdridge, 2007: 157). He questions whether we should judge the validity of the research on its practical impact. I observe that my project has evolved organically and in direct response to the dramatherapy community; I consider that a particular advantage of 'insider knowledge' is being able to identify what's needed, or valued, within one's own community. I tend to live by William Morris'<sup>12</sup> philosophy: 'Have nothing in your houses that you do not

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<sup>12</sup> William Morris (1834–1896) was an English textile designer, poet, novelist, translator, and socialist activist. Associated with the English Arts and Crafts Movement, he was a major

know to be useful, or believe to be beautiful' (1882). From my perspective, this encapsulates the essence of my approach – as evidenced by the usefulness of the products and, in my view, by the beauty of the profound elements contained within the research journey.

Similarly to Cooper's (2011) notion of pluralism in counselling research, triangulation has been employed in order to view the phenomena of the experience of dramatherapists working with children with life-limiting or life-threatening conditions from three different angles, and through three different methodologies. Each individual participant's experience is unique in itself (including mine), but comprehension of the phenomena of working with children with life-limiting or life-threatening conditions can expand considerably when we view these as *collections* of experiences.

### **3.10. Limitations**

In order to encourage the flow of the project, limitations have been considered and compensatory aspects introduced through the design of the individual phases. For example, a possible limitation of individual interviews might be that the interviewer can be seen as the 'expert'. As dramatherapy is such a small profession, and as I have created a body of work and offered training in the area of bereavement, this may certainly be the case. The design of the project aims to balance this unhelpful notion of 'expert' through focus groups, where the emphasis is on members of the group as the 'expert' in the topic rather than the interviewer (McLeod: 2003).

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contributor to the revival of traditional textile arts and methods of production in Britain. His literary contributions helped to establish the modern fantasy genre. The now-famous phrase quoted above is recorded in *Hopes and Fears for Art: Five Lectures Delivered in Birmingham, London, and Nottingham, 1878–1881* (1882).

#### **4. Level Three – Method**

The practical tasks involved with the setting up, data collection and analysis and discussion of findings in each phase are described in detail in the relevant chapters.

#### **5. Conclusion**

This chapter has offered an overview of the choices I have made in the design of this research project, and provides the rationale for bringing together a cycle of heuristic, focus group and individual interviews as a three-phase methodology with which to research the experience of dramatherapists working with children with life-limiting and life-threatening conditions. Using the image of the Ouroboros to represent the flow of this project, I consider my personal experience as a dramatherapist in relation to other practitioners in the field, in a reflexive manner.

This chapter has described key considerations in the research design for the three phases in the development of the work. The discussion has been organised according to McLeod's (2003) layers of activity: the first layer concerns the philosophical considerations of the historical development of phenomenology, taking into account relevant notions from Husserl, Merleau-Ponty and Heidegger; the second layer of activity concerns the methodology used and details a number of key aspects that I took into account when developing the project, including the project community, co-researchers, signatories, practice-based research, the practitioner-researcher, application of the philosophical approach, the imagined reader, the research bias, validity and the limitations of the methodology. McLeod's third layer of activity is the practical, concrete application of the research methods and



these are not included here, since each relevant chapter begins with an appropriate detailed description of methods used.

## Chapter 4 – Ethics

### 1. Introduction

The consideration of ethical issues has been an ongoing, continuous process during this research project. This chapter offers an overview of these considerations – namely, ethical guidelines, consent and representation. Specific ethical issues pertinent to each phase of the project are addressed in the relevant chapters.

### 2. Ethical guidelines

This research focuses on therapists' experiences and does not include direct research with clients, but remains consistent with guidelines from several relevant bodies: Conduct, Performance and Ethics guidelines from the Health and Social Care Professions Council (HCPC) Standards; Code of Ethics from The British Association of Dramatherapists (BADth); and Research Ethics Guidelines from Metanoia Institute and Middlesex University (see Fig. 10, below).

#### **Metanoia Institute and Middlesex University Research Ethics Form**

1. Will you describe the research procedures in advance to participants so that they are informed about what to expect? **Yes**
2. Is the project based on voluntary participation? **Yes**
3. Does your research involve offering inducement to participate (e.g. payment or other reward)? **No**
4. Will you obtain written consent for participation? **Yes**
5. If the research is observational, will you ask participants for their consent to being observed? **Yes**
6. Will you tell participants that they may withdraw from the research at any time and for any reason and inform them of how they may withdraw? **Yes**
7. Will you ensure that participants are not subtly induced, either to participate initially, or to remain in the project? **Yes**
8. Will you give participants the option of omitting questions from interviews or questionnaires that they do not want to answer? **Yes**

9. Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs? **Yes**
10. Have you made provision for the safe keeping of written data or video/audio recordings? **Yes**
11. Will you debrief participants at the end of their participation? **Yes**
12. Have you ensured that your research is culture/belief/social system sensitive and that every precaution has been taken to ensure the dignity, respect and safety of the participants? **Yes**
13. Is there a realistic risk of any participant experiencing either physical or psychological distress or discomfort? If YES, will you tell them what to do if they should experience any problems (e.g. who they can contact for help)? **Yes (see below)**
14. Is there an existing relationship between the researcher and any of the research participants? If YES, please describe the ethical implications and the safeguards in place to minimise risks. **No**
15. Will the project involve working with children under 16 years of age? If YES, please describe parental consent and safeguarding procedures. **No**
16. Will your project involve deliberately misleading participants in any way? If YES, please explain why this is necessary. **No**
17. Will you need to obtain ethical approval from any other organisation or source? If YES, please attach letter confirming their ethical approval. **No**
18. Are there any other ethical considerations in relation to your project that you wish to bring to the attention of the Research Ethics Committee that are not covered by the above? **No**

**Question 13:**

It is possible that describing the experience of working with bereavement may cause psychological distress to the research participants. Provision for this possibility will be indicated within the consent and information literature. It will involve offering a follow-up meeting with me to discuss the interview, and signposting to organisations and literature that may support distress caused by sharing information about personal loss.

**Figure 10: Metanoia Institute and Middlesex University research ethics form**

These codes and guidelines were checked regularly to ensure they were attended to. However, as Smith identifies, although it is certainly useful to meet the ethical ‘start-up criteria’ (Smith, 2009: 53) of professional bodies, further layers of ethical considerations were identified. Borrowing Yalom’s use of the notion of the ‘therapeutic act’ being of more value, at times, than the ‘therapeutic word’ (Yalom, 1999: 111), I considered the similar notion of the *ethical* act being of more value than ethical words – a principle of practice and belief central to my work.

As part of my ongoing ethical review process, the form shown in Fig. 10 was updated and resubmitted to the Ethics panel, to take into account the development of interviewing research participants with whom I had an

existing professional relationship. Ethical aspects pertinent to inclusion of participants where there is an existing relationship – including notions of status and power (Etherington, 2004: 226) – are addressed accordingly in the chapters where these ethical issues arose. As Clandinin & Connelly note, ‘personal experience methods inevitably are relationship methods’ (1994: 425). With relationships come ethical considerations; my own highly developed ethical attitude towards relationships ensured that I engaged with these guidelines as living documents.

As a therapist working for the last 10 years in NHS paediatric palliative care, I have experience of the complex end-of-life ethical issues within relationships that arise regularly within my day-to-day caseload. A typical example would be my involvement with a child whose illness necessitates a gastrostomy as it is no longer viable for them to eat orally. Where the child/family does not want this major surgery and the resulting change in life circumstances, I am often involved in working within therapy sessions with the client, and in discussions between the family and professionals, in order for this decision to be made. This involves bringing together the client’s feelings, the family’s views, medical ethical procedures framed in legislation, and close liaison with teams of professionals in order to reach the best possible outcome for the child. The concept of ethics as an ongoing and continuous process could not be more acutely present than in these circumstances.

I find resonance in Frank’s concept when he suggests that ‘thinking with stories is the basis of narrative ethics’ (Frank, 2013: 158). These are far from the TV hospital scenes where the life support machine is dramatically turned off and the camera flashes to the faces of the patient, the shocked family and the calm, authoritarian doctor. These ethical resolutions can take months to reach and involve substantial amounts of ‘thinking with’.

### **3. Participant safety**

I endeavoured to ‘anticipate any safety issues’ (Smith, 2009: 54) by thinking ahead and discussing potential issues with the project team. Bereavement is challenging work, and in addition to any possible emotional distress, I considered the unlikely possibility of research participants in Phases Two or Three bringing issues that may be of Fitness To Practice concern. Where appropriate, I planned to discuss this firstly with the interviewee within the moment, then within my own clinical supervision, and – only if absolutely necessary – with managers or the HCPC. Therapists, of course, are trained to have heightened awareness with clients, and with this comes responsibility for our research participants and for ourselves. Throughout the project I engaged in additional clinical supervision and art therapy sessions to monitor and ensure that the intensity of the research and any potential negative impact on the direction, style or quality of my ongoing clinical work was supported. The dramatherapists involved are all HCPC-registered and therefore also engaged in regular supervision. Although the project does not rely on this mechanism – with follow-up support being offered after the interviews and by ensuring that I was actively available for discussion – supervision can offer a valuable layer of processing, should difficult feelings arise. It is also hoped that the interviews may lead to insights for the therapists, and therefore that the process itself may prove to be of value – as explored in Chapter 3 and referred to throughout the project.

### **4. Consent**

‘Consent is perhaps the most fundamental of all ethical principles.’  
(Langdrige, 2007: 62)

Consent issues (McLeod, 2003: 170) pertinent to each phase of the project are detailed within each relevant chapter. For example, the focus groups (Smith, 1995) brought up the issue of levels of confidentiality between group members; as researcher, after group discussion I had to 'let go' of this and trust the participants to work with it according to their own processes and work culture. The emphasis throughout has been on transparency and revisiting to negotiate the consent process. Consent forms (see Appendix 10) were always accompanied by a Project Information Sheet (see Appendix 9), and time was built into interviews for questions and discussion in order to ensure 'informed' (McLeod, 2003) or educated consent.

The most challenging aspect has been how to analyse, interpret and represent material, and how to work with the transition from the confidential interview to the public domain – especially when participants referred to family bereavements. Etherington outlines the potential difficulty in this area:

Knowing how to protect the confidentiality of people who have not given their informed consent to be included in the research when story tellers' or narrators' stories are closely bound up with theirs. Dilemmas like this can be discussed with participants so that mutually agreed and morally satisfactory decisions might be reached. (Etherington, 2004: 82)

## **5. Representation**

Josselson (1996, see below) captures succinctly the discomfort and confusion I've experienced throughout the project as I've struggled to represent the research participants' stories. Perhaps my struggles to find a method with which to analyse the interview data reflected these difficulties.

The question of how to analyse data is an important ethical and methodological consideration – one that with my heightened desire to 'do the right thing' by the participants took a long time to 'feel right'. Perhaps this is a

key difficulty facing the therapist in carrying out research: the utter contrast in how we work within the face-to-face relationship within the interview or therapy session, and how we take this outside the room. I resonate with Josselson when she says:

I worry intensely about how people will feel about what I write about them. I worry about the intrusiveness of the experience of being 'written down', fixed in print, formulated, summed up, encapsulated in language, reduced in some way to what the words contain. Language can never contain a whole person, so every act of writing a person's life is inevitably a violation. (Josselson, 1996: 63)

I found a unique form of representation while devising the play, from my own data gathered in the intensive, heuristic Phase One of the project. Much later on in the research, when I was struggling to find a way of representing data from Phases Two and Three, I realised that I had instinctively utilised the oblique element of the dramatic art form to represent the data I'd collected in Phase One. The heuristic piece of work captured my personal experience of being a dramatherapist working with children with life-limiting or life-threatening conditions, and therefore offered me the freedom to represent my findings according to my own vision. In some ways this made my task more difficult when making ethical decisions about how to represent the focus groups and the interviews, as I'd experienced such a satisfying and 'good fit' in the first phase in terms of representation.

## **6. Conclusion**

This chapter has provided an overview of the ethical considerations identified as relevant for this project, describing the steps taken to address these in a meaningful way while avoiding what Josselson (1996: xii) refers to as 'merely waving flags about confidentiality and anonymity [in] a superficial, unthoughtful response.' Firstly, the obligatory guidelines for ethical practice

were submitted, as appropriate, and in order to ensure that ethical considerations were an ongoing process I constantly referred back to them. The next ethical consideration for this project concerned participant safety, and this was addressed by ensuring clear communication and support were in place throughout the project. This was followed by the issue of consent and confidentiality, which was particularly sensitive and complex due to the nature of the research topic and thus involved a number of different approaches. Finally, representation of the research data was a complicated and challenging ethical consideration – one that required a good deal of input from my academic advisor and consultant. As Etherington (2004: 82) acknowledges, 'ethical issues abound in the practice and representations of reflexive research, perhaps no more so than in other kinds of research, but the greater transparency allows us to have a greater awareness of them.'

Transparency has been shown to be the key ethical consideration all the way through this research.



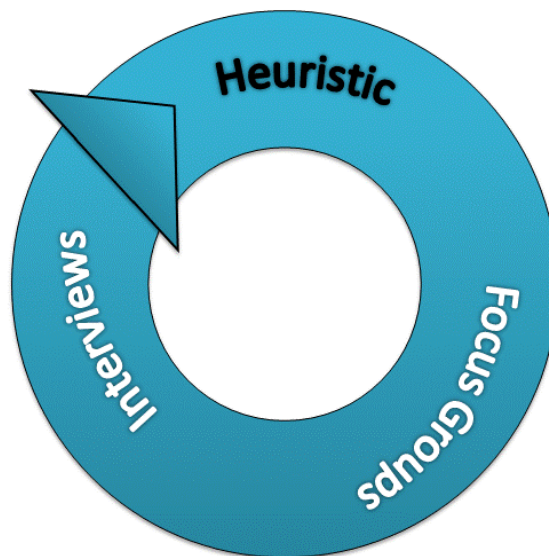


Figure 11: Research Design – Phase One

## Chapter 5 – Phase One: Intensive Heuristic Enquiry

### 1. Introduction

‘Though I cannot see it with my eyes, I trust that the current knows where it is going. I shall let go, and let it take me where it will.’ (Bach, 1977: 6)

This first phase of the project involved a period of creative ‘letting go’ in order to explore my own experience as a dramatherapist working with children with life-limiting or life-threatening conditions. This chapter begins with an analysis of heuristic methodology and its limitations, and continues with ethical considerations specific to this phase of the research. The chapter includes extracts and images taken specifically from my Practice Evaluation Project (PEP) and from the six-year research period, with this deep personal

inquiry underpinning the project as a whole. Creative data is presented through Moustakas' (1990) six stages of inquiry, and this is followed by a discussion of the personal insights gained.

## **2. Relevance**

The first phase of the project required a design that would allow an exploration of the complex, personal process of the dramatherapist (in this case myself). As Barber identifies:

As a practitioner-researcher, a human instrument who experiences alongside others, I regard myself as my primary facilitative and research tool and because I am a social being constructed in the same way as those I study, I look within myself and to my own experience to glean a richer understanding of others. (Barber, 2006: 24)

In light of this, I chose to work within a heuristic methodology as it provides an objective structure for the examination of the subjective process. As Moustakas describes:

Heuristic inquiry is a process that begins with a question or problem which the researcher seeks to illuminate or answer. The question is one that has been a personal challenge and puzzlement in the search to understand one's self and the world in which one lives. (Moustakas, 1990: 15)

Moustakas outlines a framework that allows deep personal inquiry through six stages: initial engagement; immersion; incubation; illumination; explication; and creative synthesis. This structure both contains and allows the fluid movement of personal experience, while also allowing the experience to be explicated into findings that can be shared.

A method of art-based research, as employed in this project, can also serve as a tool to dig deeper into the experience of the therapist. McNiff identifies

that ‘art-based research expands heuristic research by introducing the materials of creative expression to the experimental processes’ (McNiff, 1998: 54). Phase One of the project takes an integrative approach, adopting a heuristic framework to explore creative data, aligned with McNiff’s model of art-based research. To generate this data I took part in art therapy sessions – as referred to in Research Design, Chapter 3 – and engaged with other artists’ work and performances, as well as my personal journals and voice recordings of my reflections. The transpersonal and spiritual aspect within my work led to me to investigate further methodologies, such as those explored by Braun & Anderson (1998), who utilise dreams, artwork and creative writing. I have therefore also included dreams in my data.

McNiff (1998) suggests that experimental activity should remain at the centre of an arts-based research project. Writing from within a Jungian framework, Romanyshyn (2007) highlights the perceived split between academic research and the inner experience of the researcher – or, as he refers to it, the ‘soul’ – suggesting the value of exploration and sharing of inner experience. I am still thinking about Romanyshyn’s concept of ‘soul’, and will be for some time. The Concise Oxford Dictionary (Sykes, 1982) offers one definition of soul as the ‘spiritual or immaterial part of man held to survive death’; perhaps my inner flinching at the use of the word outside of a religious context is connected to my working this out in my own spiritual life. The project constantly touches, challenges and develops my own beliefs, as explored in my research journal:

The profound nature of my research project – that of death – puts me in touch with God more and more... I allow myself to be held, vulnerable and loved. I allow myself to hold on longer to the glimpses of what my project is really about. As I accompany clients, they ask: ‘What is the meaning of my life?’ I am also asking: ‘What is the meaning of **my** life?’ (19 February 2013)

Even though I am still pondering this, I admire Romanyshyn for his courage in finding words to describe such vast aspects of research. While teaching trainee therapists, I frequently highlight that we need to articulate in words *what we do*, and one of the first tasks I set students is to explain verbally, 'What is dramatherapy?'.

Romanyshyn employs Jungian concepts that support the subjective aspects of therapy; therefore in my discussion of the data I employ the Jungian concepts of symbol, the numinous and the collective unconscious. These allow me to draw out my own broad interpretations from my creative work and attempt to articulate inner experience. Romanyshyn uses the 'alchemical' process – whereby the combination of two elements (client and therapist) creates something new – to explore transformation. Through the heuristic process in this phase, the 'academic' (for want of a better word) and the 'soul' (again, for want of a better word) come together to transform the researcher and the therapist elements of myself into a practitioner whole. In turn the client, the reader and the institution all may be touched in some way.

### **3. Limitations**

Sela-Smith (2002) suggests that the majority of research claiming to be utilizing Moustakas' heuristic method is in fact doing something different. She states that 'the self-search within an experience is replaced by what I interpret as a phenomenological explication of the definition of an experience (Sela-Smith, 2002: 70). However, I consider that what might be perceived as a limitation in Moustakas' method is in fact a *strength* of this project, as I am seeking to collect *phenomenological* experiences of dramatherapists – including my own.

McLeod (2003) acknowledges two major challenges within a heuristic method: firstly in achieving sufficient detachment to write up the experience and communicate it effectively; and secondly in remaining open enough that the core of the experience is communicated. I agree with both of these points, as I struggled to clearly communicate my symbolic findings. However, this struggle underwent its own transformation as Phase One flowed into Phases Two and Three. Within the hermeneutic cycle of the project, Phase One (the part) became part of the whole; with this transformation I 'let go' of the need for crisp explanation and analysis, and I allowed Phase One to continue to flow into the rest of the research by drawing through my personal themes.

McNiff (1998) also highlights the limitations of heuristic methodology, noting that it can become a one-sided representation of the researcher's process and may thus neglect the exploration of any relationship present. This was also compensated for by focusing the research firstly on my own experience of dramatherapy with children with life-limiting or life-threatening conditions, and then by developing the research in relation to others.

Through my interaction with the materials in my own art therapy and creative writing, I also found ways of avoiding 'splitting off' and becoming isolated (from the relationship with my clients and from the research), enabling some outward channelling of an inner process. This is consistent with McNiff's argument that 'while art-based research makes good use of heuristic "self-dialogue", it also includes the study of external phenomena and dialogue with the object' (McNiff, 1998: 55).

Moustakas acknowledges that while there is value in the use of heuristic methodology with one participant, 'a study will achieve richer, deeper, more profound, and more varied meanings when it includes depictions of the experience of others' (Moustakas, 1990: 47). I had initially planned to include

three co-participants through semi-structured interviews in Phase One, and had spoken informally with a dramatherapist and a dance movement therapist who work within a secure forensic setting – both of whom had expressed experiences similar to my own while working with adult patients reflecting on their own deaths through the art form of drama. I was curious to investigate these experiences within a formal framework; however, keeping the balance of the three phases in mind, I made the project decision for Phase One to focus specifically on my own experiences.

One of the challenges I found while working within this methodology was that of becoming attuned to the point at which each heuristic phase evolved into the next. I overcame this challenge by endeavouring to allow Moustakas' framework to lightly hold my process rather than utilising it as rulebook.

Finally, as McLeod identifies, it can be difficult to find ways of disseminating and publishing heuristic projects because they are 'inherently unbounded and do not readily fit into academic schedules and publication formats' (McLeod, 2011: 208. Two journals rejected the article I adapted from this chapter and, although frustrating, I consider these experiences valuable in my development as a researcher and I continue to refine and shape the work into an article format for future consideration. The limitation identified by McLeod above was more significantly compensated for by the sharing of my findings in presentation format at a Sesame/BADth research day (2012 – see Appendix 11), and by two of the products that emerged as a result of the research (the play and the BADth Bereavement Special Interest Group). Details of these products are discussed in Chapter 8 – Outcomes and Discussion.

## **4. Ethical considerations**

‘Can I bear to sort out my untidy heaps of thoughts? Apart from being a muddle, they are private and mine.’ (Etherington, 2008: 52)

Throughout the process I engaged in extra clinical supervision to ensure that the intensity of the research would not have a negative impact on the direction, style or quality of my ongoing therapeutic work. ‘Alyson the therapist’ (as the subject of the research) certainly gave consent to ‘Alyson the researcher’, but she did not know what it was she had consented to, as – in a similar way to therapy – it is not possible to commit with certainty to what will unfold. Nor did the researcher know what she was really asking of her subject. These two roles sometimes worked at different paces, but their intention was entirely shared. There were, however, extremely painful periods when I was certainly more demanding of myself as my own ‘boss’ within the research than I ever conceivably would be of others – often pushing myself to continue when difficult material emerged. Ethically, this informed the way I worked with participants in the subsequent two phases, ensuring as far as possible that they understood what the research was about, and offering support throughout.

## **5. Stages of heuristic enquiry**

### **5.1. Initial engagement**

As the bereavement service developed I noticed patterns emerging and began to understand how I am affected by the experience of working with children with life-limiting or life-threatening conditions. I was having many profound and extra-ordinary experiences within the job, and had a strong desire to step back and take stock of what was happening for me in this role – to make sense of it and then to share my thoughts with other

dramatherapists. I also was receiving and increasing number of requests, drawing on my bereavement specialism, for supervision, consultation and training, which led me to reflect more deeply on my experiences. As Moustakas writes:

The task of the initial engagement is to discover an intense interest, a passionate concern that calls out to the researcher, one that holds important social meanings and personal, compelling implications. (Moustakas, 1990: 19)

My question has developed with the passing of time, with different clients, further training and life experience, leading ultimately to the focus of this project. Following discussion with my job-share partner, with whom I have worked closely since the beginning of the bereavement service, I decided to immerse myself in the experience. Months of intensive heuristic enquiry followed in order to try and answer my own question, and to build the foundation of the project.

In the presentation of my creative data, extracts from reflective journals, notes and poems appear on the right-hand side of the page, following Etherington's model (2004).



### August–September 2010

A piece of black ribbon, picked up from the floor of a Catholic church, came with me to the first session of art therapy. The bookmark had probably become separated from a Bible or prayer book. It is visible in the bottom left-hand corner of Fig. 12, below.



**Figure 12: *This Is Not a Stormy Sea***

**Photographed wet**

**1 September 2010**

#### ***Dream***

*There is a film crew recording at my house.  
I am uncomfortable with the intrusion but know they have to be  
there.  
A well-known arts therapist and her husband arrive at my house for  
the weekend.  
I am expecting them but am taken aback by how formal they are.  
They are dressed for dinner, she in an evening dress with fur stole,  
he in a tuxedo.*

*I only have a few bits and pieces in the fridge. It is embarrassing.  
They are polite but say they have decided not to stay.  
(25 September 2010)*

#### **Dream**

*There is a sailing boat that I have borrowed to sail along the  
English coastline from one place to another.  
Someone I know well (in reality a trusted, authority figure in my  
life) shows me how to sail and then leaves, saying he will meet me  
at the other end.  
I set off.  
I put up the sail as I have been shown, but the boat grounds itself  
in the shallow water.  
I have to clamber off onto land.  
I find the friend but am terrified that I have written the boat off.  
I am worried he will be angry.  
He helps me find the boat.  
It has freed itself and is undamaged.  
(30 September 2010)*

## **5.2. Immersion: October 2010**

#### **Research journal**

*The deep well of immersion is a dark period, plagued by my  
resistance and frustration at 'falling in' to a subject area that  
can be described as 'dark': children's death. Strong parallel  
processes like ocean currents have pulled me down. Often during  
this period of indwelling I have feared not only that I will not be  
washed onto the shore but that there is no shore.*

#### **Child's funeral attended by a dramatherapist**

*You are dead  
I am alive  
You are in a Cinderella coach  
I am in my black trousers and NHS badge  
You journey here pulled by two white horses  
I come in Dianne's seven-seater VW people carrier  
You lay in the back alone  
I sit in the back with my colleague and friend  
You haven't eaten or drunk since I've known you  
We drink cappuccino on the way  
They say you look 'more alive dead than you did alive'  
I do not know how I look and no one has told me  
You have no feelings today  
I do not want to have feelings today*

You are dead  
I am alive.



**Figure 13: Shadow Image of Funeral Cortège**

**Notes after art therapy**

*I made my shadow image of (client/child) funeral cortège today.*

*I spooked myself. A deep childlike fear was inside of me. I had to look up when the first black wire tentacle came out of the carriage to check that the art therapist was still there and looking after me.*

*Perhaps this is what is under the 'This Is Not a Stormy Sea' picture?*

*It could be. It was certainly frightening enough. Yet I did not find it difficult to stay with it.*

*And I did not want to stop. It felt compelling and safe enough to do it.*

*I wouldn't be able to do that at home on my own. I would be too frightened.*

*This touches upon something very young within me, a very childlike fear.*

*The transference here is strong. Surely any adult would want*

to prevent a child from being afraid?  
I am realising how frightened some of the clients are.  
It is only here, safely within the boundaries of art therapy  
that I have been able to make conscious how frightened we (the  
child and I) actually are.  
'This Is Not a Stormy Sea'.  
Yes, it is...  
Perhaps, within the systemic work, the shadow is kept firmly  
at bay, and as therapist I am the only person holding or  
allowing the shadow?  
Out of these moments that I seek to research there has been  
transformation for the client and for me too.  
In my client process notes I refer to a moment within the  
session:  
'Freed-up. A gateway session...'  
Perhaps with numinousity there always comes illumination for  
the client  
and maybe the therapist?

### **Research journal**

Wonderful is the session  
where we are only working with the spirit or the unconscious -  
or dare I say soul.  
The Body Betrayed is out of the picture and we are free of its  
limits, inconvenience and pain.  
We are freed up to be with the processes and not tied to the  
wheelchair, the tubes, the confines of the sickness.  
The feelings may not be 'nice' but there is relief in being  
deep, deep in them without restraint.  
This is not depression or being sunk.  
This is having a designated space to live, where the spirit  
can breathe freely.

## **5.3. Incubation: November 2010**



**Figure 14: *Tortoise On Path Without Eyes***  
**12 November 2010**

**Art therapy notes**

*Tortoise:*

*You haven't got any eyes and it's too late to put any on now.  
 No, it's far too late...  
 (12 November 2010)*

**Research journal**

*I am looking so hard I can no longer see.  
 (16 November 2010)*

**Process notes**

*Death is everywhere -  
 So where can I live?  
 (29 November 2010)*

During this period a dark, fuzzy haze descended upon me. I became very anxious and frightened. A series of 'accidents' and interruptions forced me to stop focusing on the work. For example, as I sat at my kitchen table my shed was broken into, just a few metres away. At work I accidentally sent an email, meant for only one person, to the whole staff team. The electrics in my car went seemingly crazy and I got locked inside it and then, later in the

day, locked out of it. As these events unfolded I was able to consciously relate this to my unconscious working overtime, but seemed powerless to change what was happening in my world. I was vulnerable and afraid to leave the house. Through these synchronistic (Jung, 1952) events I grew to understand that – much as I desired to – I could not control or rush the heuristic process I had started. More alarming at that point, neither did I feel I could undo what I had done. I could not *un-know* what I now knew.

These events forced me to stop consciously focusing on the question I had been immersed in, and I took my foot off the pedal and went to work with a sense of relief that ‘life goes on’. I began to feel safer and came back to myself. I got a high trellis put around my garden; my car was fixed; I became extra careful with emails and enjoyed time away from study. This period echoes the dual process model (Strobe & Shut, 1999), which introduces the concept of oscillation between coping behaviours that focus on the loss and those that focus on the future – both being important for adaptation and finding new meaning after a significant death. I had to take time away from such intense focus in order to gain some perspective.

#### **5.4. Illumination: December 2010 – January 2011**





*Today I articulated in art therapy for the first  
time what the discrepancy is between what I am  
perceived to do and what I actually do.  
For me, my experience is of accompanying the client  
on their voyage.  
The moments that are at the heart of this research  
are full of vitality, energy, passion and life.  
They are sometimes adrenaline-fuelled, heart  
pumping;  
they are sometimes peaceful and still.  
But there is always a numinous quality that results  
in some kind of shift, learning or illumination for  
the client and for me as a therapist and a person.  
(10 December 2010)*

### **5.5. Explication: January–February 2011**

Themes that emerged were identified through the intensive review of creative data. This included transcribing and spending time with my voice recordings, and reading my research journal, notes and literature. During this I highlighted key words and made notes of the feelings, atmospheres and moods I had noticed during this period.

#### ***Fear, isolation and shame***

Fear is often present within the work – for both the client and the therapist. The level of this fear surprised me. My responses vary within different sessions and with different clients, but they are authentic. This fear can lead to a feeling of risk within interventions; if I consider the opposite of risk to be safety, then I understand why it is challenging for me to be with a child who feels unsafe due to their illness. Being afraid can be lonely and sometimes shameful. It can be difficult to say, ‘I am afraid,’ and fear, isolation and shame can lead to silence. Unconsciously, I sought out this doctorate programme to explore and express this fear. Mirroring the programme handbook, I have used this research to ‘give voice and awareness to the unspoken, unspeakable, unsayable’ (Metanoia Institute and Middlesex University, 2013: 116).



### ***The unknown***

A recurrent theme, which explains why the work is emotionally demanding for me, is the level of uncertainty the client experiences. Out of the intensity of the research I have gained a new understanding of my unconscious choosing of which layer of 'knowing' to engage with – as tacit knowledge has become conscious (Moustakas, 1990).

### ***Pace***

Not only does the client need to work at their own pace, but so do I. As the therapist I can only see what I allow myself to see – what I am *able* to see. From the outset, I aimed to ensure that I did not limit the client's pace with my own protective strategies. I now understand that this is also a shared process, and that there is therapeutic value in the client being impacted by the therapist's pace. Just as the therapist may internalize some of the client's process, this may also happen the other way round.

### ***Inner resources revealed to me***

My training and skills offer me a trustworthy therapeutic framework in which to work with a client, and yet I am *with* them from my deepest wisdom. My personal, unique cultural and spiritual beliefs can enhance clinical work. Rather than suppressing these areas of myself in order to put the emphasis on the client's unique cultural make-up, my tacit knowledge identified consciously through this study serves to support and develop the client's process.

## 5.6. Creative synthesis: February–March 2011



**Figure 16: Tortoise on Path with Temporary Eyes**  
(*Tortoise On Path Without Eyes*, of 12 November 2010, re-visited and re-named)  
11 February 2011

### ***Voice recording after art therapy session***

*Tortoise:*

*You don't have any eyes.*

*Last session, I was adamant it was 'too late' to draw any on, even though it would have been really easy to pick up a black felt tip and give you a dot.*

*Suddenly I know what to do!*

*I cut a tiny piece of paper out and colour it in black.*

*I stick the tiny eye onto your face.*

*You have temporary eyes.*

*(11 February 2011)*

Originally I wanted to explore the moments of risk I sometimes felt in sessions, but I had abandoned the word 'risk' as it did not seem to fit (perhaps too 'risky'?). However, my art therapist used the word again and it

brought me up sharp. She was explaining how the client takes the creative risk in the arts therapies, and that is what I was doing. This was the moment I had been looking to reach. And most significantly, it illuminated why there is suffering within the moment of risk. The deep breath halting fear.

**Notes after art therapy**

*'It would be easier to work in NatWest, but I'm enjoying it,'  
I found myself  
commenting to a friend who asked how work was going. This is  
another version of 'This Is Not a Stormy Sea'.  
(February 2011)*

**Transcription of voice recording**

*You see a place differently when you leave it. This is a  
stormy sea and I can survive it.  
(March 2011)*

## 6. Discussion

Levine (1997) highlights the need for order and chaos, light and shadow, science and art to engage in dialogue and be present within imaginative research. This notion contributes to the theoretical underpinning of my project, which incorporates art-based research in a heuristic methodology. Jung suggests:

Anyone who gives up all belief in survival merely marches towards oblivion, but one who puts faith in the archetype follows a living path right up until the moment of death. Both, to be sure, remain in uncertainty, but the one lives against his instincts, the others with them. (Jung, 1983: 337)

The archetype and the collective unconscious are core elements of Jung's work, and they inform my personal interpretation of the creative data. By examining the symbols created within art therapy and in dreams, I am able to begin to explicate meaning from the data. My personal symbols and archetypes reflect a collective unconscious, and are therefore linked closely to the client's personal unconscious (Jung, 1980). As Jung writes:

The numinosum – whatever its cause may be – is an experience of the subject independent of his will [...] The numinosum is either a quality belonging to a visible object or the influence of an invisible presence that causes a peculiar alteration of consciousness. (Jung, 1937: 10)

I engaged with the data through reflection on the symbolic content. The dreams, images and symbols I encountered contain strong archetypal themes, which connect my personal unconscious to the collective unconscious (Jung, 1964). Through the use of symbol, the autobiographic content of the data is linked to the wider cultural and social context – as with Yalom's 'rippling' concept, where 'each of us creates often without our conscious intent or knowledge concentric circles of influence that may affect others for years, even for generations' (Yalom, 2008: 83).

In the following discussion and examination of images, I attempt to make my personal understandings available to the reader. Specifically, the key themes that emerged during the explication of meaning from the images were: fear; isolation and shame; the unknown; pace; and inner resources.

### ***‘Stormy Sea’ painting***

The sea may represent the mediating agent between the air and the earth – and therefore between life and death. The oceans can be seen as the source of life, and therefore to return to that source – which is sometimes referred to as the ‘mother’ – is to die. This made sense in relation to the renaming of my picture. At my own pace, I was able to acknowledge the turbulence involved within my work through my engagement with the picture.

The alteration in my conscious understanding of the artwork highlights a numinous quality to this experience – in Jung’s words, ‘a confrontation with a force that implies a not-yet-disclosed, attractive and fateful meaning’ (Jung, 1937). The ribbon, picked up from the floor of a church, brings a spiritual thread; it is only visible in the bottom left-hand corner of the picture, but it runs right across the whole image and is buried underneath the layers of paint. I am reminded that it had come from a Bible or prayer book, and I wonder whether my impulse to retrieve it and take it to art therapy reflects a desire to become more connected to my spiritual process.

Within the vitality of the client and dramatherapist’s relationship we are both afraid of death. We possess a deep knowing of our mortality. The symbols and archetypes represented within the stories, movement and sounds that emerge within therapy sessions allow the client to access their inner resources and manage the uncertainty of the present and future. At times the creative work, supported by the boundaries and interventions of the

therapist, allows the fear and isolation to be transformed and viewed, through the distance of the art form, from a different perspective.

### ***'Tortoise' drawings***

I was surprised to find that the earth-bound turtle and tortoise frequently appear as symbols within story and art. The Eastern interpretation (Volker, 1975) is that the shell represents heaven and the body represents earth, life, death and the afterlife. The tortoise is universally slow and may symbolise longevity and wisdom; the therapist is confined/bound within the limitations of the separateness of the client and their own (the therapist's) personal journey. The therapist will steadily, slowly stay with the client throughout the therapeutic process, within both the constraints and the freedom of their differing experiences.

### ***Dreams***

There appears to be a clear theme running through the pictures of the sea and the recorded dream. A boat is a vehicle, which suggests travel or journey; within the dream I have been taught how to make that journey, but I fail, which causes distress. The boat may represent the womb or cradle, and perhaps this links to the symbol of the sea representing the mother. This cradle has freed itself, and thus the child separates itself from the mother. It may also be that the boat journeys through the unconscious process of therapy, and that the client needs to undertake this alone. The dream about the unsuccessful visit of the arts therapist and her husband may represent a difficult aspect of the impact of the research process on me; it occurred early within the initial engagement phase, and it may be that the formality of the visiting therapist – who in reality is a respected expert in her field – could represent the 'expert' dramatherapist within me. The stance I adopt within the dream may represent my new role of a researcher who is feeling less than 'expert'. Perhaps the lack of food suggests a fear of containing anything of use and the threat of being found out while being observed for all to see.

The husband may represent the masculine (thinking function), while the wife possibly represents the feminine (feeling function) – and yet, significantly, it is her participation that concerns me.

Participating in a research process myself informs the design of future projects. Gaining personal experience of the impact of the research process, which is different to the personal process within the research, enables the design to be sympathetic to the potential vulnerability of participants. It allows the opportunity to add further layers of support for participants – layers I may not otherwise have been aware of.

## **7. Conclusion**

This chapter has described the setting up of the intensive first phase of the research project, sharing key examples of the creative data that emerged from my journey through the six heuristic research stages developed by Moustakas. Through the explication of key themes I have gained personal understanding of the question, 'What is the experience of a dramatherapist working with a child with a life-threatening or life-limiting condition?'. This is now followed through into Phase Two of the project in Chapter 6 – Focus Groups.

I feel more confident to offer less interpretation and analysis of my own material than of the focus groups and individual interviews that follow. In a wider context, I see Phase One as a hard-earned learning curve, during which I struggled to understand how best to convey my experience. It is the bedside table of my project; much of the understanding remains at a tacit level and surfaces when needed. I have changed my mind with confidence and arrived at an understanding that not all knowledge should or can be

explicated. While reflecting on the research process of Phase One, I recognise this learning point as vital to the following phases of research.

In terms of bias within the research, and in my clinical practice, I have learned that there are often powerful, transferential processes present within the work. Due to my personal bereavement experience, I am more likely to face these feelings head-on in order to dispense of them quickly. I have always been sensitive to them in the past, but am now able to recognise and work with more conscious knowledge and discipline.

Yalom reflects on the privilege of being a therapist, noticing that 'I rarely hear my therapist colleagues complain their lives lack meaning' (Yalom, 2002: 256). Ultimately, as a result of this first phase of the research, I understand more deeply that to be so closely involved with a child's process is a unique privilege. And with privilege comes responsibility – to do the best one can within the work. I therefore conclude that this research meets some of my personal and professional responsibility to the client, to myself, and to the wider dramatherapy community.



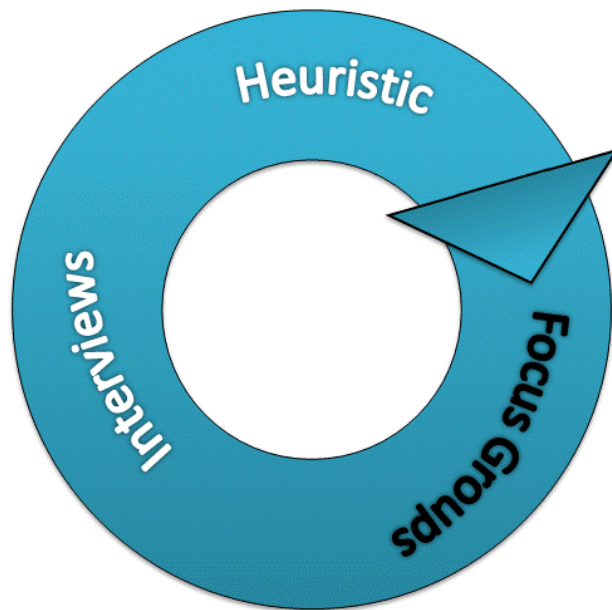


Figure 17: Research Design – Phase Two

## Chapter 6 – Phase Two: Focus Groups

### 1. Introduction

This chapter begins with a literature review of the relevance and limitations of a focus group as a methodology for researching the experiences of professionals working with children with life-limiting and life-threatening conditions. The application of this methodology in the research is organised into three sections: the 'before' section outlines the preparations for the focus groups and includes an analysis of sampling and triangulation, the process of setting up the groups, ethical considerations and consent issues; the 'during' section analyses the role of the facilitator, the recording of the groups and data collection; and the 'after' section includes a critique of thematic analysis as a methodology for data analysis and a description of how this methodology was applied to the data collection. This is followed by an

analysis and discussion of the findings. The chapter concludes with recommendations for future practice and research.

## **2. Relevance**

Consideration was given to whether the project needed focus groups or group interviews. The focus group is more interested in people in discussion as members of a group rather than as individuals (Bryman, 2012). This aspect was important; I was not simply seeking the answers to questions, but looking to gain a *sense* of how teachers, nurses and therapists experience working with children with life-limiting or life-threatening conditions. Focus groups allow the introduction of themes, and they capture group participants' responses in relation to those themes and to each other. The conversation builds and develops; it is a dynamic exchange. Individuals challenge each other in a way that as an interviewer I might not. This process means that the researcher may gain more realistic accounts of what people really think. In addition, participants ask each other questions; this offered, for example, the opportunity for a nurse to ask a question of another nurse, allowing inquiry from inside the profession.

Most significantly, focus groups allow a group of research informants to interact with other and generate useful qualitative data – not only in response to the researcher's topics but through spontaneous dialogue with each other. This was reflected in how the groups were set up (McLeod, 2011). Krueger (1988) suggests that focus groups offer the opportunity to capture discussion, debate and negotiations in everyday life. This was an important consideration in my choice of data-collecting methodology, as I notice that colleagues working within bereavement can speak about their work in quite a routine manner. Work in a hospital or Special Educational Needs school can also be routine, and yet what of the extraordinary aspects of working with

issues surrounding death? Each of the focus groups took place in the specific group's place of work, therefore ensuring that the participants were in their own surroundings and in the geographical location of the topic of discussion, so that I could capture their conversations in context.

An inspiring example of a similar type of focus group data collection can be found in *Troubling the Angels* (Lather & Smithies, 1997), which documents the political and social changes experienced by a group of women living with HIV/AIDS, who met over a period of five years (initially as part of a support group which then developed into a focus group). In contrast to the groups in my project, Lather & Smithies' research is very much written with the women as co-researchers rather than research participants. 'The women are the voice, the researchers are the hands and feet' (1997: xix). They describe how the women filled the groups with their opinions and experiences, which resulted in the original support groups developing into a project that was meaningful for the women, the researchers and the wider global AIDS community. Lather & Smithies initially planned to conduct multiple individual interviews, but changed their methodology after noticing the richness of the material coming out of the group process – which they believed could not be created purely from the research participants' interaction with the researcher.

Krueger (1988) suggests that focus groups should consist of similar types of people with something in common in order to prevent unhelpful misunderstandings of lifestyle, age or other factors. By the nature of their work, the participant groups I selected included individuals who already had similar features. For example, nurses, teachers and therapists are more likely to be female than male. In addition, the profession-specific groups shared a common professional language. Krueger (1988) continues to warn that existing groups – e.g. work colleagues – may be negatively impacted by hierarchy and politics within an organisation. What Krueger identifies as a restrictive feature of work-based groups seemed to me to be of specific

interest to this project; I decided that organisational dynamics would inevitably be present, and this in itself may be of importance.

Focus groups have been selected for this stage of the project as they allow a rigorous information-gathering structure (Bloor et al., 2001) involving different perspectives. This contrasts with and expands on the heuristic research initially carried out during the first stage of the project, which focused on my personal relationship with the dramatherapy work.

### **3. Limitations**

Cooperative inquiry (Heron, 1996) – working with co-researchers – was considered but discounted, as the emphasis during this second phase of the project is on gaining information from research participants in a focused, time-efficient way. Each of the target groups had limited time resources but was able to commit to one meeting. Within schools and hospitals it can be challenging to enable participants to attend a focus group whilst ensuring enough staff remain on duty to work with the children; a focus group cannot be prioritised when emergencies or staff sickness occurs, and therefore can be cancelled at short notice. Even from one focus group, a large amount of data is generated and this can be time-consuming and difficult to manage. Bloor et al. (2001) suggest that a focus group session lasting one hour can take up to eight hours to transcribe, while Bryman (2012) acknowledges the vast amount of time needed to arrange, transcribe and analyse data. He suggests that smaller studies using focus groups such as this one retain value as long as there is a clear rationale for their purpose.

Audio recordings can be inaudible due to two or more participants speaking at the same time, which can affect the accuracy of transcriptions. More confident speakers may take more time, leaving other people's views

unvoiced. Participants may be more likely to express views from the group's culture even if they differ from their own individual views (Morgan, 1998).

There are certain individuals and research themes that may be inappropriate for focus groups; Madriz (2000) suggests that when discomfort might arise from sharing with others, or intimate details of private lives are explored, individual interviews are preferable. However, the decision to run focus groups to discuss this sensitive topic was made with the specific intention of creating an opportunity for the staff teams to share their experiences with each other, and was partly based on requests for staff support groups that had been made in previous years.

As a dramatherapist, it is possible that out of the three groups I may have a deeper understanding of, or bias towards, the dramatherapy focus group. I aimed to compensate for this by noticing whether it arose, and planned to engage in further discussion with members of the nurse or educator groups. I'm also considering submitting a version of this chapter to a medical or education journal, and will therefore be seeking guidance from colleagues in those areas who have agreed to act as critical friends.

## **4. Before**

### **4.1. Triangulation**

Cohen & Manion (2000: 254) define triangulation as an 'attempt to map out, or explain more fully, the richness and complexity of human behaviour by studying it from more than one standpoint.' Denzin (1978: 291) identifies four basic types of triangulation:

- **Data triangulation** involves time, space, and persons
- **Investigator triangulation** involves multiple researchers in an investigation

- **Theory triangulation** involves using more than one theoretical scheme in the interpretation of the phenomenon
- **Methodological triangulation** involves using more than one method to gather data, such as interviews, observations, questionnaires, and documents.

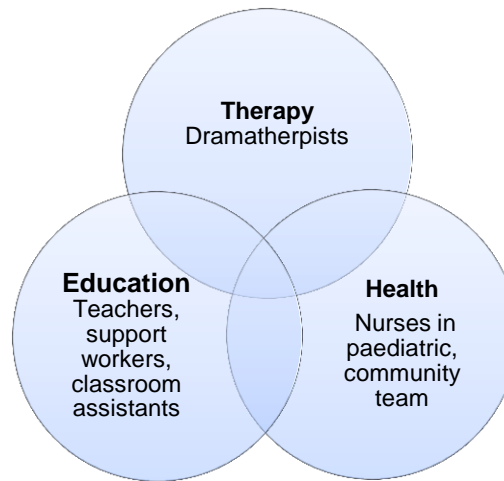
Within this second phase of the project, data triangulation was selected by asking three different groups of professionals about their experiences of working with children with life-limiting or life-threatening conditions. It was particularly important to broaden out into the wider context, in contrast with the intimacy and intense personal inquiry of the first, heuristic phase of the project. As argued, significantly, by Jones:

The norm in dramatherapy research should be to value the interdisciplinary: the relevance and innovative possibilities of contact between different fields or areas of knowledge. Research in dramatherapy should recognize both the value of discipline-specific research, where the focus is primarily of dramatherapy, along with the value of the collaborative research with other professionals and other disciplines' ABC of research. (Jones, 2012: 116–138)

The three types of practitioner I chose as being most relevant for my study – therapists, educationists and health professionals – represent the professionals I work alongside on a day-to-day basis. We all have different tasks in relation to the client, and I was interested in how these groups would respond to and expand on the personal themes from Phase One. How much had I integrated aspects of these 'other' roles within my own professional identity, and what impact does this have on my practice?

The focus group phase demonstrates that the project has not taken place in isolation but has been fully collaborative, involving data collection from 21 professionals from three disciplines. In addition to supporting Jones's recommendation that dramatherapy research values the 'interdisciplinary', as

stated above, it also enhances the trustworthiness of the research through detailed thematic analysis from three sources, as detailed in Fig. 18, below.



**Figure 18: Interdisciplinary focus groups**

#### **4.2. Sampling**

The recommended number of groups and participants for focus group research varies within the literature, as helpfully summarised by Bryman (2012: 506) allowing comparison of composition of focus groups to take place in nine different areas of social research. This supported me to assess minimum and maximum numbers of participants, and the number of groups appropriate to the project. For example, Morgan (1998a) suggests a typical group size should be between six and 10 members, but takes into account the emotional engagement with the topic and recommends smaller groups for sensitive or complex subjects. Three focus groups were therefore held – a smaller number than the large-scale research projects referred to by Bryman (2012), who acknowledges that large numbers of groups are unnecessary when high levels of diversity are not anticipated in connection with the topic.

Groups took place in the following order due to availability of participants, researcher and camera operator, and to the scheduling of rooms:

### ***Dramatherapists***

The British Association of Dramatherapists (BADth) says:

Dramatherapy has as its main focus the intentional use of healing aspects of drama and theatre as the therapeutic process. It is a method of working and playing that uses action methods to facilitate creativity, imagination, learning, insight and growth. (2013)

A dramatherapy organisation in London was approached with the suggestion of a focus group within their team of dramatherapists. My professional relationship with the organisation is longstanding; I have facilitated several 'Bereavement and Dramatherapy' training days in previous years. Eight therapists in the organisation opted to participate, all of whom have experience of bereavement work to varying extents. Within this group there was a range of post-qualification experience, from the newly qualified to the very experienced. The profession of dramatherapy in Great Britain is relatively small, with BADth having approximately 700 members. I've taught two of the participants from this focus group as students; have worked with three as colleagues; know two from dramatherapy conferences and events; and one of them I had not previously met. The existing relationships between myself, the researcher and the research participants are discussed in Chapter 4 (Ethics) and in section 4.3, below.

### ***Educators***

The education group consisted of a staff team at one of the Special Educational Needs schools that I visit weekly to work with several clients. A request was made by the head teacher at a staff meeting for anyone interested to sign up for the group, which was to take place at the end of the school day. It drew a lot of interest and there was a very good response. Various members of staff approached me to find out more. Two weeks prior to the date set for the focus group, one of the children at school died very suddenly and this appeared to impact staff being drawn to the focus group.



The final group consisted of eight teachers (of infant, junior and senior classes), classroom assistants, and children's one-to-one support workers. The original date was rearranged on the morning of the meeting due to a union meeting within the school.

### **Nurses**

This group consisted of members of the NHS palliative care nursing team that I am part of. These nurses administer medical treatment and care in the homes of children who have life-limiting or life-threatening conditions. During the time of the research the team was very short-staffed, as several key members had recently left, leaving the remaining nurses under pressure with a heavy workload. The original scheduled group was cancelled due to patient visits, and it was challenging to find an alternative date as the team were so busy. After some difficulty in rescheduling, the group eventually took place the day before Christmas Eve with six nurses taking part.

### **4.3. Ethical considerations**

There were specific ethical issues taken into account during the focus group phase due to the sensitivity of the topic. Smith (1995) offers a number of relevant suggestions for focus groups aiming to research sensitive topics. These include: the need for the facilitator to monitor the stress levels of participants and to be prepared to intervene when necessary; the importance of having small groups; and the value of debriefing sessions in which participants can discuss their reactions to the discussion. He also emphasizes the importance of having a co-leader with clinical experience present in order to assess the participants' levels of (dis)comfort.

Smith's points were applied as follows during the focus group stage of the project: participants were clearly briefed as to the purpose of the discussions

and my role as facilitator, guiding them through potentially stressful moments; informal individual conversations took place frequently over the ensuing weeks and I was available to offer support where requested; the presence of my co-worker and her role in the focus group was acknowledged, and her agreement to confidentiality confirmed. In addition, the presence of my clinical colleague as camera operator offered a further layer of containment and support for both the participants and myself.

Careful thought was given to the existing and ongoing professional relationships between myself and my colleagues in the groups. Throughout the setting-up process, our existing relationships appeared to be beneficial to the project as they meant professional trust already existed. Pre-existing relationships between researcher and participants can facilitate a rapport which can lead to a more authentic discussion. Researching within my own extended network of teams and colleagues, however, necessitated my being mindful of the possibility of participants feeling *obliged* to agree to taking part and wanting to support me personally. In order to address this aspect, invitations to take part were issued to wider teams in an attempt to take possible pressure off close colleagues.

There are unique ethical aspects of confidentiality when using focus groups as a research methodology (Homan, 1991). Firstly, focus group participants are required to respect the confidentiality of the discussions by not revealing the contents of the discussions outside of the focus groups. Secondly, as participants in the focus groups work with the same children on a daily basis, it seemed unavoidable and important that the participants could speak freely about these named children without anonymising them. I therefore took the ethical stance of fully anonymising both the participants and the children discussed within the transcriptions. The audio and film footage adhere to the guidelines for confidentiality that are detailed in the Project Information Sheet

and consent forms (see Appendices 11 and 12). Transcripts were checked with a member of each group to ensure no clients could be identified.

#### **4.4. Consent**

Specific issues of consent arose in the Focus Group phase of this research due to the large number of participants and the sensitive nature of the topic under discussion.

Firstly, information sheets and consent forms were emailed to participants in advance to allow time for them to read and ask any clarifying questions about them. (Further copies were available on the day.) Secondly, time was offered at the beginning of each Focus Group for questions and discussion to take place. It was important that participants had a sense of how the groups they were participating in fitted into the larger project, in order for the consent to be informed. This perhaps mirrored the aspect of transparency present within the therapist/client relationship (Clarkson, 2009), and reflected the integrity of the project. By discussing this in addition to providing written project information, I was able to ensure that consent was a *process* rather than a black-and-white procedure. I was mindful of the more complex aspects of trust between the participants and researcher, and was reminded of the working alliance (Clarkson, 2009), which enables the client and therapist to continue working through difficult aspects of the relationship which they otherwise would not be able to.

The process of running the Focus Group has highlighted that the consent form that was used should have included an item referring to shared confidentiality, and the project information should have explained this in more detail. This would have helped to formalise the importance of shared confidentiality, which Smith (1995) identifies as a specific ethical issue. Smith

(1995) states that in the context of a Focus Group the facilitator does not have control over what participants disclose about each other's contribution after they leave, and therefore cannot imply that absolute confidentiality will be kept. In my experience of running the groups, this involved ensuring that each participant understood the importance the groups privacy, but also accepting that this is in contrast with the precise nature of confidential keeping involved in other types of data in the project – e.g. individual interviews. I also note that in each of the work settings highlighted there is a culture of sharing information, with regular, naturally occurring opportunities for discussions in the staff room, in offices or through social events.

Finally, further consideration was given to the issue of consent through the agreement of the head teacher of the school, the director of the dramatherapy organisation and the clinical team leader of the nursing team, for the groups to take place on their premises and within work time.

#### **4.5. Respondent validity**

One member from each of the focus groups, and the cameraperson, read and approved the accuracy of the transcripts in order to ensure that they were a valid account of events.

### **5. During**

Each group ran for between one-and-a-half and two hours. Participants sat in a circle on chairs and a sign was placed on the door requesting no interruptions. I used a prompt sheet (see Appendix 12) for reminders about structure and the themes to be introduced. At the beginning of each group I offered an overview of my programme of study; this gave a wider sense of

containment and structure to the project as a whole. I then explained specific aspects of the project with particular emphasis on the phase they were taking part in – the focus groups.

This phase of the research has a number of unique and unusual aspects. Firstly, this is the first time research has taken an all-round professional view of the process of working with the life-limited or life-threatened child. Not only has this experience enhanced my understanding of dramatherapy, but it has also enhanced my professional understanding of the way nurses and educators work with these children. This means I'm able to work more effectively alongside nurses and educators, which in turn results in better care for the children. I'm also better able to anticipate the needs and concerns of these professionals, and this has had a direct impact on my practice – for example, by taking these concerns to wider, multi-disciplinary discussions.

The second unique aspect concerns the process of a dramatherapist running a focus group (this is elaborated below). Furthermore, the role of the dramatherapist as cameraperson was unusual in that she offered a further layer of containment, as also discussed below. Finally, the wide range of types of data collected gave an unusually rich source of information, allowing fresh insight to be gained.

### **5.1. Dramatherapist as focus group facilitator**

During the early stages of planning I thought there may be value in a colleague, rather than myself, facilitating the focus groups to ensure objectivity; but after feedback from the Metanoia Learning Agreement panel, and careful consideration of resources, I decided to facilitate the groups myself. This was an important decision as it placed me at the centre of the

research process and acknowledged the range of my roles – colleague, researcher, and practitioner.

The process of a dramatherapist running a focus group was a unique feature of this research. Moderating or facilitating focus groups involves creating an environment where the views and experiences of the participants in relation to the research topic can be gathered (Wilkinson, 1998); as a dramatherapist I have experience in facilitating many types of therapy groups, and was therefore able build on these skills in combination with my skills as a researcher. Familiar, day-to-day therapy skills included holding; allowing; facilitating the *process* rather than the questions or answers; creating a therapeutic container for feelings and sensitive information; confidentiality; picking up on the subtle hierarchy or status of participants in relationship with each other; introducing themes whilst allowing the group to fill the space; and boundary-keeping. However, one of the challenges I experienced was in limiting my own contributions – specifically in moments when the group needed encouragement to expand on a particularly relevant area or to stay on the topic of the inquiry.

I reflected in my research journal on the long period of time I had spent alone with the early heuristic process during Phase One of this research, and how thirst-quenching it was to be with others, discussing a topic I had lived and breathed for several years. The deep exploration of my own practice in the first heuristic phase fed into the focus group phase in a dynamic way. One of the ways in which I experienced the focus group was as though the findings from the first phase of research had come to life – much like the way in which the play (product 1) brought my findings to life. This was extremely exciting; it confirmed the value of the BADth Special Interest Group as a product, and flowed into my facilitation of the focus groups.

The early meetings allowed me to hear other dramatherapists' experiences in an informal way without pressure to 'research' or record. In this way I could offer and receive support. I became more aware of the different ways in which therapists choose to share their experiences of working with dying children, and of how I might feel and react in response to them. The Special Interest Group and the focus groups exposed me to new ways of being and of developing professional knowledge.

I considered the potential for personal material to be overwhelming, and how I could keep the focus groups close to the area of research. The aim was to guide the groups to speak about their experiences at work whilst taking into account the personal influences; this is often a delicate balance, and it had taken me a long time to achieve within training sessions with people in a professional setting. For example, in a very early training I offered in 2000 to care assistants working with terminally ill patients in their own homes, there was far too much emphasis on personal process. I encouraged them to share feelings about the job, which opened the floodgates for emotions around personal and professional bereavement. This then made the task of training almost impossible.

Since then I have developed far more effective methods of training, as summarised below:

<b>Training strategy</b>	<b>Results in...</b>
Making a firm working alliance at the beginning of the training	Containment
Stating that bereavement issues at work touch us all at some point	Acknowledging, respecting and naming

Asking people to think of a client or patient they've worked with in the past, and to use this example throughout the day to apply learning and keep the training work-based	Professional domain
Frequent pair work to enable building of relationship and trust with one person	Offers a smaller, safer environment in contrast to larger group

**Figure 19: Strategies/methods for bereavement training**

Bager-Charleson & Wright (2012) considered the skills or qualities of the therapist and the qualitative researcher in the Professional Knowledge seminar *Reflective Writing for Personal and Professional Development*. The experience of running the focus groups was intriguing to me; I noticed that my role as dramatherapist, researcher and focus group facilitator could come together effectively to produce rich, sensitive and exciting data.

## **5.2. Data collection**

Each group was filmed using a digital camera, and audio was recorded using a Dictaphone. The camera was operated by my clinical colleague, whose role throughout the project is described in Research Design, Chapter 3.

The table below outlines the types of material gathered during the focus group phase of the research, and summarises the methods used to collect and process the material into the data used for analysis.



<b>Type of material</b>	<b>Data collection method</b>	<b>Process used</b>	<b>Data</b>
Words	Dictaphone	I transcribed from the sound recording as soon as possible after each group.	Typed transcript
Non-verbal communication (body language)	Filmed by digital camera on a tripod  Observation	The film footage was watched carefully with specific observations of body language, congruence and group dynamics.	Film footage and hand-written notes on transcript
Unconscious material	Researcher/facilitator's reflexive journal; researcher's own art therapy	Reflexive journaling continued throughout the process, with my somatic responses and feelings being noted to record potential transference material.	Journal artwork; hand-written notes on transcript
Observations from research assistant	Research assistant's reflexive journal	Research assistant journaled throughout the process – this was then given to the researcher.	Journal; researcher's hand-written notes

**Figure 20: Focus group data and methods of collection**

## **6. After**

### **6.1. Thematic analysis**

The aim of the focus group phase of the project was to gather experiences from different professions working with children with life-limiting or life-threatening conditions, in order to identify those themes in the data which capture meaning that is relevant to the research question and can be brought into individual interviews. Thematic analysis was selected as it offered the flexibility required to adopt an eagle-eyed approach in identifying general themes, whilst retaining individual contributions on the ground. I was looking for patterns threaded through the three different professions' experience of working with the same client group, despite their being engaged in different tasks.

Braun & Clarke (2006: 77) describe thematic analysis as 'a poorly demarcated and rarely acknowledged, yet widely used qualitative analytic method.' It has been argued (Boyatzis, 1998) that thematic analysis does not constitute a method of analysis in itself because the systematic process of extracting themes from data can form a part of a wide range of qualitative approaches to data analysis. This means that, having extracted themes, the researcher still needs to decide what these themes represent; for example, does a theme represent a discursive construction, a thought, a feeling or a psychological mechanism? Does the researcher take the theme at face value – as something that directly reflects the research participant's experience – or do they approach the theme as something that needs to be

explained in its own right? Answers to these types of questions will reveal the epistemological and theoretical positions adopted by the researcher, and it is those positions that have implications for the approach to interpretation that is adopted in the study.

Thematic analysis can underpin both 'empathic' and 'suspicious' interpretations, and it can therefore be associated with research across our continuum, including both 'tentative' and 'prescriptive' approaches – and indeed anything in between. Thematic analysis allows for a researcher who is also a therapist to let her thinking and feeling functions operate together in order to view the data from varied standpoints, both empathetic and suspicious. Thus what Braun & Clarke (2006: 77) identify as a weakness in effect provides a positive rationale for the choice of this approach for this particular research.

## **6.2. Application**

As identified by Bryman (2012), there are various definitions of what constitutes a theme. For the purposes of this analysis I adapted aspects of Ryan & Bernard's (2003) recommendations that a theme is a subject that occurs regularly and creates a form of pattern. This might take place through words, non-verbally through body language, through metaphor or in an absence of information offered by the participants.

I read each of the three transcripts several times and contemplated the contents over a period of weeks. Spending time with the data (reading it, watching it, listening to recordings), I developed a coding system to identify themes common to all three groups. I then returned to the transcripts and reviewed them, taking into account how these themes were introduced,

participants' approach to them and whether they were similar or different in each group.

Within the analysis I defined a theme as 'prevalent' if it appeared in each of the three groups. Where a theme emerged within a group it is marked with a cross in Fig. 21, below.

<b>Theme</b>	<b>Dramatherapy</b>	<b>Education</b>	<b>Nurses</b>
Shock	x		
Family	x	x	
Overwhelming feelings	x		
Own losses	x	x	x
Wider circle of people/the world	x	x	
Colleagues	x	x	x
Institution/work setting	x		
Own mortality	x		x
Own experience helping/not helping within the work	x	x	
Being a parent yourself and how this affects the work	x	x	
Own strategies for dealing with the work	x	x	
Risk	x	x	x
Anxiety		x	x

Getting it right/getting it wrong	x	x	x
Responsibility	x	x	x
Making it better		x	x
Being prepared			x
Trust	x		x
Pain			x
Professional identity (e.g. as a nurse, as a teacher)		x	x
Switching off, 'holding' child in mind when not with them		x	x
Impact on your own faith	x	x	x
Doing your best			x

**Figure 21: Focus group themes**

## **7. Findings**

Analysis of the data from the focus groups revealed six prevalent themes that were evident in each group. The themes are described below, where illustrative quotes are given in *italic* and are followed by a letter denoting the professional group from which the quote came: (DT) for dramatherapists, (N) for nurses and (E) for educationists. The themes of 'risk', 'responsibility' and 'getting it right or wrong' are described together due to their similarities. Absent themes are also explored.

## 7.1. Own losses and mortality

*'You don't shout it from the rooftops, but it's in there.'* (DT)

Perhaps unsurprisingly, participants emphasized the relevance of their own bereavement history and how it impacts their day-to-day work. There was a mixture of ways in which participants used their own losses to inform their work in a helpful way – *'I've never felt fearful of those things and I think it's because of my personal experience of death in my own family early in life, and because of that I always trust myself that it will be OK'* (N) – and of the ways in which personal loss can make the job more difficult – *'I find myself full of grief almost every day since [the child's] death, and I wonder whether... my father died recently; well, three years ago... and I wonder whether it hits on that grief'* (E).

Lack of personal loss was challenged in terms of people being qualified to do the work: *'If you've not lived that, how could you know?'* (E). There was a general sense that personal experience is helpful, although in contrast one therapist participant reflected on her lack of close personal loss and searched for a reason for her connection to the work. She identified that *'there's going to be a flash of our own mortality'* in the work, and wondered whether this was her pull to the client group. She continued, *'My resources aren't familiarity, intimate familiarity; I think one of my resources is working with fear and wanting to step into the abyss'* (DT).

## 7.2. Colleagues

*'Somebody's looking out for you.'* (N)

Each focus group referred to the benefits of working with colleagues, but identified different benefits. For example, for the nurses, the notion of having peer support – members of your actual profession who have an

understanding of what an experience might have been like even if they had not been there – was important:

*‘What I struggle with is the ability to explain to someone else, if you’re at a particular visit and it’s been particularly traumatic. To actually explain it you’d have to take that person with you. And as you explain it you think, actually it doesn’t sound as dramatic because it’s about your own experience in that visit.’ (N)*

In addition, dramatherapists not only referred to the peer aspect – *‘Lunchtimes, somewhere to go back and spill the beans if you need to’ (DT)* – but also to the active relationship with co-facilitators, not simply for support but within the fabric of the work.

*‘It helped because we were co-facilitating, so I had someone else holding the space, but I felt very impacted by it. I didn’t want to do it – to experience it. I didn’t want to revisit that place with her (the child), and at the same time I longed to do it and longed to hold it and be there. It felt quite impactful, and there again that process of being able to talk about it afterwards – being able to de-role in the session – was really helpful. In the moment, I always remember that...’ (DT)*

Education staff described the support of colleagues as *‘vital’ (E)*.

### **7.3. Risk and responsibility: getting it right or wrong**

*‘What if I get this wrong?’ (N)*

*‘When someone does die you get one shot.’ (DT)*

A strong theme within the health and education focus groups was that of ‘getting it right or wrong’, perhaps because of the task-based nature of their roles – e.g. teaching and medical procedures have a clear right and wrong element that is absent in therapy. However, participants in these groups went on to explore ‘saying the right thing’ to children and families:

*'I can remember a child who was literally on the point of death and the mother coming to me in the hallway saying, "You've got to tell her now," and me thinking, "Oh my God, what am I going to say?". So that's the fear – that you're going to say the right thing because if you say the wrong thing it's never going to be forgotten.'* (N)

The idea of 'doing your best' seemed to comfort and compensate for the fear of 'getting it wrong':

*'If I had got it wrong it would have been damned unfortunate that I had got it wrong, but I didn't get it wrong on purpose; I did my best and I used all the skills that I have personally and professionally.'* (N)

The significance of the death of a child as a unique occasion seemed to bring a specific pressure to the professional:

*'Dying, or death, happens once, and it might need to be a certain way, so I wonder whether that's why it feels so precious and lonely.'* (DT)

As well as feeling responsible for the sick child, feelings of responsibility appeared for others in the scenario, such as the whole class of children (education) and the family unit (nurses). A nurse described the responsibility of holding complex family dynamics within the home setting: *'It's not even the child at the end of their life. That might be the easy bit!'* (N), while a teacher referred to the responsibility of balancing the needs of the child who is very ill in the class with those of the other children as *'impossible'* (E).

Another aspect of personal responsibility was the question of how much emotion should be shown at work. Some participants were clear that it was not appropriate to *'burden others with how you're feeling. You've got a right to feel how you feel, but it's a job'* (E), with others agreeing: *'there's nothing wrong with being sad if you're grieving, you can do that at home, but you can't do that publicly. It isn't right'* (E). This was balanced by the idea that if the adults don't show sadness then the other children may feel that when they themselves die it will have no impact and they will not be missed. *'Is it*



*so frightening for them to see us cry?’ (N). The notion of achieving a balance between how much or how little emotion to show children prompted discussion, with a teacher commenting, ‘Sometimes I think we overcompensate by appearing that it’s all OK’ (E).*

#### **7.4. Impact on your own faith**

*‘I’ve changed my beliefs since doing this job.’ (N)*

There seemed to be a sense of relief in all groups at being given the space to share the extent to which faith and spirituality impact their professional life – something that, whilst clearly important to all groups, is not actively encouraged at work. As professionals, it can be challenging to find a place for religious beliefs – *‘a very private thing’ (DT)* – when it is not common to express personal opinion to clients.

This is interesting, as each of the groups identified that the work had had an impact of some kind on their spirituality, either in a positive way – *‘Really a source of strength when working with particularly sad cases’ (DT)* – or in a way that prompted them to question their beliefs: *‘My dad was church warden, Sunday school, went to church all the time, then you see all these children dying...’ (N)*. For some, there was evidence of increased spirituality:

*‘...then you see people die, you hold their hands and they say to someone, “I’m coming,” and they die, so I’ve become more spiritual with nursing.’ (N)*

Even those who consider themselves to be non-practicing accept that religious ritual can be helpful. Referring to her Jewish background, a teacher participant said:

*'I'm pretty much, religious belief-wise, an atheist – but my religious tradition is actually very helpful. It says – and I'm paraphrasing very badly here – you're allowed to feel like shit for a year and then you're allowed to feel better. It gives you time to go: I don't have to feel like shit now...'. (E)*

## **7.5. Absent or indirect themes**

There were certain points where participants mentioned very specific personal bereavements, and as facilitator I needed to be mindful of how these conversations unfolded in order to support the individuals to contain potentially overwhelming grief and yet still feel able bring in personal connections.

*'I was shocked at how I reacted to [child in school]'s death because I couldn't move. I couldn't put my legs in front of one another. Looking back, it was like my mum's death. I was just in a daze. That was a sudden death, and I held it together during the day but when my husband came home he put his arm around me and I just completely sobbed, I was just shocked at my reaction...'. (E)*

In this sense it's difficult to identify how much more detail of close family deaths participants might have chosen to share had I not been containing the discussions. Personal bereavements were present in each group as participants made links such as the one mentioned above, but the way the focus groups were set up appeared to succeed in keeping the personal aspects within the professional domain. The overall design of the research project predicted this aspect, with the individual interviews planned to allow for expansion in this area.

Isolation was a theme that emerged for me in Phase One, where I explored the solo nature of life's journey. I thus brought this theme into the focus groups, but it did not appear as a prevalent theme for the participants in analysis of the data. However, members of the groups approached me in the

weeks after the meetings to continue the discussion, to gain support, to air issues raised, to comment on particular aspects and to offer further thoughts. This appears to be evidence that members of the three professions represented in the focus groups do indeed experience some sense of isolation, and have a desire to and see value in discussing the issues at the core of this research. This is explored further in the following section in this chapter.

## **8. Discussion**

The six prevalent themes that emerged from each group suggest that, on a human level, these three professional groups have similar experiences, but that the task and role of each group results in different approaches. On a human level, each group acknowledged the value of working alongside colleagues. They each found that the work touched on their personal bereavement history and they felt a sense of responsibility for the children they worked with. Each group also found that the work impacted on their faith. On a professional level, education staff and nurses expressed a frustration at 'not knowing' what might happen, whereas dramatherapists were familiar with this concept and able to 'hold' this and see it as an important aspect of supporting the client. Education staff and nurses were concerned about 'getting it wrong' for the child; in contrast, dramatherapists did not question this – rather they viewed it as an important aspect of the therapeutic work. Education staff and nurses, who do not have supervision, viewed an important strategy for looking after themselves as 'getting on with it', whereas dramatherapists mainly look after themselves by exploring their feelings and through supervision.

Dramatherapists use their own experiences and reflexivity as an important part of their work, whereas education staff and nurses consider their own

feelings to be coincidental and sometimes less important. Ken Doka's (1989) notion of 'disenfranchised grief' – whereby a person identifies that they are not entitled to experience grief to the same depth as others involved – was evident. All three groups appeared to grapple with an unwritten rule that the family of a child who dies are the primary mourners – which is indeed the case, but professionals find it difficult to find a place for their own grief. This can be confusing, and does not help to make sense of the intense sadness professionals may feel. Dramatherapists adapt to fit with other professionals in various situations connected to their work because of their role. They use creativity to support themselves and their clients in difficult encounters, and are therefore able to use aspects of their training for themselves as well as for clients. The presence of a dramatherapist can allow school staff and nurses to continue with their specific tasks knowing that the therapist is attending to the emotional needs of the child.

The job of working with children with very serious illnesses is typically viewed as a sad one, whereas the data also suggests it is a thought-provoking and satisfying one that has the ability to develop the worker spiritually, intellectually and in terms of engaging with their own mortality. The sample was predominantly female, which widely mirrors the workforce in these areas, but I consider there to be value in looking more closely at the benefits of mixed genders in teams, where a combination of male and female characteristics can offer more balanced care.

The focus group participants involved were between 35 and 60 years of age, with an average age of 45 years. In Erik Erikson's *Stages of Psychosocial Development* (1977), he identifies this period in life as the development stage 'generativity vs. stagnation', where the existential question is: *Can I make my life count?* This is relevant in that it links strongly with Phase One of the project. Generativity, in the psychosocial sense, refers to the concern for establishing and guiding the next generation, and is said to stem from a

sense of optimism about humanity. Socially valued work such as teaching, nursing and therapy are all expressions of generativity. Simply having or wanting children does not, in and of itself, achieve generativity.

During middle age the primary developmental task is one of contributing to society and helping to guide future generations; when a person makes a contribution during this period, a sense of productivity and accomplishment results. If this developmental conflict is not successfully passed through, a feeling of stagnation may develop – dissatisfaction with the relative lack of productivity. Participants of the focus groups are perhaps involved in a range of central tasks that Erickson identifies as key to achieving this productivity, including maintaining a healthy life pattern; helping your own children and grown-up children to be responsible adults; and reversing roles with ageing parents. In addition, during this stage of life there are adjustments to be made in accepting physical changes in one's own ageing body.

Any child with a serious medical condition in the UK will come into contact with numerous professionals such as those involved in the focus groups. All these people bring with them their own bereavement history, which will impact the way they interact with the child. Worden (2004) offers the example of a counsellor who may be over-anxious about the possible death of her own children, which may in turn result in her having great difficulty working with a parent who has lost a child. This simple example illustrates the complexity of any professional's personal process when working with a seriously unwell child.

Worden (2004) makes three recommendations for mental health counsellors working with bereavement. Referring to Mary Vachon (1979) – whose research with mental health workers in both hospice and acute hospital settings concludes that the best care can be given if caregivers are able to have an understanding of their own needs – Worden suggests, in summary,

that grief counsellors and therapists should be able to: 1) know their personal limitations; 2) avoid burnout by practising 'active grieving'; and 3) know how to ask for help.

The concept of 'active grieving' did not appear directly in the groups; there is therefore potential for this to be introduced within the teams that took part in the research. Here, Worden is referring to activities such as allowing oneself to go through a period of grieving, attending the funeral, and not feeling guilty if they do not feel the same intensity of sadness for each loss in the workplace.

I notice that isolation emerged as a key theme from my personal heuristic research, and that the support of colleagues was a prevalent theme within focus groups. Sharing with dramatherapy colleagues in the BADth Bereavement Special Interest Group allowed me to identify that this sense of isolation is related to existential issues regarding the solo nature of life, and is not due to a lack of collegiate support. As James Anthony Froude said, 'We enter the world alone. We leave the world alone.' Froude perhaps adapts the biblical notion from 1 Timothy, 6:7 (King James Bible, 1611 Cambridge version): 'For we brought nothing into this world, and it is certain we can carry nothing out.'

Worden's (2004) recommendation for self-care and self-support is relevant, with all focus groups making reference to seeking help and support from colleagues. The literature identifies good relationships with colleagues in nursing (Chapman, 1993), and within teaching (1978), as being a key part of self-support within the work setting – although, perhaps not surprisingly, much of the research in this area invested in seeking to formalize this through development of mentoring schemes and staff development programmes. No literature was found specifically on therapists' valuing of colleagues, although it's clear from the dramatherapists' focus group and

personal experience that this is the case. The focus group identified a deeper level of therapists' collegiate relationships – that of co-facilitating in psychodynamic dramatherapy sessions. This is also an area of research that needs developing, as there is currently no literature available.

Erikson's aforementioned instinctive drive at this stage of life for optimism, coupled with the frustration associated with the illness and death of a child in the professional's care, perhaps intensifies the emotional state that's experienced, and is stressful as it disrupts normal developmental expectations. Stagnation, or 'doing nothing', goes against the developmental drive to create, invest and develop the future, and can perhaps lead to a feeling of 'doing it wrong'.

Returning to Worden's first and third recommendations (know your personal limitations, and know how to ask for help), it's interesting that they were identified very clearly by a teacher in the education focus group:

*'You need to be mindful of your limitations; don't think you can do everything, and be honest and allow people to be honest [...] like, "I don't want that responsibility; it's not something I can do at this point."'*  
(E)

This reminds me of Epicurus, the Greek philosopher, who said, 'It is possible to provide security against other ills, but as far as death is concerned, we men live in a city without walls' (1993). Providing and maintaining the metaphorical walls referred to by Epicurus is seen as an adult responsibility, and it is universally acknowledged that an adult's duty is to protect and nurture children until they themselves are independent adults in the world. Death removes these 'walls', and consequently adults may feel they've done something 'wrong'.

There's an abundance of literature exploring the spiritual aspects of patients in hospice care (Nolan, 2012), but little referring to the spirituality of those who work with the dying. Heyse-Moore (1996) uses the term 'spiritual pain' to describe the anguish and meaninglessness that may be experienced by the dying person – but what of the 'spiritual pain' of the staff?

Kushner states: 'There is only one question which really matters; why do bad things happen to good people?' (Kushner, 2002: 3). The innocence of children – and therefore their inherent goodness – provoked this question in different forms within each focus group. The participants experience death of children not just as a one-off event but as a regular occurrence.

An aspect of bereavement training I notice is most requested, and clearly one that troubles professionals, is how to answer children's questions about death. Often the adult will be shocked at the directness of children's thoughts – perhaps because they contrast sharply with the complexity produced by rationality of thought developed in adulthood. Often children's questions are simply information-gathering, for example: 'Where do people go when they die?'. In a similar way children ask questions about other things, such as going on holiday, simply because they do not have or do not understand the information yet. In a work setting, to have these types of questions asked, sometimes over and over again, challenges the worker and forces reflections and thoughts on personal views and circumstances.

Within the intensive heuristic first phase of the project I found my spirituality enhanced by these testing questions, which either came directly from children or through my involvement in their deaths. I'm left wondering why in some people the experience of being involved in the dying process of clients strengthens spiritual aspects, while in others it lessens them or results in non-belief. These existential questions do not have clear answers, but



engaging with them allows them to develop and contribute to making meaning in life. As Frankl says:

Life, I would say is a life-long question and answer period. As to the answers, I do not weary of saying that we can only answer to life by answering for our lives. Responding to life means being responsible for our lives. (Frankl, 1979: 110)

## **9. Conclusion**

This chapter began with a discussion of the relevance and limitations of focus groups within this project, followed by a critical description of the 'before', 'during' and 'after' stages involved in this phase of the research. The themes that emerged were the participants' own losses and mortality; the impact on their faith; the relevance of colleagues; and the notion of responsibility in the work. This chapter has highlighted throughout how the new learning illustrated by these themes can be incorporated into different areas of future practice – including supervision, support and training – to ultimately improve professional practice with children with life-limiting and life-threatening conditions.

Emerging as essential is psychological support through clinical supervision; talking to colleagues; and discussion space regarding spiritual beliefs, as working with children with life-limiting or life-threatening conditions can bring up professionals' own bereavement issues. In addition, due to the sense of risk, responsibility and the fear of 'getting it wrong' that this work can bring up, practical support should be offered by way of organisational procedures, guidelines and regular line management.

Additionally, evident in the data is the fact that dramatherapists tend to adapt to other professional disciplines that may be working with the same client. This certainly reinforces my own experience; for example, I might adapt part

of a dramatherapy session to support a speech and language therapist in creating methods of communication for a child whose speech is deteriorating. It's also evident that a dramatherapist working in a school can be seen as the person who is there to support everyone – children, parents and staff. More emphasis on how to manage these boundaries may be included in training and supervision.

Further research is needed in order to explore the coping strategies of nurses and education staff. Although this phase of the project suggests the groups themselves identify an ability to 'get on with it', more in-depth research may inform the type of support offered to them.

The specific intention and function of therapeutic co-facilitation of dramatherapists has no published literature or research, although dramatherapists regularly use the co-facilitation relationship productively within sessions. Examples in my current practice include: 1) the opportunity for the client to 'kill off' one therapist whilst saving the healthy one; 2) utilising transference processes with clients who do not communicate through words due to learning disability or loss of function as a result of illness; 3) enabling clients with very little movement to direct two therapists in enactment; and 4) research and evaluation of the formation of a carefully put together group of three (one client, two therapists) when circumstances result in the client being unable to access a therapy group formed of other clients due to acute illness, disability, social/communication difficulties or emotional and behavioural difficulties.



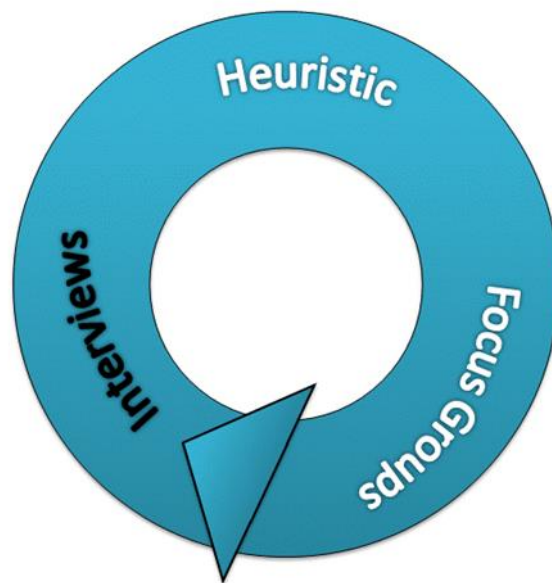


Figure 22: Research Design – Phase Three

## **Chapter 7 – Phase Three: Individual Interviews**

### **1. Introduction**

This chapter uses interviews to explore the unique experiences of four dramatherapists working with children with life-limiting and life-threatening conditions. It draws on previous research by returning to the themes identified in the intensive, heuristic Phase One of the project, which were then further explored in Phase Two (the focus group stage). The specific methodology for the interviews and analysis of the data generated is explained below.

The chapter begins with a justification of the use of interviews for this phase of the research, followed by an analysis of its limitations. Interpretive Phenomenological Analysis (IPA) is contextualised within this phase of the project and evaluated as an appropriate tool for examining the data generated by the interviews. This is followed by a section outlining the preparations for the interviews, including an explanation of sampling, the process of setting up the interviews, ethical considerations and consent issues. There then follow analyses of the role of the 'interviewer', the recording of the interviews and data collection. I go on to provide a description of how this methodology was applied to the data, and then a critique of IPA as a methodology for data analysis. This is followed by an analysis and discussion of the findings, and the chapter concludes with recommendations for future practice and research.

## **2. Value**

Consideration was given to the type of interviews that would be most appropriate for Phase Three of the project. Professional Knowledge seminars during the DPsyche programme (Souter-Anderson, 2013; Livholts, 2013) stressed the importance of designing methodology to suit the research rather than designing the research to fit the methodology. Building on the experience gained in Phases One and Two, where a heuristic method framed personal inquiry and a focus group method was employed to capture professionals' experience, I decided semi-structured interviews were most appropriate in order to capture the complex experiences of the dramatherapist, using an IPA framework.

Interviewing peers and colleagues already known to the interviewer brings positive aspects and also more challenging elements (Pope, 1992); I therefore developed certain criteria for the selection of the interviewees (see section 5 of this chapter). One advantage of interviewing fellow dramatherapists is that, as professionals, we are trained in the same discipline and share a common understanding of dramatherapy techniques used with children with life-threatening and life-limiting conditions – an understanding I anticipated would lead to easier access to the experience of working with this client group, without the need to explain the nuts and bolts of the job. To ensure I was not making assumptions about that experience, I used clarifying questions during the interviews, which marked a notable difference between any 'ordinary' conversation I may have found myself having outside of the interview situation with any of the participants. This is highlighted by Platt (1981), who points to the usefulness of interviewing colleagues or peers in that they are more likely to 'open up' to a person they know and trust. However, it is then important to recognise the danger of over-involvement and over-identification.

An additional monitoring process was developed from the work of Coar & Sim (2006), who identify three key themes in their investigations regarding health professionals interviewing their peers:

- The interview as an examination
- The interview as an education process
- The relationship with the informant

Involving peers in the research project meant that interviews took place not as a one-off meeting but in the wider context of the existing relationship. Interaction with participants took place before the interview, and continues to take place since.

Previous personal experience as an interviewee informed the way I approached the interviews. Several years ago, a colleague came to my home and recorded an interview with me about a specific aspect of dramatherapy; despite working with her regularly since then, the occasion has never been mentioned, and to date I have no idea what happened to the material. So I am left with the fantasies of why this might be. Perhaps, as Coar & Sim (2006) suggest, I did not pass the 'exam' – the interviewer did not learn anything of value from me, or our relationship got in the way somehow. My continuing silence and lack of self-advocacy in this situation is an example of how powerful the experience of interview can be, and reminds me that transparency with interviewees is essential, minimising the opportunity for misunderstandings.

Josselson (1996) recounts similar feelings in discussions with research participants she had interviewed for a book:

Here I learned from what could not be said – there is something discomfiting here but no matter, the book can be buried among the hundreds on the shelf and, I felt, we would tacitly agree not to speak about his being in the book, much as people may dissociate from an old love affair in the interests of working together – just pretend it never really happened, but I was left with the distress of not being able

to name and understand my own discomfort, which felt like some mixture of shame, guilt, and dread. (Josselson 1996: 63)

I recognise this glimpse of intimacy in the interviewing context, but would be very disturbed if I'd placed a participant in this project in a similar situation to that described above. I identify this as an area where the care and attention to detail I offer as a therapist needs to be given the same emphasis as a researcher.

In order to monitor Coar & Sim's (2006) findings, within this project I endeavoured to convey the value of participants' responses so as to minimise any notion of the interview as an examination with right or wrong answers. I accepted that there was inevitably a collegiate educational value in the interview for both parties, and monitored any impact of the existing relationship between myself and the participants by asking them openly within the interview about the experience of being interviewed by a peer. All four sections of these transcripts are given in Appendix 13.

The task of bringing the intimacy of a one-to-one interview through to public access in the final document is challenging to me, and I endeavoured to take my empathetic stance into the writing-up stage in order to maintain the integrity of the process and the safety of the participant. I consider this contributes to the rigour of the project by adding another layer of trustworthiness to the research. The issue of representation (Etherington, 2004), as discussed in Chapter 3, has been an important methodological aspect to the project; how participants' stories are brought to the wider world is a significant stage of the research. I am reminded of the recurrent theme of responsibility, which was present throughout Phases One and Two, and wondered how this mirrors the intense responsibility I feel to 'get it right' whilst interviewing. Likewise, how can I 'get it right' when representing the stories I hear? To quote one of the nurses from the focus group, 'I can only do my best'. At this stage I identify that this means dialoguing with the



participants, gaining their input about this stage of the research and trusting the integrity embedded within the project.

Hawkins' research details interviews with counsellors who work with non-verbal adults with profound disabilities. Hawkins describes her 'affinity with those who cannot speak' (2002: 1). This resonates with my project as each of my participants endeavoured to describe their unique experience with children, which is often facilitated through dramatherapy without words. To me, affinity is a feeling of identification, a connection, a feeling of similarity. I often experience this affinity with the clients I work with, and I felt it also with the research participants. Individual interviews allow me to explore the texture of this affinity, or resonance, as they offer important insights into the dramatherapist's experience.

### **3. Limitations**

One of the limitations of individual interviews may be that the interviewer can be seen as the 'expert'. As dramatherapy is such a small profession – in which I have worked extensively and have contributed to the training of many therapists – I recognise that I may be viewed in this way. In a positive sense, the intensive heuristic first phase of this research and its subsequent presentation (2012 – see Appendix 11) further developed this personal expertise – but it may also have increased interviewees' inhibitions. The design of the project aims to balance this through the focus groups in Phase Two, where the emphasis is on the members of the group as 'experts' in the topic – not the researcher.

#### **4. Interpretative Phenomenological Analysis (IPA)**

IPA was employed as it supported the aim of the final phase of data collection, Phase Three of the project: to focus in depth on the dramatherapist's experience of working with children with life-limiting or life-threatening conditions, in their own terms. Smith's definition of IPA captures the relevance of this approach:

Interpretative phenomenological analysis (IPA) is a qualitative research approach committed to the examination of how people make sense of their major life experiences. IPA is phenomenological in that it is concerned with exploring experience in its own terms. (Smith, 2009: 1)

The three key principles of IPA are phenomenology, hermeneutics and idiography. Phenomenology and hermeneutics are core to the methodology of this project, and are described in detail in Research Design, Chapter 3. Idiography is concerned with the particular, therefore:

IPA is committed to understanding how particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people, in a particular context. (Smith, 2009: 29)

Smith (2009: 182) draws on four principles to ensure transparency and coherence in using IPA for analysing qualitative data, thereby ensuring rigour in this type of research. I have followed his principles, firstly by describing in section 5 (Sampling) how the participants were selected; secondly by addressing in sections 6 and 7 (Setting up the interviews and Ethical considerations) how the interview schedule was constructed; thirdly by describing in sections 8 and 9 (Role of interviewer and Application) how the interviews were conducted; and finally by outlining in detail in section 10 (Analysis) the steps taken during the process of analysis.

## 5. Sampling

The sampling criteria for interview participants were:

- That they are an HCPC-registered dramatherapist
- That they have substantial experience of working with children with life-limiting or life-threatening conditions
- That they are interested in the process of being interviewed about their work as a benefit for clients and for their practice
- That they did not take part in a focus group during Phase One of the project.

The selection of interviewees was to be made from the small number of dramatherapists in the country who are working in the specialised area that this research is investigating. Dramatherapy is a small profession, with only 704 dramatherapists being registered with BADth. Each of the interviewees was trained in the Sesame approach to dramatherapy.

For the pilot interview, which formed my preparation, I selected a co-researcher with extensive experience in adult mental health but also with some experience with adolescents who have mental health issues alongside their life-limiting diagnosis. A pilot interview was carried out in order to gain experience of this type of interview methodology, as well as to try out the structure and questions I had devised. For the three subsequent interviews, I selected one co-researcher who is also a close clinical colleague, and two research participants, both of whom I have supervised and trained. All the dramatherapists were female as no male therapists were available who fitted the criteria. (This is not particularly surprising, as out the 704 current members of BADth only 111 are male.)

The interviewees' ages ranged between 28 and 60 years. I approached each participant directly in person and discussed the idea of being interviewed; each had some notion of the type of research I was involved in, and during

these initial conversations I described in further detail how the project was progressing and how they might be involved. After a thorough assessment of the context of this third phase of the research, and of the literature on appropriate sample size for interviews (Smith, 2009), four dramatherapists were selected. It is clear that one cannot generalise from a sample of this size – and nor would I wish to reduce the dramatherapists' experiences. Jung problematizes the concept of generalisation through this example by stating:

If, for instance, I determine the weight of each stone in a bed of pebbles and get an average weight of 145 grams, this tells me very little about the real nature of the pebbles. Anyone who thought, on the basis of these findings, that he could pick up a pebble of 145 grams at the first try would be in for a serious disappointment. Indeed, it might well happen that however long he searched he would not find a single pebble weighing exactly 145 grams. (Jung, 2002: 5)

## **6. Setting up the interviews**

Each interviewee was offered a choice of where they would like to meet – their own home, their or my work setting, or my study at home – as it was important they felt comfortable and that the location could be safe and free from interruptions (Smith: 2009). It also offered the opportunity for them to take part in decision-making regarding the research, thereby lessening the potential for the expert/participant role divide. Where possible, I endeavoured to offer the following choices in order to balance Coar & Sim's (2006) points, listed in section 2 of this chapter.

Interviewees were offered:

- A choice of location
- Anonymity/pseudonym
- A choice of length of interview
- A second, follow-up interview, meeting or communication

A mutually convenient date and time was set for each meeting. These arrangements were usually made by email or by text.

## **7. Ethical considerations**

The ethical issue of consent was addressed by using a Project Information Sheet (Appendix 14) and Consent Sheet (Appendix 15), which were emailed to each participant ahead of their interview. Discussion or email exchange enabled participants to be aware of approximately how long the interview might last. Consent was additionally discussed during the interviews, as was the content of the consent form. Each participant was asked if they wanted to make any adaptations to the consent form before signing.

The individual interviews brought specific ethical issues to the project. Etherington (2004) identifies two particularly relevant issues: firstly, how can the researcher protect the confidentiality of people who have not given their informed consent to be included when the narrative is closely bound with their own story? In the planning stage, I took the decision to address this as a continual process, building several stages into the schedule to check back with interviewees about how aspects of information shared in the writing-up process would be referred to. Secondly, how much of my own process do I disclose in research writing, taking into account the significance of a reflexive approach? I addressed this in the same way as above, using a process of checking in with myself and my project team. This enabled me to assess those of my personal responses that would bring value to the research whilst retaining a feeling of safety for myself. My competency and understanding in this area has developed since my earlier research; I now notice how I can identify and utilize personal resonance as I work with data, and begin to understand the real purpose of reflexivity within the research process. I liken this to exercising an existing muscle that is used, 'without thinking', tacitly and fluently in my dramatherapy practice with clients. The same developed

muscle is employed within research, but the skills needed to use it effectively have to be learned and practised.

There were several stages of consultation with the interviewees throughout the process. Towards the end of interviews I would ask each participant if there was anything they wanted to add, change or go back to for further comment. The interview transcript was then sent to each interviewee to check for accuracy, and a second interview, meeting or communication was offered, with the aim of ensuring that the interviewee could develop the material they had shared.

As HCPC-registered therapists, all participants are in clinical supervision, and I took this into account when considering the support available to each of them. It is also likely that participants are in ongoing personal therapy, although I did not consider this an appropriate inquiry and therefore did not actively seek this information out. However, I did not assume that the participants' supervision or therapy took away my responsibilities, and I identified these as a significant layer of existing support to those involved. I continued to offer support after the interview and to engage in an ongoing dialogue.

The ethical issue of anonymity is complex in this project, and there is no clear overall model in the literature to use as a guide. There were two categories of interviewee, each with unique considerations regarding anonymity. Firstly, the two co-researchers, who had previously agreed to be named within the research and were identified through their type of participation – for example by taking part in public performances of the play. Secondly, for the two research participants interviewed, the consideration was whether they were to be named in the writing or not. After discussion, both decided to select their own pseudonyms. Etherington (2000) works with this issue by agreeing pseudonyms with her interviewees and then checking transcripts with them for identifiable features. In Etherington's research, sections of transcripts

detailing discussions with 'Mike' and 'Stephen' illustrate the depth of thinking around the potential impact of research participants' stories being shared openly. For both categories of interviewee within my project, representation of the interview content within the final research report was approached sensitively. I felt a great responsibility to share the information with a wider audience with respect and care, and I endeavoured to carry this empathetic stance through into the writing-up stage. The issue of anonymity was discussed with each participant before the interview and revisited during the writing-up stage.

A further ethical issue was that of the impact of telling the story of bereavement. An important part of therapy is facilitating the telling of the story; within bereavement support the value of telling the story of personal loss is a well-documented way of integrating a death of a significant other into the present and future, such as in Walter's (1996a) biographical model of grief, which places an emphasis on talking to others about the deceased. In research interviews, the story is being asked for a different reason than in therapy, and this change of emphasis is significant. Through the process of telling the story in dramatherapy, change happens – whereas in a research interview the story takes on a different purpose. In dramatherapy the main intention of telling the story is to help validate and integrate the experience for the client; in this research the main intention in telling the story is to provide data to contribute towards greater understanding and better practice in the profession. However, in the telling of their stories, there may also have been a similar benefit for the interviewees.

## **8. Role of interviewer**

The tension between the roles of therapist and researcher within myself (Mearns & McLeod, 1988) was present during the interview stage of the

research in a more noticeable way than in Phases One or Two, and this is because an interview can be similar to a therapy process. Drawing on the exploration of the differences and similarities in the roles of therapist/researcher/focus group facilitator in Chapter 6, I became aware during the interviews of how helpful the skills of a therapist are, but also of how careful I needed to be when personal material arose in an interview. As a therapist my role is to support the client to make links and work through issues, developing insight in a way that is useful to them; as a researcher the task is to collect the data for analysis. I experienced a period of becoming familiar with this researcher aspect and learning how to maintain an empathetic stance, compassionate understanding and observation whilst respecting the quality and authenticity of the relationship.

Representation of the findings is an ethical consideration, as it forms a 'counterpoint' to anonymity (Smith, 2009: 53). Like Hawkins (2002), I was frustrated, and felt very tempted to print the whole transcript and let it speak for itself. I recognise this frustration from earlier research, when I felt confused that my creative processing was 'not enough'. I relate this to being with clients and entering into their creative worlds – where healing and change takes place freely when we allow ourselves to go where we are called. I find the journey from the landscape of sessions to a place of doctoral presentation difficult and, when lost in that landscape, meaningless. Then I remind myself of the true purpose of the project – to explore therapists' experience in order to offer better quality support to the clients – and I once again feel motivated to continue.

## **9. Application**

Silverman (2011) and Kvale (1996) strongly advise never to begin interviews until the analytical framework has been decided, and with this in mind I took



into account how I was going to work with the data while designing the structure and style of the interviews. As all of the interviewees were dramatherapists, I was able to plan the style and structure of interviews while remaining open to the content by taking into account the following:

- Each interviewee would be familiar with the process of using metaphor, story and image
- Each interviewee would be comfortable and 'confident enough' about an open style of questioning during the interview, with a conversational tone, and would not need a structured interview
- Each interviewee could draw upon a dramatherapeutic vocabulary to describe their experiences

As illustrated below in Fig. 23, a core question (Smith: 2009) at the beginning of each interview was therefore asked. In effect, I was asking them the same question I had asked myself in Phase One of the project: What is your experience as a dramatherapist working with children with life-limiting or life-threatening conditions? This being focus of the inquiry, it seemed clear that this question needed to be asked directly and openly. It offered the opportunity for participants to be 'free to express themselves on their own terms' (Smith, 2009: 67).

I continued to refine the way I interviewed as the interviews progressed; for example, the opening question ('What is your experience of working with children with life-limiting or life-threatening conditions?') prompted more of a job description or CV-type response from the first two interviewees, Kate and Tabitha, and I therefore asked the same question of Ali during the last interview but followed it up with 'What is it actually like?'. This prompted a much more subjective response, which enabled me to gain a richer account of the experience rather than just a practical list of tasks.

As the interview continued I remained alert to whether the established themes from Phases One and Two had appeared, and if necessary introduced them to gain the interviewee's responses.

### **Prompt sheet for interviews**

What is your experience of working as a dramatherapist with children with life-limiting or life-threatening conditions?

What is it actually like?

Themes from focus groups to be introduced if not naturally occurring in response to first question:

- Own losses and mortality
- Colleagues
- Getting it wrong/right; risk; responsibility
- Impact on own faith

Existing relationship with interviewer – how has this been for you?

**Figure 23: Interviewer prompt sheet for individual interviews**

## **10. Analysis**

The recordings of each interview were transcribed as soon after the event as possible. Taking into account the flexibility of an IPA approach, I based the analysis on the framework outlined by Smith (2009) in order to make sense of the dramatherapists' experiences. To ensure transparency, an example of a transcript is included in Appendix 16.

### ***Step 1: Reading and re-reading***

During this first stage of analysis I immersed myself in the interview data by reading the transcripts and listening to the recordings – and often a combination of the two. This intimate stage brought me closer to each participant. In addition to bereavement, which formed the core topic of the interviews, two strong overarching themes emerged in my initial notes: firstly, the sensitivity and care that each therapist devotes to the vocational work; and secondly, their willingness to engage with aspects of their own process – however painful – in order to support their dramatherapy practice. I naturally began to make general notes on anything that ‘jumped out’, or anything of specific interest, and noticed that the aspects I myself was drawn to tended to be the aspects that particularly mattered to the participants.

### ***Step 2: Initial noting***

There was considerable overlap between the first stage of analysis and the second, which involved detailed examination of the language used; and on reflection I understand this to be due to my close attention during the interview and then within the lengthy transcription period. I continued with the analysis by noting the text when descriptive, linguistic and conceptual comments occurred, taking each category of language in turn as I found it easier to identify one type of language at a time.

### ***Step 3: Developing emergent themes***

I listed themes on their own Post-it notes in their original order and identified common links between them. Some themes naturally clustered together – such as those linked with bereavement – while others needed to be broken up further (areas connected to movement, for example). I stayed in close contact with the transcripts while I moved the themes around into different patterns.

### ***Step 4: Searching for connections across emergent themes***

Next I put together a table of themes in a coherent order. I decided on names for the themes and noted the page number of the quotes so as to link them to the relevant section in the transcript. Some themes did not seem particularly relevant to the main inquiry and therefore were not taken forward into the next stage.

#### ***Step 5: Moving to the next case***

I followed the process described above by repeating steps 1, 2 and 3 for each of the four interviews, with a resulting table of themes for each of the four participants. I continually moved back and forth between the transcript and the tables of themes in order to check that I was capturing the meaning as closely as possible. I also tried to bracket ideas emerging from analysis of previous cases while working on the new transcript, which is in keeping with IPA's idiographic commitment (Smith, 2009: 100).

#### ***Step 6: Looking for patterns across cases***

I lay each of the four tables of themes out and looked across them for patterns or anything that had not been present when working on them individually. A master table of themes for the whole group of participants, with superordinate themes illustrating the master theme for each participant, was made. In the interest of transparency, Appendices 18, 19, 20 and 21 contain examples from the steps above, including a section of an interview transcript with notes; a table of superordinate themes for all four interviewees; and a table of master themes for the whole group.

### **11. Findings**

A pilot interview was undertaken so that I could practice and gain feedback on interview techniques, design and consent issues. As Robson (2002: 290) identifies, 'You don't become a good interviewer just by reading about it. Skills are involved which require practice, preferably under 'low risk' conditions where it is possible to receive feedback on your performance.' To

ensure transparency I discussed with the co-researcher that this was my first in a series of interviews, and we agreed that I could check particular aspects of her experience and continue to gain feedback throughout the process as a whole. The rich data from the pilot was analysed according to IPA principles and is included within the presentation of the following three interviews.

Each participant is introduced below and the texture of each interview described. The titles for each section are taken from stories specified by each participant as being significant in their work, and capture an essence of their interviews. The main themes are then presented. (Each story can be heard on Disc 1.)

***Interview One: Kate – The End of The Dream (Disc 1, Track 3)***

The pilot interview took place in Kate's flat. Kate, a co-researcher on the project, had a broken leg at the time and was unable to leave home, so the interview was also a good opportunity to have a 'visitor' and the meeting had quite a relaxed and informal tone. Kate and I trained together as dramatherapists in 1995 and have much in common, including mutual friends, work ventures and social events. We have also supported each other through significant personal bereavements. Kate works in a large psychiatric hospital and has a private supervision practice; she was a professional actress before training as a dramatherapist, and we worked closely together to devise the play that forms a product of this project.

Themes that emerged through the analysis of Kate's interview were: her feelings of responsibility for the clients she works with; her own and the clients' vulnerability; her own bereavement history and mortality; spirituality; the value of working alongside colleagues; opposites; and the size and scale of life and death.

***Interview Two: Tabitha – The Day The Sea Went Out (Disc 1, Track 4)***

Tabitha – a research participant within the project – works in a special needs primary school, is a placement supervisor with dramatherapy students and a clinical supervisor in private practice. I met her 10 years ago when I was supervising her student placements. I currently supervise her clinical work, but this was the first time I had been to her home. When I arrived Tabitha updated me on her auntie, who was very ill at the time. Tabitha's mother died when Tabitha was a child, and her aunt had taken a significant mothering role in her upbringing. This was an extremely distressing and worrying time for her. Tabitha happened to be looking after a friend's cat, Geoffrey – a beautiful grey, bigger-than-average cat who made us laugh often.

Themes that emerged from Tabitha's interview were: the impact of time and how busy her job is; balancing the opposites symbolically within sessions, in the wider school context and within the personal and professional domain; the size of the task of working with people impacted by death of a child – particularly with staff in schools; the concept of not knowing; doing aspects of the job 'right'; and responsibility within the work.

***Interview Three: Amy – A Grief Observed (Disc 1, Track 5)***

I met Amy – a research participant – 12 years ago when I supervised her student placement at a pupil referral unit for children with emotional behavioural difficulties. I also supervised her for a period of time following her qualification. For the interview Amy invited me to her home; not having been before, I got lost on the way from the station and she kindly came to find me on her bike. It was 9.00am, and we had agreed that Amy needed to leave home by 11.00am to get to one of the schools where she works with children with learning and physical disabilities.

Themes that emerged in analysis of Amy's interview were: therapeutic relationships with clients; her own bereavement and grief and the impact of this on her work; the concept of time; therapeutic concepts specific to bereavement; the enormity, complexity and overwhelming nature of death; her Christian faith; feelings of right and wrong that can come up in clinical work; layers of knowing; and the isolation that can be felt within the work.

***Interview Four: Ali Kelly – The Orphan and the Tree (Disc 1, Track 6)***

Ali, a co-researcher on the project, came to my house for the interview as it is close to our office and it offered a change of environment from our NHS setting. She is familiar with my home, having been there on many occasions. Before starting the interview and turning on the voice recorder we had a general work catch-up: clients, schools, hospital visits, and a particular focus on a child we had been involved with for many years who was particularly unwell at that time (and who has since died). Ali had visited this child in hospital earlier in the day and relayed information about how she was. This had an emotional impact on both of us and created a profound, serious tone.

Themes that emerged from Ali's interview were: the complexity and overwhelming nature of the work; the value of sharing the experience of the job with colleagues; opposites and paradoxes in the work (good and bad, right and wrong); her own and her clients' spirituality; the passing of time; the relevance of love in the work; and feelings of responsibility towards the clients.

## **12. Discussion of themes**

Throughout the analysis of the interview data, as might be expected, bereavement emerged as the overarching theme, with five further master themes also emerging – each with several subordinate themes. These are shown in Fig 24, below. Not surprisingly, running through all the material is

the interviewees' relationship and response to bereavement within both the personal and professional realms. The master and subordinate themes are therefore all in response to, and in dialogue with, the overarching theme of bereavement. In this section I will focus on this core theme and concentrate on the participants' accounts of their relationship with bereavement. This encompasses close personal losses, their own mortality, and personal bereavement in relation to the work. The themes of time, opposites, movement, enormity and spirituality are then discussed in the context of bereavement. The demonstration of sensitivity and care for their clients, and a desire for self-understanding, is evident throughout the interviews.

<b>1. Bereavement (overarching theme)</b> Close personal loss Own mortality Personal bereavement in relation to the work
<b>2. Time</b> Words associated with time Past, present, future Transpersonal/the numinous
<b>3. Opposites</b> Tension of opposites Right and wrong
<b>4. Movement</b> Metaphorical movement Transition
<b>5. Enormity</b> Overwhelming feelings within the work Size of issue
<b>6. Spirituality</b>



Relationship with own faith Trying to make sense of the client's situation
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**Figure 24: Summary of master and superordinate themes**

### ***Theme One – Bereavement***

The participants' close personal bereavements, identified by them within the interviews, contribute to the way in which they involve themselves in the clinical work and engage with therapeutic relationships. These intimate experiences go to make up part of the lens through which they view their dramatherapy practice, and they were a recurrent theme throughout the interviews. This is explored in more depth in relation to the themes of time, opposites, movement, enormity and spirituality in the following sections.

Each participant spoke about her close personal loss and bereavement history and, apart from Tabitha, specifically named the relationship with the relative who had died.

Amy: *'My sister passed away...'*

Ali: *'When my mum died...'*

Kate: *'The death of my brother was quite different to the death of my father.'*

Tabitha referred indirectly to the death of her mother throughout. The word 'death' is used throughout the interviews, and there were only occasional metaphoric descriptions such as 'passed away', used by Amy above to describe the death of her sister. It may be that as professionals working in this area the interviewees are trained in and are more confident with using the term 'death', whereas in the focus groups, educators used the word

significantly less frequently than nurses or dramatherapists, preferring metaphorical terms such as 'passed away' or 'gone'.

The impact of the raised awareness of the participants' own mortality is present in various ways. Kate shares her fears:

*'I'm absolutely terrified of dying. It's just the not being here...'*

This contrasts with Ali, who frames her thinking about her inevitable future death by reflecting on the value of her life as a whole, saying:

*'If I died tomorrow, I've had a really fantastic life, and I'm really grateful for that.'*

In contrast to the three other participants, Tabitha's loss occurred during childhood, and she has therefore passed through adolescence and young adulthood and arrived at her mid-thirties without her mother's physical presence. Here she contextualises her thinking about her own mortality:

*'It's always been present for me anyway, so I don't know that I've thought about it any more than I would think about it. I think about it quite a lot anyway.'*

This childhood loss also makes sense of Tabitha's belief that her own loss is 'present, even though it's not linked' to her work, and it is significant that she is the only participant who speaks about a need to 'protect' herself. Might it be that these contradictions are an attempt to protect herself from her own early childhood pain?

Tabitha's approach contrasts with Kate's, who elaborates on the relationship between personal losses and her dramatherapy practice but again does so with a certain indirect quality, perhaps also protecting herself:

*'When you're working with people who are going to die and you haven't been through that yourself there is a sense that this fear is a bit like death, I don't know and therefore it's going to be so devastating'*

*it will be indescribable in pain and magnitude and I won't survive but when you've lost someone close to you nothing can ever be that bad again.'*

This extract can be viewed in the context of Kate's experience of the traumatic death of two relatives – her brother and her father – in a relatively short space of time, and of her extensive dramatherapy experience of working in adult mental health. This helps make sense of the way in which she mixes her tenses and moves between personal and professional contexts. She contrasts the experience of professionals who don't have that familiarity with bereavement to her own close encounters. There's a sense she's communicating something important about herself when she's talking about others who don't have that experience – something about how huge her personal losses are. It may be that she's actually saying her **own** involvement is, or was, '*indescribable in pain and magnitude,*' and that she fears she herself will not survive. And yet, at the end of the extract she implies that this experience has given her strength, as she knows she has endured previous pain and that '*nothing can ever be that bad again*'. Her own extensive experience of bereavement, and others' lack of similar experiences, seem closely intertwined.

Amy makes a direct link between her calling towards the job and her personal bereavement, reinforcing the vocational element:

*'The client material that you need kind of pops up... There's an attraction to it from my part... I didn't necessarily want to work in bereavement. It found me. I wouldn't be here if I hadn't lost my sister. You're suddenly in a club.'*

Our relationship with death is highly personal. The impact of the loss of a family member is woven through each of the interviews – brother and father, sister, and two of the participants' mothers. Due to our pre-existing relationships, I had knowledge of these losses either through friendship,

being work colleagues or through the supervisory relationship, and this is evident in the way participants share this information within the interviews, which at times can seem quite factual.

The depth of the story is held in the history of the relationship, and this mirrors the therapist's relationship with the client. It is important to take into account that each therapist will be in their unique moment of a personal grief journey – whether as an adult referring back to the loss of a parent in childhood, to the death of a sibling in adulthood, to the death of a parent in adulthood, or a combination of these. The length of time that has passed since the bereavement; how resilient they are generally in life circumstances; the nature and significance of the relationship; other cumulative losses; and their stage of life all impact on how they respond to the bereavements and integrate them into their lives, and this is of specific interest to this study as it concerns bereavements in relation to their dramatherapy practice. It appears that the losses are still very present but are woven into the fabric of life and work. Adams resonates with the participants when she describes close bereavements as follows:

The crises in life from which we never truly recover. Though gradually they become part the fabric of our day-to-day living. Removed from the immediate tragedy and yet ever present; the constant, underground gnawing at the heart that means we are forever different from the person we were before. (Adams, 2013: 105)

It's interesting that discussion around one's own mortality came up in the dramatherapists' focus group – but not in the nurses' or educators' group – and again in the interviews with dramatherapists. Perhaps this demonstrates the difference in the focus of their respective work tasks. The dramatherapists attend to the emotional, the nurses to the medical and the school staff to educational – although there is much overlap.

The interviews emphasised how important it is as a dramatherapist to take notice of one's own bereavement history, as these events make up the unique lens through which we view the therapy work. Supervision strives for distance in order to keep safety within the work; therefore specialist training for supervisors, highlighting the impact of the therapist's own bereavements within the dramatherapy practice, is essential to prevent the therapists' bereavement wounds being unhelpfully and painfully ripped open over and over again. As Didion says, 'Grief has no distance' (Didion, 2006: 27) – and supervision, speaking broadly, needs to be prepared to monitor and address this. The therapist needs to have arrived at a place of sufficient resilience, where they can themselves (or within their identified support network) sufficiently repair the open wound in order to continue helpfully within the therapeutic relationship. This is captured eloquently by Kearney, who asks:

Who, therefore, is the healer in these encounters and who is the wounded one? We need to realise that Chiron's story is our story. As we reach out to the other who is dying.' (Kearney, 1996: 146)

While the awareness of personal bereavement can be challenging, there can also be fulfilling elements, as discussed by Tasker, who lists 'understanding our own relationship to death' (Hartley, 2013: 205) as an important aspect of sustaining wellbeing when working in palliative care. Grainger (2012: 124) highlights the value of the process of grief, stating that 'those who have completed the passage regard it as a considerable significance for the way that they henceforth view the business of being human. In other words, the process of grieving works.' Although few studies highlight the benefits of bereavement work to professionals, within the context of voluntary work in bereavement care Brotherton (1997) highlights a sense of fulfilment and privilege, both of which are implicit within these interviews.

The vulnerability of the clients came through the voices of the dramatherapists, and like Hawkins (2002: 205) in her interviews with therapists working with clients with learning disabilities, at times I felt

overwhelmed and without hope. The fluidity of moving between the client, the therapist's losses and my own experiences was evident in my countertransference as I worked with the data.

The important overarching theme of bereavement continues to be discussed in relationship with the developing themes below.

### ***Theme Two – Time***

One of the most challenging aspects of the work of a dramatherapist with children who are dying is the unpredictable nature of the time and the irregular rhythm of the end of life. This theme highlights the extent to which aspects of time – the lack of it, the past, present and future, and therapeutic concepts of time such as the transpersonal (Clarkson, 2003) or the timeless qualities of the numinous (Jung, 1980) – impact the participants. These notions are vibrant within the interviews and are embedded in the transcripts. This theme regularly sees the participants attempting to contextualise themselves and the clients within a framework of time and to capture associated qualities, often using time-related words conceptually, journeying backwards and forwards and using psychological terms. This analysis identifies and deconstructs the notion of time within the participants' accounts.

Words and phrases such as 'end', 'suddenly', 'at the beginning', were often used to place thoughts and feelings in the context of time. Tabitha describes how the lack of time brought up difficult feelings for her in response to managing the death of a pupil at the Special Educational Needs school where she works. The extract illustrates how a teacher asked her to step out of role, to do the thing no-one else wanted or knew how to do, in this case with very little warning:

*'When a child dies we do an assembly. It's not part of my role and it would be a bit unusual I think for people to see me in assembly talking, but because the teacher involved with the class found it*

*difficult to say, she asked me, before the assembly, if I would say a little bit as well to kind of help her out, and I did it but it was just last-minute and I didn't have time to think about it and could see that she was struggling, but afterwards I thought, "Oh, I didn't do that right," and I wish I'd known a bit more and I would have thought about it a bit more.'*

Tabitha locates herself within the school staff team, but recognises that speaking at special assemblies to acknowledge and support children following the death of a peer is not part of her established role. Here, however, she is identified and approached by a teacher as someone who can 'help out' and who is likely to be prepared to step out of her established role to give support at this relatively formal occasion. In Tabitha's narrative she moves irregularly between before, during and after the event, adding to her feelings of discomfort at not being given the opportunity to prepare herself for the task. Tabitha demonstrates that she is prepared to endure this discomfort in order to alleviate her colleague's struggle, but at the cost of her feeling that she '*didn't do that right*' – a feeling also identified by educators and nurses in the focus groups during Phase Two of this project.

Kate looks ahead in time, stating: '*I don't want to be a dramatherapist when I'm 60,*' while Ali acknowledges: '*I've been getting older,*' and uses the term '*legacy*' when reflecting on what she and the client might leave behind.

In the following extensive quote, Amy speaks of needing time and space between her own bereavement and her dramatherapy work with an adolescent client with physical and learning disabilities at a Special Educational Needs college. She vividly describes a moment when this becomes evident to her during an incident at the college where a client sought her out between sessions:

*'I was too close. I was just... it was too emotional. I couldn't step back, you know, I was really involved but to a point where it was really personal, so I think I was just merging, with her grief, so we were sitting in that grief together. In fact, I can think of one occasion where*

*I was sitting at the school and I must have been emailing or doing something on the computer, and she actually came into the room and sat down next to me, which is something that she sometimes did, and eventually I think someone came, maybe a couple of minutes or something, and I remember she was crying and I found myself getting quite upset. I think this was around that time, probably when I thought, well maybe it was too close. I wasn't able to have that perspective to see what was mine and what was hers and then to be able to actually use what was mine to support her, so having it as one foot in, one foot out, I suppose. It was too much, you know. I do think there is a thing about there needs to be space and time in between, certainly... because that's the thing with bereavement, it can happen again, but perhaps that initial shock of having lost someone close to you, that perhaps there needs to be time between those things happening to really be able to have an understanding and perspective.'*

The above extract draws our attention to the delicate decision-making that confronts therapists after a personal bereavement. In this case, Amy uses time as some form of measurement to help her know when she is or is not able to continue with the work. The underdistancing (Landy, 1993: 5) she experiences contrasts with Tabitha's sense of overdistancing, where she says her bereavement history is '*present but not linked*' with client work.

In therapy, the numinous is the timeless (Jung, 1968), and this is illustrated by Tabitha when she talks about a session with group of children:

*'Suddenly a quietness descends on everybody in quite a profound way. I think it feels quite surreal, like you can't really describe it to somebody else, you know, someone who doesn't do that sort of work.'*

Within sessions an alteration of consciousness can occur, with a shift taking place in the client's unconscious process. Life is time-limited, whereas death is eternal, and when the numinous occurs, something of the eternal timeless quality is present. The therapist and client are in touch with something 'other'. Timelessness is central to the work of the dramatherapist with



children whose time is limited, and it presents a further example of the paradox of the work.

There are several other important issues in the above extract: Tabitha describes the dreamlike aspects of the work, also differentiating between those who might understand because they do '*that sort of work*' and those who do not. This resonates with Amy's description of the feeling she had after the death of her sister, that '*you're suddenly in a club*'. When Tabitha says '*you can't really describe it to somebody else*,' she echoes the other participants, who also identify this aspect of the work.

The phase model of Kubler-Ross (1969) was developed directly in relation to what happens with the passing of time after bereavement. Time is often mentioned in response to the event of death, and language is punctuated with time-related metaphors such as 'time heals' and 'only time can help' – as though time is a magical ingredient that we cannot buy or find and we simply have no control over. Tide and time wait for no man, as they say... and it is this lack of empowerment and loss of the 'assumptive world' (Kauffman, 2002) that can be usefully supported in therapy. Small steps to regain the feeling of control can support the client to rebuild their life.

The numinous qualities of snow and ice (Ronnberg, 2010: 78) particularly came into my consciousness during Tabitha's interview. Earlier in the project, Falling Tree Productions – an independent radio production company – had approached me; the producer, Nina Perry, had heard from a participant on a CPD day I had run about an exercise I sometimes use in training that involves passing an ice cube around a circle of people. This exercise opens up a metaphorical discussion about the sensations, expectations and experience of holding the ice. Naturally, it melts as it is passed from hand to hand, and finally – often before it makes its way around the full circle – it is gone. This reflects the notions of death being frozen in time, of life slipping

away, of transformation, and of death leaving a trace on each person it touches. Each moment in time is unique for each participant, as each touch of the ice is entirely personal.



**Figure 25: *Paysage de Neige* by Cuno Amiet (1904)**

Through the ritual of a dramatherapy session, containment is offered for the timeless aspects of bereavement to be experienced and explored. The painting reproduced in Fig. 25 represents to me the numinous texture of my project and several of the themes that have emerged: stillness, silence, enormity and existential aloneness.

Identifying the theme of time so clearly within the interviews has raised my awareness to the issue within my own practice. Dramatherapy interventions can 'play' with this notion in order to support the client in contextualising their loss. I once made a 'time line' with a client, on a long piece of wallpaper spread across the room; we plotted the death of her sister, where she was now, and anticipated milestones such as going to university and getting

married. Over the sessions we walked through these past, present and future stages. This quite direct work also informed more indirect material, which I introduced into the session. For example, introducing the fairytale of *Sleeping Beauty* enabled her to play with the notion of the missing parts of her life, what had made this happen (the death of her sibling) and the possibility of being able to make choices about how and when to wake up to these changes and new experiences in life. I tried this for myself in supervision and found it to be a very powerful exercise. Grainger articulates it:

By giving our experiences the form of a story we rescue ourselves from our own incoherence, falling back on the urge to give shape to the things which challenge our ways of organising our worlds.  
(Grainger, 2012: 129)

The NHS bereavement model that I developed with Ali Kelly operates mostly with non-time-limited interventions, and contrasts with many bereavement services that offer a set number of sessions. This model evolved in response to pre-bereavement work, which has unique time-related complexities. One of the main challenges is that it's impossible to predict how long a life-limited or life-threatened child may live. Practically, this creates dilemmas in managing the waiting list, as clients may be involved with the service for weeks or years, depending on their unique circumstances. The issues of time that occur within the service are illustrated within the common types of referrals described below, each of which is followed by the service response to the specific issue of time.

**Example 1:** a child with a progressive brain tumour, having undergone radiotherapy over the previous six months, has now reached a stage where no further treatment can be offered. They are referred at this point for dramatherapy. The medical teams involved (specialist cancer hospital professionals, hospice and community paediatric nurses) are hoping to 'get them home by the end of the week'. Using the information provided on the

referral form, the service would prioritise this child for assessment. We would also need to ensure that – if appropriate after assessment – the service has capacity to offer weekly therapy provision at home, at the hospital or at the hospice. Factoring in travel time is important, as the service needs to work with the client wherever they may be in order to minimise interruptions within the series of sessions. In order to cater for this type of referral, we aim to keep an emergency or overflow slot so that a therapist is available, as it is obviously not appropriate for these children to be put on a waiting list.

**Example 2:** a 10-year-old child has a genetic, degenerative condition but is reasonably well at the point of referral. It is expected that the condition will begin to affect her over the next few years and it is rare for children with this condition to reach their 16th birthday. On receiving this referral, an initial telephone conversation with the parents takes place in order to introduce the service and establish any current specific issues. A home visit may be arranged and a phone call to the school (with parents' permission) made. Following this early information-gathering, a short series of introductory dramatherapy sessions may take place in order to begin the therapeutic support – or it may be decided with the parents and school to wait. If this is the case the service would contact the family and school, perhaps each term, in order to maintain communication in preparation for future intervention.

**Example 3:** a young person with profound physical and learning disabilities resulting from serious birth trauma responds well to non-verbal movement with touch and sound. As weekly dramatherapy at school progresses, the therapists acknowledge a slow, delicate and timeless quality within sessions. The 45 minutes allocated – which includes collecting the child from class, supporting them in and out of their wheelchair and handover of information between teacher/support worker and therapist – is not enough to allow the gentle unfolding of the therapeutic work, and the total session time is therefore increased to an hour and a half. Also relevant to this referral is the

developmental stage of the client. Age-related grieving is an important part of the dramatherapist's assessment and intervention; the developmental stage of the unwell child or the sibling influences how they grieve, in addition to their attachment style and social and family circumstances.

Developmental age may be much lower than chronological age, and this affects the work. In addition, the therapist needs time in supervision to think through the psychodynamic processes that heavily inform the clinical work.

In contrast to the pre-bereavement work discussed above, post-bereavement work with siblings is usually more straightforward and predictable in terms of time management – for example, a brief intervention of six dramatherapy sessions (Gersie, 1996) with a sibling, or an hour's consultation with the teacher of a sibling, may be sufficient input from a bereavement service. In her interview, Amy uses the phrase '*lifetime's work*', which was the name of a training day offered by myself and Ali Kelly to arts therapists several years ago. This phrase captures the notion that grief may take a whole lifetime to work through but is also something that can be supported. As illustrated in the focus groups, teachers and school staff particularly feel a huge pressure to 'make things better' for children in their care, and feel a relief when it's pointed out that the child will be managing the loss for most of their lives and that it is not their sole responsibility to make it better for the child by the end of the academic year.



**Figure 26: Kronos**

As shown above, death and time are embedded not only in the participant's accounts of their experience of working as dramatherapists but in the very

fabric of everyday life and language. Lakoff & Johnson (2003: 9) suggest that the way in which time is viewed is a cultural issue, and they identify that 'time in our culture is a valuable commodity.' This can be seen in dramatherapy practice, as illustrated by the interview extracts presented earlier in this chapter. Kronos, the Greek god, was originally simply 'the god of time', but he evolved through this association with time to become 'Death the Reaper' – seen above with his scythe and timer (by his foot) in a picture from the Wellcome Trust exhibition (2013).

Time is a key element for any therapist working with clients, but it is particularly relevant in both pre- and post-bereavement, as discussed above.

### ***Theme Three – Opposites***

The paradox of life and death emerges throughout the four interviews and is reflected in metaphor, in descriptions of work-related situations and through expressions of feeling. As Tabitha says of work, it '*feels like a black-and-white scale*', with little scope for grey in her description. Ali echoes this when she says the work '*feels full of contradictions*'.

Also identifying a contradiction is Kate, who talks about the issues on her mind in the following complex extract:

*'As I get older I'm not sure [work] is sustainable, not because I don't want to, it's the opposite, but life experience has taught me it is something I can sustain but I don't know whether I want to as I get older the choice is more I want to move away from it because it's more omnipresent, death, life...'*

Kate identifies a shift in her desire to continue being a dramatherapist working with bereavement, implying that she feels better equipped to do so with an increasing experience of life (i.e. with age), but that as death comes closer it becomes a larger and more pressing issue. Developing this thought, she explains her choice about whether to continue the work and raises the

possibility of leaving – something that is not mentioned by any other participant. In this specific extract the themes of time, opposites, movement and enormity are all present in her description of her relationship to work, linking these thoughts to the project as a whole.

Amy expands the notion of bereavement through death by introducing the notion of loss of bodily function, referring to a client as follows:

*'It's not necessarily about bereavement. I think more loss. He has cerebral palsy and has very limited use of his body. His body's kind of tensed the whole time... I don't know what it is but he really evokes that reaction in me of like I can't get it right, you know. I've got to find something to help him with, or to do, somehow he can express... because he's so limited, I don't know, somehow, how to sort of remedy that.'*

Amy uses the word '*limited*' here in comparison to a body *without* limits, or a healthy, functioning body. This description encapsulates the implicit contrast with, or opposite of, the healthy body, which profound disability brings.

Ali succinctly describes the tension in the extreme feelings her work can bring up, and also challenges the assumption that the sum total of the work is distressing without any enjoyable aspects:

*'The upsetting bit makes the good bit really, really good and the good bit makes the upsetting bit really, really upsetting.'*

Tabitha summarises the whole project in the following extract, where she speaks of the difficulty of finding the balance between carrying out a professional job and the inevitable connections made with families and colleagues in an area of work that touches on so many personal feelings:

*'I find it difficult to get the balance between being... coming in and doing it as a professional and also kind of knowing the people quite well and kind of having quite strong feelings about the people myself, that I don't want to come in and sort of be something in a robotic way*

*to protect myself in that situation, but then, at the same time, it's also difficult to get the balance between doing a clear job and not breaking down, but actually it's feeling honest enough that those feelings are there and present and genuine at the same time. I think I find that bit quite tricky.'*

This struggle and endeavour can be seen repeatedly in each phase of the research. Tabitha uses the phrase '*clear job*' as a balance or opposite to '*not breaking down*', and goes on to identify what she feels she needs to do. Not surprisingly, and with some humour, she also identifies that achieving this very complex solution is '*quite tricky*'. Experienced practitioners, through insights gained in personal therapy and supervision, are often able to identify what is needed – in Tabitha's case '*feeling honest enough that those feelings are there and present and genuine at the same time*' – but they often find it challenging to achieve this balance.

The tension Tabitha describes is summarised in Jung's description of opposites as 'the ineradicable and indispensable pre-conditions of all psychic life' (Jung, 1977:23). The Dual Process Model (Stroebe & Shut, 1999) describes the movement between two types of stressors in grief: that of loss (restoration-oriented) and a dynamic, regulatory coping process of oscillation whereby the grieving individual at times confronts and at other times avoids the different tasks of grieving.

Using story in dramatherapy can support the client in a place of loss and restoration, allowing exploration of the tension this can evoke by offering a further layer of understanding. The powerful African story *Children of Wax*, which can be heard on Disc 1, Track 3, offers many opportunities to embody, enact and play with extremes – light and dark, hot and cold, being satisfied with life or not, confinement and freedom, and ultimately being alive and being dead. The transformational metaphor of the boy melting and changing into a bird allows exploration of spirituality, offering it a definite shape (that of the bird) that can be worked with. Grainger suggests that 'story-metaphors



answer a human need for shape, not at a propositional level but considerably deeper than that' (2012: 129).

The theme of opposites supports the findings of the focus groups during Phase Two, where the usefulness of co-facilitation was highlighted. Co-facilitation allows the paradox of living and dying to be embodied and explored within dramatherapy sessions; it offers the client dramatic distance through interacting with the extremes of their experience. A typical example of this might be a child who describes the nights in hospital as lonely and frightening, but who enjoys the daytimes because he gets visitors and presents. Dramatherapy provides the opportunity to take on the roles of day and night through dialogue, movement, sounds or sensory activity, and for the client to engage with these experiences with specific specialist support. Roles in the session can be swapped frequently, with the therapists taking on any aspect of this stressful 24-hour rhythm to enable the client to 'be' either day or night, or for themselves to be in the role of patient. This gives the opportunity for the impossible to be expressed – for day to rage at night, for the 'patient' to voice fears or to battle with night, or for day and night to meet and for the opposites to be balanced, with insight into the tension being gained. Jung refers to this process as:

[...] a rhythm of negative and positive, loss and gain, dark and light. Its beginning is almost invariably characterised by one's getting stuck in a cline alley or in some impossible situation; and its goal is, broadly speaking, illumination. (Jung, 1958: 38–40)

A further example in clinical practice of the tension of opposites occurs when a client experiences the contrast between the boredom of his or her illness and the sudden, frantic activity that takes place during the serious, life-threatening episodes he or she endures. Dramatherapy sessions, utilising two therapists, can enable the client's greater understanding of these two

states of being; and although they remain irreconcilable in many ways, as a result of dramatherapy sessions they would be more manageable.

Dramatherapy with non-verbal clients with life-limiting or life-threatening conditions can rely heavily on transference processes to inform the therapeutic relationship and the therapeutic work that comes out of that relationship. Due to the complex nature of the client's process of living until death, the transferences experienced by the therapist in these sessions may be powerful and, at times within the actual session, overwhelming. When two therapists are actively engaged in the psychodynamic element of the practice, embodying the opposites, it enables possible transferences to be fully utilised for the benefit of the work. Joint supervision ensures the safety and effectiveness of this method.

I note with interest that the 'capacity to deal creatively with paradox and the holding of two or more opposing points of view' (Metanoia Institute/Middlesex University 2013/14: 115) is regarded as helpful when assessing quality in a practitioner doctorate. As this research mines deeper, I begin to understand more fully the complexity in this guidance, and that this place of 'holding' is not a bland, neutral place but a dynamic potential space where change can happen. The symbol of the Ouroboros, shown in Fig. 7, with its top half black and lower half white (suggesting the opposites), helps to explain the ceaseless rotations of life and death, light and darkness and appearance and disappearance, with the implied impulse of the snake biting its own tail (Cirlot, 1971: 59). This project inhabits the landscape of the 'place of holding', with frequent impulses to return to the beginning in order to gain deeper understanding of the end of the journey.

Erikson observes that 'the grief process is solely concerned with overcoming our natural opposition to, and active rejection of life-change upon which our survival as persons depend' (Grainger, 2012 132). This helps to make sense of the range of opposite-related motifs recurring throughout the project. For

example, during Phase One this theme occurred in two series of my paintings – *This Is Not a Stormy Sea*, followed by a later, opposite version, *This Is a Stormy Sea*. In a similar way the painting *Tortoise on Path Without Eyes* developed into *Tortoise On Path With Temporary Eyes*. I link Erikson's idea with my natural desire to initially resist such difficult concepts as death and loss, and then through processing them being able to find ways of overcoming them in order to survive these changes.

#### ***Theme Four – Movement***

Movement is a change of location or position. Within dramatherapy, the term can refer to an outer, physical, bodily change of location or position, or an inner emotional and psychological change of location or position. The theme of movement ripples through the interviews and is clearly visible within the analysis; themes of movement within words, metaphors and conceptual frameworks of the participants were all tracked. It is relevant that I (the interviewer), as well as each of the therapists interviewed, am trained in the Sesame approach to dramatherapy, and therefore Laban's notion of movement is present in each participant's approach to practice. Sesame-trained therapists are concerned with the metaphorical clues clients may offer, and they thread these through into the drama (including movement) in order for the client to work on unconscious material represented in metaphorical language.

Amy speaks conceptually about the referral of a child with a particularly complex medical condition and life circumstances:

*'The energy around that child, that kind of get pushed in your direction, because no-one knows what to do with them.'*

The '*energy around that child*' firstly refers to a type of intensity that might include discussion, action, or emotional or practical input from professionals.

A kind of buzz or shift of tone can occur when such a child is mentioned within the informality of the staff room or during more structured multi-disciplinary meetings. Clearly, and secondly, the child does not physically 'get pushed'; rather, Amy uses metaphorical language to describe how it feels within the direct, firm action of the referral process. Finally, the rather hopeless sense of the child being so problematical that other professionals involved don't know how to help results in the child being referred to the dramatherapist, who is able to adapt in order to offer the kind of support demonstrated earlier in the example of the teacher putting Tabitha on the spot in assembly. Amy also identifies the '*pushed in your direction*' aspect and a metaphoric sense of '*handing it over*':

*'There is a responsibility to get it right and the head teacher of this school is very clear it's something she doesn't want to have to manage and she's very open about that, therefore kind of handing it over to me to do that and for there to be guidelines of things to follow.'*

She goes on to describe this situation with a metaphor that also suggests the process of bereavement as being difficult to grasp:

*'I feel it's a tricky one to [get right]. It's like a slippery bar of soap. You can't quite get a good grip on what it is that you need, kind of thing, or what other people might need...'*

This element is consistent with the findings from the focus group, which suggested that a strength of dramatherapists is their ability to adapt in order to accommodate other professionals who look to them for support with a range of tasks associated with the death of a child within their particular setting.

Kate introduces movement as a powerful force for sustaining life, recognising that dramatherapists attune to even the most subtle of outer and inner client movements:

*'My favourite saying is "trust any movement" – the slightest change can occur, can be enough to sustain.'*

'To sustain' can mean to strengthen or support, to bear weight without breaking or falling, to undergo suffering, or something continuing for an extended period of time – all of which are relevant to Tabitha's description of a child living longer than expected: *'When a child is carrying on and carrying on...'* This metaphorical concept of carrying offers a powerful image of the physical movement involved in the endurance, in the continuation and in the weight of 'carrying' something for an extended period of time. The image might refer to aspects of what is involved for the child to stay alive, but also of the therapist's action of supporting them to move from one place (life) to another (death). The ability of the client or the therapist to sustain, or to have the resilience required to endure the end-of-life process, is described metaphorically by Ali:

*'Like a field of wheat kind of blowing in the wind that's growing but can also be quite beaten around – something about movement.'*

Ali describes her strong feelings about a young person she has worked with for a number of years moving from child to adult NHS services:

*'It's felt quite challenging, the fact that we have to make the transition. We have to kind of support her transition to adult services, we actually, my feeling is, actually, she doesn't seem like an adult, and I don't know... it feels... I feel really resistant at her going over to adult services and I'm aware that might be something she really wants to do, but I think about having a different sort of support and I think, of all the history that we've held with her, around her spirituality and her thinking about dying and her legacy.'*

This description resonates with the ultimate transition between life and death, which Ali has accompanied the child on to this point. The move between NHS services forces her into the role of unwilling participant: this transition will happen whether Ali agrees with it or not, whether she considers it in the

best interests of the client or not. There is also the sense of sorrow for Ali at having to let go of the client she feels she has a '*history*' with.

Tabitha describes a different type of transition that children with life-limiting or life-threatening conditions might make:

*'Some of our children come to us here in the special needs primary school from a mainstream school where they have been very vulnerable.'*

Any process of changing from one location or position to another can be a particularly vulnerable time for people impacted by bereavement, bringing up loss of security and challenging what is known in their assumptive world (Parkes: 1971). Within the NHS Bereavement Service we routinely contact families of bereaved children we have worked with in the past when siblings transition into secondary school, to monitor how they're coping and if necessary to offer an update to the support previously provided.

In one particular case, an 11-year-old girl whose sister had died four years previously was particularly daunted by leaving the junior school she and her sister had attended and by meeting a new peer group, in case they asked whether she had any siblings. For her, the fantasies of their reactions were terrifying and led to her wish that she would do badly in her exams so that the new school would not accept her. She also worried that leaving school would somehow be disloyal to her sister, who in her mind had remained at the same age as when she had died. In dramatherapy we engaged with this fear and dread of moving schools and we enabled her to update her relationship with her deceased sister – the importance of which Christ (2000) highlights. Junior school had offered consistency, familiarity and safety during a time when the opposite was happening in her inner world, as discussed by Rowling (2003), and we thought creatively about how these qualities were now internalised and would make the transition with her. We thought about

how her sister might feel about her leaving the school, what she would say and who her teacher might have been if she had been coming back in the autumn term. She had questions about her sister's illness, which she had not understood as a seven-year-old at the time of her death but which she now wanted to understand at a deeper, more mature level. This was a short piece of 'top-up' work – only three sessions – but was evaluated by the girl herself, by her parents and teacher as being 'invaluable' in helping her to move – emotionally as well as physically – to her new school.

In the story of *Children of Wax*, mentioned above, the path from the hut that the boy runs down when he can no longer stand being confined represents the transition between life and death. On occasion, as part of my work with this story, I have asked a group of trainee therapists to make this path for themselves out of images, postcards or their own drawings of parts of the story.

During the planning stage of the interviews I considered whether interviews incorporating creative methods – including movement – might be of value. This raised a methodological challenge regarding the interpretation and representation of participants' symbolic material. However, I decided on an open, non-directive approach whereby participants could choose to engage with the topic, and prepared to work with the resulting data knowing that Laban's movement analysis was available should participants engage outwardly in physical action. It so happens that movement did emerge strongly as a conceptual theme, but none of the rooms selected for interviews lent themselves to larger physical movement expression. It's also possible that therapists, who use oblique, symbolic methods *within* client work, find using words helpful in *clarifying* client work, and helpful in bringing the less tangible aspects of the work to consciousness.

### **Theme Five – Enormity**

Enormity is a daunting concept to write about – or even think to about – and yet it comes through as a prevalent theme in the interviews, frequently being referred to as part of the experience of dramatherapists working with children with life-limiting or life-threatening conditions.

Amy refers to a boy with *‘this enormous story’*, and goes on to say:

*‘I have noticed that I’d been very kind of going with great trepidation into this room because... sort of like meeting a king, you know, it was sort of this... oh my God, how... you know and I think it is right, he obviously is going to need a lot of time building up trust, I think it’s right to go in gently. But equally he’s just a normal human being. He’s a little boy. He’s just a little boy, that’s it.’*

Amy’s initially hesitant description of the client indicates how daunted she feels. She contrasts her disempowering feelings of *‘trepidation’* by metaphorically empowering him in the high status role of *‘king’*. She then appears to equalise this for herself by introducing an opposite – that of him being *‘a normal human being’*, and then as if to reassure herself, further sliding further down the hierarchy scale by describing him in an even less intimidating way as that of *‘just a little boy’*, emphasising this through repetition. Significantly, here she identifies that *‘time’* is the quality required to enable *‘trust’* needed for the therapy work. It is not clear whether Amy is referring to the trust as a two-way process or only from the client towards her – or indeed the other way round. On one hand Amy is acknowledging that the client is within an immense set of circumstances (his illness), which have been personified by others so that he personally has become immense – a *‘king’*, in fact – but she then utilises the concept of opposite to contradict her initial description, reassuring herself, finding her own solution to her initial *‘trepidation’* by drawing on her inner resources.



Geographically, the high status description occurs at the threshold of the session, in the transition between the wider school context of the referral associated with the boy's '*enormous story*' and the therapy space where Amy begins to utilize her professional skills, and gradually we see his status change from that of a king to '*just a little boy*'.

This extract resonates with Amy's whole interview, illuminating wider themes as we see the transitional movement between the outer and inner space of the room; the identification of time being needed; the balancing of overwhelming feelings through the opposites; the enormity of the anticipation of being with the client; and finally reference to Amy's own faith.

Similarly, Kate refers to the enormity of the work:

*'I don't make decisions about turning off the ventilator but I work with that child's process, which is similar, you work with the process. I don't make what people might call the big decisions, but I feel as though I hold very big things with the client and I know that my own bereavement history has a big effect on the way I hold.'*

This extract from Tabitha's interview draws our attention to the enormity of the expectations of other people involved in each scenario:

*'So it's been a bit of a mixture, working with the actual child, and then maybe the class as well, and then after somebody has died, then working with anybody connected with that child in a death day-to-day kind of manner.'*

Ali's description, and in particular her notion of the '*big bag of earth*' in relation to the little child's coffin, is a metaphor for the enormity of death. It also reflects how she carries out profound tasks as part of our NHS service:

*'That very first girl I worked with, you know, going to the cemetery and doing work on the garden and things with her, that you could, you know, you can put into the metaphor and symbolism and so on, but actually it wouldn't be seen as typical dramatherapy... she hadn't been and her mum didn't want to take her and she really wanted to go and she made a beautiful garden and actually that's... I'd forgotten about that but it's something that felt very symbolic with a big bag of earth,*

*you know. Putting it on the little child's coffin, you know, grave space, because it was so small, because he was only a baby... And I think that, in a way, that, from the start, that was the first child I worked with in this service, or one of them...'*

The contrast between the '*big bag of earth*' and '*little child's coffin*' resonates with the story of the hare<sup>13</sup>, which I use particularly when children are feeling overwhelmed. Story and myth enactment is a central technique in enabling the client to select roles in order to engage with overwhelming feelings. Dramatic distancing (Landy, 1993) enables manageable engagement with these overwhelming feelings. Techniques of overdistancing in dramatherapy include narrative or storytelling and projective techniques such as figures, puppetry and masks. Clients can also view themselves in underdistanced forms of dramatherapy, such as role-reversal and doubling. Dramatherapy techniques can be viewed on a continuum from under- to over-distanced, and any given technique can be used throughout this spectrum of distancing.

This project endeavours to grasp the numinous qualities within the work of dramatherapists working with children with life-limiting or life-threatening conditions; but perhaps this is an impossibility – a powerlessness in the face of an enormous and overwhelming task, attempting to capture those mysterious moments when there is some shift in consciousness. Tracey Emin, artist and writer, contemplates that 'death is a strange thing: there is an overwhelming feeling of powerlessness – full of empty' (Emin, 2005: 205). The deeper the research into this topic goes, the more I wonder whether even a doctorate focusing on bereavement can give me much knowledge of

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<sup>13</sup> 'When Hare discovered Death, he ran back to the place where he lived. He shouted and cried: 'My people must not die.' Then he suddenly realised: Everything will one day die! He imagined the sloping rocks. They just fell away. He imagined the big mountains. They fell apart. He imagined the place below the earth. Everything that lived in the soil stopped scurrying about; they froze and died. He imagined the skies high above him, and the birds which had been flying stopped flying and fell to earth, dead. He crawled into the place where he lived. He reached for his blanket, and rolled himself into it. He lay there and wept. There will not be enough earth for all that dies. He buried himself in his blanket. He made no sound.' (Gersie, 1991: 34)

grief. As Rilke (Kearney, 1996: 19) writes: 'I don't have much knowledge yet in grief – so this massive darkness makes me feel small.'

A common metaphor for bereavement is 'the elephant in the room', and this reflects the difficulty many people have in talking about bereavement. In contrast, a dramatherapist is constantly attending to the elephant in the room, using a variety of techniques to cope with the enormity of death. One of the key ways in which dramatherapy attends to bereavement is through ritual (Roose-Evans, 1994) – for example, with children we may choose a song or a game for the beginning and ending ritual in order to contain more difficult material in-between or inside the session. 'Shout, Whisper, Wave' is a very simple but effective way of starting a session, whereby the child chooses how they wish to be greeted by the therapist (or if working in a group by the other children) – with a loud shout, a small quiet voice, or a wave and a more neutral-sounding voice. This ritual is particularly effective as it offers a safe, known structure for the child, who does not need to be concerned about forgetting or getting it wrong. Over the weeks, as familiarity with the ritual increases, the volume can become more extreme between loud and quiet, and the greeting can be brought into movement with the whole body, offering the opportunity for the client to express themselves physically. The three simple choices reduce any overwhelming feelings of choice. This can also be done as a goodbye ritual, which also allows assessment for the clients themselves, and/or for the therapists, of emotional shifts from the beginning to end of the session. In addition, as part of group work, this exercise involves everyone at all times and so builds empathy with other people's feelings, which in turn lessens the isolation of loss.

Memory boxes – creating a specific storage container; another practice often used in varying models of bereavement work (Stokes, 2004) – not only store and physically keep safe precious items, but they also contain the overwhelming emotions – boxing them up so they can, to an extent, be opened and closed when the bereaved child needs or wants to do so. The Charter for Bereaved Children ([www.winstonswish.org.uk](http://www.winstonswish.org.uk)), which hangs on my NHS office wall, states that bereaved children have the right to ‘remember the person who has died for the rest of their lives, sharing special as well as difficult memories’. Dramatherapy supports this but also creates boundaries to enable the child to remember in a way that is manageable.

In dramatherapy, feelings that may be experienced as overwhelming can also be contained using physical movement techniques. Sherbourne – a pioneer of developmental movement with children – states that ‘all children have two basic needs; they need to feel at home in their own bodies and so to gain mastery, and they need to be able to form relationships’ (1990: 1). Both of these points are particularly pertinent to bereavement, where feeling out of control in life and a significant change in a relationship with a loved one has occurred.

### ***Theme Six – Spirituality***

In the literature there seems to be some confusion over the definition of spirituality, but ‘the holistic notion of spirituality is probably widely acceptable in a society whose de facto norms are highly secular, yet it leaves open a religious understanding of the word’ (Hay & Nye, 2006: 22). On a personal level, spirituality is the aspect of me that connects to something bigger than myself, enabling me to begin to make sense of the harrowing circumstances of the families I work with on a daily basis. This is based on my Christian belief system. Of the interviewees, only Amy shared this perspective that her spirituality is based on her Christian faith and that this supports her in her work:

*'A complete lifeline that I've had to really hold on strongly to my belief and my faith and certainly when I'm working with clients. I think it has deepened. I really do.'*

In contrast, the other interviewees, while explicitly stating that they do not 'believe', reveal concern with what I have called 'spirituality'. They frame their spirituality in relation to a God that they do not necessarily believe in. For example, Ali uses a type of metaphor to describe what she considers happens to the 'spirit' after death – *'[It] scatters into the air for me'* – while also endeavouring to understand her feelings:

*'I have been also kind of searching for some sort of, I suppose, meaning-making out of so much sadness and tragedy really and I think for me, very clearly, it's become even clearer to me that I don't believe in a God or a particular faith.'*

As a woman in her mid-fifties, this idea of 'searching' and 'meaning-making' may be linked to Ali's developmental stage in life, where the emotional focus moves into an area of making sense of what she's offering future generations.

Returning to listen once again to Ali's voice in the audio recording, I sense disappointment and sorrow in her tone – most probably influenced by her morning's work, referred to previously in this chapter, and by her visit to a young person enduring a particularly painful and lengthy dying process. This extract captures a moment in time for Ali that contrasts with the wider interview, where she expresses the hope and love she experiences in her interaction with children and families. This contrast is consistent throughout the interviews with each participant as they move between a range of feelings. Ali's use of the word 'tragedy' implies a catastrophe with a senseless element – a disastrous happening that cannot be justified – and there is hesitation as she struggles to locate an adjective, selecting 'searching' to describe how she manages and what she is actually doing with

this experience. There is also the sense of clarity of thought and decision-making about her spirituality developing with increased experiences.

Despite Kate saying, about her own future death, that '*I don't believe in God any more so it's even more terrifying*,' I see spirituality in her practice through her choice of story – *The End of the Dream*, which explores the cycle of life and death and the passing of wisdom onto future generations.

Similarly, while Tabitha states that '*I don't not believe, which is a bit sitting on the fence*,' I see spirituality in her practice as she continues with reference to a possible afterlife for the children:

*'It feels too difficult to think about it, so sort of denial, I don't know, but I like hearing from the different faiths what their traditions are and ideas are. I always find that quite a nice warm feeling and like to believe that whatever they believe is what's happening for that child.'*

Tabitha vicariously gains the benefits of the children's faiths whilst identifying this as an area that is '*too difficult*' for her to gain comfort from directly. She enters into a circular process of gaining comfort by believing in what the children believe in – almost as though they merit this but she does not. This may link to the age at which she lost her mother, resulting in a certain emotional distance which she can overcome indirectly by entering into children's beliefs that she feels are too difficult to enter into herself.

Despite the vivid metaphor Amy uses to describe her Christian faith ('*a complete lifeline*'), she struggles to make sense of the clients' situations:

*'There's no making sense of it. If you do that you're going to drive yourself to complete insanity and I think I've been there.'*

This offers a further example of the fast and frequent extremes of thoughts and feelings that dramatherapists endeavour to find ways of managing. Contextualising Amy's comment within her grief after the death of her sister

makes sense of the insider knowledge she identifies; she somewhat harshly takes responsibility for driving herself to '*complete insanity*' – rather than seeing it as a result of extreme family circumstances. Kate, on the other hand, takes a more philosophical approach: '*I can't make sense of it. It is what it is.*'

Spirituality has traditionally been associated with the psychological process of dying and bereavement. King et al., (1994) suggest it may be helpful to separate out three elements within spirituality – religious, spiritual and philosophical beliefs – and that all, some or none of these elements may be present in each person. This helps to make sense of this complex theme within the interviews. Amy, for example, suggests that her religious belief is a method of coping with the work (Carver et al., 1989), whereas Kate draws on a more philosophical approach. Parkes (1996) suggests the experience of loss requires people to revise their assumptions of the world and their place within it; we see each of the interviewees questioning their spirituality in their professional response to the dying process and to the deaths of clients they are involved with.

Jaaniste, referring to her research with elderly clients with dementia, states that a dramatherapy group can offer 'a holding environment where existential issues and key life questions can be worked with creatively [and also] ultimately the transition to a dignified and spiritually meaningful death' (2012; 16).

Since the 1960s, when Billy Lindkvist's early research in South Africa into the healing rituals of the Zulu people identified Ubuntu as part of her developing therapeutic model (Sesame drama and movement therapy), the notion of Ubuntu has become more visible in Western society. Barack Obama (2013) referred to the concept when speaking about Nelson Mandela after his death. Furthermore, Archbishop Desmond Tutu (1999) says:

A person with Ubuntu is open and available to others, affirming of others, does not feel threatened that others are able and good, based from a proper self-assurance that comes from knowing that he or she belongs in a greater whole and is diminished when others are humiliated or diminished, when others are tortured or oppressed. (Tutu, 1999: 35)

In a similar way to Lindkvist, I see Ubuntu as a spiritual concept and am surprised and excited to see it so evident in each of the dramatherapists interviewed. Struggling to discuss or neaten the theme of spirituality is (another) enormous task in a project that is working with an often overwhelming topic. Maybe this is similar to my struggle with the term 'soul' used by Romanyshyn (1999; 207); I will need more time than the lifespan of this project to work this out.

However, my updated engagement with Lindkvist's integration of Ubuntu within dramatherapy identifies a hermeneutic link between this particular emergent theme of spirituality and the larger picture emerging within Phase Three, and this seems exciting. Carved on Jung's tombstone are the words: 'Bidden or unbidden god is always present' (from the reply given by the Delphic Oracle to the Spartans in the 5th century BC). For me this summarises my belief that the spiritual element connects us (the part) to the whole (the world and others).

### **13. Conclusion**

Having looked inwards during Phase One of this research – in what could be described as an in-depth interview with myself – and then outward in Phase Two towards the interdisciplinary nature of the work, in-depth interviews were selected in order to explore the individual dramatherapist's experience in greater detail. I interviewed four practising dramatherapists and then used



IPA to mine the rich data in order to focus analytically on the nuances and subtleties that the interviewees had revealed. These interviewees were selected because they were HCPC-registered dramatherapists working with children with life-limiting or life-threatening conditions, and were all interested in the research project as a benefit to their clients through gaining deeper insights into their own practice.

There were two prevailing aspects that I experienced in the interviews. Firstly, the sensitivity and care that each therapist devotes to client work. In this sense the work is truly vocational. Working as a dramatherapist with children with life-limiting and life-threatening conditions is not an easy job. As Frank states: 'Telling does not come easy, and neither does listening. Seriously ill people are wounded not just in body but in voice' (2013: xxi). The kindness, compassion and discipline, richly evident in the interviews, are testament to the unique personal and professional qualities needed to do this work.

Secondly, the therapists' desire for self-understanding through challenging work, and their willingness to engage with all aspects of their selves – however painful – in order to support the work, shone through in the interviews. Frank goes on to say that 'critical illness offers the experience of being taken to the threshold of life' (2010), and maybe this is part of the draw for professionals. Working with the critically ill offers the opportunity, time and time again, to witness the threshold and learn about our own lives –: but this raises a fear of one's own mortality.

Six master themes, each with their own subordinate themes, were identified as being representative of the experience of the dramatherapist working with children with life-limiting or life-threatening conditions. Firstly, the dramatherapists' own experience of personal bereavements, their own mortality and their processing of these in relation to the work were clearly

evident. Secondly, the theme of time – actual or metaphorical – was important as it offered a past, present and future framework for the therapists' thinking, as well as containment of the numinous within their experience and expression of the work. Thirdly, opposites emerged frequently, connecting closely with the theme of enormity. The concept of right and wrong, which had previously emerged in Phase Two within the inter-disciplinary focus groups, was also a concern. Next, movement was often verbalised through metaphor to describe experiences. In addition, enormity fell into a theme capturing the sheer size of the task they are engaged in; and finally the theme of spirituality was evident – in the therapists' relationship with their own faith, spiritual or philosophical beliefs.

Some of the themes that had emerged from the earlier phases of the project were not evident in the interviews: being alone, for example. Moustakas (1972) wrote *Loneliness* and Storr (1997) wrote *Solitude*, echoing this lived experience of the realisation that we are alone in the world. Moustakas' heuristic inquiry investigates his five-year-old daughter's serious heart defect and offers a strange parallel to the topic of children's illness within this project, but from a parent's perspective. I feel connected to Moustakas' heuristic methodology, and although this may be irrational in some ways, I feel that his research methods must surely be akin to my work as they investigate such similar phenomena. Storr (1997) also writes about solitude through an existential lens of being alone and its value within being alive, which touches on my everyday life experience. Dramatherapy can work with the loneliness clients experience in grief by working alongside them, as Gersie states:

The storyteller simply offers us the gift of a story, told to us and for us, here and now. A thread of wonder is woven; a bridge of companionship is built. We need this contact, often greatly, when we suffer the aloneness of grief. (Gersie, 1991: 229)

Perhaps a limitation in the research design explains why the theme of loneliness did not emerge in the interviews: I had pulled through themes from each previous phase, which meant that 'loneliness' from Phase One (our existential isolation in the world, as experienced by myself as dramatherapist) was transformed into 'working with colleagues' by the nurses and educators in Phase Two. In this way, the theme of isolation became diluted in the process of being pulled through into Phase Three, and did not emerge.

The findings that have emerged from this phase of the research have important implications for the development of dedicated training for supervisors and practitioners in the field of dramatherapy with children with life-threatening and life-limiting conditions. Firstly, the emotionally demanding nature of the work may present specific difficulties in supervision when the dramatherapist's own bereavement history may need to be addressed in order to maintain the safety of the work. Secondly, inclusion of issues around time are recommended in training for dramatherapists in this field, so that practitioners can identify the unique and unusual qualities around time that surround death and bereavement, and so that therapeutic interventions can be informed and models of good practice within services developed.

The surprisingly strong theme of the opposites that dramatherapists are called upon to hold in this paradoxical work further suggests an area of training that needs to be explicitly addressed. The research identified transitions as a vulnerable time for both clients and practitioners; with regard to the theme of movement, current training prepares therapists to support client vulnerability but it does not acknowledge that transition can present unique difficulties for the therapist herself, and this is an area that warrants specific attention in training. Similarly, current training prepares practitioners to contain the overwhelming feelings that clients with life-limiting and life-threatening conditions can experience; however, it does not prepare dramatherapists to

manage their own overwhelming feelings. Finally, time should be made in training and in supervision for reflection on the dramatherapists' own spirituality, whether religious, spiritual or philosophical. This research has revealed that practitioners go through different phases of connection with spirituality, and that time to think this through with others is helpful when making sense of the potentially overwhelming subject of death.

During this phase of the project a song called *Counting Stars* by the band One Republic (2013 – see Disc 1, Track 8) was everywhere – on the radio, in the car, as background music in shops... and I played it loudly, allowing myself to be overwhelmed by its loudness and energy as I danced around the house as a break from writing. The line '*everything that kills me makes me feel alive*' repeated over and over in my mind, and I was left wondering whether it bluntly connected with the idea expressed by Frank above – that being close to death brings us closer to the activity of being alive.

## Chapter 8 – Outcomes and Discussion

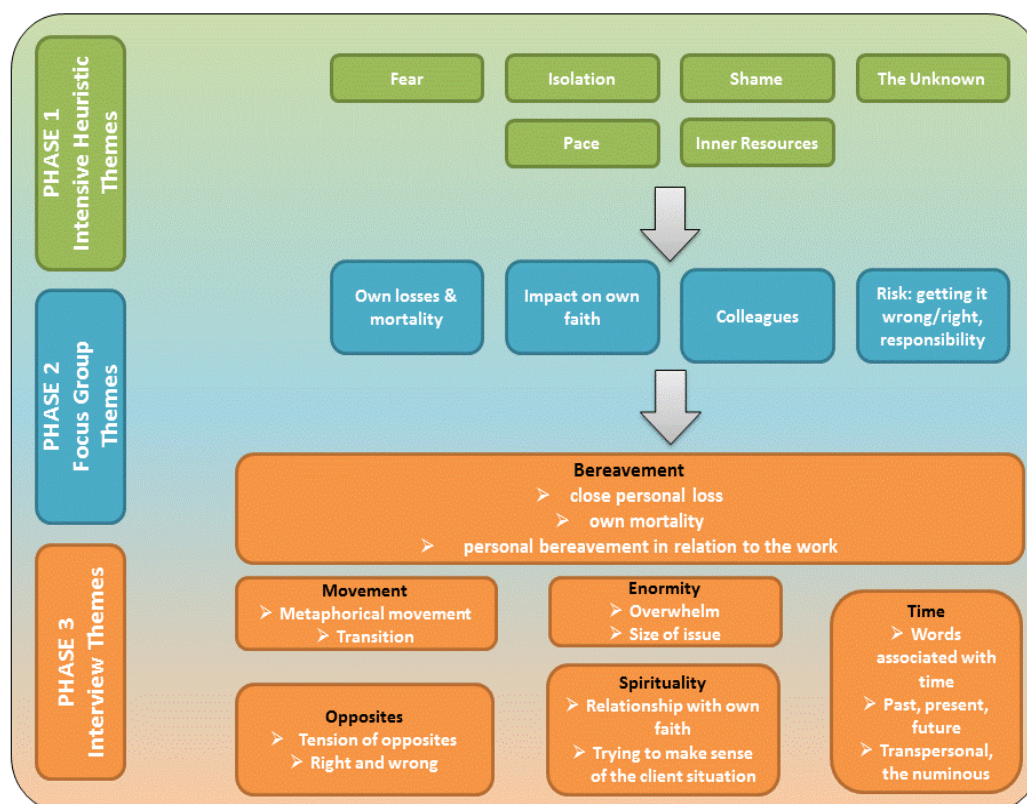


Figure 27: Themes from Phases One, Two and Three of the research project

### 1. Introduction

The products that emerged from this research project are a synthesis of the themes identified throughout the three phases. The outcomes of the project include a chapter in a book for arts therapists and educators (Leigh, 2012); a play performed at three professional conferences for British and international arts therapists, mental health professionals and service users; a bereavement Special Interest Group for dramatherapists; and an article submitted to a professional peer-reviewed journal. (See Fig. 28, below.)

Through critique and feedback in different arenas, the products demonstrate the usefulness of the learning and knowledge – to dramatherapists and to the wider therapeutic community – that emerged from the research enquiry. The products are in different styles, thus appealing both to the intellectual and to the experiential, with the aim of being of interest and benefit to a wide range of professionals and, therefore, clients.

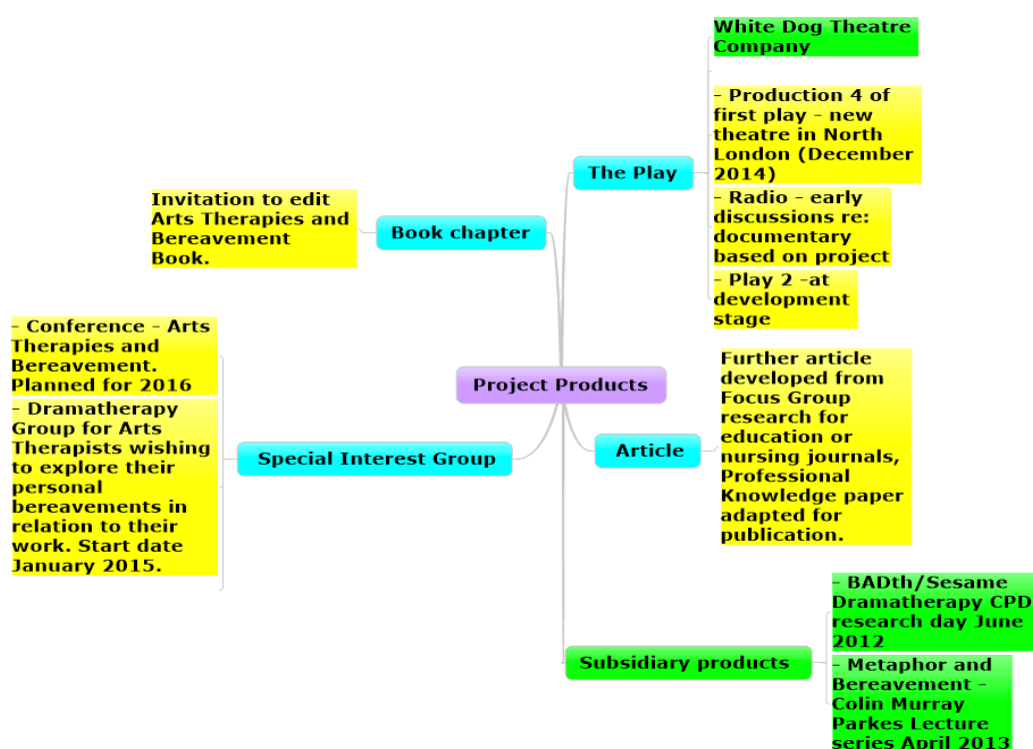


Figure 28: Products – core, subsidiary and post-doctorate

This chapter will discuss each product by presenting a précis of its evolution; an exploration of the way in which it represents my learning and knowledge; a discussion of its usefulness and impact; and then a critique. In addition, the evolution of each product is woven through all the chapters, demonstrating the organic and iterative nature of this live research. The chapter concludes with a discussion of the future development and legacy of the products.

## 2. Book chapter

The chapter 'Beginning, Middle, End, Beginning' in the book *Dramathrapy with Children, Young People and Schools: Creativity, Sociability, Communication and Learning* (Leigh, 2012: 117–125) endeavours to articulate tacit knowledge into clinical practice.

Ali Kelly and myself were approached by the editors of the therapies team at Routledge, who were aware, through professional events, of our specialism in the NHS service. They were looking to commission a chapter for a new dramathrapy book on bereavement with regard to children with life-limiting or life-threatening conditions. They were planning a publication with the specific aim of documenting aspects of dramathrapy practice for a readership across a range of professions.

We set about writing an example of practice that would encapsulate a typical piece of dramathrapy work within our specialism. In addition to the direct client work, the example included the unique aspects of how our service has evolved around the client base, and therefore includes sibling work, co-facilitation and pre-/post-bereavement work. The exercise of writing this together resulted in much discussion and analysis of how, what and why we work in the way we do, and the very nature of the writing process enabled implicit knowledge to be made explicit on the page. Word limits restricted the inclusion of some important aspects of the work, such as the complex ethical issues, the dynamics of co-facilitation and the therapist's self-care (these could only be touched upon briefly in the book chapter), but the experience prompted us to create some protected time – to gain some distance from the front-line work and take an outbreath in a job that is always full of activity.

The chapter has local impact as it continues to provide a resource for other professionals I am in contact with through NHS work, and for trainee

dramatherapists who I teach. It provides invaluable information on our model of practice for educators, social workers, health care workers and others involved in working with children with life-limiting or life-threatening conditions. This dissemination is routinely implemented by giving a copy of the chapter to education staff as a training tool on inset days in schools; to care staff who may be actively participating in an individual dramatherapy session while they're supporting the client; and to MA students on arts therapies training courses. More globally, the NHS published a picture of Ali and myself holding the book in which the chapter is published, with the caption 'Trust Therapists Literary Success' (NHS, 2012). In addition, the editor at Routledge informed me that the book is being translated into Korean.

### **3. The play**

The play *How Do You Think I Feel?* is a synthesis of the themes and learning that emerged during Phase One of the project (the intensive heuristic phase) and it constitutes a form of dissemination. It was devised as a means of tackling the problems of sharing tacit knowledge in an informed and critical way.

In writing up Phase One, I found that words got in the way of sharing my experience with the reader/audience. I found the words and the images one-dimensional – dead on the page – and the sharing of the experience felt unfinished. There was a sense that the dramatic embodiment used within dramatherapy was being left out of the work. I felt confused about my imagined reader, and concerned that I would not be able to convey my experience fully. From a dramatic viewpoint, I thought there was more to be shared, and this was resolved through my learning on the Professional Knowledge (PK) seminars. In Lynne Souter Anderson's (2010b) PK seminar



on the use of clay within therapy, as noted in my PK paper, I learned about listening and following through these feelings:

When the group were deciding what to do with their clay treasures – for example, put them in the recycling bin, take them home or leave them – Lynne suggested that if you're not sure what to do with something you've made then perhaps it's unfinished. I thought about my art therapy folder holding pictures, clay, models – all sorts of art I'd made as I processed aspects of my research. I tried out the 'test', asking each piece 'what are you going to do now?'. It was a strange sort of game – and I admit it's quite difficult to explain – but it was compelling to me and quite intriguing how instantly I could identify what I would or would not do with each piece of work.

I felt very strongly that the heuristic research needed 'legs', and therefore the play was born. By creating the play I would bring Sartre's philosophical notion of how 'in [the] context of personal and social relationships [...] we are better able to conceive of our experiences as contingent upon the presence – and absence – of our relationships to other people' (Smith, 2009: 21). The play brought my research into direct and immediate relationship with other people.

Taking note of my personal process throughout the devising of the play, I engaged my internal supervisor – which, according to Shohet & Hawkins (1989), is a composite, drawing on a myriad of sources including therapy training, external supervision, inner resources and life experience. In addition, I was employing the internal supervisor as part of the practitioner-researcher role, as a way of keeping distance from my own personal material for the purposes of the research process. Etherington (2004) acknowledges the difficulty of representing reflexivity in written text; similarly, within a modality where the dramatherapist's process is key to the client work, I wondered how the profession could ensure research findings are disseminated in a feeling and thinking format – in both a 'formal' and 'loose-

fitting' manner. How can the dramatic format be retained and utilised when sharing research findings?

During a workshop at the 2010 BADth conference, John Casson (2004) explained his research involving dramatherapy and psychodrama with adults who hear voices, and introduced a play that he wrote after submission of his PhD and before taking his viva. He explained that there was more for the material to say, and that he had channelled his energy into changing its shape to a script called *Voices and Visions*. Unlike the play I've written for this project, Casson's script, with its large cast of 25 characters, is representational drama – meaning that the characters closely represent the real clients, perhaps reflecting psychodrama techniques, in contrast to the more oblique, symbolic approach taken within my piece. Therefore, in addition to the paper copy of the research documentation – which in many ways was like a transcript of my process – there was a desire to dramatise and embody the research outcomes.

I felt that the formal attire of the written document offered useful containment and structure, but that the experience and feeling of the research topic asked for the 'loose, comfortable clothing' of dramatherapy. The wardrobe of the practitioner-researcher perhaps needs both. As a means of retaining the dramatic art form, the primary themes from the research were brought to theatre workshops with a theatre director. Out of these workshops, my heuristic *transcript* developed into a theatrical *script* spotlighting the experiential aspect of practice (see Appendix 20).

Explicating and presenting tacit knowledge can risk oversimplifying deep, rich knowledge, and can be reductionist in areas that are expansive. I therefore placed an emphasis on a user-friendly product. 'Product' is not a fashionable word within the arts therapies, with its emphasis on process, and yet the importance of finding a way of sharing that process, and its results, became

key for this research. It happened in two ways: through a presentation at the BADth/Sesame Research Day, June 2012 (see Appendix 11 for the event flyer); and through weaving the themes that emerged from the research into the play and distilling them into one particular scene, offering a creative synthesis of the essence of the research. It is not autobiographical and does not refer directly to my personal experiences, but rather represents them symbolically through the creation of characters, movement and script.

In another example of the circular nature of my research, the play returns me to my (pre-dramatherapy) performance arts training, integrating performance skills with therapeutic knowledge and reflecting Jones's observation that 'theatre is [...] an activity set apart from everyday reality, which at the same time has a vital function in reflecting upon and reacting to that reality' (Jones, 1996: 3). Although I use drama techniques daily in my dramatherapy work, this was the first time in about 20 years that I had taken part in a formal performance in a theatre space. It proved both terrifying and exhilarating.

My co-researcher on this project, Kate McCormack, is also a dramatherapist and a trained actor, so it was an obvious and exciting development in the project when she agreed to be part of the devising and performance of the play. Kate utilised a personal contact and suggested a director, Dave Cotton, who agreed to work with us to facilitate the transition from research paper to performance of the finished play. My experience of theatre practitioners is that they're often fascinated by dramatherapy, as they've experienced the powerful nature of drama and are keen to find out 'how it works'. The key difference between drama and dramatherapy is that dramatherapists have psychological training and are able to utilise both the psychology and the drama to work with the client. Dave Cotton is an experienced theatre director who has managed a number of theatres and arts venues, and he was interested to learn how dramatherapy works. My decision to bring in a director was based on the importance of distancing – as discussed by Landy

(1993) – in order to prevent the piece from becoming an exercise in process only. For instance, a director was needed to oversee the whole theatrical event and shape it into a piece of theatre so that we, as actors and dramatherapists, could focus on content. Working with a director also mirrored the role of a supervisor within therapy work, and offered a view outside of the process.

We identified and submitted a proposal for a performance at a specific event – the ECArTE conference in 2011, entitled *The Intelligence of Feeling* – as its focus that particular year offered potential for wider dissemination of my research project. In choosing the ECArTE conference, with its audience of arts therapists, we made the assumption of a shared therapeutic language. The proposal for the conference was accepted and the three of us – myself, Kate McCormack and Dave Cotton – met regularly and devised the performance text through workshops that included drama games, exercises and story-making. Potential was created for the audience to take the role of witness, therapist and client within their experience of the piece.

*How Do You Think I Feel?* took shape during rehearsals in various spaces at our places of work – psychiatric hospital, drama school, church hall... anywhere we could utilise free rehearsal space. We video-recorded the workshops and Kate and myself worked on aspects of the play individually between rehearsals. We often found ourselves checking, with the director and with each other, whether the material was too exposing, and when this was found to be the case we anonymised it further by distilling the essence into movement, sounds or role-creation. This is an example of the privacy and containment that dramatherapy can offer clients through drama techniques – or the oblique approach (Lindkvist, 1998). The mythic, archetypal aspects of the play allowed the personal aspects to be represented in a way that ensured confidentiality.

One scene in particular, as shown on the DVD (see Disc 2, Track 1), explores themes that had emerged in the intensive heuristic phase of the research. Themes of inner resources, isolation, loss and pace appear in this scene through the use of the drama game 'Grandmother's Footsteps', which involves the character creeping forward using dialogue (dynamic interaction). The personal tacit knowledge of the therapist (myself), explicated through the heuristic method (Phase One), is utilised within this scene – thus allowing the audience to experience some of the therapist's experience. The two main characters are client and therapist; there is constant switching of roles between the actors in order to explore how the inner processes of the therapist and client are drawn upon, and how the therapeutic relationship touches on both at any one time. The therapeutic framework contains the relationship in order for the work to take place; however, the multitudes of roles brought to a session by therapist and client are represented here through embodiment, dialogue and voice.

Two characters – Anne and Caroline – are present on the stage throughout. Anne and Caroline take on many different roles, and the script demands that the audience works hard throughout to identify which character is the client and which is the therapist. Their roles have been made interchangeable in order to explore the countertransference present in sessions. A series of scenes using dramatherapy techniques – including story enactment, movement, voice and projected play – explores the impact of the relationship on both the therapist and the client. The audience is invited to view the therapist's or client's backstory, her previous life experiences, which inform moments within the therapeutic relationship and offer material which is then worked on within sessions.

**[Please view Disc 2, Track 1, which shows a pivotal scene in the play, before continuing to read the following commentary.]**

Within the recorded scene the themes of fear, isolation, shame, the unknown, inner resources and pace are synthesised and embodied within movement, voice, the dynamic interaction between Anne and Caroline, and through words. This offers the audience the opportunity to experience on some level my own experience of working as a dramatherapist with children with life-limiting or life-threatening conditions. The aspects of myself that make up the practitioner-researcher are fully engaged in this example of work: the researcher part of me engaged with the intense heuristic phase of the project, which explored my therapist experiences; the project worker in me thought through how to resolve the representation of these findings and developed an innovative way of overcoming this tricky problem, putting in proposals and organising opportunities to maximise the impact of the research. Finally, the actor in me stepped forward to devise and perform.

### **3.1. Production 1**

In its 2011 conference programme, ECArTE describes itself as follows:

A consortium of Universities which was founded in 1991 and currently comprises 32 member institutions from 14 European countries. Its primary purpose is to represent and encourage the development of the Arts Therapies at a European level, in particular the courses offering nationally validated and professionally recognised training for arts therapists. ([www.ecarte.info](http://www.ecarte.info))

This particular bi-annual conference was held at the University of Lucca in Tuscany, Italy, and we performed the play on the third day of the conference, in a beautiful room with arched windows within the university. There was no conventional stage and the audience sat in rows. We noted audience comments and feedback informally over the following days of the conference. Evaluation consisted of capturing feedback that was offered after the performance (see Appendix 6). It was at this point that I recognised the need for a more formal means of evaluation.

Several dress rehearsals preceded this first performance; there was to be an audience of approximately 70 people and I had underestimated how nervous I would be. The prospect of sharing aspects of my research in such a public way felt very exposing, and this fear was a significant aspect of my experience. However, my adrenaline shifted and changed with the first step onto the stage, transforming into productive energy.

I had not anticipated the quality of the silences or pauses during the play; as an audience member commented, *'The way you dealt with the mobile phone going off was so skilled. How you held the pause and used it in the scene – that was skill! Or I guess it's because you're therapists you know the value of the pause!'*. This is something that is impossible to rehearse and is a unique dynamic created between the actors and audience within the moment. An audience of European arts therapists, with their diverse discipline cultures (music, dance, art and drama) and location cultures (countries from all over the world were represented), is unique within the moment.

With this performance I experienced and learned how to combine my therapist's presence and my actor's presence, which several audience members commented on: *'What presence! I had a physical reaction to it. Not just a head reaction – a tingling reaction. You were very vulnerable.'* Hougham (2013: 99) describes presence as being 'curiously manifest through the ways in which an individual inhabits and alters the space around them, arguably less a result of action and more a quality of being.'

A movement therapist, who had seen the play at the conference, asked what happened between the scenes; this led me to think about transitions in the grief process, and for the next performance we specifically utilised scene changes by offering more insight into the characters, thus making these shifts as significant as the main action, and embodying Jung's concept that no moment in life is more important than another. In addition, we received the

following comment regarding the stage: *'I liked the way you used the space – you don't see people using corners,'* which encouraged us to develop the use of edges and 'in-between' areas to explore symbolically, through movement (outer), the emotional, psychological (inner) processes occurring within the characters. The comment, *'It was so good to see a real piece of theatre in this context'* illustrates that the play enabled the research to be disseminated in an interdisciplinary, specialised work context in an innovative form. It felt as if we were translating theoretical knowledge into a lived experience, and in this way the performance seemed to push at the boundaries of professional knowledge.

As a result of this performance, the ECArTE committee opened discussions with me about editing a book on bereavement and arts therapies, and this is planned for future post-doctoral work, demonstrating the influence of this research project. In addition, members of the arts therapy communities – and more specifically the dramatherapy community – frequently asked about other productions involving therapy and theatre, which led to the creation of the White Dog Theatre Company, described below.

### **3.2. Production 2**

On its website, BADth describes itself as follows:

The professional organisation for Dramatherapists in the United Kingdom. The main objects of the Association are: to promote the advancement of the profession; to be the representational body for Dramatherapists working in the UK; to promote, maintain, improve and advance the education of the public about the benefits, theory and practice of Dramatherapy; to be an advocate for the establishment and maintenance of fair pay and conditions of service for Dramatherapists; to forge links with Dramatherapists and Dramatherapy organisations in other countries. ([badth.org.uk](http://badth.org.uk))



Their 2012 annual conference was held at the University of Scarborough. As the primary event for dissemination of research and good practice in the field, this was the ideal forum for the second production of the play. The play was performed on the final evening of the conference, in a black box studio space with professional lighting and sound. There was a stage with wings and a backstage area, and the audience of about 150 people was seated on tiered seating. This enabled us to more fully realise dramatic techniques. I arranged for a conference delegate to approach audience members after the performance to ask them if they had any comments about the play; in contrast with the more structured approach to seeking feedback after Production 3 of the play (see below), as well as in the focus group and interview phases, this unstructured approach was intended to allow audience members to express their responses to the stimulus of the play without being guided or limited in any way.

During the lead-up to this performance I had been facilitating and writing up Phase Two of the project (the focus group phase). Due to the interest from both theatre colleagues and the dramatherapy community, Kate and I decided to create a therapeutic theatre company to house the play and offer some form of structure for development of a similar genre of work in the future. 'White Dog Theatre Company' was so named as an opposite of the term 'black dog' – a common metaphor for depression, death and melancholy; 'White Dog' reflects health, spirituality and life. In addition, Kate owns a beautiful white Husky dog, which was often present at rehearsals, so this seemed a particularly relevant and fun name for the company. Around this time, both Kate and myself were experiencing some turbulence in our personal lives, and inspired by these troubles I wrote the following introduction to the play, which appeared in the programme for the production:

**How Do You Think I Feel?**

**Devised and written by Alyson Coleman and Kate McCormack**

**Directed by Dave Cotton**

Sometimes, something or someone keeps you alive and you don't even know it. You might have a feeling but you don't actually know it.

This is a play about a therapist and client. Or maybe a client and therapist.

The path in the woods made from breadcrumbs. The wagging of the White Dog's tale. It's the 'when the mother died, the father married again'. Striving for the brick - then yearning for the straw.

Here is the ripple of the clients we've worked with and the clients we've been. The therapists we've worked with and the therapists we are.

**Alyson Coleman** went to stage school and worked as a cabaret dancer, performer and in comedy for many years. She trained as a dramatherapist in 1995 and now works with children and bereavement within the NHS and as a lecturer at Royal Central School of Speech and Drama, London. She is a student, supervisor, practitioner, researcher and writer.

**Dave Cotton** has managed a number of theatres and arts venues including The Pleasance Theatre in London, Harrow Arts Centre and The Palace Theatre Paignton, as well as managing development teams for various London Authorities, including East London where he worked closely with Theatre Royal Stratford East.

**Kate McCormack** is a trained actress, dramatherapist and supervisor. She has appeared in numerous plays and short films, television and has worked at the Bethlem Royal Hospital for the past sixteen years specialising in psychiatry, eating disorders and self-harm. In addition she now works within

education. For the past twenty years she has run a children's theatre company with three or four annual productions. She supervises students on both the Roehampton and Central dramatherapy trainings.

**Figure 29: *How Do You Think I Feel?* programme from production at BADth conference, 2012**

The performance was reviewed and photographs printed in *The Prompt* – the BADth newsletter (see Appendix 21), which is emailed to all members. As a consequence of the performance, White Dog Theatre Company was invited to perform the play, with an additional workshop, as part of the MA Dramatherapy course at Anglia Ruskin University in Cambridge, for which negotiations are in progress.

### **3.3. Production 3**

South London and Maudsley (SLAM) NHS Foundation Trust states that it:

[...] provides the widest range of NHS mental health services in the UK. It also provides substance misuse services for people who are addicted to drugs and/or alcohol. The services include the Maudsley Hospital and the Bethlem Royal Hospital and work closely with the Institute of Psychiatry, King's College London. ([www.slam.nhs.uk](http://www.slam.nhs.uk))

As a member of staff at SLAM, Kate was invited to perform the play by the Arts Therapies Champion within the Trust, and it became a central feature of an event to launch The Ortus Centre – a new building and education centre attached to the Maudsley Hospital. This event was thoroughly evaluated by the Trust, with a DVD being made of the production; a panel of 'experts' and audience discussion after the performance; and written evaluation from audience members, which is shown in Appendix 22. The event promoted interdisciplinary dialogue and created a great deal of interest, with 120

people attending and 40 on the waiting list. The audience consisted of mental health professionals including psychiatrists, nurses, occupational therapists, arts therapists, clinical supervisors and mental health service users. Also attending were arts therapies students, lecturers and programme leaders of several arts therapies training providers. Several artists who work for the Trust were also present. The panel consisted of a consultant psychiatrist, a Child and Adolescent Mental Health arts therapist, occupational therapist and members of NHS staff.

The production and subsequent discussion challenged assumptions about arts therapies within the NHS, which historically have been seen as a rather mysterious activity that is confidential and not clearly understood. A psychiatrist who had expressed sceptical views on the benefit of arts therapies later contacted me to request a dramatherapy student for a placement in his unit; the student I introduced him to, now qualified and HCPC-registered, is still involved with the unit and, with the support of the initially sceptical psychiatrist, is currently in the process of converting his student placement into paid work. He describes how this happened in Appendix 23.

One of the written evaluation comments about the performance was that there were not enough service users present in the audience. I felt slightly uncomfortable from the beginning about the mixed audience, fearing that the play might not be easily understood by non-therapists. I wondered how the content and style of the play might have differed if it had been written for the 'client' and not for the 'therapist'. It challenged me to think that it had been devised through my experiences as client and as therapist, but because it had been devised for arts therapist audiences there were parts I had inevitably adapted. For example, the switching of the roles is a key theme and explores how the therapist brings her history and personal narrative to the therapy space. However, this is potentially confusing to real clients who

may not have an understanding of transference processes. If the play had been written for a service user audience, it might have included more educational aspects such as working alliance, therapeutic relationship and boundaries.

### ***Subsidiary and post-doctoral products***

A consultation by the HCPC in 2012 on a proposal to amend their standards of education and training was carried out with a wide range of individuals and organisations, including education providers, professional bodies and charities. As a result, recommendations were made regarding the involvement of service users in approved programmes of arts therapies training, and an amendment to the standards was made, stating that 'service users and carers must be involved in the programme' (HCPC, 2013: 2). This prompted me to consider how the MA in Dramatherapy at Royal Central School of Speech and Drama could develop the involvement of service users, or clients, in a more integrated way, and it coincided with the questions that arose for me out of the play's third performance in the psychiatric setting.

The use of drama to devise a play or film *with* service users, enabling the sharing of experiences in dramatherapy, is an exciting and organic development. I am currently designing this new module for the training and we aim to introduce it in the academic year beginning 2015, having taken the following steps: firstly, during the annual Placement In Partnership day, which involves placement hosts attending a Continued Professional Development at Royal Central School of Speech and Drama, I facilitated an information and ideas-gathering exercise with placement managers to gauge their opinions on service user involvement on the training programme. A diverse range of institutions and client groups was represented at this event, including a manager and staff of a drug and alcohol addiction rehabilitation centre; Special Educational Needs Co-ordinator of a mainstream infant and

junior school; a day centre manager for adults with learning disabilities; a music therapist from an adult hospice setting; an occupation therapist; a manager of an eating disorder psychiatric unit; and a senior staff nurse at a nursing home for elderly people with dementia. This exercise harvested a rich source of ideas, which will influence how the module develops.

Secondly, several managers who were particularly enthusiastic about the concept have agreed to become 'partners' in the module, working towards its development and being an active part of the pilot project. Finally, I am in the process of formalising this module in writing to become part of the course document.

#### **4. BADth Special Interest Group**

I formed the BADth Special Interest Group (SIG) as a direct and proactive response to the theme of isolation that emerged from Phase One of the research. There is no one definition of a SIG, but my understanding from various sources is that a SIG is a group of people with a shared interest in collaboratively exploring a specific area of knowledge in order to work towards developing their understanding and skills within their practice. In the context of this project, the SIG brings dramatherapists' tacit knowledge into practice through active discussion and debate. The group meets with the approval and support of its professional organisation, BADth.

I put an advert (see Appendix 24) in *The Prompt* – the BADth newsletter – giving a date and location for the first meeting. I was struck by the high number of responses, by email and phone, expressing interest in the details, with therapists expressing surprise and pleasure at finding other therapists working in the same area. I had not been aware of how widely bereavement impacts the work of dramatherapists. From the initial meeting with four

participants, the numbers have grown as word of the SIG has spread, and there is now a regular community of approximately 30 dramatherapists. We meet termly at Royal Central School of Speech and Drama, where I lecture on the MA Dramatherapy training course, and where I can utilise space for the meetings.

I put a great deal of time and thought into how I could make the SIG an informal space where relaxed conversations could develop. The interviews in Phase Three of this project brought out the enormity of the task of working with bereavement as a therapist; the advert for the SIG therefore stressed that the meetings would not be an additional task for busy practitioners, but would provide space and time to breathe while reflecting together on philosophical, practical and personal aspects of the work. I was unable to attend the most recent meeting due to family commitments, but the group ran independently of me. They opted to evaluate the SIG (see Appendix 25), and these comments are incorporated in the discussion below.

It was very exciting to see my 'inner' themes from Phase One become 'outer' as group members developed ways of expressing inner processes among colleagues with the aim of support and safety.

By email, in advance of the first group, I had issued an invitation to each person to bring something to share – such as a problem or a question – in order to stimulate discussion. This loosely remains the format. Answers to complex problems can be formulated by practitioners meeting in an informal situation without the primary task of paying particular attention to a clinical caseload. The unspeakable can be expressed in this space, such as fears about the work. It's a place for philosophical discussion – it is not supervision as there is no responsibility for clinical work – which frees up the space for shared discussion, inevitably resulting in support. As McLeod says, 'In therapy new ideas come from practitioners' (2003: 184). The group has been

a place full of creativity, although there is also space for silence, pauses for thought and reflection.

As one group member commented, *'I felt so much better going back to work on Monday last time we got together because I felt as if I'd sorted something out in my head that had been worrying me.'* As du Plock says:

Good research is a living thing: it should leap off the page to revitalize some aspect of our way of being as therapists. In doing so it mirrors the characteristic of good therapy, that there is a genuine connection between the meaning worlds of client and therapist and, in the meeting, some sharing of experience. (du Plock, 2004: 32)

General feedback suggests it would be good to meet more often, but I feel cautious to do so at this time as most therapists have busy lives with many additional work-related events taking place during weekends and evenings. However, my view on this may change if the group continues to feel they would benefit from increasing the frequency of meetings, and with several people wishing to organise the conference and CPD events it may be that a few people could meet outside of the SIG to develop these plans.

A current subsidiary product to the SIG involves a small group of participants motivated to take on the task of organising an 'arts therapy and bereavement' conference as a CPD event. In addition, the SIG has crystallised a notion that emerged strongly in all phases of the research, which is that therapists need to work through their own bereavement in order to maintain the safety of the clients and of themselves. Myself and Ali Kelly – co-researcher in this project and my NHS job-share partner – are planning to start a dramatherapy group for arts therapists, with the specific aim of exploring their own bereavement in relation to their work. An advert for this group (see Appendix 26) will be placed in *The Prompt* in October 2014, with a view to starting the group in January 2015.



## 5. Article

It has been my aim, as part of the research process, to share and disseminate my findings by writing articles for peer-reviewed journals. This has proved to be a very difficult process for me, reflecting McLeod's explanation of the difficulty of finding ways of disseminating and publishing heuristic projects as they are 'inherently unboundaried and do not readily fit into academic schedules and publication formats' (2011: 208).

I wrote an article based on Phase One of this research project and submitted it for publication in November 2013 to *Bereavement Care*. It was rejected on the grounds that it would be more suitable for publication in a therapy journal (as described in the editor's email in Appendix 27); I have thus submitted it for publication in *Dramatherapy*, which is the official journal of BADth. I am considering other material from the project for development into articles for publication in peer-reviewed journals – for example, the findings from the focus groups would be of interest to educators and nurses and therefore may be submitted to the *British Journal of Special Educational Needs*, or the *Paediatric Palliative Care Journal*. The Professional Knowledge paper, which has been awarded the Jenifer Elton Wilson Award for an Outstanding Paper, synthesises my learning and seems pertinent to share with other arts therapists through publication in journals such as *Arts and Health*.

## 6. Conclusion

As I wrote in my Professional Knowledge paper, my aim was to make products out of my research that would contribute to moving forward the professional practice of dramatherapists working in bereavement. I wrote:

New knowledge moves professions forward and develops skills bases. Most importantly, capturing tacit knowledge results in being able to learn from experienced therapists before working with the client. One person's tacit knowledge has limited impact. It can also be isolating, limited and lack legacy as the knowledge goes with you. It can be challenging to transfer this knowledge to other disciplines, for example from the Arts Therapies to the medical model, but this is important for professional credibility. This IS the point of my project. (Coleman, 2013)

The first product was a chapter in a book documenting my dramatherapy practice with children with life-limiting conditions. This was aimed at a wide readership of professionals, in addition to therapists, including health professionals and teachers. The second product was a play, written and devised in collaboration with a co-researcher and performed three times – at a dramatherapy conference, a European arts therapy conference and an NHS adult mental health event. A Special Interest Group for dramatherapists was established and continues to thrive, and finally, a journal article is in development. I believe these products evidence what du Plock (2014: 177) identifies as the three criteria for doctoral success: firstly, 'their professional experience, developed continuously through active and effective engagement with individuals and groups of clients in a wide range of contexts'; secondly, 'the forms of research resulting in "products" of demonstrable interest and usefulness to practitioners'; and finally, 'the leadership qualities and skills whereby professionals are able to set up training, consultancy and organisations dedicated to psycho-therapy provision.'

The play and the SIG address the question I raised in my PK paper:

Tacit knowledge (as opposed to formal or explicit knowledge) is the kind of knowledge that is difficult to transfer to another person by means of writing it down or verbalising it' (Polyani, 1967). Therefore this poses a problem for dramatherapists whose knowledge base is largely 'tacit'. How can we ensure as a professional community that our knowledge is shared and not lost? (Coleman, 2013)

These products continue to take the research to the practitioners and a wider audience. The SIG is ongoing, with new ideas for further products being developed by the group members. Further productions of the play are planned, including its first performance in a theatre in London for a general public audience in December 2014.

Put simply, I consider that these products 'work' as they've made an impact on arts therapists (and, as a bonus, on other practitioners involved in a range of support services). I believe this is because, as a practitioner-researcher, I have followed my genuine interests and motivation for the work, collaborating throughout with a range of stakeholders, forming a strong project community and creating products that fit me comfortably, and which I have genuinely enjoyed developing and bringing to life.

This chapter has captured the current state of the four core products generated through this research project – but each of them has 'legs' and continues to grow and generate further opportunities. Each product is currently in the public domain and working hard to meet the original aim of my project: to find ways of sharing tacit knowledge.

## Chapter 9 – Conclusion

The title of the published book chapter that came out of the research project – ‘Beginning, Middle, End, Beginning’ – synthesises the reflexive nature of this journey. This conclusion brings to an end the doctoral phase of my research, so that post-doctoral research may begin. Being a dramatherapist working with children with life-limiting or life-threatening conditions sits somewhere on the continuum between what I think of as ‘ordinary’ and ‘extraordinary’, with the shifts between these polarities happening frequently and quickly: ‘ordinary’ because in every job there are routine aspects, and ‘extraordinary’ because being confronted by the philosophical elements of a child’s life and death is, well, extraordinary – as I am acutely aware at this very time of writing.

I am mindful that I need to stop writing, get into my NHS uniform and go to a ‘work’ funeral – that of a little girl who has died of a brain tumour. I’ve been working with her and her older brother for over a year and have been supporting the complexities of this family, who arrived in the UK after fleeing civil war in their home country. The little girl’s brother interprets for their mother, who speaks no English. Returning to my observation in Phase One that people sometimes comment on how difficult my job must be, I now also acknowledge the personal and professional satisfaction I feel despite it being, indeed, hard to view the tiny white coffin containing the client I’ve worked with, knowing that in some part I have equipped her brother to read the poem he wrote for her at the service and to know that *his* life will continue. My own ordinary and extraordinary experiences of working with such children made it seem urgent for me to study the experiences of other dramatherapists doing this kind of work; in addition to the desire to answer the question ‘Is my experience really what it’s like for others?’, I also felt that a doctorate would

anchor the importance of the work, advocate the benefit for the children and raise the profile of the bereavement service that I had developed.

I embarked on the first phase using heuristic inquiry as a means of exploring my own experience of working as a dramatherapist with children with life-limiting and life-threatening conditions. In this way I learned that I experience fear, isolation, the unknown, the pace of personal and client process and inner resources within my dramatherapy. This learning impacted on my practice, colleagues and clients in that it deepened my understanding of my own experience and the issues that affect me in relation to the work. I also understood that in order to find what I was searching for I would need to widen out the inquiry and find out what other professional groups thought and felt about working with these children.

This led me into the second phase, where I used focus groups to look more deeply into the above experiences by discussing them with three groups of professionals who had experience of working with these children – namely staff in a Special Educational Needs school, paediatric nurses from my NHS team and a group of dramatherapists. Insights and understanding gained here led me to conclude that even though the tasks of all three of these groups of professionals are different, they are all impacted in their work by their own losses and mortality, by their own faith, by colleagues and the elements of getting it right or wrong, and by the responsibility of the work. New interdisciplinary knowledge emerged from these focus groups, which influenced the development of the next phase of the research and of the emerging products.

In the third phase of the project I carried out individual interviews with four dramatherapists in order to gain a deeper understanding of the themes I had drawn down from the previous stages. Interpretive phenomenological analysis of the data confirmed my understanding that dramatherapists' own

bereavement history impacts their practice, but surprised me with new insights – including how they're impacted by the enormity of philosophical and practical elements, and how prominently time features throughout the whole process of the job. Further development and dissemination of the products emerged with this deepening understanding.

Four core products emerged from the research: a chapter in a book; a play performed three times; a Special Interest Group; and a journal article. Several subsidiary products also emerged, including a Continuing Professional Development day for dramatherapists; a lecture for bereavement professionals; and the creation of a theatre company with a therapy focus. Post-doctoral projects include editing an arts therapies bereavement book (see Appendix 28); a second play; a radio programme; a further production of the first play; and the facilitation of a new therapy group for arts therapists to explore their own bereavement.

The book chapter entitled 'Beginning, Middle, End, Beginning', which appeared in *Dramatherapy with Children, Young People and Schools: Creativity, Sociability, Communication and Learning* (Leigh, 2012: 117–125), was written in collaboration with Ali Kelly (my co-researcher throughout the project) during Phase One of the research. In the writing of the chapter, we focussed in depth on the model of dramatherapy we have developed, and in this process we consolidated our understanding of our practice, thus making our tacit knowledge explicit for ourselves as practitioners, for myself as practitioner-researcher, and for the reader. The understanding gained in writing this chapter enabled me to grasp the concerns of the other professionals involved in the focus groups in Phase Two of the research.

The devising of the play *How Do You Think I Feel?* with Kate McCormack, my co-researcher, began during Phase One and has continued to develop throughout the project, using knowledge gained in Phases Two and Three of

the research and the experience of – and feedback from – three performances in a range of multi-disciplinary professional settings. Aside from the tangible result of making complex tacit knowledge explicit (which I referred to in my application for the programme as ‘seeking to make the complex simple’), the collaborative enterprise of devising and performing the play utilised many of my personal and professional creative qualities. It excited and motivated me, ensuring that this element of the project brought and continues to bring much personal happiness. The development of the journal article fosters further professional credibility within the dramatherapy community, and potentially also within education and medical disciplines.

In chemistry, the term ‘product’ refers to the substance created when a chemical reaction ends. At the end of this project, the subsidiary and post-doctoral products of the research – what I call ‘legacy products’ – ensure that the project lives on. Within the context of the SIG, the project acts as a bridge between excellence in clinical practice and the dramatherapy community by identifying the benefit of bringing together practitioners and facilitating the formation and sustaining of the group. This develops our therapy skills base through the sharing of tacit knowledge, and creates a legacy of explicit knowledge that is disseminated locally through the group members’ clients and organisations, and in a broader context through the planned conference and CPD days. During the time of the research, three subsidiary products emerged: White Dog Theatre Company has been created to develop theatre pieces which continue to promote dramatherapy; I was invited to present a lecture – *Metaphor and Bereavement* – at a Colin Murray Parkes lecture series for an audience of bereavement professionals; and I was invited to present my research at a CPD event for the Sesame Institute and BADth for an audience of dramatherapists.

Post-doctorate opportunities to continue the legacy of the project include being invited to edit a book for arts therapists working in bereavement, which

is now under discussion, and the fourth performance of *How Do You Think I Feel?* to an audience that does not solely consist of therapists. In addition, using the experience of devising and performing the play, I am now working on the development of a second play based on service-user involvement in therapy training. Finally, early discussions about a radio programme are taking place with a producer with whom I worked on an earlier piece (as described in Chapter 7).

The writing up of the project has been a journey in its own right, reflecting the therapeutic process with much finding, losing and finding again. My sense is that I have managed to find and present what is important. For aspects that are lost for the moment, I believe their time is yet to come.

The origin of the word 'bereavement', as stated in The Oxford English dictionary (1982) is to 'rob' or 'spoil'; my belief is that this project has in some way enabled me to reclaim time, to hold the opposites within the work more comfortably, to be emotionally active enough to move, to be strong enough to face the enormity of the work and to deepen my spirituality – all of which had not been so clear and accessible at the beginning of this journey. Gersie warns that 'silence on death issues leaves us vulnerable to manipulation, as well as frightened and impoverished' (1991: 37). This research breaks my deeper silence. The countless formal and informal conversations about the work within the project community, and even with 'the man on the bus', form a message – sometimes loud, sometimes quiet, but nonetheless clear – that the work is important.

There have been many surprises, including the memorable and not particularly pleasant challenge of deconstructing my own protective strategies for coping with what the work brings up. As Frank says, illness 'provides us with many windows and mirrors' (Frank, 2002: 158). I would expand on this by adding that seeing in and out and viewing my reflection



has also provided me with doors that have opened – doors of opportunity, which I now confidently step through. I have also been surprised to discover that the Sesame model of dramatherapy, in which I trained and now teach, is so clearly underpinned by Ubuntu; I am extremely surprised by the strong pull I feel to connect with this form of spirituality and that this aspect of my training was there, under my nose, all the time.

Climbing this personal Everest has brought many highs and lows, with sightings of the peak but also many demoralising returns, seemingly empty-handed, to base camp in order to summon the courage to begin the climb again. The lowest of lows include my first chaotic Practice Evaluation Project submission, written before gaining my life-changing dyspraxia support; wrestling with the overwhelming size of the project; the melancholic reality of spending large amounts of time alone, reading and writing about bereavement; entering the battlefield with inner, critical voices revisiting from all eras; and clocking up debt after making various project decisions (such as giving up my private practice, taking an unpaid career break and accumulating a host of project expenses).

The absolute highs are all occasions where I felt seen and understood: being awarded the Jenifer Elton Wilson prize for my Professional Knowledge paper; performing the play and knowing completely that it represents my experience of the work; collegiate learning and laughter with my trusted Cohort 11 and DPpsych candidates; receiving a comment from a member of the Metanoia staff team that my project seemed ‘embodied’. Surprisingly, making an appearance on my list of project highs is the sceptical consultant psychiatrist who saw the play in the mental health setting and then contacted me in my lecturer role to request a dramatherapy student on placement on his ward. This remains a highlight as it evidenced and validated certain things of which I am very proud: my role within the training of future dramatherapists – which I carry out enthusiastically and with attention to detail – and the winning over

of an authoritative figure through the quality of the research presented in a drama format.

The impact of this doctoral project as a whole is likely to last for my lifetime. It has been the deepest of self-assessments, identifying my strengths and weaknesses both personally and professionally, enabling me to play to my strengths and to gain support where I need it.

Returning to the core aim of this project, which was to improve the care given to children experiencing life-limiting and life-threatening illness and to their siblings who may be experiencing loss, I consider this has been met through the development of the products and their legacy.

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