

# **An Exploration of Psychotherapists' Experiences of Bereavement and Personal Illness**

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## Abstract

*Aim: The aim of the research was to explore psychotherapists' experiences of bereavement or personal illness and the impact on clinical practice as well as themselves, as practitioners. Method: Semi-structured interviews were conducted with six experienced and accredited psychotherapists and the data was analysed using thematic analysis. Findings: Three themes emerged from the analysis encompassing the self-care practices and supports that the cohort found helpful, such as personal therapy, exercise, a healthy diet and meditative practices. The theme of professional practice included aspects of reflective process with regard to self-disclosure and client reactions to disclosure as well. There were issues of role-reversal in some instances with the client caring and supporting the therapist. It also found that discussion of the implications for clients of unexpected events in their therapist's life, such as serious illness or death, was limited from the therapist's own reflection and practice, as well as an absence of reflecting on personal crises in the course of therapeutic work as part of therapist training courses. Illness and bereavement have impacts on the professional working life of the psychotherapist as well as on their personal outlook. As the use of self is integral in the work this change ripples into client work. Some therapists reported considerable changes in their outlook on life and meaning. The findings highlighted that some research participants described feeling greater empathy towards their clients and a deeper therapeutic connectedness with them. Conclusion: Bereavement and illness are just two of the many personally challenging life events that a therapist may likely experience during their lifetime of therapeutic work. Self-care is imperative in order to resource the therapist in their physical and mental well-being. Personal therapy may be particularly supportive at times of distress and supervision a necessity as the therapist experiences and processes life-change. Some self-disclosure may be necessary during such times due to absence from planned appointments, particularly in the case of illness and prolonged unavailability. Therefore reflecting on the implications for practice with clients, in advance of sudden life events can support professional best practice.*

# Chapter One

## Introduction

Bereavement and loss are just two of the many experiences that may lead a person to seek the support of a psychotherapist and equally, the psychotherapist will experience loss. Loss can be experienced in so many forms, not only in death. The breakdown of a relationship or divorce, (Pappas, 1989), grown up children leaving home, adoption, miscarriage (Cullington-Roberts, 2004) or abortion as well as loss of health through illness (Cristy, 2001; Fajardo, 2013; Maggio, 2007; Morrison, 1997) or disability, are all examples of loss. Bereavement and loss are universal and therefore psychotherapists will inevitably experience personal losses during their working life.

Two prominent clinicians have written of bereavement and loss, notably John Bowlby and Sigmund Freud. Bowlby wrote extensively about attachment; the strong relational bonds that are developed with others from infancy and therefore to more completely understand the psychological experience of loss it is firstly necessary to understand attachment, (Worden, 2010). When those bonds with another are threatened or severed then it is understandable that a powerful emotional reaction occurs, (Worden, 2003). Bowlby's theory rests on the necessity of a present and attentive care-giver attuned to a baby's needs as vital for survival. This early attachment extends on through childhood and adulthood as other relationships are forged. It is not to be unexpected therefore that the nature and strength of the attachment has significant bearing on the depth of emotion and grieving, following death, (Worden, 2003). When the death of a loved one occurs then the permanent separation may represent deep loss on many levels.

Freud's (2001/1917) brief paper, "Mourning and Melancholia" explored the experience of mourning; considered as the painful loss of a loved one characterised by a loss of interest in the world and a pre-occupation with the person as well as a loss of a capacity to adopt any new love-object. The grief experienced with the death of a significant person can be tumultuous and overwhelming. The physical manifestations of loss may include sleeplessness and fatigue, pain and loss of appetite. The emotional impact can encompass feelings of numbness, shock and disbelief, deep sadness, anger, anxiety and irritability, (Adelman & Malawista, 2013).

This, in essence, is an expected grieving process in reaction to a lost attachment. In time, the reality of the loss of the person is fully felt and the energy and emotion invested in them in the mourning process gradually changes. In Freud's words "...when the work of mourning is completed the ego becomes free and uninhibited again." (2001/1917, p.245).

Worden (2003) referred to the tasks of mourning; accepting the reality of the death, experiencing the pain of loss and adapting to the loss. The final task is where a connection to the deceased can be maintained but in way that will mean life is lived as well. This may represent acceptance of the loss of the person and simultaneously understanding that life goes on and can be lived. Understandably this process takes time; Worden (2003) suggested that in considering the time for a full resolution of mourning then two years would not be overly long. In the latest edition of his book, Worden (2010) wrote that in some way mourning never actually finishes, (cited by Kouriatis & Brown, 2011).

Illness can be temporary and brief or in the case of more serious health issues it may be acute, chronic as well as life-threatening. Doka, (2009, cited by Corr & Corr, 2013) wrote of the stress and worry that can arise with life-threatening illness, from the pre-diagnosis stage where there may be worry and fear about symptoms to following through with medics. The acute phase is where diagnosis and treatment are an integral part, as well as gaining knowledge of the disease and experiencing the accompanying emotions and concerns. The chronic phase includes the adjustments necessary for living with the disease, such as feelings of uncertainty and perhaps a further decline. There may be a recovery phase which requires managing the after-effects of illness and potential permanent changes such as losses in function or abilities as well as concern about relapse, as life has changed. The terminal phase may entail continued challenges, on-going interventions or symptom or pain management as well as experiencing relationships with friends and family as the end of life nears. All of these phases have challenges and uncertainties and naturally may lead to being preoccupied, introspective and emotionally distressed.

The use of self is integral to psychotherapy so if a therapist is in emotional distress, then this may affect her capacity to be with her client at a time where she may need to attend to her own requirements. Whilst the relationship is a two way process for client and therapist, the flow of personal information and experience is one-way so that the client does not know, or

knows very little, of the therapist's life beyond the therapy room. Yet when life-changing events occur there may be times, such as unexpected or prolonged absences or where a death in the therapist's family becomes more publically known from a notice in a newspaper, when it is necessary to share more from the therapist's life. These times may call upon the therapist to disclose more of herself than usual.

These issues have invited exploration and reflection in the form of therapist dilemmas in *Éisteacht*, the journal of the Irish Association for Counselling and Psychotherapy, with a focus on the ethical issues at stake. In one issue (Autumn, 2004), a therapist presented the question on how best to prepare for her own critical illness or death with regard to serving her clients best interests. One respondent answered saying that there was no failsafe mechanism and that clients would process the news in their own individual way. He did express the view that allowing a supervisor or trusted colleague access to an appointments diary may provide a route to giving the news; this may be particularly pertinent in private practice, (McKeon, 2004). In a later edition, (Winter, 2007) the subject of therapist illness was discussed and the response was that the client would need to know, especially as the diagnosis became terminal. The author felt that it was imperative that the therapist shared the news in person, if possible, and dissuaded the practitioner from donning a mask however tempting but instead encouraging honesty and congruence, (O' Farrell, 2007).

When considering the psychotherapist who is grieving a loss, it is highly likely that she will work whilst going through her own process. In terms of illness, a therapist may also continue to work, depending on the type or severity of her illness. For the therapist in private practice there may also be the economic incentive to continue working. It is therefore expected that continuing client work whilst grieving for a lost love or experiencing health concerns has some impact on the therapist and, potentially, her client.

### **Aim**

The aim of the research was to explore the experiences of psychotherapists who had experienced loss through bereavement or through personal illness with a view to broadening understanding about the potential impact on therapeutic work with clients. It also aimed to understand what may be helpful to others who experience loss in the

course of their work in managing their professional commitments as well as their self-care.

### **Objectives**

- To explore therapists' experiences of self-disclosure
- To explore supports and self-care practices that may be helpful to the bereaved or ill psychotherapist
- To explore the impact of personal loss on the therapist, both personally and professionally
- To explore therapist experiences in relationship with clients at the time of bereavement or illness.

## Chapter Two

### Literature Review

Whilst there is not a great deal of literature addressing the issue of psychotherapists' experiences of bereavement or illness there are some journal articles that have been published over the years. Mostly these are personal accounts, (Dewald, 1982; Callahan & Ditloff, 2007; Chasen, 2001; Halpert, 1982; Klyman, 1994; Kooperman, 2013; Vamos, 1993) however there is some empirical research which has been published more recently, (Broadbent, 2013; Kouriatis & Brown, 2013-2014). Schwartz and Silver (1990) published an edited book called "Illness in the Analyst: Implication for the treatment relationship" which was a compilation of psychotherapists' experiences of illness and their therapeutic work. It was prompted following an American Psychoanalytic Association conference on illness and the analyst, organised by Paul Dewald, Sander Abend and Eugene Halpert in 1980. Working groups, established in the wake of the conference, yielded an exchange by analysts who shared their experiences of their illnesses. This exchange uncovered feelings of guilt and shame; isolation and fear in speaking, because of their concerns about the perceptions of colleagues who were their source of referrals, once their illness became apparent or known, as well as the corresponding impact on their economic situation, (Junkers, 2013). According to Junkers (2013), prior to this there was scant literature as it was only at this point that the analyst as a person began to feature in debates, (Junkers, 2013).

Silver (2001) wrote of the gender differences that emerged in the contributions to the compilation. Women appeared to openly acknowledge their situations as well as consider the positive and destructive aspects of their client's reactions. Men tended to focus more on technical considerations and their wish for anonymity. Silver also raised the issue of the role of training and professional institutes, with the hope of seeing them respond directly by incorporating training and reflective practice for their trainees, in considering the impact of illness along with some practical responses for continuity of care, (2001).

One of the core aspects which featured in many of the articles on illness was disclosure and the dilemma of whether to disclose to clients or not. Consideration was given as well to change in personal philosophy and approach to work with clients, as well as the practical

implications for professional practice, particularly in the case of illness where there may have been an interruption to practice. Illness is a possibility but not an inevitable occurrence so it is not something that every person will experience in their working lifetime however bereavement is a highly likely event for all, at some stage. Psychotherapists will most likely experience the death of someone significant to them so therefore the literature review will consider the experience of the bereaved therapist as well as the ill therapist.

### **The Bereaved Therapist**

Chasen (2001) wrote of her experience of the death of her child in a car accident and her subsequent return to work. She explored how she responded to client's enquiries at her loss, as well as the impact the news had on her clients and their work together, including her personal responses in the aftermath of the tragedy. She decided that she would disclose if she was asked who had died but equally would not tell those who did not ask. Her first client on her return was a client who was also a mother and longing for a second child and Chasen (2001) wrote that she felt extremely sympathetic for her. She also wrote that a theme for her clients was their guilt about being pre-occupied with their own issues when they seemed insignificant in comparison to her loss. Chasen (2001) felt that the death of her son left her feeling "unneeded and useless" and in her return to client work she was surprised at her capacity to concentrate and that the feelings of being needed, wanted and useful abated her feeling of uselessness for a time. She also expressed the way that her clients gave her comfort by continuing to come and letting her do her work. Likewise, one client who was due to finish felt she could not leave and Chasen (2001) also acknowledged for herself that she would miss her and did not want her to leave at such a critical time.

Klyman, (1994) cited Givelbar and Simon (1990) who commented that a large number of therapists took very little time off. She also wrote that some emotions may be repudiated, such as feeling needy, self-preoccupied or fragile. As well as that there may be some comfort in being able to work and function, (Klyman, 1994).

Kouriatis and Brown (2013) interviewed six therapists, with a mix of theoretical orientations, about their experience of loss which held significance for them. It appeared that grief was not only psychological in origin but also had a physical, cognitive and relational effect on them. In terms of coping with the bereavement it was found that receiving support from

others helped. This was diverse and covered support within their personal environment such as family and friends as well as the professional field, from therapy, supervision and colleagues. Seeing clients proved helpful as this temporarily meant that they could escape and have a sense that life could continue. Kouriatis and Brown's research also showed there were advancements in therapeutic work stemming from the loss experience. Participants reported increased empathy and an increased ability of "walking alongside with the client", (p. 101) as well as being bolder in their approach and feeling more confident in addressing sensitive issues in therapy, (Kouriatis & Brown, 2013-2014).

Broadbent (2013) carried out empirical research on the personal bereavement experiences of humanistic psychotherapists, from which four themes emerged following her analysis. The first theme was bereavement as a unique experience, which encompassed the affective impact, the grief process and sense of self and world view. The next was about re-learning the world, which included personal growth and being heard. The third considered the interaction of the personal and the professional and self-awareness and reflection was instrumental here, as was supervision. All the participants had safe and trusting relationships with their supervisors, where they felt validated and were able to discuss their bereavements and possible implications. The final theme was the impact on therapeutic practice with reference to self-disclosure. The findings emphasised the unique experience of loss and the transformation that can occur within the self and the subsequent ripple in the therapeutic relationship.

### **Self-disclosure**

Some degree of therapist self-disclosure is an inevitable aspect of psychotherapy which at times cannot be avoided, but yet requires consideration and forethought. It can be ethically and professionally unsound to disclose personal information as it may violate the boundaries of the relationship. Goldstein, (1994) wrote that there are some instances where not self-disclosing was not ethically sound, such as when a therapist has a serious illness or even their impending death that would have a severe effect on the client. Theoretical orientation may be a factor in self-disclosure, with psychoanalytically trained psychotherapists least likely to disclose reasons for absence with the view that this may impede the development of the transference relationship, (Barnett, 2011).

However, there may be instances where it can be a helpful and supportive to the client, such as in expressing feelings or reactions in the context of the session, where appropriate, (Barnett, 2011). Kouriatis and Brown (2011) cited research by Tsai, Plummer, Kanter, Newring and Kohlenberg (2010) which noted that self-disclosure could be of value in the therapeutic relationship as the client may reflect on previous feelings and themes not previously shared or it may deepen the relationship and allow for more openness in disclosures, (Morrison, 1997). Chasen (2001) also reported a similar experience. Her news evoked anxiety in one client as she recalled the fear that she would not see her therapist again or that she would be upset and she, as client, would not know what to say. However, the work deepened on one level as the client began to talk about traumas in her life, an example perhaps of how the disclosure of such personal information perhaps may lead to deeper exploratory work with the client. Another positive effect may be the offering of genuine authenticity in a real relationship, (Morrison, 1997), therefore also allowing for clients to make informed decisions with regard to the choice to continue or be referred. Broadbent's (2013) research found that self-disclosure may be made as a therapeutic intervention, for the client's benefit and within an ethical framework, as participants considered how it could help client's realise a shared humanity; one therapist commented on how disclosing her loss was appreciated by her clients who had also lost a child.

Vamos (1993) wrote of the experience of four of her clients who became aware of the death of her partner. In one case a client who had been in periodic treatment for depression linked to a diagnosis of multiple sclerosis had delayed contacting her and when asked why, the client expressed the fear that the therapist had "enough to cope with", (p. 298). Vamos (1993) reflected that this was a reiteration of her client's experience of her husband, who was not able to manage her care. Rather than explore the client's immediate feelings, she instead offered a remark that acknowledged the difficulty for her in having to worry about the therapist at a time when she was struggling and needed support. This response was enough to re-establish the alliance and work continued. Vamos (1993) reflected on the options available to her in this instance with the chance to conceal her loss, especially given that many of her clients were very ill or facing death themselves. She described how not disclosing was protective as it allowed an avoidance of her reality and she could maintain an appearance of strength. It also allowed her time to feel some control over her emotions, in

talking about her husband's death and she expressed discomfort at the thought of crying in front of her clients. Interesting also to note was that, at the time, she reflected that she had not given much thought to her decision and even then there remained an uncertainty about whether she should have shared it or not. Morrison (1997) wrote of working in therapeutic practice for ten years whilst experiencing recurrent breast cancer. She decided at the time that she would disclose her illness if asked by her clients and likewise would not, if there was no enquiry from them, (Morrison, 1997). She recounts deliberating over telling one client, since it was already known by one of his family members and she felt conflicted; she highlighted that when she talked with a mentor, the response was that it was on her mind and therefore could get in the way of therapy, hence she disclosed and responded to the client's reaction.

Reaction to disclosure can vary hugely but in Fajardo's experience it generally deepened the relationship, (Fajardo, 2013). She wrote of the variable reactions received from her clients when she spoke of her illness; there was the desire to help, a fear of talking about illness and death in case it was hurtful, anger at the thought of the disruption to their process, hurt and sadness at past losses and illnesses as well as feelings of guilt and shame about talking of seemingly trivial issues. Anger may be expressed, as well as guilt, stemming from the client's self-preoccupation, (Guy & Souder, 1986).

At the time of writing, Vamos (1993) highlighted the lack of experiential material available on disclosure and the uncertainty of how to proceed, exacerbating her sense of aloneness. Kouriatis and Brown in their review in 2011, nearly twenty years on from Vamos' article, also found a scarcity of research exploring how personal losses impact well-being and professional practice, (Kouriatis & Brown, 2011).

### **Professional Practice**

As the therapists' use of self is integral to their therapeutic work, it is useful to explore the impact that loss has on sense of self and consequently, work with clients. Callahan and Ditloff (2007), both therapists, wrote of the stillbirth of their daughter, the ensuing distress and professional transformation. For Callahan (2007), she expressed the realisation that loss was on-going and acute pain recurred. She reflected on changes in her practice as a result of her experience, especially with those who were bereaved, such as being more attentive

to remembering, using the person's name and in acknowledging that the loss was remembered and important. She also took steps to understand her client's experiences and realities, beyond what may have appeared rational. For Ditloff (2007), he experienced an existential crisis in his perceptions of life and meaning, along with a realisation of the loss of his perceived omnipotence. Consequently, he found greater compassion and empathy for others as a therapist, as well as recognising the importance of being present to a client. In their relationship with one another and their shared grieving and talking, Ditloff (2007) came to an enhanced awareness of the importance of listening as well as the vital need for support, leading to him asking this of his clients and where support was limited, helping them to develop networks.

There seem to be few guidelines that explore how a therapist may respond to personal loss in their professional work. The Irish Association for Counselling and Psychotherapy (IACP) Code of Ethics and Practice makes reference under limits to competence, with the following statement,

“...practitioners shall ... refrain offering a service when their functioning is impaired due to personal or emotional difficulties, illness, disability, alcohol, drugs or any other cause” (IACP).

Another issue to consider therefore is ethical responsibility and Halpert (1982) wrote about the need to stay alert and be empathic and objective, which may be a struggle for an ill therapist experiencing pain, fear or exhaustion. He also referenced the fact that Freud suffered with oral cancer for the last seventeen years of his life and yet continued to work throughout, but without writing about transference, countertransference or his ability to work at that time, (1982). Ethical dilemmas present in therapeutic work and with illness there may arise the issue of taking on new clients. Morrison (1997) decided on a case by case basis, referring some clients to other therapists, depending on their prior experiences of illness in their family life or abandonment issues, whilst retaining others. There were some clients to whom she disclosed her illness when she felt the material they brought seemed to contain an unconscious awareness or nonverbal communication; she explored with them the ramifications of this information, (Morrison, 1997).

Junkers highlighted the conflict that can arise for the analyst who, whilst not wanting to interrupt the analytic space by informing the client of their ill-health, has a responsibility for

practice. The emotional distress and physical impact of serious illness leaves its mark on the analyst and therefore can impact on their abilities in perceiving countertransference to making informed interpretations, (Junkers, 2013).

Personal distress and its impact on professional life is inevitable and the therapist needs to attend to the challenges this can present. Not addressing them in clinical supervision or by not seeking personal therapy, when needed, may impact on objectivity and judgement, (Barnett, 2011), with implications for the therapeutic work. Such implications may include a role-reversal of the client-therapist relationship with the client caring for their therapist and this may be a risk when the illness of the therapist is known, (Denis, 2013) or even when a bereavement is disclosed. Whilst being in supervision is an ethical requirement for professional practice, at times of personal stress returning to therapy may also be necessary as a source of support, (Junkers, 2013; Kooperman, 2013). As Junkers wrote,

“Professional help can make it easier for sick analysts not only to make ethically conscionable decisions but also to cope with this personal crisis in their lives”,  
(Junkers, 2013, p. 65)

Therefore, there is encouragement for therapists to engage in reflection on the impact of stressful experiences and life events in order to be aware of the potential effects on their practice, (Barnett, 2011) as well as the capacity for awareness of their limitations, (Maggio, 2007). When working as a psychotherapist is an individual's primary source of income there can be the dilemma of continuing to work because of the necessity of an income, (Kooperman, 2013). An economic threat at a time of life-changing experience, can be considerable, (Klyman, 1994) hence there may be a desire to continue or to return earlier than perhaps ideal. Morrison reflected that this could in some way account for the denial by therapists with serious illness of their capacities to continue working, (Morrison, 1997).

Bram (1995) proposed that training programmes and supervisors address the issues of vulnerability and mortality with therapists, so that there may be some thought ahead of the reality of the experience with the inevitability of loss in life, through illness or bereavement. Likewise, Counselman and Alonso (1993) also recommended that therapist training programmes should include exploration of crises management for the therapist. There is a call from an ethical standpoint, as well as from personal self-awareness and professional practice, that therapists need to consider the practical implications of unexpected

incapacitation. This requirement can be met by producing a professional will, outlining steps for the care of a private practice and clients in the event of serious illness or death, (Becher, Ogasawara & Harris, 2012). Kooperman (2013) made recommendations for practice based on her conversations with bereaved and ill therapists, as well as her own experience of her son's serious accident. She suggested having a policy about client contact and confidentiality in the event of absence and keeping an up to date appointments diary with client contact information that was accessible by a trusted colleague, in case of crisis.

### **The Ill Therapist**

Illness can be considered as a loss of health because of the impact it has on the physical and psychological well-being of the person. If the illness is long term or terminal then the ramifications for the therapist in their work is highly significant and presents challenging dilemmas. As Counselman and Alonso, (1993) stated, there is no way to truly substitute the therapeutic relationship as it cannot be easily replaced given that it is uniquely created between two people. Dewald, (1982) found that only two of his seventeen clients sought an interim therapist when he was ill.

One of the dilemmas related to disclosure of illness centred on how much information may be given, if any at all. Counselman and Alonso, (1993) cited Abend (1982) who, despite his initial intention not to disclose his illness, capitulated on a case by case basis according to the client's needs. Guy and Souder (1986) also cited Abend (1982) who suggested that therapists reflected on certain issues, including whether there was a wish to diffuse a client's anger, or a personal need to invite sympathy or care. Dewald (1982) rationalized his response in telling his clients that he was ill by believing that it would protect them from undue anxiety. If a therapist does disclose, then he needs to be open to what feelings the client may express. However, a psychotherapist who tells a client of an impending absence for a number of weeks, but without reason, may be perceived as secretive. The lack of information could elicit unnecessary worry or fears for the client, (Barnett, 2011) or abandonment issues (Kooperman, 2013) and so it can be a delicate balance.

In terms of countertransference, the information gleaned from a questionnaire given out by Counselman and Alonso (1993) revealed that there was anxiety about returning to work; one was distracted about upcoming surgery and another expressed that their own mortality

was an issue. Another spoke of his denial of his illness and how that played out with his clients was that he had to extend his absence just that bit longer. Also of interest is that, of the 22 questionnaires sent out, only 9 were completed and the authors surmised, this could indicate how difficult it was for therapists to write about their experience. Yet, Maggio (2007), in her article on working with a chronic illness, cited the experience of writing about her illness as a way of viewing and coping with her lupus diagnosis. She experienced it as a balancing act between acknowledging her struggle with her illness and yet not denying or minimising it. She also did not want her illness to define her and she came to the realisation that being more open about it with others gave her permission to care about herself, as well as portray to her students and clients the value in accepting personal limitations. She recommended the creation of an audience, either directly in terms of family, friends and colleagues or indirectly via the written word to bear witness to the struggle of chronic illness, (Maggio, 2007). She cited Penn (2001), who discussed the value of journaling in that it externalised the experience in some way, allowing a reflective stance that could enhance further communication with others close to the individual. Maggio described her writing as therapeutic as well as overwhelming at times and yet found it a source of support in that it helped shift her perspective, (Maggio, 2007).

### **Self-care and Support**

Self-care is an important part of psychotherapy practice, in supporting the therapist to feel physically and mentally resourced in the work, lessening the risk of impaired functioning, fatigue and burnout. Mahoney (1997) carried out an anonymous survey regarding the personal problems and self-care patterns of 155 psychotherapists and found that recreational reading, hobbies, holidays and exercise were the most cited forms of self-care. Meditation and peer supervision were also frequently reported and yet interestingly personal therapy was one of least reported forms of self-care. Whilst personal therapy was one of the lesser reported aspects of self-care, it was notable that nearly half of female respondents had been in personal therapy compared to only 28% of male respondents.

Barnett, Baker, Elman and Schoener (2007) wrote that self-care was imperative in the work. They cited a term from Kramen-Kahn and Hansen (1998), “positive career sustaining behaviours”, which support a balance between personal and professional life including

exercise, healthy diet, rest and breaks from work, as well as attending to physical, emotional, relationship and spiritual needs. Barnett et al. (2007) also advocated peer support, supervision groups, personal therapy and individual supervision as ways to counteract the professional isolation that can be incurred, especially in private practice. (Barnett, Baker, Elman, & Schoener, 2007). Norcross (2000) commented on studies that found that psychotherapists upheld and valued intermittent personal therapy in their self-care practice.

Given that there is limited research in the area and that coping with loss and the impact on professional work is relatively unexplored, the aim of this research is to contribute and broaden understanding. Many of the journal articles are written from a personal perspective, so research which draws on and analyses the experience of several therapists may reveal themes and factors with a common thread. Bereavement is an inevitable experience for the majority and the likelihood of experiencing personal illness may be considerable, particularly with ageing. With this in mind, the research aimed to investigate what may be helpful to psychotherapists who wished to reflect on the potential impact of these life events on themselves and on their therapeutic work with clients. Of particular interest was the availability and utilisation of supports, both professional and personal, as well as an individual's self-care practices.

## **Chapter Three**

### **Methodology**

The appeal of qualitative research is that it can provide detail and a depth of analysis that is helpful to the practitioner, (McLeod, 2003). This therefore made qualitative research the preferred option in this study with the aim of exploring psychotherapist's personal experiences of bereavement and illness, as well as ascertaining what may be helpful to colleagues who may experience similar losses in the course of their work. McLeod wrote that "The fundamental goal of qualitative investigation is to uncover and illuminate what things mean to people." (2003, p. 73).

Qualitative research has a number of defining characteristics which include; information being drawn primarily from linguistic data and that the researcher is in close contact with the participants. In addition to this, conclusions are based on the experience of being immersed in the data rather than formed from pre-conceived theories, known as inductive analysis. Also, a factor of qualitative research is the view that participants are actively engaged in co-creating their social world as well as involved in the research process, (McLeod, 2003, p. 72).

#### **Sampling**

Whilst loss may have many guises, the focus of this research was exclusively on therapists' experience of bereavement and illness. The sample was drawn from practicing psychotherapists who had been bereaved or had had a personal illness. As qualitative research involves in-depth exploration of personal experience with the aim of producing descriptive accounts (McLeod, 2003), only a small sample is required; in this instance six psychotherapists were sought as participants in individual semi-structured interviews. The sample was selected from practicing psychotherapists who had been in practice for five or more years. The reason for this was that it was anticipated that they would have more experience of client work and also may have worked with clients over a longer period of time and therefore have had longer therapeutic relationships.

It was anticipated that a snowball sampling method would be used for the recruitment of therapists who were willing to be interviewed about their experiences and their therapeutic work. Initial approaches were made to contacts of the researcher, who were psychotherapists and secondly an introductory letter and poster (see Appendix A) was sent to counselling and psychotherapy centres in the Greater Dublin area to solicit interest in participation. Two thirds of the participants were recruited from direct contacts of the researcher and one third responded having seen the poster in their place of practice. The snowball sampling method is an example of a purposive method, in that participants are selected on the basis of certain criteria. In this instance all the participants had practiced for a minimum of five years and were accredited and they had all personally experienced bereavement or illness. Another requirement was theoretical orientation, in that all participants were either working from a humanistic and integrative approach or a psychoanalytic approach.

It was decided that due to the sensitive and personal subject matter there would be some exclusion criterion, so this included psychotherapists who were very recently bereaved or those who were currently receiving treatment for illness. In terms of inclusion criterion, the requirements for participation was that all participants had to be psychotherapists working in psychotherapy in Ireland who had directly experienced loss through a past bereavement or had had experienced illness, chronic, acute or life-threatening but that it was not a recent diagnosis. The participants' experiences of bereavement were not determined beyond it being the loss of a person, significant to them.

The sample size was six psychotherapists and the aim was for a mix of psychotherapists in terms of their theoretical orientation, gender and personal experience. The final cohort was comprised of five humanistic/integrative psychotherapists and one psychoanalytic psychotherapist; whilst more of a balance was sought, the time frame meant that it was not possible to find further participants with psychoanalysis as their core training. The average age of the participants was 55 and the average number of years of practice was 17, so there was a significant amount of psychotherapy practice and experience in the research cohort. The table below illustrates the gender, age, years of practice, theoretical orientation and personal experience of the participant cohort:

	<b>Gender</b>	<b>Age</b>	<b>Years Practicing</b>	<b>Orientation</b>	<b>Experience</b>
T1	Female	58	18	Humanistic/Integrative	Illness
T2	Female	42	12	Psychoanalytic	Bereavement
T3	Male	56	22	Humanistic/Integrative	Bereavement
T4	Female	48	16	Humanistic/Integrative	Bereavement
T5	Female	69	25	Humanistic/Integrative	Illness
T6	Male	55	7	Humanistic/Integrative	Bereavement

### **Data Collection**

The chosen method of gathering data was by interview. As McLeod (2003) wrote, “The research interview is a flexible way of gathering research data that is detailed and personal”, (p. 74). Semi-structured interviewing in this instance was an effective method as there was some prior focus in certain areas of enquiry but it also left scope for the participant to explore their own experiences and perceptions. There were a number of interview questions (see Appendix D) collated prior to the interview but the semi-structured approach gave the interviewer a freedom to expand certain themes depending on the responses of the participant during the course of the interview, without having to adhere to a rigid set of questions. This approach yielded in-depth experiential data for analysis. Interviews lasted between 35 minutes and one hour. Interviews were recorded and then transcribed verbatim which yielded detailed transcripts.

### **Data Analysis**

Once the interviews were transcribed, the method that was used to analyse the data was thematic analysis. This method is used to discover and analyse patterns or themes that appear in data and is especially useful in instances where there is a lot of detail, such as interviews or focus groups. A benefit of this method is that,

“...thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data”, (Braun & Clarke, 2006, p. 78).

Repeated and detailed analysis of the data was carried out and this is where topics, comments and words that were present in the narrative were coded. Recurring themes started to emerge across the data set with each re-read and coding (see Appendix E). As Braun and Clarke (2006) wrote, this approach also entails researcher judgment with regard to determining a theme and this requires a flexible and open outlook, rather than pre-conceived ideas about what may emerge. The choice of this method of analysis is that it is flexible and can generate unexpected and new insights, (Braun and Clarke, 2006), so it is particularly suited to in-depth interviews with a large volume of data. Thematic analysis can start at the point of data collection, as during interviews certain commonalities of experience may emerge and the researcher can tune in to what she hears and analyse and reflect as the interviews progress.

### **Limitations**

As this was a qualitative research study which yielded a volume of in-depth data, the focus was on a small sample of participants only. Therefore there was no intention of making generalisations from the findings but rather to understand the individual's experience and to see what may emerge as commonalities.

### **Ethical Issues**

Research involves the collation of data which entails gathering personal information and experiences. It is therefore vitally important to maintain clear boundaries, including adherence to ethical practice with regard to the collection and storage of data as well as ensuring that the final written work is protective of an individual's identity. Consideration must also be given to the nature of the research. In this instance, exploring experiences of loss is a personal and sensitive issue which needs to be managed responsibly with relevant support for the participant to ensure their emotional well-being.

Informed consent is a necessity in research and participants were provided with a description of the study, informed of the research procedures, the potential risks involved in taking part and they were assured of the confidentiality of the information given (see Appendix B). Client identity data was kept separately from any research data. Interview recordings were transcribed by the researcher and erased once completed. The transcript data was stored on a computer that was password protected by using passwords known

only to the researcher. There was a detailed consent form (see Appendix C) which participants were asked to sign and a copy was given to them. They were assured that they could withdraw their consent at any stage of the research. To protect the identity of the research participants a unique number was ascribed to their data which was carried through in the research, known only to the researcher. As the information shared was personal, a sensitive approach was taken with regard to removing any pertinent information which could indicate the identity of the participant and therefore compromise anonymity.

## Chapter Four

### Results

This chapter reveals the findings of the qualitative research from the semi-structured interviews. Six interviews were held with accredited psychotherapists. Five of them were in private practice and one worked in a counselling centre. The transcripts were coded using thematic analysis and several themes emerged regarding the impact on the therapist of bereavement or illness and the implications for professional practice. The three principal themes are:

- 1) Self-care and supports
- 2) Professional Practice (including self-disclosure, client reactions and clinical work)
- 3) Personal impact and reflection (self and work)

#### **1) Self-care and supports**

Self-care seemed to feature for all the women in the study as they all referenced their own self-care practices and how these had changed and adapted through their experience of their loss.

The two female therapists who had been treated for cancer remarked on their level of self-care before diagnosis and afterwards.

T5: "I really looked after myself when I was sick, I had to, I was doing relaxation and having little naps"

This was in contrast to before her diagnosis and treatment when she said she used to skip dinner when seeing late clients.

T5: "I think being sick gave me permission to do those things, the self-care bit".

She said that she now leaves more space between clients, paces herself better and she gets more rest. She used a CD with Progressive Muscular Relaxation exercises throughout chemotherapy and radiotherapy and continues to do so. She said it had been recommended by the cancer helpline that she had been in touch with during treatment.

T1: "I went back to yoga, I had sort of stopped for a couple of years at that stage and began to be aware of self-care and be aware of the impact of the work...I was just better at self-care"

The therapist (T1) said how she better supports herself now by stopping and having lunch and taking walks. She reflected that in her earlier years as a therapist she would have run herself ragged whereas now she has a greater awareness of the impact of the work and has paid greater attention to self-care. She very much stressed the impact of the work, particularly the cumulative effects and how self-care is vital.

One therapist (T2) spent considerable periods of time travelling to support her mother throughout illness before she died and noted that her self-care had been compromised from not shopping or eating well. After the death of her mother she relished the sanctuary of her home, cooking good meals, going to yoga and being part of a running club for the support from this community and found that this really helped her in her grief.

T2 "I would be very aware of my own responsibility to keep myself well, so I would have been exercising and eating well"

Three of the six interviewees were in personal therapy either at the time of their illness/bereavement or they went back into it shortly after.

T5: "before I got sick I was going to therapy and I am not now and I am not able for the journey at the moment... I don't have therapy myself which is probably not a good idea because I think when the treatment is over it is the worst time"

The therapist (T2) whose mother died after a lengthy illness experienced the support of therapy during that time, acknowledging her grief during the progression of her mother's illness. She felt that the consistent presence of therapy for her meant taking responsibility for herself in a situation where she felt powerless vis a vis her mother's illness.

T2: "I think that [personal therapy] hugely supported me because I think I was grieving her all the way along"

T2: "... that space allowed [me] to talk about all the things that I needed to talk about and so they did not get acted out in the family system"

Another therapist (T4) had been in therapy during the time of her husband's illness and after he died she felt the benefit of her therapy,

T4: “therapy was very useful in that it was supportive therapy...it needed to be supportive [rather] than deep emotional, I was far too emotional to be uncovering anything”

Neither of the male therapists referred to personal therapy as a support during their grief and there was limited reference to supports or self-care other than supervision.

One therapist (T3) alluded to a caution with his supervisor around his experience of bereavement as he did not want to be told that he should stop counselling. This therapist had experienced a period of depression and he was not able to work for six months.

T3: “I think that grief and loss can be very closely associated with depression and with a denial of reality, [it] actually affects behaviour ... I do think it affects us in ways we don't know”

Another (T6) said that he spent a session with his supervisor talking about the death of his father and that he had a small peer supervision group from his initial training group and has found them to be very supportive during this time.

As some of the therapists worked in therapy centres at the time of their illness or bereavement there was some support from colleagues and administrative staff that was considered invaluable,

T4: “ I had enormous support and resources made available to me to help me manage the time...my supervisor was fantastic...the administrator was wonderful, she and a colleague they would just take over at those crisis moments, to help contact my clients or to let my clients know.”

This was in contrast to those in private practice, one therapist (T5) felt hurt at the lack of support from the professional body that she is a member of and had been involved with over a number of years. This has affected her sense of belonging with the organisation,

T5: “It made me realise that the relationship I have with [the] professional organisation isn't that kind of supportive relationship and maybe it can't be but at the time I was a bit surprised.”

She expressed a wish that organisations, that are aware of one of their member's going through a serious illness, made a note and sent the good wishes of the organisation. She found the support of a colleague within an organisation which referred clients to her and from whom she received regular emails of support and good wishes, as extremely supportive.

Her experience had led her to considering setting up a support group for psychotherapists going through serious illness. This seemed to derive partly from the lack of support from her professional body but also from her knowledge of having worked throughout her treatment for cancer; continuing work had been a recommendation of her oncologist. She wanted to encourage other therapists to reflect on how they might work during illness but not to tell them how.

One therapist (T4) commented that she had looked for literature on bereavement and felt anger at the books she came across with their messages of moving on and finding meaning in what happened, two messages that did not resonate with her feelings of loss. She found the best for her to be the book "The Year of Magical Thinking" by Joan Didion, which described her journey of seeking knowledge and an understanding of her husband's sudden death.

## **2) Professional Practice**

### **Self-disclosure**

When a therapist's availability is impacted by their personal life then self-disclosure may be a factor, especially if a client asks questions about their absence. Training orientation can be a factor as can the therapist's personal stance on self-disclosure which is individual and multifarious, evident in the findings.

The one psychoanalytically trained psychotherapist (T2) in the study sample chose not to disclose the reasons behind her cancelled appointments. She cancelled her clients on the day of their appointment and for the subsequent week by phoning them directly herself; she cited a serious family illness at the time and when her mother died she did not disclose the death. Her reasoning for this was that she felt it would not allow the clients to work with the experience of having been cancelled at short notice. She relayed that one client felt dumped by her and had experienced the cancellation of her session as difficult, which created an opportunity to explore this in the therapeutic relationship,

T2: "...she [client] was a lovely person, there was no way, now way she would have allowed herself to express those authentic feelings so that is why I felt it was the right decision"

She recounted the boundaries of the psychoanalytic contract with its clear cancellation policy and a month's notice of planned absence, referring to the rigidity of the framework that she felt that client work could not be impacted. To this end she did not contemplate taking time out in the week to attend to her mother during her illness so that rather than her personal life impacting on her client work, it was the client work impacting on her commitments to family.

Another therapist (T4) who was bereaved said that her clients had been told that she was away due to a family crisis or family illness and then that there had been a family bereavement but she did not voice whether she had indicated what would be shared with her client.

Both male therapists disclosed to their clients that their fathers had died, hence their absence and cancelled appointments. One (T6) had shared with his clients that his father was very ill during the previous session so that they perhaps were prepared for his subsequent absence when he died. He chose to tell them as this reflected his own humanistic perspective on being real in the relationship in the work. When his father did die, he contacted them by text.

T6: "I had a choice of telling my clients why I am not going to be available ... my supervisor is psychoanalytic and she would have said to me, just say to your clients that for personal reasons you are going to miss the next couple of weeks ... perhaps not to say that there was a bereavement in the family"

Not only did his perspective influence his choice to tell them but also the length of the relationship with his clients; as his work was mostly long-term he felt the relationships had a depth that he felt it OK to say.

The other male therapist (T3) commented that in his counselling work he shared at a deeper level but where appropriate with clients. His view was that,

T3: when they [clients] see someone else being human and a lot of people don't know how to be human they are afraid of their feelings and their deep emotions ... to actually meet someone who has needs and desires and can talk about them can be a very uplifting thing"

In this respect he appeared to disclose personal experience more frequently in his work with clients. He described himself as being a great believer in the person-centred approach.

Self-disclosure regarding illness can mean a different reflection for the therapist, depending on the nature of the illness and their anticipated availability for the work. One therapist (T1) in the study chose to stop client work completely for the duration of her treatment for cancer. She disclosed to clients that she would be taking time out for family reasons and that she would be back in three months. She felt it would not have been fair to her clients and that it was in her client's best interests not to work. What informed her was her awareness of a colleague who had been in therapy with a therapist who got sick and the role reversed between client who was a psychotherapist and her own therapist. She said that resonated with her at the time and she did not want that to happen, hence her decision. She offered her clients referral on to another therapist but none switched.

Another therapist (T5) chose to work throughout her treatment. She reduced her work with clients to appointments every three weeks; the week that she felt her best after chemotherapy. She disclosed her diagnosis,

T5: "I debated with myself about telling them what was wrong but the kind of way I work with my clients I am very open anyway ... they were going to see me and they would see it, like I got a wig and all that but I looked a bit sick"

She did give them all the option of moving on to someone else but none of them chose to take up a referral to another therapist. Again she reflected that all of her clients were long term relationships and that if they had not been she would not have given them the details. She also cited her own experience of being the client of a sick therapist and this informed her decision. In this instance she had heard about his illness directly from him and then when he became ill again at a later stage he also shared this with her as he ended his work with clients. She heard of his death at the time and having that awareness helped her process the loss of him.

### **Client reactions**

The therapist (T1) who chose to take time off from client work said that she had just one or two queries from clients about the reason for her break; one long term client's response was to ask more,

T1: "She just didn't accept that [family reasons], you know, is there something wrong with you and I couldn't lie and say no ... we had been in relationship, it was important to her, look I said I have an early diagnosis, everything will be fine"

When she returned to work the client subsequently asked how she was and she replied she was well and that was the end of the discussion. This therapist felt that the disclosure was in response to what was in the space in the moment for the client.

The second therapist (T5) with illness said that she was brought gifts by a few of her clients that she accepted because she felt she could not have not accepted them, reflecting that they were personal gifts and how could she have said to them that she was not going to accept them. They were concerned and caring towards her and recounted stories of people they knew who had cancer and got better.

T5: "...coming to me a long time...a youngish woman...I think she started to cry when I told her, I actually had to console her".

Some of this therapist's clients asked how she was and others never asked which she said whilst fascinating did not surprise her.

A male therapist (T6) expressed his view that one of his clients used his loss as an opportunity to hug him, which he felt was intrusive and he physically shuddered as he recounted the experience,

T6: "I am not sure really, there may be some erotic transference going on but it is not explicit, we haven't talked about it so from that perspective I just didn't like it, it wasn't nice"

He commented on the role reversal of being cared for by clients in this instance and that they listened to him for a short while before getting down to the business of whatever they were bringing to therapy.

Whilst the clients of the psychoanalytic therapist (T2) did not know of the reason for two cancelled sessions she said that one remarked about knowing that it must have been something serious for her to have cancelled.

The therapist (T4) who was absent from work for a time because of her husband's illness followed by his death said that when she returned she was very conscious of looking out for her client's anger at her disappearance and their possible insecurity of whether she would go again. She felt that at times she would have insisted that they talk about her absence and she was certain that her going had an effect on them.

T4: I have thought and wondered whether they stayed out of sympathy with me because they knew or sensed I was a bit lost and they didn't want to add to my loss ... or would have felt protective of me and that has occurred to me"

One of the participants (T5) also expressed her reflection on the same issue, wondering if some of her clients kept coming because they did not want to abandon her in her illness and she examined her conscience at times. She also noticed that when she returned to full time practice a few ended their therapy then. Some clients left for the duration of her chemotherapy and returned afterwards, one male client did not come during but returned and stayed for a year.

T5: "I wondered whether he found it very hard, was he worried about watching me be sick, he was a soft, gentle kind of man."

Whilst some of the reactions to the therapist's disclosure were conscious actions there were other aspects that perhaps were reflective of how loss manifested in the work at a more unconscious level.

One therapist (T1) noted that when she went back to work after time off for treatment that, "cancer hit me from every quarter...it was like a magnet". She recounted that she saw a couple, one of whom had cancer and then within 2 or 3 weeks a new client came in wearing a headscarf and going through chemo,

T1: "It was very close to the bone and I wondered whether I should refer on but I was OK and she never knew that I had [cancer] and I was actually able to hold it"

The therapist said she explored the issue in supervision and felt that she did not want to reject the client who had specifically requested to come back to her after the initial assessment, as she felt she was a particularly vulnerable stage. They subsequently did work together and the therapist commented that they did a very nice piece of work.

The therapist (T2) who did not disclose her bereavement noted that within weeks of her mother's death, a male client had to cancel a session due to illness of a female relative who was a maternal figure to him. He had to travel to be with her and was with her when she was dying. The therapist exclaimed her amazement in the research interview at him bringing his experience of his loss to their session, mirroring her own feelings of loss. She did not charge him for the session he cancelled because of his bereavement and she commented that it felt good to give this gesture as an expression of her humanity.

The therapist (T5) who worked throughout her illness noticed that after she got her all-clear then several of her clients talked about their parent's ill health and she wondered whether this reflected their knowledge of her personal experience in understanding the impact of serious illness.

She also had a client who expressed her concerns for her therapist as she wanted to tell her about a major event in her life (relationship breakdown) but hoped it would not be too much for her (the therapist). The therapist responded to assure her that it would not be.

### **Clinical work**

One therapist (T4) reflected on her capacity to work after her bereavement and considered whether she should work or not. She was conscious of the safety of her clients and asked herself how she would know if she was unable to do the work and what would the signs be, which she identified as feeling overwhelmed or forgetting appointments.

One of the aspects of considering work when ill has to be the financial loss during illness, especially in private practice. Whilst the therapist (T5) who worked through treatment saw existing clients she did not take on any new referrals and when her chemotherapy finished she had radiotherapy, which although it had less of an impact on her physically she said she still passed on any calls she received. She was conscious of getting sick again and then without having the length of an established relationship she was concerned about the impact that her illness might have for a new client. Consequently her practice was very small with just three new clients in recent months and the previous eight or nine long term clients. At her busiest she would have 24 hours of practice a week and then when the recession hit it went to about 16.

T5: "I still have a very small practice, it takes a very long time to build up and again people hear that you are off sick and say she is very good but she is off sick and then people don't ring"

In therapy centres, especially those with an administration team, there was greater scope for referral to another therapist for support during absences. One therapist (T1) said that the centre she worked in at the time developed a policy in light of the illness of a therapist as a colleague had become seriously ill very quickly and died. In that instance it meant that

colleagues took on the clients of the therapist who had died, in order to help them process the loss of their therapist without an ending process.

None had given thought to what would happen for their clients in the event of their own sudden illness or death and nor had it come up in their training. One (T5) had been involved in the governing body of a professional counselling and psychotherapy organisation regarding duty of care and what to do if a therapist got sick but she had only contemplated it in the abstract and not in relation to herself. The two youngest therapists said that they had not considered it, primarily because of their age.

The therapist (T5) who worked throughout her treatment did reflect on her work during the interview and expressed a wonder about her practice when she was awaiting the outcome of the treatment and her prognosis. She said that there were times she felt preoccupied and therefore not at her best, acknowledging that this was a risky time. She also knew there had been times during treatment when she found her memory was affected, an effect of cancer treatment referred to as “chemo brain”. She felt disconcerted by this and wondered whether she would need to give up working.

One therapist (T1) specifically commented on her practice of having an agreement with a therapist colleague that if anything happened to either of them then they would each take care of each other’s clients, in making contact with them and seeing them as well as destroying client notes and records. She said this was the case now that she was in private practice but that previously when working in an agency there was a diary of appointments and client details were held in the centre.

### **3) Personal Impact and Reflection**

#### **Self**

One therapist (T1) found that her own mortality became very present when she received her diagnosis. Whilst she acknowledged a fear around a re-occurrence of the cancer she felt the longer term impact meant she was more positive in her outlook. It really seemed to prompt her thinking about the impact of the work on the practitioner and the psychic energy that is involved in holding a number of clients and that rituals can be helpful in self-care.

Another therapist (T4) described her relief in working after her bereavement and that it was a good thing for her to do. She noted that she was able to sit with her clients, feel for them and think with them despite feeling shattered.

Another therapist (T5) became aware of her previous illusion of being indispensable to her clients and she felt this was no longer the case and the outcome for her of this realisation was that she felt less pressured. She noticed that things that bothered her before her illness impacted her less subsequently. She was also more aware of her mortality in knowing on some level that if she got sick again then she would most likely have to give up work.

One therapist (T6) reflected on how experience of bereavement had brought him down to earth a bit; it developed his awareness about his own optimism and how this may be for others, reflecting that it may be too much for some people,

T6: "maybe it [bereavement] would have taken that dancing kind of space off my personality at times, the whistling kind of floating optimistic side...just a little bit softened and quietened"

A bereaved therapist (T4) noted during her husband's illness that others wanted things to be better or for good news and that it was very difficult for people to stay with her and not know, to sit in it without fear. Likewise what had seemed important previously, felt less so.

Another therapist (T3) felt that he did not fully experience his feelings at his father's death,

T3: I did think I should give up client work alright at the time but I felt in such denial that I couldn't get in touch with my feelings that I thought it could be years before I actually got in touch with my feelings.

His grief at the loss of his father brought issues of his mother's death many, many years previous to the fore and a lot of feelings for him arose in processing this grief too, perhaps a complicated grief. He did speak of working with a client with grief issues and wondered whether he was working on his own grief as he felt tuned into the sensitivity of this and the fear, recognising the challenge to himself to work on his own grief. He acknowledged that it took a long time to feel the sadness of his loss at a depth that made him feel comfortable.

Another therapist (T2) felt the physical effects of her grief after the death of her mother. She felt extreme tiredness and conflicted, on the one hand wanting to take time off from work and on the other hand feeling guilt about not being able to cope. She felt she could

not give herself permission to take the time off and when she got through it, she felt proud of herself. She noticed how she did not always want to be around others, finding her capacity for company to be diminished at times.

## **Work**

In terms of the work, one therapist (T1) who had cancer felt that it deepened her empathy with her clients and she felt a stronger connection to them. She also felt that it deepened her awareness of loss and also that she felt she was better able to sit with the loss that a client may be experiencing. From the point of view of work with couples, her experience and subsequent reading developed her knowledge and awareness of illness and the impact on the couple relationship.

A bereaved therapist (T4) experienced significant changes in her view of life, she quoted a saying from a theologian that she had held close “all will be well, all manner of things shall be well” and that since her loss this did not stand for her anymore; equally she had found she had less of a stake in her belief system being right,

T4: “I am able to be with people and want to be with people in a much more uncertain place, in the not-knowing place, which is very therapeutic”

This was somewhat echoed by another therapist (T5), who commented that she experienced a change in her vision of therapy for her clients, with a focus on being in the moment rather than the future. The knowing seemed to be about herself in the work whereas for the other therapist it was about her not-knowing,

T5: “I don’t worry too much about the future with clients, I am better at staying knowing that I can only handle what is happening today – their issues I mean.”

This was in contrast to the longer view of therapy that she had prior to her illness and she noted that she now worked from a more immediate day to day perspective. Previously she used to envisage potential change for her clients over a period of time, reflecting how they might be later in the year.

A bereaved therapist (T2) described her reflection on her relationship with her mother after her death and noted that perhaps it helped her therapy work, her awareness that relationships change over time and that this can help in the work with clients who are struggling in relationship,

T2: “the knowingness of that probably has made me much calmer in the presence of clients in being able to witness their process rather than trying to solve ... just to be present to it”.

## Chapter Five

### Discussion

This research set out to explore the loss experiences of psychotherapists, from either bereavement or personal illness and considered the impacts on themselves as practitioners and in their work with clients. Self-disclosure featured in a great deal of the literature, (Barnett, 2011; Chasen, 2001; Fajardo, 2013; Kouriatis & Brown, 2011; Morrison, 1997; Vamos, 1993) and seems to be prevalent in psychotherapist's thoughts at times of illness and bereavement. The participants in this study were no exception and there were a variety of approaches to and degrees of disclosure. Given that there is little research in the area of therapists' life experiences and the impact, it was also an area of interest to research how individuals supported themselves in their professional work at an especially challenging time in their personal life. Loss can lead to change, in one's self and environment. Bereavement has the psychological impact of grief and there is the adjustment to a new environment; one without the person who has died. With illness there is the loss of health and possibly regimes for treatment or changes in lifestyle, depending on the nature of the condition. Both can entail confronting existential issues of mortality and meaning in life. Therefore the study also explored the therapist's perception of the impact of the loss with any changes in themselves and in their work as a consequence.

#### **1) Self-care and supports**

The work of psychotherapy can be emotionally taxing therefore self-care is an important part of professional practice. There was a distinct gender difference in the incorporation of self-care within the research cohort as interestingly, whilst the female research participants all referenced their self-care practice during the time of their loss, neither of the male therapists commented on their self-care during their interviews. The female research participants mentioned a wide variety of self-care practices from exercising, to cooking good meals and having lunch to relaxation exercises and yoga. All of these practices are cited by research on self-care by Mahoney (1997) and Barnett, Baker, Elman and Schoener, (2007). One therapist (T1) repeatedly referenced the importance of self-care in the work and the impact of the work on the self in "holding" clients. Whilst the researcher did not specifically ask about the therapist's view of her illness, there was a repeated emphasis on the

cumulative impact of work and the “psychic energy” involved. This led to the researcher wondering whether the therapist, as part of a personal reflection, had considered that therapeutic work had impacted on her physical and mental well-being and therefore perhaps a contributing factor in her illness. Certainly her illness led to improved self-care practice after her return to health.

Junkers (2013) commented about a return to therapy as a support for sick therapists. Three of the six participants were engaged in personal therapy at the time of their bereavement or illness and commented on the value of this as a huge support at the time. The three were all female participants and this reflected the greater engagement of female therapists in personal therapy as a form of self-care than male therapists, as indicated by Mahoney’s (1997) research. He found that nearly half of female therapists were in personal therapy, in contrast to 27% of males. Kouriatis and Brown’s research, (2013) also found that personal therapy was cited as a support in the work, after bereavement. Given the emphasis of personal therapy in psychotherapy training, at times of distress it was not unexpected to find a relatively high uptake of therapy amongst the cohort.

Likewise supervision was mentioned as a support during the process of illness in terms of assessing the impact of personal illness upon professional life by one therapist (T1). Whereas the other therapist (T5) attended neither personal therapy nor supervision during her cancer treatment but felt supported by colleagues in the profession in terms of peer supervision and support. For those who were bereaved, supervision was referred to as a support but not in any great detail, perhaps because it is standard practice it did not warrant a specific or detailed mention. Kouriatis and Brown (2013) also found that supervision was mentioned within the context of professional supports but it did not stand out. Whereas, Broadbent’s (2013) research found that honest and safe relationships with supervisors were deemed instrumental in bridging the personal and professional lives of bereaved therapists.

## **2) Professional practice**

Being in private practice as opposed to being employed as a psychotherapist may be a factor in continuing in work whilst ill. Not working may mean no income for those who are self-employed, which may be a considerable concern. Morrison (1997) reflected on the fear of a loss of income that could pervade the denial and influence the decision on the capacity to

work. The therapist (T1) who took time off worked in a centre, whereas the therapist (T5) who continued work was in private practice. This therapist (T5) did reflect that she did not think about having cancer at the time of her continuing the work, which may be a form of denial. In addition to this she did not attend therapy because there was a reluctance to talk about how she felt for fear of not being able to cope.

Another ethical dilemma that can be an issue in psychotherapy work is in taking on new clients. Personal illness can also then be a factor in the ethical decision-making process and clearly a dilemma, especially so for a therapist in private practice with bills to pay, (Kooperman, 2013). This issue arose with the therapist who continued working during treatment (T5) as she passed on referrals because she was conscious of the impact of getting ill a second time on new clients with just a short therapeutic relationship. Disclosing illness can also impact on private practice and the therapist's economic situation if referrals from colleagues cease due to ill-health, (Junkers, 2013). From her own experience of illness, Morrison, (1997) decided on a case by case basis, depending on their experience of illness or abandonment in which case she referred on, but she did take new referrals.

None of the research participants acknowledged having considered their own mortality in light of their client work, ahead of their experience of death or illness. Two commented on their younger age as perhaps a factor in this. Only one therapist (T1) commented on her practice with regard to client care in the event of her sudden incapacitation either through death or illness. This may be considered a professional will, as considered by Becher, Ogasawara, & Harris, (2012) and meets with the recommendations of having a policy regarding client contact and confidentiality in the event of absence and an accessible up to date appointments diary, as suggested by Kooperman, (2013).

The issue of personal events such as illness or sudden death and the ramifications for professional work had not arisen in any of the research participant's training programmes. This echoed the proposal by some authors, (Bram, 1995; Counselman & Alonso, 1993; Silver, 2001) that training programmes include the exploration of loss and crises for students in training, which would offer the opportunity to reflect on their situation. The therapist in practice the longest had twenty-five years as a practitioner whereas the shortest length of practice was seven years yet neither had encountered these issues in their training, even

within the last decade. With the prodigious level of loss and grief in therapeutic work as well as in human life it would be remiss of training programmes not to incorporate or facilitate exploration of mortality with trainees, in view of the intensity and depth of relationship between therapist and client. This is perhaps further evidenced in the findings as in instances where there was a break in therapy, very few clients between the three that took extended breaks due to their circumstances (T1, T4,T5) either left therapy or accepted a referral on, choosing instead to wait until their therapist returned.

Role-reversal may be considered a risk to the therapy relationship, (Denis, 2013) and if continued or ignored then there may be ethical ramifications to be considered here and the need for supervision is imperative. Role-reversal featured in the findings from two perspectives, both pertaining to disclosure. One therapist (T6) openly acknowledged there were moments of role-reversal in keeping with his humanistic orientation and the real relationship. He knowingly and authentically accepted commiserations from some of his clients and responded to some of their personal questions as well, on their learning of his father's death. This resulted in receiving hugs from some of his clients and he openly shared with the researcher that he shed a few tears with some clients when he spoke of his father. He did disclose a degree of discomfort with one client, surmising that there was some erotic transference present. The therapist (T5) who disclosed her illness accepted some personal gifts offered by clients such as a blanket and a hot water bottle as it seemed they were mindful of her well-being whilst she was in the therapist's chair. She also spoke of one client who expressed a concern about whether she would be able for an issue she wished to talk about, namely the end of her marriage. This again perhaps indicated a role-reversal with the client "minding" the therapist, maybe indicative of the client's concerns with her therapist's capacity to contain her and bear her loss.

Abend, (1982, cited in Denis, 2013) stated that therapists would not intentionally ask clients to be considerate or caring of them but wondered whether by sharing one's troubles it might be a subtle way of doing so. In the instances above the therapist who worked through her illness did not take a break from the work so throughout tests, diagnosis and treatment she continued to see clients. She said herself that she did not think about cancer which would suggest a degree of denial by carrying on her routine as much as possible. Also she

said that she told everyone about her diagnosis as she felt that the more who knew, the more support there would be and the telling extended to clients.

### **Self-disclosure**

As Barnett (2011) wrote, training orientation can be a factor in self-disclosure with the psychoanalytically trained therapist revealing less personal information. In this research, the reflection of Barnett's was borne out as even though only one of the research participant's training orientation was psychoanalytic, she revealed very little personal information compared to those with a humanistic/integrative orientation. Whilst she disclosed a family illness she did not later reference her bereavement. Four of the five humanistic/integrative psychotherapists disclosed directly to their clients either that they were ill or had been bereaved. The fifth psychotherapist, whilst she did not disclose directly herself, it was apparent that her clients were aware of her loss from other sources. The length of the relationship appeared to be a factor in self-disclosure as when information was given it was in response to those in long-term therapeutic relationships.

Both male therapists (T3, T6) had quite openly disclosed the deaths of their fathers to clients. One (T6) therapist did so from his humanistic perspective of being real in relationship with his clients and the other commented on his belief that clients benefit in seeing another human being express and be open about their emotions, from the perspective of a shared humanity echoing the view of Morrison (1997) with the positive effects of the real relationship. The authentic response complemented the research by Broadbent, (2013) as from her analysis of bereaved psychotherapists she found some expression of the view that self-disclosure of bereavement may be helpful to clients in hearing about experiences common to humanity, such as death. The research has also commented on how self-disclosure can be of value in the therapeutic relationship, (Kouriatis & Brown, 2011; Morrison, 1997; Chasen, 2001). In the experience of the research participants there were outcomes to the disclosure of illness and bereavement, one therapist (T5) noted that her clients talked about their experiences of parental illness, perhaps as a consequence of her own disclosure.

However the reasons for self-disclosure are numerous and need to be in the best interests of the client. When it comes to personal illness, especially if it is serious, then as Goldstein

(1994) wrote, disclosure may be the more ethically sound choice. In the instance of the therapist (T5) who disclosed her illness to her clients it would appear she did so from an authentic response to her clients. By informing them they could then make an informed decision whether to remain in therapy with her or not. As she said, there was also the likelihood that they would see her in her poorer health with the physical manifestations of cancer treatment, such as losing her hair. In this instance then it may be difficult to decide whether stopping client work is the best option as this course of action can have a tangible impact on clients, especially those in long term work.

When a therapist took time out from practice or reduced their practice, which in three instances was due to illness either theirs or a relative, then they offered clients a referral to another therapist. Most clients declined the offer which may not be unexpected as Counselman and Alonso (1993) stated in their article that there is no way to truly substitute a therapeutic relationship because of its co-creation and of Dewald's seventeen clients, only two sought an interim therapist when he was ill and stopped practicing, (1982). One therapist (T4) commented that she knew that one or two of her clients had attended another therapist in the practice during her time away from her work but they did return when she re-commenced practice.

### **Client reactions**

Client reactions to losses experienced by their therapist can yield a rich plethora of responses, as unique as the client themselves, hence why a therapist may consider each individual client in turn when it comes to self- disclosure or not. The research findings exemplified this with an array of reactions. The therapist (T5) who continued to work through illness found that some asked how she was feeling each time and others completely ignored the issue. There was the question in at least two of the therapists' minds as to whether the clients stayed out of sympathy and support, perhaps reflecting the experience of Chasen (2001) who had a client who did not want to leave therapy even though she was due to finish.

The responses echo the experience of Fajardo, (2013) including the wish to help and the fear of talking about illness or death as well as past losses and illness coming into the therapy room. This was the experience of one therapist (T5) whose clients spoke of parental

illnesses, but only once she had the all-clear therefore perhaps protecting her. One therapist (T4) looked out for anger from her clients regarding her prolonged absence. As noted above, overall clients stayed with their therapist. The psychoanalytically trained therapist (T2) did not disclose her bereavement, in accordance with the psychoanalytic tradition and she worked with the reactions to her absence and noted that one client would not have expressed her genuine feelings if she had known her therapist had been bereaved.

### **3) Personal Impact and Reflection**

#### **Self**

Callahan and Ditloff (2007) described their responses to the death of their daughter and the professional transformation following their loss. Ditloff (2007) commented on his existential crisis of life and its meaning, similarly the therapist whose husband died after an illness equally found her belief that all would be well was shaken and she reflected that she could not find meaning in what happened. Her sense of the world was affected, as were her beliefs and she found that her attitude changed and in some ways this was more therapeutic for her clients.

Several bereaved therapists described their psychological reactions to their bereavement; feelings of guilt, sadness and denial. Others (T2, T4) also mentioned the physical impact, such as extreme feelings of tiredness and for one she noticed her diminished capacity for being in the company of others at times. This demonstrates that grief is not only psychological in origin but has other effects as well including the physical, cognitive and relational, as discussed by Kouriatis and Brown, (2013-2014).

Klyman, (1994) wrote about the comfort that could be provided in working and Kouriatis and Brown's (2013) study found that therapists found seeing clients helpful, as it meant they could temporarily escape and life could continue. Chasen (2001) felt surprised at her capacity to concentrate, as well as a comfort she gained from her clients continuing to come and letting her do her work. From the results, half of the participants described their work in a way that may be understood as a resource to them in some way. One described feeling relieved about being able to work (T4); for another it was seeing a new client very shortly after a bereavement which meant he could do something when other work (study) was less

productive (T6) . For one of the therapists with illness (T5) the recommendation to continue work came from her oncologist. It may be surmised that life going on as normal and being able to function may be reassuring to the individual in that they can manage and survive their loss or at least temporarily escape.

## **Work**

Participants described a number of impacts on their work as therapists, following their experiences of loss. There was a sense of feeling a deeper empathy in the work, the issue of loss was more present and one therapist (T1) felt that she was better able to sit with the loss than before. Another, (T4) described how she felt she could be with people in a different way, in a more uncertain and “not-knowing” place which she held to be very therapeutic and she felt a stronger connection. One (T2) outlined how her experience of change in relationship had resonated and resulted in her feeling calmer in the presence of clients as a witness to their process. These experiences are akin to those mentioned in the research by Kouriatis and Brown, (2013-2014), particularly the increased empathy and of the “being alongside” the client, which he termed advancements. Likewise, Callahan and Ditloff (2007) felt more attentive to those who had been bereaved as their own experience directly informed their practice with clients. The psychoanalytic therapist had a client who was bereaved in similar circumstances to herself and she described feeling a greater connection to him. It would have been interesting to know how he experienced her as his therapist at this time also.

Many of the earlier accounts of illness were written by psychoanalysts, (Dewald, 1982; Halpert, 1982) for whom the unconscious and their neutrality were integral in therapeutic work. A majority of the participants in this study were humanistic/integrative practitioners so the frequency and degree of disclosure may partly reflect theoretical orientation with the centrality of the real relationship and authenticity. Given that there was only one psychoanalytically trained therapist (T2) in the study sample it is only possible to infer the differences between training orientations and practice. The structure and rigidity of the psychoanalytic approach perhaps meant there was a clearer path for this practitioner, in that personal disclosure was not considered within the framework of the working relationship. However, the practice of another psychoanalytic therapist was evident but in

the role of supervisor to one of the therapists who was bereaved. The supervisor's response was that the therapist might account for the cancelled sessions with reference to personal reasons only, rather than bereavement. This did not fit with his personal philosophy and so therefore he disclosed the reason for his absence.

Overall the findings concur with the literature regarding illness and the therapist in that disclosure features because of the impact that illness has on availability of the therapist at a time of personal crisis. The individuality of the practitioner's philosophy and approach, the length of the therapeutic relationship and to some extent the client's personality and life experiences are factors in relation to the degree of self-disclosure. Self-care and supports are a necessity for psychotherapists and are particularly emphasised at times of personal stress such as bereavement. Of interest is the prevalence of a return to personal therapy for support at such times. Likewise the research indicates the role that training and professional bodies may both play in their response to, and support of, psychotherapists with regard to their personal loss and professional practice. Inevitably the impact of loss on the practitioner is considerable and therefore changes in their outlook and consequently their therapeutic work are to be expected, with a deepening of empathy reported as well as a greater sense of the unknown and the being alongside the client in the work.

## Chapter Six

### Conclusion

Bereavement and loss are universal experiences in life and a psychotherapist is no exception to these losses in her life as she sits along with her clients who grapple and wrest with the impacts of their life losses. The use of self is integral to psychotherapy, so if a therapist is in emotional distress, then this may affect her capacity to be with her client at a time where she may need to attend to her own needs. Therefore, this research set out to explore the experience of psychotherapists who have either had a person close to them die, or they themselves have had a serious illness. Both may have an impact on the individual and their wider circle of friends and family but also may impact on their professional life in their work with their clients.

Earlier literature on the subject was largely focused on illness and the therapist, primarily written from the personal experience of the author. These accounts seemed to be dominated by the experience of psychoanalytic psychotherapists, perhaps because of the psychoanalytic imperative for neutrality on the part of the analyst, which can be challenged when the analyst is ill. In more recent years there have been some publications of empirical research on the experience of therapists' personal bereavements and the participants have included humanistic and integrative practitioners.

In this research self-disclosure featured, as anticipated, given the impact that death and illness can have on the therapeutic relationship with regard to absences from practice. The findings demonstrated the varied approaches to disclosure of personal experience by the participants and also some of the factors involved in professional practice. Clearly the perspective on disclosure is diverse, with some practitioners disclosing more than others. Some highlighted the importance of the real relationship and the commonality of humanity in shared experiences in their work with clients. The literature reflected the divergent views on disclosure, with some authors reflecting on the benefits to clients, such as a deepening of the relationship or where it allowed for thoughts and feelings surrounding previously unspoken events to be expressed. An example of this was the experiences of parental illness which were shared by some of the clients of the therapist who disclosed and worked

through her treatment for cancer. At other times, role-reversal may occur with the client minding the therapist, either directly by being selective in what they bring to therapy or even to the extent of continuing to come because they do not feel they can leave therapy at a time when the therapist may be vulnerable. This thought featured for two of the therapists as they reflected on whether clients continued to come out of sympathy and support for them. The value of this in the work is in reflecting and working therapeutically with what may be present for the client and being attentive to their reactions and process. Overall there is no answer with regard to disclosure as each therapist works in a unique way. Providing the client's best interest is uppermost and the therapist is able to honestly reflect with the support of a supervisor, then the risk of harm to the client may be minimised.

Psychoanalytic psychotherapists pay close attention to the transference relationship and therefore disclose the least personal information, so theoretical orientation has a role in disclosure. Whilst this may be more manageable regarding bereavement, when it comes to personal illness then ethical issues can arise in the work, (Goldstein, 1994). In this study, the psychoanalytic therapist disclosed the least, perhaps reflecting the difference in theoretical orientation. However she was bereaved, so in the case of ill health perhaps there may have been a different outcome in terms of disclosure. It also highlighted some of the self-care practices of the cohort, including re-engaging with personal therapy and supervision for support. Whilst 50% of the cohort was in personal therapy regarding their loss, which corresponded with research by Mahoney (1997) on uptake of therapy for personal difficulties, there was a gender difference in his research and in this research neither of the male participants cited personal therapy as a source of support at their time of loss. All of the female participants reflected on their self-care practices, especially at the time of their bereavement or ill health but neither of the male participants referred to self-care. At times of personal difficulty, the importance of self-care is greater so that the therapist is resourced in their physical and mental well-being. Whilst there was a general awareness of self-care, in the processing of their loss it seemed that greater attention was paid to it and in the case of the therapists who were ill, the attention to self-care remained. Supervision is vital and perhaps given that it is an integral part of the work it did not receive much of a focus in the comments of the therapists.

There are some issues that may be of interest and relevance to those engaged in training psychotherapists or managing therapy centres, as well as the professional bodies. As only one of the six had a clear practice with regard to her clients in the event of unexpected incident, this may warrant a degree of reflection, especially for those working in private practice. Those working in therapy centres may consider developing a policy in the instance that a therapist is suddenly incapacitated, in order to have a process for contact and support for the person's clients. The research also highlighted how the participants had seemingly not reflected on their mortality to the extent that they did not have a plan in place and the impact of managing personal crises in professional life had not featured in their training. Whilst it is not possible to fully consider a response to a hypothetical occurrence, it is unlikely that in a crisis situation a therapist is able to reflect clearly as her attention and focus is elsewhere, therefore some prior reflection may be beneficial.

In terms of training programmes it may be useful for institutions to consider how they respond to trainees' personal crises as they occur and how they may incorporate some reflection on such eventualities and offer appropriate responses, such as guidelines for a professional will, within the training syllabus. Professional bodies have ethical guidelines and code of conduct statements which are beneficial in considering clinical practice dilemmas and maybe some guidelines in light of illness may be additionally helpful. One therapist considered the benefit of a group for therapists going through illness and given the isolation that can be felt, especially in private practice, this could be a constructive support. Continuing professional development is instrumental in reflective practice and therefore forums for discussion on the clinical implications of bereavement and illness may be valuable to practitioners and not solely the preserve of the one to one supervisory relationship.

It is acknowledged that personal loss is a unique experience and the process of that experience is individual to the therapist's own circumstances and journey. Whilst some empirical research in the area of personal experience and professional practice is evident, this research has some further recommendations for future areas of study. Further empirical research with humanistic and integrative therapists and their experience of illness would be useful to complement the personal accounts that are in existence, many of which date from the late twentieth century and are largely written from a psychoanalytic

perspective. Another issue worth exploring is the role and practice of the supervisor who is working with a therapist who is sick, especially in terms of their clinical work, as this may have heightened ethical dilemmas for the supervisor. Whilst these recommendations are focussed on the therapist's experience it may also be informative to explore the client's experience of their therapist's self-disclosure, giving insight in to the client's perspective, especially in relation to their therapist's illness, other losses or prolonged absence.

It is not necessary or feasible for psychotherapists to withdraw from practice at times of personal distress, unless not to do so puts a client or the therapist at risk of harm. The research has highlighted some of the issues that may surface at times of loss such as bereavement or illness and concludes that the therapist's self-awareness and self-care is paramount in reflective clinical work.

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## **Appendices**

### **Appendix A**

#### **Participants Required for Qualitative Research Study on the Psychotherapist's Personal Experience of Bereavement or Illness**

**Location: Dublin/Kildare**

**Date: March/April 2014**

My name is Sarah Devilly and I am final year student studying for an MA in Psychotherapy at Dublin Business School. I am interested in researching the area of the practicing psychotherapist's personal experience of bereavement and/or personal illness and the impact on the self as practitioner, as well as an exploration of the potential impact on therapeutic work with clients.

I am inviting interested psychotherapists to take part in my research by participating in a qualitative interview of approximately one hour's duration, at a mutually agreed time and location during the months of March and April 2014.

I am seeking to interview psychotherapists with five or more years of post-accreditation practice, who have either

a) personal experience of bereavement, whilst practicing as a psychotherapist

OR

b) personal experience of serious illness, whilst practicing as a psychotherapist

Initial psychotherapy training must be either psychoanalytic or humanistic/integrative in orientation

If you are interested and would like to find out more I would welcome hearing from you

I can be contacted at: xxxx

## Appendix B

### INFORMATION FORM

My name is Sarah Devilly and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which is concerned with exploring the impact of bereavement and/or personal illness on the therapist and their therapeutic practice. I will be exploring the views of people like you, all of whom work as psychotherapists

#### What is involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, in having experienced a loss through bereavement or personal illness whilst practicing as a psychotherapist. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this I will ask you a series of questions relating to the research question and your own work.

#### Confidentiality

All information obtained from you during the research will be kept anonymous. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

#### DECLARATION

**I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.**

**I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records.**

**Name of Participant (in block letters)** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date**    /    /

Appendix C

CONSENT FORM

Title:

**An Exploration of Therapists' Experiences of Bereavement or Personal Illness**

**Please tick the appropriate answer.**

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

Yes  
 No

I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason.

Yes  
 No

I understand that my identity will remain confidential at all times.

Yes  
 No

I am aware of the potential risks of this research study.

Yes  No

I am aware that audio recordings will be made of sessions

Yes  No

I have been given a copy of the Information Leaflet and this Consent form for my records.

Yes

No

Participant \_\_\_\_\_  
Signature and dated

\_\_\_\_\_  
Name in block capitals

**To be completed by the researcher.**

I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/her to ask questions on any aspect of the study that concerned them.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name in Block Capitals

\_\_\_\_\_  
Date

## Appendix D

### **An Exploration of Therapists' Experiences of Bereavement or Personal Illness Interview Questions**

1. Can you tell me a little about what drew you to psychotherapy as an area of work?
2. Can you tell me about your experience of bereavement/illness whilst practicing as a therapist?
3. Can you tell me whether you had thought about or reflected on client work in light of a change in your circumstances, prior to your experience? (e.g. accident, health reasons)
4. What feelings arose for you personally? And in your work with clients at the time of bereavement/diagnosis?
5. How did you find it seeing clients whilst experiencing loss through bereavement/ill-health
6. How did you manage the change in your circumstances with respect to your client work? Did you disclose your reasons for any absence from client work? If yes, why and what did you share? If no, why not
7. How did clients react to your absence?
8. How was it for you to return to practice?
9. Can you describe any differences or changes in how you work, since your experience? (of bereavement/illness)
10. Were you asked personal questions by clients? How were they received and responded too? Any particularly notable reactions? Did loss manifest unconsciously in your work?
11. What, if any, supports did you find helpful? (return to therapy, increased supervision, support from colleagues, contact with professional body)
12. Reflecting on your experience is there anything you would like to share with other therapist's facing illness or loss
13. Is there anything that I have not asked about that you would like to add?

## Appendix E

### Themes

<b>Initial Themes</b>	<b>Middle-stage Themes</b>	<b>Final Themes</b>
Self-care	Self-care	Self-care and Supports
Personal Therapy	Professional Supports	
Supervision		
Personal impact of loss	Personal loss	
Professional Practice	Professional Practice	Professional Practice
Client work		Subthemes: Self-disclosure Client Reactions Clinical Work
Change in the work/relationship with client	Change in the work/relationship with client	
Personal experience of illness/bereavement	Personal experience	Personal Impact and Reflections
Self-disclosure	Self-disclosure	Subthemes: Self Work
Client reactions to disclosure	Clients reactions	