Exploration of the Psychotherapists Reaction When Encountering Clients Death

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…no one is finally dead until the ripples they cause in the world die away—until the clock he wound up winds down, until the wine she made has finished its ferment, until the crop they planted is harvested. The span of someone’s life, they say, is only the core of their actual existence.

Terry Pratchett, *Reaper Man*
For Joan. Thank You.
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Abstract

The purpose of this research is twofold. Firstly it aims to explore therapists’ emotions, thoughts and other reactions associated with experiencing clients’ death. Within this it investigates the eventual impact of this phenomenon and ways of dealing with it, on professional and personal life of clinicians and their clinical practice. The second purpose is to contribute to the discussion on the subject of therapists’ grief over clients’ death. It was decided that adaptation of qualitative inquiry method as a research design will be most beneficial for this study. Semi structured interviews were conducted with four participants recruited by the gatekeepers. Data collated were subject to thematic analysis. Results were presented under themes: (1) relation between the style of the relationship and the intensity of grief, (2) emotional reactions, (3) obstacles and support in processing grief and (4) various way of closing the therapy. Findings of this research confirmed opinions expressed in the available literature: encountering clients’ death does have an impact on the therapist. Participants reported this experience shaping their way of working with clients, mentioning both positive and negative impact. The therapists who encountered clients’ death earlier in their practice had been affected in a stronger way. Recommendations for further research were then addressed.
Chapter 1: Introduction

Psychotherapists are walking next to clients in their journey to discover themselves. For psychotherapy to bring change there is a need to create an intimate relationship, to invest ourselves, to attach to our clients. Due to this bond creating nature of the relationship eventual death of our client shall awake emotions in the therapist (Dwyer, Deshields, & Nanna, 2012; Rubel, 2004; Worden, 2009). This research project is centred on exploring the psychotherapists experience, when encountering the death of their clients.

Death, despite it being an inevitable experience, is very often avoided as a subject of conversation. People hardly ever talk about past losses they have experienced, any fears of losing someone they are currently attached to, nor do they really spend time elaborating on the fact that they themselves can die at any given time. Yalom (1980) discussing the main existential concerns of every individual noticed little research was conducted in the field of psychotherapy on the subject of death. He also mentioned therapists inattention to death in therapy as well as in their personal life and linked it with the “collective denial in the entire field of psychotherapy” (p. 59). Yalom discussed reasons for such an avoidance and came to conclusion that it is the therapists fear of facing their own mortality that is impacting on their attitude. Further on he listed emotions and emotional states described by the research in bereavement, some of them being anger, pointlessness of life and perceiving world as dangerous. He suggested that all of them, if explored, would lead to uncovering the dismissed effect of bereavement: the bereaved awareness of their own mortality. Yalom believed that therapists, like many people outside this profession, are in denial of their death anxiety, and thus will not attend to the subject in their practice, as well as personal life.

Worden (2009) when talking about normal and complicated grief stated that the attachment style that was between the survivor and the deceased is of a great influence. Complicated
mourning was described as exaggerated, delayed or chronic. He also portrayed the phenomenon of disenfranchised grief. This term was introduced by Ken Doka in 1980s and refers to losses which are not socially sanctioned. He used terms socially negated and socially unspeakable losses. Worden (2009) described normal grief, also called uncomplicated grief, as one with the broad range of reaction (feelings, physical sensations, cognitions and behaviours) that are usually experienced after loss. While discussing the process of mourning he introduced four tasks which need to be entered in order to healthily process the grief. In his view it is essential that issues of each one of them will be addressed in order to process the loss and he acknowledges that it does require effort.

It would appear natural that individuals working in a profession which aims to help people would be able to recognize their own anxieties and be able to work on them. It would also seem legitimate to expect from practitioners the ability to form safe attachments with their clients and thus process eventual grief in a healthy manner. With this in mind this research sets out to explore what is the therapists’ experience of and reaction to encountering a clients’ death.

**Aims and Objectives**

The purpose of this research is twofold. Firstly it aims to explore therapists emotions, thoughts and other reactions associated with experiencing clients’ death. Within this it investigates the eventual impact of this phenomenon and ways of dealing with it, on the professional and personal life of clinicians and their clinical practice. The second purpose is to contribute to the discussion on the subject of therapists’ grief over clients’ death. This topic has been neglected in Irish publications and has only been touched upon in global literature (Kouriatis & Brown, 2011). In the profession of applied empathy there is a significant emphasis put upon the well-being of practitioners. Thus it is crucial to examine therapists’ reactions to various important
events in their professional life in order to build the body of literature which will be of assistance to trainees as well as experienced therapists.

The objective of the proposed research is to explore, describe and allow for understanding of the reaction of the therapist while experiencing clients’ death. It aims to acquire an insight into the perspective of clinicians practising humanistic, integrative, systemic and/or psychoanalytic approach.

**Rationale for This Research**

It became apparent through the literature review in regards to the subject of clients’ death and its impact on the psychotherapists, there was no sufficient exploration in the professional literature. Apart from article “Impact of patient suicide on front-line Staff in Ireland” (Gaffney, Russell, Collins, Bergin, Halligan, Carey, Coyle, 2009) all available literature is from UK and USA based writers. Current exploration of therapist reaction to clients’ death included impact, ways of dealing and awareness of chosen strategy to process grief, if acknowledging it at all. Investigated were basis of therapist conviction around the “anticipated” reaction to this unusual but still possible event. Explored were reasons for maintaining the belief or eventual changes in the view after the experience. Particular attention was paid to ways therapists shape their view on death. The subject of therapist grief after clients’ death has been neglected in Irish research and this research aims at contributing to the discussions in the field. While the impact of suicide has been acknowledged and recognized, reaction to other types of death was neglected in literature. Research aimed to help to determine if there is a need to address this phenomenon during trainings in order to support preventing burn out as an effect of possible complicated or disenfranchised grief. Making research findings available to publicity will also
be of help to clinicians who are reluctant in expressing and processing grief over clients passing.
Chapter 2: Literature Review

Introduction

The aim of this literature review is to explore publications which documents professional attitudes of psychotherapists’ while experiencing clients’ death. The purpose of research was to improve and inform existing practice thus it was decided to focus on last 10 years of publications. It will present theoretical views on how the death of a client could influence practitioners’ professional life. Types of aftercare and support used to recognize and process grief are also described. Practical concerns on how to socially approach this situation are discussed. Presented are impacts on personal and professional growth as well as clinical practice reported by clinicians. Discussed are sorts of publications available. But first we move to study the types of clients death that have their place in worlds’ professional literature and to recognizing which helping professions practitioners were involved in exploring this subject.

Points of View and Types of Death

Reaction to clients death was explored in the literature from the point of view of experienced individuals working within helping professions (Breen, O’Connor, Hewitt, and Lobb, 2014; Rayburn, 2008, Strom-Gottfried and Mowbray, 2006) which included providers of therapeutic services with distinction of analytical clinicians (Aronson, 2009; Tillman, 2006) and psychologists (Foster and Vacha-Haase, 2013; Gill, 2012; Knox, Burkard, Jackson, Schaack, and Hess, 2006; O’Brien, 2011). Some research has been done from the point of view of trainees of such a professions and it included recommendations for training (Coverdale and Weiss Roberts, 2007; Gill, 2012; Knox, Burkard, Jackson, Schaack, and Hess, 2006). In the limited literature available on this subject most common was exploration of the effects of
clients’ suicide (Coverdale and Weiss Roberts, 2007; Gill, 2012; Knox, Burkard, Jackson, Schaack, and Hess, 2006; Tillman, 2006) with only one article addressing the Irish perspective (Gaffney et al., 2009). In terms of reaction to natural and/or undetermined death of a client there were available published case studies of therapists exploring their own experience in this matter (Aronson, 2009; Dwyer, Deshields, and Nanna, 2012; Foster and Vacha-Haase, 2013; O’Brien, 2011; Veilleux, 2011; Wilson and Gilbert, 2008). In the literature subject of psychotherapist response to and the impact of clients’ natural or undetermined death was not explored in form of qualitative research apart from unpublished paper of Schwartz (Schwartz as cited in Kouriatis and Brown, 2011). There was some body of research aiming at addressing the influence of clients death from the point of view of professionals working with terminally ill and dying (Breen et al., 2014; Foster and Vacha-Haase, 2013; O’Brien, 2011; Rayburn, 2008) where practitioners openly admitted that clients’ death had impact on them, and that seeking support and processing grief facilitated their growth and prevented burn out (Strom-Gottfried and Mowbray, 2006). Despite such a clear message from the therapists who encountered clients death during their practice there is not much qualitative research done. Subject of being faced with clients’ death, especially other than suicide, and therapist needs and ways to recognize and process grief seemed to be neglected in the professional literature.

1. Psychotherapists Grief

Worden (2009) stated that meeting loss in the therapeutic settings awakens therapists’ own history of losses (Worden, 2009, p.252). Unprocessed loss can impact therapists’ ability to assists clients with recognizing their loss or fear of it. He made it explicit that it is necessary for clinicians to work through their own losses. Other authors reported that unresolved personal issues around death did complicate processing grief over clients death (Foster and Vacha-Haase, 2013; O’Brien, 2011; Rayburn, 2008). Authors did mention support received as means
facilitating burnout prevention (Strom-Gottfried and Mowbray, 2006). Worden (2009:256) stated that it is necessary for the clinician to “practice active grieving”. He emphasised the necessity to recognize, admit, express and seek support in processing grief after clients’ death. All this is in order to avoid this unresolved issue impacting on work with other clients. Clients inevitably bring the subject of loss and all emotions around it into the therapy room and practitioners need to have their own losses worked through in order to be of assistance. Dwyer et al (2012) emphasised that the therapeutic relationship is very intimate and bond creating thus it is obvious that clients’ death will awake emotions in therapist (Dwyer et al., 2012). Some authors suggested that the nature of therapeutic profession, namely focus on client, caused this lack of research on therapists experiences (Kouriatis and Brown, 2011). Throughout the published literature little attention given to reactions and impacts of non-suicidal death and the need for research has been noticed (Dwyer et al., 2012; Foster and Vacha-Haase, 2013; Kouriatis and Brown, 2011; Strom-Gottfried and Mowbray, 2006) with particular mention of poor number of publications from the psychotherapist point of view (Strom-Gottfried and Mowbray, 2006).

Strom-Gottfried and Mowbray (2006) elaborated on anticipatory grief calling this a situation when it is possible to prepare for clients death. Their research showed evidence that this can have both positive and negative outcomes. On one hand therapists and client may have a chance to work through unfinished business and enhance communication. On the other hand it may lead to detachment, avoidance of the client or working with other dying clients, distancing from distress by being less empathic and personally involved. It happens that professionals experience physical and emotional reactions associated with grief (Strom-Gottfried and Mowbray, 2006).
2. The vow of silence

In the limited literature available on the subject of therapists’ experience of clients’ death what was widely mentioned is an unspoken ‘vow of silence’ (Gill, 2012; Strom-Gottfried and Mowbray, 2006). Authors mentioned that this lead to their grief not being recognized by co-workers (Foster and Vacha-Haase, 2013; Kouriatis and Brown, 2011). Dwyer (2012) named “pathologizing” clinicians expression of sadness after clients’ passing (Dwyer et al., 2012, p. 123-129). Some of mentioned authors reported how this “conspiracy of silence” prevented from applying adequate self-care and diminished creating available peer support groups. This lead to disenfranchising this particular grief by the therapists themselves as well as their professional and private environment (Dwyer et al., 2012; Foster and Vacha-Haase, 2013; Kouriatis and Brown, 2011). Disenfranchised grief as a definition was introduced in 1985 by Kenneth J. Doka. It referred to a grief that developed when significant loss of an individual was not socially recognized and an individual felt like having no right to grief (Stroebe, 2008). Schwartz (Schwartz as cited in Kouriatis and Brown, 2011) in her qualitative study of therapists’ reaction discovered that it is very often therapists’ themselves who disenfranchise their own grief after clients’ death. All authors who touched upon the impact of silence in the subject urged to increasing number of publications and emphasised importance of addressing this issue.

3. Reported reality

The available literature, reports that acknowledged grief does have an impact on professional and personal growth as well as clinical practice. Varying in the extent and direction this can range from increased sensitivity to other clients (Veilleux, 2011) through less tolerance to some negative or self-harming behaviour of others, feeling pressure to address some issues in therapeutic relationship and difficulties in forming new attachment (Schwartz as cited in
Kouriatis and Brown, 2011; Strom-Gottfried and Mowbray, 2006). Some reported problems with focusing, increased effort in dealing with immediate emotional reactions, taking more breaks (Foster and Vacha-Haase, 2013, Strom-Gottfried and Mowbray, 2006). It was noted that experiencing clients’ death facilitated facing clinicians’ own mortality and shaping their personal views on death. Elevated awareness of own mortality allowed for reducing the fear of it and improved relations with family, especially the older relatives (Dwyer et al., 2012; Foster and Vacha-Haase, 2013). Authors mentioned developing a concept of “good death” which related to clients ready to die, seeing death as a relief form pain, death with the sense of dignity (Foster and Vacha-Haase, 2013; Rayburn, 2008).

Also all researchers pointed that intensity of grief depended on the nature and depth of lost relationship, its length and how predictable death was. History of personal losses of the therapist and awareness of views on the subject of death were named as an important factor (Strom-Gottfried and Mowbray, 2006) as well as feelings of personal responsibility (Veilleux, 2011). In terms of emotions awoken by the death of a client all authors mentioned a wide range of them, starting with sadness, through relief, anger and joy.

In one case study on the subject of natural death of the client (Dwyer, Deshields, and Nanna, 2012) it was brought to attention that after the death there may be increased amount of challenges a therapist can meet. This can include attempts to provoke breaches of confidentiality of the relationship represented by inquiries from family or medical staff present in the last period of life of deceased individual (Gill, 2012; Knox et al., 2006; Veilleux, 2011). Researches mentioned poor professional literature on subject how the death of a client and associated decisions can be dealt with, as an example giving concerns about attendance on a funeral, passing on condolences, contacting family (Dwyer et al., 2012; Foster and Vacha-Haase, 2013; Kouriatis and Brown, 2011; Veilleux, 2011). Authors pointed out the limited recommendations and guidance for new practitioners-to-be on how such an end to the
therapeutic relationship may be dealt with (Dwyer et al., 2012; Veilleux, 2011). Within those available authors emphasised importance of knowing personal limitations in terms of number of clients (especially dying clients) one can have an intimate relationship with at a particular time (Worden, 2009, p. 255; Strom-Gottfried and Mowbray, 2006). Worden (2009) recommends “active grieving”, to include attending a funeral, and reaching for support. He mentioned at the same time that therapists are keen to avoid looking for help (Worden, 2009, pp. 255–256). This opinion is also shared by other clinicians (O’Brien, 2011; Worden, 2009). It is apparent that there are no guidelines whatsoever on how to socially recognize clients’ death. Many authors reported struggle in deciding how to socially approach this situation. Being left with the notion of lack of closure to the therapy and knowledge of unfinished business of a deceased client was also mentioned (Schwartz as cited in Kouriatis and Brown, 2011).

4. The role of Self-care and After-care

While support after clients’ death is facilitated in places where clinicians experience it more often (Worden, 2009, p 257; Dwyer et al., 2012) psychotherapists in private practice and in centres where this is not a common event need to look for support on their own. Many authors mentioned significance of pre-action education recommending that talking about possibility of this situation to happen and guidance on addressing it would benefit in facilitating recognizing associated emotions and seeking help in dealing with them (Dwyer et al., 2012; O’Brien, 2011, Strom-Gottfried and Mowbray, 2006). It was noted that silence on the subject of therapists’ grief after clients’ death, both during and post the training, diminishes creating such a peer support sources as well as prevents from seeking adequate assistance (Strom-Gottfried and Mowbray, 2006). In terms of preparation some authors pointed that having created and maintained forms of self-care helps meeting clients’ death with all emotions awaken by it
(Dwyer et al., 2012; Foster and Vacha-Haase, 2013; Kouriatis and Brown, 2011; O’Brien, 2011; Strom-Gottfried and Mowbray, 2006).

As means of processing grief over clients death it was reported that peer consultation and support was of invaluable meaning (Dwyer et al., 2012) along with supervisors non-judgmental support in form of listening as well as sharing the guilt associated with undetermined or suicidal death (Gill, 2012; Knox et al., 2006, Strom-Gottfried and Mowbray, 2006). It was reported that often therapists were left with knowledge of clients’ unfinished business, notion of unfinished processes in the therapy, and lack of closure to the therapeutic relationship. In such a cases authors who were familiar with grief over clients’ death emphasised importance of creating or attending “goodbye rituals”, which help to “end” the therapy (Dwyer et al., 2012; Kouriatis and Brown, 2011: Strom-Gottfried and Mowbray, 2006). Mentioned authors of case studies did confirm that publication was a way of expressing the grief in order to process it.

Conclusions

Throughout the published literature little attention given to reactions and impacts of non-suicidal death and the need for research is noticed (Dwyer et al., 2012; Foster and Vacha-Haase, 2013; Kouriatis and Brown, 2011; Strom-Gottfried and Mowbray, 2006). From the available literature it is apparent that all authors who decided to raise the subject reported evident impact this experience had on therapist professional and personal life. Despite such a clear message from therapist who encountered clients death there is not much qualitative research done. Subject of being faced with clients’ death, especially other than suicide, and therapists’ needs and ways to recognize and process grief is neglected in the professional literature. Changing this will add to facilitating self-care and growth in this empathy based profession.
Chapter 3: Methodology

Introduction
This chapter outlines the methodology used in this project of exploration of the therapists experience when encountering clients’ death. It addresses the ethical considerations for this study. It sets out inclusion and exclusion criteria, as well as ways of selecting participants. It also addresses reasons for using qualitative approach, semi structured interviews and thematic analysis.

Research Strategy
As Bryman (2004) outlined the rationale for using the qualitative research strategy in social studies lies in the key difference between people and the objects of the analysis of the natural science. In contrast to atoms, molecules, chemicals and so on, human beings have an ability to attribute meaning to events and to their environment, and to communicate it. This factor lead to suggesting that required is a methodology which allows studying people which takes this key difference into consideration. With the above in mind it was decided that adaptation of qualitative inquiry method as a research design will be most beneficial for this study. Qualitative approaches enable examining experiences and processes in order to allow for understanding of them (Harper and Thompson, 2012, p. 5). Qualitative inquiry is language based one in which experiences are not reduced to numerical form (Cooper, 2008, p. 186) but usually to topics (themes) or categories which are assessed subjectively (Rudestam and Newton, 2001, p. 36). It allows for flexibility and sensitivity in gathering and interpreting data, along with prospective discovery of new insight into the field of study. This method of research has been decided to be most appropriate in order to meet envisaged aims of this research. With attempt to examine and understand individual experience of phenomenon in study the
qualitative approach gave participants “a voice” to share with others their inner world. It is worth noticing that data were still subject to researcher’s interpretation. Using qualitative inquiry allowed for contributing to the discussion on the research question. These two types of contribution to knowledge are named as features of qualitative method by McLeod (2011, p. 1-3).

**Sampling**

It was decided to invite to the research therapists with various degrees of experience. Pre-accredited therapist and accredited therapist in continuum of practice experience were interviewed to allow for in-depth exploration of phenomena of encountering clients’ death. Qualitative study requires a relatively small sample of participants (Ritchie, Lewis, McNaughton Nicholls, and Ormston, 2014, p. 117) thus it was decided to invite four therapist who share the experience of studied phenomena. Participants were selected using gatekeepers (as described by Ritchie et al., 2014, p. 127 - 131) with amendment that the researcher used the help of clinicians known personally to gather a sample of practitioners who experienced clients’ death. Gatekeepers sought for participants consent to pass on their contact details to the researcher.

**Data Collection**

Semi-structured face-to-face interviews were conducted in this research. This method allowed for detailed examination of described experience by using: ability to elicit participants’ stories and active listening along with checking understanding. Open ended questions were used (Appendix 1) as a guidance and an invitation to elaborate on the topic. Questions were informed by the information compiled during the literature review. Hancock, Windridge and Ockleford
(2007) suggested that open ended questions give an opportunity to elaborate in details on some topics. This style also allows the interviewer to use cues and prompts to invite the interviewee to further elaboration on response to questions. Such a design can also enable probing and gentle following on the line of enquiry chosen by the researcher.

Due to the sensitive nature of the topic interviews took place in the location chosen by the participants. Every interview was on a one-to-one basis. Before the interview started participants read and signed a consent form (Appendix 2). All participants were invited to ask questions and clarify any queries they might have had. Each interview lasted from 35 to 50 minutes and all were audio recorded using a Smartphone Application. All recordings were then downloaded to the researchers computer and subsequently transcribed.

**Data Analysis**

Collected data were subject to thematic analysis. Braun and Clarke (2006) suggested that this form of data examination “should be seen as a foundational method for qualitative analysis” (p. 78). Thematic analysis is flexible and accessible; it allows for presentation of common themes by extracting meaning from collected data (McLeod, 2011, p. 146–147). This way of identifying, reporting and interpreting patterns can provide a great deal of detailed and complex data. It is a method to present experiences, meaning attached to it and reflect realities of the interviewees (Braun and Clarke, 2006).

Following transcription data were subject to initial coding and then collated into potential themes. Themes were then reviewed and named. The report produced after included direct quotations to illustrate some findings. The whole process followed guidelines proposed by Braun and Clarke (2006).
Inclusion Criteria

This qualitative research was conducted with a small sample of participants. Interviewees had had to have an experience of encountering clients’ death and had to be qualified psychotherapists. It was decided that due to very sensitive topic of the research at least one year had to pass from the experience in question. It is important to notice that the intention was not to create a generalized picture. Research aimed at exploring to facilitate understanding of the individual experience and note if any commonalities emerged.

Ethical Concerns

The research was conducted in line with The Belmont Report (HHS.gov) guidelines for scientific research involving human subjects. It thus took into account three basic principles: respect for persons, beneficence and justice. The subject of the research was known to the participants and no deception applied. All interviewees had time to consider whether or not they wanted to take part in the study. Only after they have decided to participate gatekeepers sought their permission to pass on their contact details to the researcher. All meetings were conducted in time suitable for the participants and in their chosen location. The Informed Consent form which they all had read was confirmed as understood was then signed. It informed them about audio recordings, security measures taken to protect their anonymity and their right to withdraw at any stage. Anonymity was guaranteed prior to commencement of the interviews. All names and other identifiable data were removed from transcripts and not included in the report of findings. Participants were informed that audio recordings and transcripts will be held in a password protected file with password known only to the researcher. Due to the sensitive nature of the research, at the end of each interview participants were advised to look for support if experiencing any sort of disturbing thoughts and/or feelings during or after the meeting with the researcher.
Summary

This chapter described how the researcher planned and organized collection of data. Reasons for choosing qualitative inquiry as best suitable method were provided. It outlined how participants were chosen and contacted. It gave an account of the structure of data collection method. Ways of analysing data in order to identify and interpret occurring patterns were explained in details. It addressed limitations of the research. Ethical issues and application in line with Belmont Repost were presented and explained in details. Consent Form as well as Interview Guidelines used in the research were added as appendices.
Chapter 4: Results

Introduction

Four participants were interviewed for this research. During each interview they were asked a set of questions to help researcher get an overview of their professional experience. The demographics of each therapist are collated in the table below. The last column was added after careful analysis of all the interviews.

Table 1. Overview of the participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Time Accredited</th>
<th>Accrediting Body</th>
<th>Theoretical Approach</th>
<th>When in the professional carrier clients death occurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist 1</td>
<td>14 years</td>
<td>Currently IACP, before IACP and IAHIP</td>
<td>person centred humanistic integrative</td>
<td>First instance shortly after qualifying, since then few more</td>
</tr>
<tr>
<td>Therapist 2</td>
<td>Pre-accredited / qualified for a year</td>
<td>Probably IACP, possibly IAHIP</td>
<td>person-centered</td>
<td>During training (a year T2 took a break)</td>
</tr>
<tr>
<td>Therapist 3</td>
<td>20 years</td>
<td>Family Therapy Association of Ireland</td>
<td>systemic psychotherapist</td>
<td>10 years into the practice</td>
</tr>
<tr>
<td>Therapist 4</td>
<td>5 years</td>
<td>IACP</td>
<td>psychodynamic and person centred, existential; an integrative therapist</td>
<td>During initial training (just at the end of last year)</td>
</tr>
</tbody>
</table>

After careful thematic analysis the following themes were noticed:

1) Relation between the type of the relationship and work involved with the strength of reaction to clients death
a) Picture of the client  
b) Work involved  
c) Impact on the therapist  

2) Various emotional reactions  
3) Grief processing: obstacles and support  
4) Closure via closing sessions, rituals and contact with the family  

Presentation of Themes  

1. Relation Between the Type of the Relationship and Work Involved with the Strength of Reaction to Clients Death  

Three out of four interviewed practitioners encountered clients death at a very early stage of their professional career. Those three were the ones who reacted very emotionally while talking about the experience. From recollections of all participants the researcher recognized few subthemes.  

a) Picture of the Client  

All therapists described their clients as very impressive individuals. Therapist 1 recalled the client: "she was a lovely lady" and "She was a wonderful person". Therapist 2 smiled while saying about the client: “she was a real firecracker... She seemed very strong and very 'don't mess with me' kind of thing, but underneath it, there was a very vulnerable side of her” and later added: “she was a real character” and that “I think she was unforgettable”. Therapist 2 admitted: “I have...I had...I still have a soft spot for her. Yeah. I really liked her.” This therapist spend most time in comparison to others while talking about the client. Therapist 3 reported the client being: “an extremely well read man, loved history. So, he was a really interesting man to talk to from that point of view”. Therapist 4 four admitted: “Intellectually he challenged me,
hugely. He was a really clever guy ... He was a larger than life character” and “I will always remember him. I don't think I will ever forget who he is and who he was”.

b) Work Involved

When talking about the work involved most of the therapists described clients as striving to be more authentic. The participants stated that most of the clients were in a weekly therapy, were engaged and were coming regularly. Therapist 4 recalled working with a client who was becoming more independent after some adverse experiences which left him being dependant on others. Therapist 3 described assisting the client to become more independent after a time when his life deteriorated due to substance abuse. This practitioner stated that this client did not have a weekly sessions but often had breaks for as long as a month. Therapist 2 described a client as a lady in her fifties who sought therapy to improve her relationship with her true self and used therapy for support in becoming more assertive. All three therapist reported steady progress in work. However, Therapist 3 added that shortly before his death the client had a period of regression. He did not cope very well with re-gaining of the independence. Therapist 1 described working with the client who had a diagnosis of a terminal illness and this work was focused on getting to terms with the ultimate ending. This practitioner reported that the client had a sudden deterioration which resulted in her having only two weeks of life left. The therapist described how at the last session it was clear that client was accepting what is happening and perceived death as a relief. Therapist 1 reported having since that time a few more clients who died. All of them with diagnosis of terminal illness. The practitioner explained that their work was orientated on getting to terms with ending of life and celebrating lived life. Therapist 1 reported that work with those who eventually became more accepting was easier and left better memories.
c) Impact on the Therapist

All practitioners portrayed learning from working with clients who died. Therapist 1 reported that the most learning was from working with the very first client who died. When recalling that time Therapist 1 said: “I am getting emotional now… So it shows you that after all these years…”. When talking about clients’ feelings of relief in face of inevitable end of life within next two weeks Therapist 1 said:

“I mean I was only starting as a therapist and I didn’t really understand… although I experienced death personally I didn’t really understand what she meant. And she said: I don’t have to fight it anymore, I don’t have to try to be positive. I don’t have to try to be strong for anybody, I just can go with my body, its time. And I thought: wow that was huge learning in that”.

Therapist 2 described envisaged learning as an outcome of the fact that client died:

“I think maybe it might prepare me better if I had a client who was [terminally ill]… Maybe it might help me work with someone like that. I don't know though.”.

Therapist 2 informed that this client cancelled a session before she died due to being in hospital. Therapist 2 suggested that this could have impacted in increased worry when recently the current client cancelled feeling unwell.

Therapist 3 similarly reported that learning came from the fact that the client died. As the therapist recalled this client had a relapse into substance abuse after making a step into regaining the independence. Shortly after he died in circumstances which were classified as an accident after a period of investigation on possible intentional death. Therapist 3 wondered:

“was it [move into independence] based on this idea...that people need to keep moving and improving?”
Knowing that the accident could have been caused by the lack of awareness due to substance abuse, which was co-related with the move, Therapist 3 described a valuable lesson:

“here's only so much we can do... it's really how to listen to people really well, and to be sure that they're making as informed decision as they can around what they're doing... And just listening, not always expecting goals and progress...”

Therapist 4 talked about the impact from work with this client:

“I learned probably as much from him as I did in college about being a therapist ... you always have clients who impact you more than others or you get on with a little more or you like them a little bit more. He was one of those.”

Therapist 4 added: “realistically the style that I probably have as a therapist comes from some of the work that I did with this guy”. The fact that the client died the practitioner saw as an inseparable part of learning:

“I'm very privileged to have benefited from the work that I did with him. Unfortunately, part of the parcel, part of the benefit, is the fact that I got the benefit of seeing what it's like to be a therapist and lose somebody.”

Therapist 3, who had experienced a clients’ death while 10 years into professional practice, did not show strong emotional reaction during the interview. However, this practitioner said : “I suppose there's a little piece that does stay, even the fact that I still remember him. You know? I think there is a piece that does stay.”

Those therapists who had described their clients in a more vivid way were the ones who reacted emotionally during the interview. More enthusiastic way of talking about the client was characteristic to those therapist who experienced clients death early in their carrier.

All of the therapists reported that coming across such an experience brought up for them an awareness of the life being very fragile. One therapist noticed that therapeutic relationship is
not armoured against the external factors. Despite this two participants reported having no arrangements for someone contacting their clients in case of their death. One said that is working on such an arrangements to be put in place because it is required as a part of the Code of Ethics of an accrediting body.

2. Various Emotional Reactions

All participants reported strong emotions accompanying finding out about death and the grief after. Some participants gave an account of initial shock when being informed. Therapist 2 was on the way to family event and remembers thinking: “I was like, "What the hell?...I was like, do I have to go to this now? I've just found out one of my clients has died.” Therapist 4 described reaction to news as:

“Confusion, shock. I don't think I've ever had a reaction like it. I don't think I'd ever had a reaction like it before in my life. Honestly, I don't think I've had one since. I sat on the sofa, and I bawled.”

Some therapists reported anger directed towards other people in their clients life. Therapist 4 while attending the funeral experienced strong annoyance which was described:

“I was actually sitting in the funeral really angry, really upset, and really angry because I'm listening to it going like: that's just crap. Like: I know what he thought about you. But yet there's nothing where I could go with that or do with that.”

Therapist 3 was angry with social services workers and shared with researcher an opinion, that they did not give the client enough time to settle down in the new independent way of living. He then had to return to the place he was before, which happen shortly before he died.

Therapist 1 who had had a chance to say ‘goodbye’ to clients before they died distinguished between clients attitudes. Acceptance of what is happening was making grief period easier by giving the practitioner nicer memories. Rage, anger and deep sadness that clients were in just
before they died would bring recollections with the sense of: ‘*God, that was awful. Or poor ‘so and so’, that was cruel*’.

Those who were surprised with the news of clients’ death were under the impression that it was not timed right. That suddenness of death was reported as very distressing. They mentioned that the time of death did not allow their clients to fully experience fruits of their hard work in the therapy. And such an awareness brought sadness and disbelief. Therapist 1 who worked with clients with terminal diagnosis reported difficulties in working with parents of young children.

3. Grief Processing: Support and Obstacles

Most of the therapists spoke freely about their grief after their client died. They all reached for support and some emphasised the value of having established support in place. Peer support was listed as one of strong value to those, who had had such a group formed at the time of death. Therapist 3, who was 10 years in practice at the time, reported that it was peers that provided most support and space to talk about it as well. As this practitioner explained:

‘...*I think if you don't have support structures in place, then when an incident happens, you have to go looking for them. And you might not go looking for them quick enough. You might not even be aware that you need them until something come up. But by having them in place, it was almost like being able to deal with something.*’

Therapist 1, who had the first instance of clients’ death shortly after qualifying, recalled supportive supervision in the Agency as the means of support. Ever since this therapist has a long time established peer supervision group which was described as enormously beneficial to have. So the instances of death that followed were all processed actively using ability to express difficult emotions to known and understanding peers. Another source of support mentioned was supervision. In all cases ability to talk it through, as well as full of acceptance attitude of their supervisor was reported as helpful in admitting the importance of the experience. Personal
therapy was mentioned by only one therapist. It was one of the two who did not have an established peer support group in place at the time of the clients’ death. These two therapists sought support outside from the professional connections. Talking to partners or colleagues from other employment fields was mentioned. All within confidentiality boundaries, with only naming the fact that the person they worked with have died suddenly and that it is difficult to accept.

When discussing obstacles, Therapist 3 reported that being involved in a Gardai inquest was a disturbing experience. Since then this practitioner was often thinking about what to do when clients do not want to give you their Next of Kin contact details, or if they do not have one like that. How to act when being contacted in an emergency as their client’s only contact and how to negotiate this has been at times playing on this therapist mind.

Some of participants as inhibiting factors named fear of judgement from others. Therapist 4 explained:

“Probably the fact that I wasn't in college helped because the skill supervisor I'd had was very... everything's psychoanalytic in how she did things. It's not that we butted heads, but I'd honestly say I think if I had gone back into college and said that this had happened I think my group supervisor would have been excellent, and I really missed not having that support, but I didn't miss... the skills”

Therapist 1 said that not being able to fully express the associated emotions, especially not feeling free to cry, would be a disturbing factor. Ability to do this within the peer group was again named as invaluable asset. This therapist mentioned awareness of personal issues around death as important factors in processing grief. Having gone through difficult losses in private life, all without ability to bid farewell, this practitioner is aware that interference is possible and that support around this issues is needed and sought for. It is worth recalling at that stage that it is this practitioner who had a chance to say good bye to their clients before they died.
Therapist 4 mentioned having experienced a loss of significant others shortly before and just after the client's death. This practitioner was also aware that this could have inhibited processing the grief after the client.

Other participants either did not mention any significant losses in their life or did not have one to report. Both Therapist 2 and Therapist 3 acknowledged that their grief after the death of the client was real and sought support in processing it. Therapist 3 recalled:

“I was able to talk about that grief and how it impacted me. So, I would have got support around that. I was able to acknowledge that it was grief, so I wouldn't be fearful of knowledge and that it can have that impact. I think it's important to do that.”

Therapist 2 mentioned being a support for friends and family in their grief. This time however:

“...I think with [Client’s Name], it was one of the first times when I was able to say, "Actually I'm really mourning now, and I need help. I need people to talk to. I need ...".

All participants reported that the possibility of a death of a client was not addressed in their training. Therapist 3 remembered once off deliberation in class where the topic focused on whether any of students would attend their clients’ funeral. This practitioner suggested that with the knowledge from the first hand it would have been a different conversation: “Oh great. It was a theoretical conversation. Ah wonderful ... The intellectual conversation about whether you should go to the funeral of a client or all is great in theory”.

4. Closure via Closing Sessions, Rituals and Contact with the Family

Therapist 1 reported that having closure with clients before they died was a very emotional experience, where awareness of the fact that they will not see each other again brought up tears
for therapists and clients as well. This practitioner had also a set of rituals to pay respects to clients. This therapist keeps records with dates when clients died and tries to give them time on their anniversary with few minutes of recollection, which involves happier memories for some and more disturbing for others. Those therapists for whom clients’ death has been announced unexpectedly reported lack of closure as an important inhibiting factor in their grief.

All the participants had had contact with the family of their deceased clients. Therapist 1 who had not have known the family of the first client that died did not attend the funeral of that client. However, another clients spouse was known to this therapist and it influenced the decision to attend the funeral. The practitioner reported feeling like an outsider at the ceremony. Since then this practitioner attended only two more funerals of the clients who died. It was fairly recently (last year or two) and at this time the experience was of a different sort. No feelings of being a wrong person in a wrong place was reported.

Therapist 2 did not have a chance to attend the funeral as client died when the therapist was away on holidays for few weeks. The client’s family met with that therapist in an informal meeting. This was described:

“That was an ending. If I hadn't had that opportunity, I would have to negotiate that differently. But for me, having that space of meeting his brother and his wife, the brother's wife, I've been able to have a conversation about him.

This practitioner considered a possibility of having to go to a funeral, after a careful consideration if it will not affect the family in an unwanted way.

Therapist 3 decided to do not attend the funeral. After consideration this practitioner decided that it would interfere with family wishes. It is worth noticing that no one contacted the therapist to inform about the death – it was discovered by reading published obituary. The therapist implemented another rituals of paying respect by donating to a charity that was in line with that
clients field of concern when she was alive. Another personal ritual described by the practitioner included writing a piece in personal journal and buying a bunch of flowers which in that moment reminded the therapist about the client. This therapist wrote a condolences card to client’s partner and added phone number in it. Therapist stated that this lead to a number of therapy sessions for that partner in order to process grief. This experience was reported as disturbing and beneficial at the same time. Thanks to it the therapist found out how client have died, but have also found out about the things that were never raised by the client in the therapy.

Therapist 4 found some kind of realization in contact with client’s mother who recognized the importance of the therapy and thanked the practitioner for being there for her son. It was few months after the death happened. The practitioner recalls that at first feelings about being approach by the mother who have just lost her son were rather scary. However this therapist reported that the confidentiality has not been challenged and contact turned out to be of benefit to both of them. Therapist 4 attended the funeral. However, the experience was so full of annoyance and anger directed at the people present there that the practitioner was not able to see it as beneficial at that time.

Summary
The above themes were recognized by the researcher after a careful coding process and then analysing results and mapping them under the common titles. It is important to notice that data were subject to researcher’s interpretation. The researcher aimed at exploring the experience reported by the participants and not at a generalization of the experience itself.
Chapter 5: Discussion

This research aimed at exploring therapists experience when encountering clients’ death. Four practitioners were interviewed to collate data. Findings were then compared and contrasted with the relevant literature available on the subject. This was presented under the themes specified in the results chapter.

1. Relation Between the Type of the Relationship and Work Involved with the Strength of Reaction to Clients Death

Dwyer et al., (2012) talked about the fact that a therapeutic relationship is very intimate and creates a bond between two individuals. Authors also stated that this fact makes it obvious that a clients’ death will awaken an emotional reaction in the therapist. The therapists interviewed for this research have confirmed that statement by admitting that grief was a part of their experience. All authors reviewed in Chapter 2 pointed out that the intensity of the grief was positively co-related with the nature, depth and length of the relationship. This was also observed by the researcher during the thematic analysis of collected data.

a) Picture of the Client

All participants described their clients as very impressive individuals. Some of them spoke about their clients in a very lively manner using words like: wonderful, lovely, real character. All therapists stated that those clients have a special place in their memory. However, it is those three therapists who encountered clients’ death during their early days of clinical practice who reacted very emotionally when talking about the deceased. They also described clients as unforgettable people who brought a lot of themselves into the relationship. This is in line with
the view presented by some authors that encountering clients’ death during training has a great impact on the practitioners of helping professions (Coverdale and Weiss Roberts, 2007; Gill, 2012; Knox, Burkard, Jackson, Schaack, and Hess, 2006). The therapist who was 10 years into the practice had still had warm recollections of the client, however this practitioner did not report much about the client.

b) Work Involved

Three practitioners reported their work with the client as one bringing positive and desired by the client changes. Two of those practitioners talked about clients working towards gaining independence in the way of living and expressing themselves. One therapist was dealing with a terminally ill client and reported that this lady remained open to the therapeutic relationship until the very end of her life. The three therapists reported clients being very engaged and coming regularly for weekly sessions. They also showed strong emotions when recalling the client and work during the interview. The practitioner who reported the client being on a downhill spiral in his life, due to substance abuse and who had weeks long breaks between meetings was the one who remained steady during the research meeting.

c) Impact on the Therapist

All therapists interviewed for this project reported learning that came through working with their clients. Two of those who were in their early stages of the clinical practice said that working with the client and the fact that they had died shaped the way they work as professionals. One therapist reported that grief after a clients’ death was a first occasion when others needs were put aside and attention to therapist own needs was drawn and sought help from others. The therapist who had worked for 10 years in the practice openly sought for
support in processing grief. This is in line with recommendations of Worden (2009) who emphasised that active grieving is necessary and it should include reaching for support. Therapists are well known for not looking for help when meeting difficult times (O’Brien, 2011; Worden, 2009). However, the therapists interviewed in this research showed a different approach. All of them admitted that they did look for space to express emotions around the death.

When discussing the impact a clients’ death can have on clinical practice, Veilleux (2011) reported increased sensitivity to other clients. This has been in some way an experience of Therapist 2 who reported a situation from over a year after the client died. Another client cancelled a session for a similar reason, as the client who died, and this practitioner reported having (said to have automatic) thoughts of increased worry. Another impact noticed in literature included less tolerance to some negative or self-harming behaviour of others, feeling pressure to address some issues in therapeutic relationship and difficulties in forming new attachments (Schwartz as cited in Kouriatis and Brown, 2011; Strom-Gottfried and Mowbray, 2006). Participants in this research did not report any difficulties arising from the experience they (have) had. However Therapist 3 reported taking more care when addressing (with) clients (some moves in their lives), trying to get them to explore if this is what they truly want rather than what the social pressure is pushing them to do.

Facing therapists own mortality when encountering a clients’ death reported in the literature (Dwyer et al., 2012; Foster and Vacha-Haase, 2013) has also been mentioned by the participants of this study. However this awareness was not supported by examples of active preparation of having in place arrangements for their clients in case of their own sudden death. With the distinction of the therapist who stated that such a ‘professional will’ is required by the Code of Ethics of a particular accrediting body. Such avoidance can be an example of described by Yalom (1980) way of dealing with death anxiety: faith in own specialness.
2. **Various Emotional Reactions**

Problems with focus during the grief period as described by Worden (2009) were echoed in the literature which discussed a therapist experience when dealing with clients death (Foster and Vacha-Haase, 2013, Strom-Gottfried and Mowbray, 2006). Similar reaction was reported by Therapist 4 who had problems with recalling ways implemented to process the grief. This could have also been influenced by some circumstances in this practitioner’s personal life at that time, which will be addressed later in this paper. All participants reported having strong emotional reactions to include anger, sadness, disbelief, shock which is in line with emotions accompanying grief as described by Worden (2009) and mentioned by all authors in the literature available on the subject.

Suddenness of death was mentioned in the literature as one of the factors influencing the intensity of the grief. This was not entirely confirmed by the research. Therapist 3 who was surprised with the clients’ death did not mention being that much affected by the grief. Therapist 1 who knew the client would die in next few months had been affected by the grief and became emotional while recalling it; even after over 10 years since the experience. Developing a concept of ‘good death’ described in the literature (Foster and Vacha-Haase, 2013; Rayburn, 2008) has been confirmed in the study. Therapist 3 who worked with clients with terminal diagnosis reported discomfort while working with young parents. The same practitioner also elaborated on the fact that the client having come to terms with the approaching death is what would facilitate more welcome memories of this person. Adequately remembering those who stayed in a state of anger, deep sadness and lack of acceptance until the end would awake more disturbing memories. Therapist 2 and Therapist 4 both have stated seeing their clients’ death as untimely. Reasons for it to include: (1) young age in one case and (2) taken away chance to enjoy life more with new awareness in the other. Also the way both
practitioners saw these clients as ‘real characters’ made them mentioning loss to the world by their death.

3. Grief Processing: Support and Obstacles

Schwartz (as cited in Kouriatis and Brown, 2011) discovered in her qualitative study that it is often the therapist themselves who would disenfranchised their own grief after clients’ death. This research did not confirm that finding nor contradicted it. However, it is worth noticing that all therapists were at ease to talk about their grief after clients passing. This means that they gave themselves the right to this experience. Therapist 4 mentioned some fear of judgement from other person in this profession. This practitioner reported being glad of not having had to face this particular practitioner in these circumstances. Increased challenges to confidentiality mentioned in the literature (Dwyer et al., 2012; Gill, 2012; Knox, Burkard, Jackson, Schaack, & Hess, 2006; Veilleux, 2011) were a source of discomfort reported by the Therapist 3 in relation to the duty of being part of Garda inquest.

Non-judgemental support of the supervisors along with peer consultation were named as the most valuable means to process grief by the literature on the subject (Dwyer et al., 2012; Gill, 2012; Knox et al., 2006; Strom-Gottfried and Mowbray, 2006) as well as by the participants in this study. Therapist 1 stated that not being able to express emotions and to cry would be the most disturbing factor in grief processing. Therapist 3 expressed opinion that it is necessary to establish support structures before any of the difficult events. This practitioner suggested that not having them in place can inhibit looking for them when needed. This was also noticed by published authors who suggested that silence on the subject of the therapist experience of grief after client dies can be a cause to reluctance in seeking support (Dwyer et al., 2012; Foster and Vacha-Haase, 2013; Kouriatis and Brown, 2011). Little research conducted in the field of
psychotherapy on the subject of clients death was also named as a factor leading to lack of recognition of the therapist grief after clients death by the therapist themselves, their professional as well as private environment. Worden (2009) suggested that having unresolved personal issues around loss will impact on ability to process grief. This was confirmed by the Therapist 1 who reported having had difficult losses in their private life. Therapist 4 suggested that the fact of losing his father shortly before and mother shortly after the clients’ death could have influenced how grief after the client was processed.

Literature on the subject suggests that a way to prevent complicated grief is to address the possibility of clients death (Dwyer et al., 2012; O’Brien, 2011; Strom-Gottfried and Mowbray, 2006) especially in the training (Coverdale and Weiss Roberts, 2007; Gill, 2012; Knox et al., 2006). This was believed to facilitate the search for an adequate support and to acknowledge the grief. All participants of this research reported that this subject was not addressed in their training. However all of them have acknowledged the grief after clients’ death and sought help. Having had no guidelines on how to approach such an event socially two of them reported the struggle they experienced while making decisions about attending a funeral. The fact there were no readily available and promoted guidelines on how to socially recognize a clients’ death was also mentioned in all available publications. Only Worden (2009) recommended to actively grief, attend a funeral and pass on condolence to family.

4. **Closure via Closing Sessions, Rituals and Contact with the Family**

Schwartz (as cited in Kouriatis and Brown, 2011) found (out) that therapists, after their client died, were left with a notion of a lack of closure to the therapeutic relationship. This was mentioned also by other authors (Dwyer et al., 2012; Kouriatis and Brown, 2011; Strom-Gottfried and Mowbray, 2006) as well as confirmed in this research. Participants reported it to
be an inhibiting factor in processing grief. Authors who wrote about it emphasised the importance of either attending or creating (a) ‘goodbye rituals’. Three participants did mention some symbolic ways of paying respects to the individuals. All participants mentioned contact with the family as one of (the) importance. It facilitated finding out about the circumstances of death, recognition of the importance of the therapeutic relationship in the life of the deceased and in one case to pass on to the bereaved family some information about the deceased to ‘finalize’ some of his unfinished business. Attending the funeral was experienced in different ways by different participants, and even in a different way each time, (one therapist attended a funeral). Two clinicians who did attend funerals reported disturbing emotions and thoughts of being alienated because of their knowledge and the type of a relationship they have had with their clients. However, one of them was early in the practice and the other did not report such feelings when attending a funeral of other clients some years later. One therapist who had a chance to have closing sessions did report the importance of it. Here again mentioning that these sessions were a bit easier if client was in acceptance of inevitable death.
Chapter 6: Conclusions

This study has facilitated having an insight into the experience of the psychotherapist when encountering clients’ death. With the limited literature available on the subject this study was conducted in order to explore the phenomenon as well as contribute to the discussion on this neglected topic. Studying especially the Irish perspective seemed important as there are no publications at all which would address this issue.

Four participants were interviewed using a semi-structured approach. Themes which were discovered after a careful thematic analysis addressed the relation between the style of the relationship and the intensity of grief, emotional reactions, obstacles and support in processing grief and various way of closing the therapy.

Findings of this research confirmed opinions expressed in the available literature: encountering clients’ death does have an impact on the therapist. Participants reported this experience shaping their way of working with clients, mentioning both positive and negative impact. The therapists who encountered clients’ death earlier in their practice had been affected in a stronger way. This included emotional reactions at the time of death, as well as when recalling the experience and at the clients’ funeral. Lack of strong support sources in place has been identified to be the factor which adds to such an outcome.

Another noted difference in intensity of grief reported as well as emotional reaction present at the interview was between the psychotherapy approaches. Therapists practicing humanistic approach were affected more than the therapist who worked using the systemic approach.

Importance of having self-care structures in place was reported by all the participants. Professional literature on the subject suggests that addressing possibility of clients’ death at the time of training can facilitate openness in seeking support if strong structures are not in place yet. Having no clear guidelines on how to approach this event socially has been a cause of
participants struggle in making a decision about it. Also the peculiarity of the therapeutic relationship has been named as a cause of frustration when attending clients’ funeral. It is possible that addressing such an eventuality would prepare practitioners to the experience possibly leaving lesser after effects.

Some of the participants had rituals which helped them to ‘finish’ the therapy. One was more spontaneous in creating them, while others had rituals specific to their individual personalities. Three participants emphasised the importance of having some sort of closure. One therapist, who encountered personal losses at about the same time, has been identified as the one who could not clearly explain how the grief was processed. This could mean that maybe there is still something to work on, which was perhaps neglected while dealing with personal losses.

While the study inevitably related to the literature available it has also raised some questions not explored before. This will be addressed below in the section Recommendations for Further Research.

**Limitations**

The main limitation in this study was to find a therapist who would meet inclusion criteria and would like to participate. This may be due to the relatively small number of therapists who have encountered clients’ death as well as due to a habit of silence on the topic.

**Recommendations for Further Research**

Findings of this study confirmed that clients’ death has an important impact on psychotherapists’ clinical practice. Where not much of impact on the personal life was reported a strong emotional reaction would suggest that this impact is there. It would be beneficial to conduct a study which will research that field.
Study findings suggested that clinicians early in practice at the time of clients’ death were affected stronger than those with years of experience. It would however be beneficial to research that in further study with possibly larger sample to allow for comparison.

Also the difference in intensity due to the therapeutic approach used has been noticed. Here again a further exploration would be of a benefit. Such a study could possibly identify what, if anything, causes the difference.
References:


ProQuest Reasearch Library pg.9


Appendices
Appendix 1

Interview Guidance

As you know my thesis is about impact clients death has on the practitioner. I understand you have such an experience. Can you tell me a bit about your work with this client?

Can you tell me what was your initial experience when this client died?

How did you process your grief?

What did you find most useful at that time? And what was maybe less useful?

Has this experience impacted on your relationship with other clients?

Have this experience affected your attitude towards death?

Was this topic – clients death - covered in your training or approached by the manager of your training placement.

Did you ever think you should have an arrangement in place in case of your death?
Appendix 2

CONSENT FORM

Information

My Name is Agnieszka Zukowska and I am a final year student of BA in Counselling and Psychotherapy At Dublin Business School. I am inviting you to take part in my research project. It is aiming at exploration of therapist experience when encountering clients death. I will be exploring views of people like yourself, all of whom work as psychotherapists.

What it involves

You are asked to take part in this study because you have been identified as being suitable in having encountered clients death. If you agree to participate in this research I would like to invite you to attend an interview with myself in a setting of your convenience. It should take no longer than 30 minutes.

Anonymity

All information obtained from you during the research will be treated with strict anonymity. Notes about the research and this form which you are asked to fill in will be coded (?) and stored in a password protected file. The key to the code will be kept in a separate file locked with a different password. All passwords will be known only to myself. All data will be de-identified. Audio recordings of the interview and transcripts will be coded and kept in a secure location.

Your participation in this research is voluntary. You are free to withdraw at any point (can I make it a week?) of the study without any disadvantage.

Declaration

I have read and understood this consent form. I took time to consider whether to take part in this study. I am satisfied with the conditions listed above and agree to take part in the research.

Name (in block letters) _____________________________  
Signature                          _____________________________  
Date                                  _____________________________