

A Psychotherapist's Experience of Grief: An Heuristic Enquiry

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Figure 1 Myths about grief

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except whereby explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.



Signed: Bronwyn Alleyne

10th November, 2016

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I dedicate this research in loving memory of my Dad, who I know would have been very proud to see me graduate and emerge as a psychotherapist.

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Abstract

This research explored my subjective experience of being a bereaved psychotherapist, both personally and professionally, in a hospice and a private practice setting. The focus was to find the meaning within my grief experience by investigating, analysing, and reflecting on my experience via a systematic, internal, creative, intuitive, immersive, and deepening explorative process that the heuristic research method and methodology offered. My grief was captured in qualitative and immersive grief depictions, initial questions from which populated my personal search for the answers; and to which I recursively and painfully immersed myself in to explicate the core themes and the essence of the experience.

Core themes for explication included shame and the desire to hide my depth of feeling due to social discrimination; trauma, the need for attuned understanding and the pull to be in my humanity; the isolation of therapist grief and therapist culture as an inhibitor of normal mourning; death anxiety and aggressive responses; guilt, fate, and failure intermingling in a grief autopsy process; denial and the provocation of knowing of my mortality; team splitting and survival; moral imperatives, saving patients and intense countertransference responses; and the mutuality of patient and therapist need in psychotherapy. These themes also illuminated implications for psychotherapy practice, such as a revised understanding of grief which forefronts the humanity of both patient and therapist and the continuing bond with patients who have died; the need for a place to mourn; the reactive need to be deeply understood in a twinship relationship with someone who has known emotional trauma; a model of supervision which recognises and holds therapist grief and the unresolved and unconscious conflicts of the therapist as they are likely provoked in death situations.

My research synthesised the findings into a communicative felt narrative which ultimately determined that my grief was seeking deeper connection. It further reaffirmed the value of therapists openly dialoguing about their grief, both to bereaved therapists and the discipline of psychotherapy.

Chapter 1

Introduction

Research question

The aim of this research is to explore my experience of being a bereaved psychotherapist and, in doing so, to add to the understanding of this experience within the field of psychotherapy. The approach of exploration was, and is, seeded in my own current and felt grief, loss, and mourning experience both personally and professionally; and is now aided, deepened, and transformed by the phases and concepts of the heuristic method and methodology.

Background and rationale for my research question

Whilst it is well documented that how each individual experiences grief and mourning is unique, it is also a universal experience with typical reactions and meaning making processes (Neimeyer, 2000). Given the inevitability of loss and the commonalities in grief reactions, there is a considerable body of research about loss, grief, and mourning, as well as assessment and treatment approaches which aid therapists and multidisciplinary teams to care for the dying and the bereaved (Doka, 2009; Hagman, 2016; Meagher & Bulk, 2013; Papadatou, 2009; Rando, 1993; Worden, 2010).

As I had been working as a bereavement counsellor for a period of five years, and more recently as a psychotherapist in a hospice setting, I considered myself well versed in the assessment and treatment planning of the dying and the bereaved. My experience and my desire to be well researched has led me to be aware of a plethora of models and theories of grief, mourning, and bereavement, starting from the days of Freud, to more recent models which are now more likely to be informed, validated, and substantiated by multidisciplinary research worldwide (Hagman, 2016). How mourning has been conceptualised has changed over this time. Freud's (1917) work theorised that normal mourning was a moving from cathexis to a withdrawal of libidinal attachment to the lost loved one, where continuing bonds were considered a symptom of pathology. This conceptualisation has lingered a long time in the psychoanalytic tradition and it is only in the last 15 years that this lingering has shifted and recent advances in grief theory now call for a new psychoanalytic approach (Neimeyer, 2016). Recent changes have

seen stage, phase, and task models of grief, and are now more likely to recognise that renegotiating a changed and continuing bond to the deceased is a necessary function of accommodating the loss (Klass & Silverman, 1996; Worden, 2010). Grief is considered an active process (Attig, 2011) which involves reconstructing meaning personally and interpersonally (Neimeyer, 2000) and challenges our assumptive world (Attig, 2011).

My research had also led me to be aware of a model of grieving specifically for professionals and care providers working with the dying which holds both the impact of multiple deaths and the personal loss of the carer at its heart (Papadatou, 2009, 2000). Papadatou's model proposes that care providers are likely to grieve if they experience the death of a patient as a personal loss, which may be due to a personal bond, loss of relationships with the bereaved, the non-realisation of therapeutic goals, the shattering of assumptions, or the waking up of our own traumatic personal or unaddressed losses or an awareness of our own mortality. Similar to all bereaved, Papadatou suggested care givers' grieving involves a fluctuation between experiencing and avoiding loss and grief, the process through which personal meanings are attributed to death, dying, and caregiving. This process is influenced by the shared narrative and meanings attributed by our co-workers.

Then I became bereaved myself. Over a period of three months, toward the end 2015, a long term patient whom I cared for deeply and whom I companioned in her retelling of her life from childhood, died. My Dad also died suddenly and in what seemed like a terrified state after a long period of treatment for metastatic cancer. A young sensitive man who was also battling a life threatening illness terminated treatment suddenly. My personal and professional life was captured by profound grief.

In the initial days of my grief I was drawn to re-reading the seminal writings on grief and mourning as I knew the early theorists developed their theories based on their own painful and personal experiences. I did this as I needed help to understand and make sense of my own experience. Reading Freud's (1917) paper *Mourning and melancholia* again gave me a new understanding of what he may have meant by the turning away from reality that he termed "hallucinatory wishful psychosis" (Freud, 1917, p. 429). I had been waking in the middle of the night with my Dad appearing in my mind's eye – I could see him clearly. Freud conceptualised this as a turning away from reality as we never willingly give up our loved ones without some opposition. My lived experience of grief gave me the ability to find meaning in the experience that I could not hope to

understand from my previous reading. I was also drawn to reading Klein's (1940/1998) paper on mourning as I often felt scared and fearful in situations in and about which I would not ordinarily feel and pondered its link to depressive anxieties. I had an overwhelming need to be taken care of that could not be met by those in my immediate world. Klein's work voiced these reactions, again deepening my understanding; even though I had read these papers many times in relation to my patient work. As a psychotherapist I also began to wonder about the impact on transference situations, and I began to theorise that my own regression in grief seemed to intensify the transference and countertransference reactions present in my patient work.

My own intense, painful and sometimes surprising loss, grief, and mourning experience, has led me, similar to therapists before me (Kernberg, 2010), to question my understanding of the experience of grief and my clinical work, and to wonder how being a therapist influences and shapes my grief – and that of others. Just as Kernberg went back over his notes of a grieving client after the death of his wife when he was in his own painful and intense process, so too did I want to reflect on my work with my bereaved patients. Yet, unlike Kernberg, I also wanted to reflect on my relationship with my Dad and his dying process, with my patients who have died and my bereaved patients. Common sense suggests that our experience has a material effect on our therapeutic work with present and future patients; I envisaged that this kind of therapeutic autopsy would verify that.

Research question elaborated

It is clear that through the lens of my own experience, I found my previous understanding of grief lacking. I felt confused, both in my understanding and in myself. Like Anne Adelman (2013a), a clinical psychologist and psychoanalyst, I searched the literature to help me understand my experience after the death of my patient; and, like her, I discovered that relatively little exists on the topic of the experience of being a bereaved therapist.

Adelman and Malawista (2013) contended that the therapist's grief is complicated and has its own set of particular obstacles to openly exploring the experience with others, which may account for the relative lack of literature. In their work they offered an invitation to therapists to dialogue with themselves about the experience, and discovered a well of unacknowledged, unarticulated, and hauntingly important insights

into the experience. My reading of the contributions of many therapists resonated with much of my own experience.

Rather than having a(nother) theory of grief or a conceptual model of care, it was reading the felt experience and narrative of other therapists that was the most helpful to me. By choosing a heuristic research method to explore my own experience of grief my intention was – and is:

To dialogue with myself about my experience of being a bereaved psychotherapist;

To create a felt narrative so as to understand the meaning of my experience;

To enhance this particular field of study for psychotherapists, as my experience is likely to have some commonalities with that of other psychotherapists;

To reflect on my findings and determine some implications for my psychotherapy practice and for the discipline of psychotherapy;

Lastly, to identify future pathways for my own research in regards to my psychotherapy practice, and for the discipline of psychotherapy.

In the chapters that follow

Chapter 2 of this dissertation is devoted to my initial engagement with the research question and my grief experience. I have included excerpts from my grief depiction journal, the ones that most captured me at the start of my research. I have also included the initial questions that were stimulated in me about the experience of being a bereaved psychotherapist, which this research seeks to answer. The research question in this sense is and has only been elaborated on and simultaneously defined and become clearer in the specific questions my grief pursued. I could not pre-determine the refined elements of my research question, my grief had to determine the nuances of the questions.

In **chapter 3** I discuss the heuristic method and methodology I have used in my research and locate the method within qualitative phenomenological research. I name the seven heuristic concepts and discuss the six phases of heuristic research, how I understand and have creatively adapted them, and include some critique of the method borne from my experience of the method. I reflect critically on the validity of my research to ensure it

has some value and on what protocols I needed to employ to aid this process. The chapter continues with a discussion of my desire to embargo my research due to shame. I discuss the ethics involved in the heuristic method/ology from a conventional and a relational perspective. I conclude with what has been excluded from my research and a discussion of why this might be.

In **Chapter 4** I continue to explore my grief depictions having immersively lived, incubated, illuminated, and then brought my findings to creative synthesis, after a hard fought for and painful explication process. In this chapter I discuss and deepen my reflections through my own process, through the heuristic process, literature and using my personal therapy and various supervision arenas. It is through the eyes and feeling resonances of others, in an oscillation between my own process and their responses to my process, that I came to know my own experience more fully.

Chapter 5 includes a discussion of my findings, and my thoughts on their implications for my psychotherapy practice and for other psychotherapists. I also ponder questions which warrant further research exploration. I conclude the chapter with some final thoughts and reflections after this heuristic process. I conclude with my need to leave this immersive space so I can engage more fully in the rest of my life.

Before moving to the next chapter

Death, dying and grief awakens anxiety and pain in us all. This experience can be hard to stay with. This has been my experience throughout, both to my own grief and in noticing how it provoked a distancing effect in others.

My discussion necessarily focuses on my experience. That is the nature of a heuristic enquiry. It is my intention to give a rich and detailed description, so as to transport the reader into the experience being described (Creswell & Miller, 2000). In narrating my experience of grief involving the loss or death of someone, then I necessarily need to include sufficient descriptions of all the people who provoked the most profound responses in me and the circumstances of these responses so as to aid the reader to enter my experience. Although I have included some descriptions of others, the subject and focus of the dissertation is my own experience; thus my research did not warrant a formal ethics application. Nevertheless, as a practitioner, I have a duty to care for anyone I have worked with and so I have included my thinking about this within the

methodology chapter. I have considered my inclusions recursively, relationally, compassionately, and with heartfelt intent.

When I refer to countertransference in these pages it includes all the feelings and role responses that patients evoke in me, including what might be considered a repetition of the patient's object relations from the past, often a regressive revival of infantile needs, and the role relationship and infantile needs that I might impose intra-psychically on them due to my own personality and tendencies. Countertransference from this perspective is normal and phenomenologically important to the work of psychotherapy, as within those feelings aroused, is the unconscious and hidden material of the patient and the therapist (Sandler, 1976).

A countertransference response in this work which is omnipresent is to be drawn to the suffering of the other and, in response to this pull, is to feel like I could have done more. I needed to remind myself constantly that it was my experience that was being explored. I will not be exploring in these pages all my therapeutic wonderings, dynamic formulations, or enacted treatment plans. My own ethical practice took care of that.

I use the term patient rather than client throughout this research. In using the term patient I intend its use to be indicative of the context life threatening illness rather than psychopathology.

Chapter 2

Initial Engagement – Excerpts from My Grief Depiction Journal

Introduction

My grief depictions are a narrative account of my grief. They describe what it was like to be me in the initial months following the death of my patient, my Dad, and as a result of a patient terminating therapy soon after I returned from Dad's funeral. So many losses in a short period of time threatened to overwhelm me. I have deliberately chosen to describe my experience first before I outline my research methodology as is customary to describe in chapter 2, as it was here that I started – I started in my feelings rather than my knowledge of grief or research methods. In this way my chapters are ordered from my own subjective experience of both grief and the heuristic method.

I start the chapter with a pictorial view of the three people I 'lost' and some of the feelings I experienced as a result. The timeline and the shadowy writing symbolise my experience, sometimes on a rollercoaster, sometimes confused, and often not clear. I then include the depictions that most inhabited me at the start of my research and, as will be seen, a few from my more recent experiences that impacted me in a profound and illuminative way. As discussed further in chapter 3, each depiction needed to pass complex ethical considerations, including reflecting on the purpose of each inclusion on the merits of its communicative value to my narrative and its usefulness to adding to furthering research (Ings, 2014). For this reason I also name the purpose of each depiction. I have indented and italicised them for ease of recognition. I also discuss my initial questions and thoughts that were stimulated; questions that persisted in me and which I am pursuing answers to via this research.

The three I lost – a pictorial view

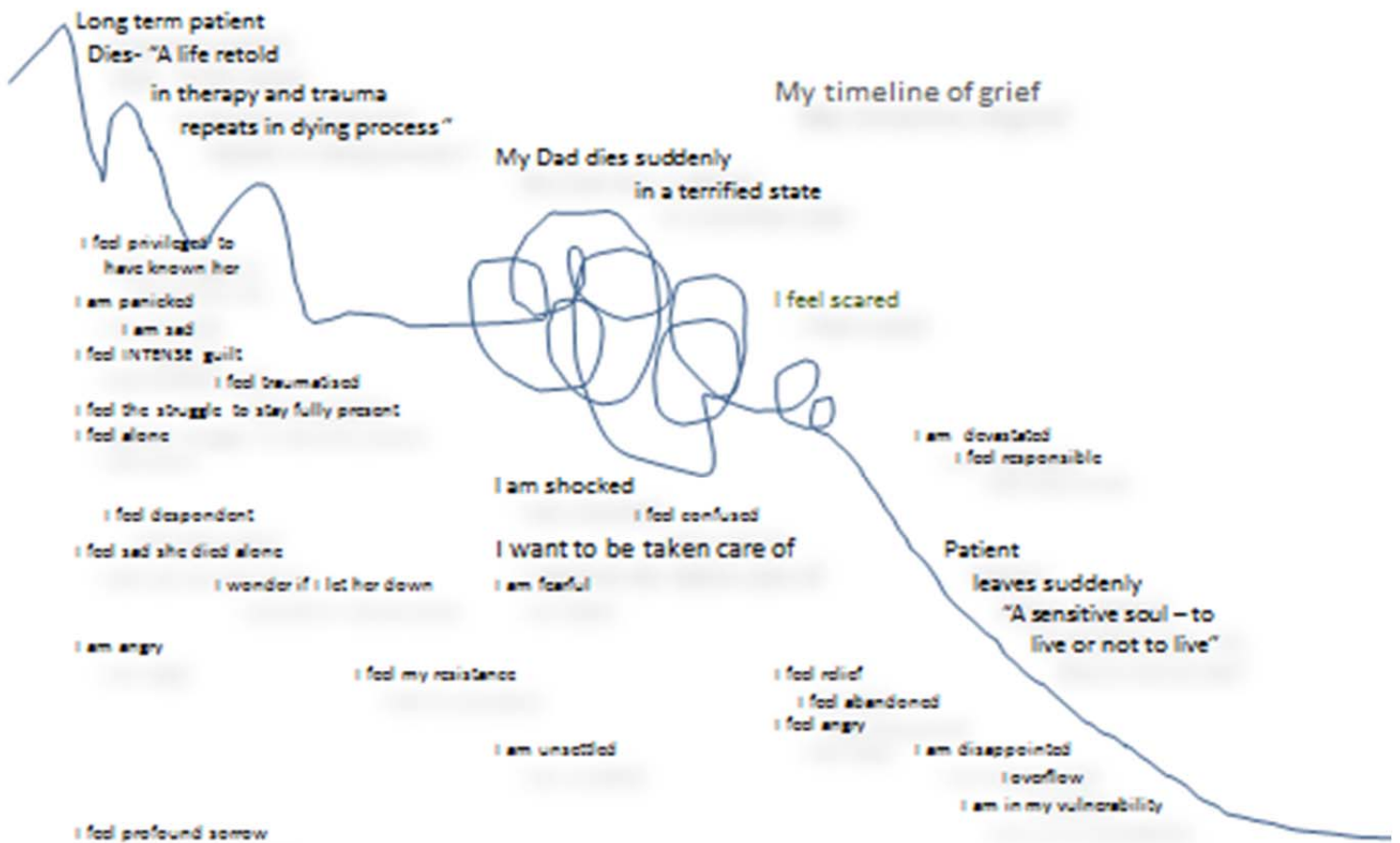


Figure 2 The three I lost – a pictorial view

An elegant woman in her last days – a remembering from 2014

I have included this remembering, as it was in my experience with this patient that I started to wonder about the intensity of the transference and countertransference responses I was feeling. I had cared for this woman in what felt for me an intimate encounter of two humanities, a moment like that of a mother and daughter. I remember this time together fondly. But in sharing my encounter in supervision, I was left feeling shamed. Was I feeling too much, or were my relational needs too provoked?

I approach the hospice bed with my heart beating faster than normal. I did not know who I was going to meet other than a lady who was admitted for end of life care. She would be dying and I could feel my own trepidation at that prospect.

I met a woman who was simultaneously beautiful, with long grey hair styled into an elegant knot on top of her head, but who was also skin and bones, possibly from the ravages of either disease or chemotherapy. I introduced myself and offered her an opportunity to share what was going on for her. I was met with a generosity of sharing of her being despite her obvious pain. The details of what we spoke of have faded for me. What I was left with was an experience of being cared for. I was instantly transported to a mother daughter relationship, I wanted to tend to her like a daughter would and I felt her motherly care of me. At the end of our time together she asked if she could give me a kiss and a hug. The tender embrace was, I felt, a reflection of our time together. On leaving I promised to return a few days later.

I heard of her death in an MDT meeting an hour before I was to see her. I felt sad at the loss of her. I also felt guilt about my failure to live up to my promised return. Had I let her down? I had been looking forward to seeing her and I realised I had been looking forward to the experience of being mothered and taken care of. I had been nurtured and also allowed into an intimate encounter with this beautiful woman in her dying days. Alongside of this I also felt naïve and silly, I knew she was imminently dying and my response was profound. What was going on?

I recounted this experience later in supervision. We discussed my desire to return and the difficulty of leaving a patient perhaps made easier by promising my return. I also remember being challenged about 'my needs' being in the room. I was left feeling shamed about my perhaps infantile need. I felt the urge to hide my deeper responses, to not share so deeply again. I have also been left with a question about intense transferences this work awakens in me. Is this part of the work or is this response woken in me due to my own relational needs or are transference and countertransference responses in death situations more intense?

This experience seeded a subtle search and a questioning of my own defences, dysfunction, and needs. Was I wrong to feel this way?

A life retold in therapy and trauma repeats in her dying process

Sheer presence is the greatest gift you can offer anyone facing death. (Yalom, 2008, p. 130)

I start with this quote as it is this belief that I keep coming back to when my grief wanders back to this patient.

I first met this patient in April, when autumn was upon us, I saw her weekly and I looked forward to our sessions. She died in winter of the following year. She was a woman in her early 60s who had strong ties to her extended past and present family. She had a bucket list of experiences that she wanted to have with each of her grandchildren before she died and she was running out of time. She feared that she would not be remembered by them.

Our therapy was one where she recounted her traumatic and difficult life with humility and humour. Through the haze of chemotherapy and radiation I felt

honoured to hear about her childhood memories of her parents and grandparents, her love of sport and her risqué humour that she learned from her Nan. I also heard about a life painfully littered with trauma, loss, crisis, and accompanying terror.

Her impending death was sometimes faced into, but for the most part she wanted to continue to laugh, live and remember the good times, despite her continued and evidently painful struggles. I laughed with her, I enjoyed her. My own judgement about when to sensitively challenge her needed denial of her impending death and when to just be with her was a tension that I took to supervision many times. It paralleled my own need to defend against her death.

I am grateful that we shared a fleeting but considered farewell before her cancer made clear thought or emotional intimacy impossible. She didn't want me to be sad when she was gone. An impossible task. I let her know that I would miss her. I feel blessed to have had this moment, and my hope is that this self-disclosure was felt and meaningful to her.

Her cancer in her last months was disfiguring and debilitating. I felt fear, discomfort, and distress in response to her deterioration. Her previously mischievous eyes could no longer engage with mine. I expressed my horror and the difficulty of mediating my own fear of her death in supervision. I felt the pull to distance myself and I needed guidance of what psychotherapy now meant in this new phase. I also began to feel intense guilt that I had not been a good enough therapist. I was now the holder of so much of her story and I worried that I couldn't remember everything and do her justice. The sanctity of confidentiality meant I could not share it anyway. There was only me. I had been passed the baton of her memories which had previously been an honour, and now were in danger of transitioning to being a burden laced with guilt. Being able to name this in my supervision group and have them acknowledge the importance, value and their experience of my work with this patient, meant I could continue to be with her without pervasive guilt and to continue to work at my own emotional availability. In the transference I suspect I had become the daughter who could not do enough, a repetition of her object relations, but also there was the strong projective pull to satisfy the need to be the one who would remember her.

I also know my response is much more than that. Her ability to share of herself was in marked contrast to my Dad's ability to share his memories with me. To have done this would mean that he would have needed to face his own impending death. I longed for a different relationship with him that would remain unrequited until the last few weeks of his life.

Given her diminishing capacity our sessions transitioned to home and then to hospice visits. She called for me to come to her hospice bed and she asked for me to help her get back home. She became angry and withdrawn when the answer from her family was no. She lay in a darkened room in a constant state of withdrawal despite my best efforts to explore what was going on for her. She hated being told what to do, she had lost her independence. She seemingly further withdrew, both from her family and from me. I became angry at her family in response to my own guilt and failure to be able to help satisfy her dying wish.

The last few visits were mostly sitting with her in silence. I would announce my arrival with some words of encouragement to talk if she wanted to. The silence

was broken intermittently by me with my own empathic wonderings or her expression of guilt around not being able to talk. Her breathing was laboured and I often felt panicked that she would die in that moment.

It's difficult to know whether her silence towards the end was an angry accusation about our inability to satisfy her desire to die at home, a necessary withdrawal from us to enable her death, due to her cancer progression or her own guilt about her family. Without her confirmatory responses, I only have my own empathetic feeling space and the wonderings of my group. My supervision group were unwaveringly supportive of me during this time despite, and perhaps in response to, how hard I was being on myself in regards to my perceived failure. I wonder if I had actually been her daughter whether she would have had her wish fulfilled. I also wonder how much anything changed as a result of our therapy, as it seems her struggles in life were repeated again in her dying process. She died as she had lived. She died alone with no family with her in her moment of passing. Her dying alone mattered to me.

I was touched and changed by our therapeutic relationship. I think my supervision group gave me the opportunity to express and process my own grief, and to reflect on my strength in being able to remain near to her and to hold sensitively my perceived critique of not being able to change her experience of herself enough to have had a peaceful death. I am grateful to have had them to let them know of her death moments after I was told and to have their heartfelt responses.

I had always found group supervision not to be as satisfying as individual supervision, mostly due to the distraction of my own family of origin dynamics being woken up and played out in the group. This experience has been transformative of my appreciation of group as a supervision format. Although grief is an individual experience, grieving in a family or a group context has been extraordinarily helpful in supporting my processing at a greater depth. Although I explored this experience in therapy and individual supervision, it is the group experience that transcended or perhaps softened my need to defend and encouraged my own humanity in the work and my own self-care.

To have this work witnessed was very much needed by me. I wanted to give her the gift of her on-going presence and to acknowledge that she did matter. Group supervision gave me the permission to be real, to not hide and stay in the safety of the therapist chair where my own intense emotional reactions could be denied and not used prudently and judiciously in service of her. Although my reliance on theory contained my anxiety and gave me guidance as how to use my empathy, it will never obviate my own fears – and neither should it.

It is my hope that for this patient that my presence, care, and love was felt by her despite her struggles with dying.

I have begun to wonder about regression so common in grief and the inevitability of re-enactment of relational patterns and trauma for patients and perhaps therapists as a result. Did our therapy achieve anything? Do my therapeutic goals need to be more realistic given people die as they have lived? I found her death traumatic in many ways. Vicariously as she became disfigured, due to her withdrawal and because of my own

personal bond with her. Cancer can be viciously cruel. My time with this patient also fed a belief that group supervision is needed by me in this work.

My Dad dies

My Dad died alone in a hospital ward. He was not surrounded by his family after a loving goodbye or a peaceful death. I was not there. He died after being admitted to hospital to get his pain under control. My parents car had been hit by a reversing garbage truck and although they were not hurt, my Dad's body was already ravaged by metastatic lung cancer, radiation, chemotherapy and his own terror, and so his body in the days after the accident went into meltdown. Mum called an ambulance when I suspect her panic overflowed and she couldn't manage him anymore. On admission Dad apparently had tearfully yelled at the doctors to 'fucking leave me alone' when they suggested more invasive tests and scans. The head nurse came running to shut their efforts down. 'He's palliative, we just need to make him comfortable and get him stable again' she said. Mum had already retreated to the halls to remove herself from the unbearableness of his pain and his barbed lashing out at everyone around him. The nurse later retrieved Mum to let her know Dad was now comfortable. She stayed for a while and left when visiting hours finished and called me to let me know Dad was in hospital again. 'He's fine' she said.

Mum was called a few hours later to say that he had died.

I was woken up by the phone ringing. Mum's first words were "he died Bron". I am shocked. I can't think. 'Oh Mum. They were just getting his pain under control'. I promise to be on the first flight. I am given the task of calling my twin sister to tell her. We co-ordinate our flights over multiple confused calls. I still muck up when the flight is and I am ready 2 hours before I need to go to the airport and I sit alone in the dark waiting until it's time to go.

Whilst I imagine these moments in my mind again and again, I don't need to imagine the feeling space of Dad's terror barbs being thrown like stinging nettles at those around him when he is frightened. I have been there and I am still extracting the barbs. I can't get close enough to my Dad to say how I feel, it's too terrifying and he doesn't want to hear.

If I could share only one feeling to explain or capture my experience of grief in the following months it would be that of fear. I was scared and fearful of all sorts of situations I normally would not be afraid of. My security in the world had been affected. I felt alone. My close relationships felt distant and abandoning. My pain does not feel responded to. I am wounded and now I am angry.

As already discussed, I was drawn to finding and rereading a paragraph in Klein's (1940/1998) paper on mourning, speaking to how the bereaved feel unsupported. Klein believed mourning meant a revisiting to an earlier development stage where reality testing was a feature. With the loss of a love one, there is a reactivation of the anxieties of guilt, fear, and persecution in the depressive position and a loss of the earlier

internalised good and safe object. Without the safety of the internalised good object, the impulse to re-internalise both the lost love object and the good object is heightened. Persecutory anxieties prevail however and give rise to hatred, ambivalence and distrust. Klein (1940) wrote in the paragraph I searched for:

The reinforcement of feelings of persecution in the state of mourning is all the more painful because, as a result of an increase in ambivalence and distrust, friendly relations with people, which might at the time be so helpful, become impeded. (p. 354)

My pervading fear has resonances in the depressive position. My increased longing to be looked after and the frustration of this desire may also be explained by the mistrust felt in my regression. Although I feel understood by reading this paragraph, I fervently believe Klein's work has enormous value for me personally and for the grieving. My intuition tells me this is only half the story. This experience cannot just be based on my own psyche. What about those around me? My experience as a bereavement counsellor also means I have spent years listening to accounts of the bereaved and how no one is really there for them.

How I am responded to in my grief increased my suffering. My Dad's death has trauma in it for me and I feel the traumatic effects in my fear. How will I recover myself and feel in relationship again? The answers to these questions I suspect will not only help me they may also help my patients.

A sensitive soul – to live or not to live

My Dad's sudden death meant that there was a necessary interruption to my work with my patients, the consequences of which sometimes prove difficult to recover from. I include this depiction which provoked a question in me about inviting others into death situations after a termination or a death, and what responses it provokes. Responses which I need to be able to mediate in this work as they happen frequently in death situations to which I have been a witness. I wonder whether the life and death tension, perhaps in an unconscious attempt to save a patient, provokes more intense responses.

I left my panel interview rattled. From my perspective it seemed like a digging expedition had been executed on me, the purpose of which was to get me to say out loud that I had abandoned my patient by repeating his childhood trauma. Once this skeleton was exhumed, and picked over, I was then challenged to name what I intended to do about it. No mention had been made of the context of the 'abandonment', the sudden death of my Dad. Our therapy had been

interrupted, and then cut short after only a few sessions on my return. He wanted to find his own answers. He wanted to go it alone.

I walked into the clinic shocked about how the interview had gone. I recounted to those who asked how I felt put upon to name my responsibility to his abandonment and the lack of acknowledgement of how much I had given to the care of him through the entirety of the therapy or that my Dad had died. I was hurt and angered by this. The tears flooded out of me. A swell of supportive anger ensued which I cut short. I felt painfully hurt and angry only because they just honed in on what I already felt, profound guilt. Fate had meant my tragedy trumped his tragedy for the weeks that I was away, the disruption of which precipitated his going it alone. His retreat and withdrawal despite his need of me was, I believe, an attempt at respite from his intensely experienced feelings, to find safety.

Abandonment, guilt, fate, and anger intermingled asking me to make sense of his sudden departure, searching for my responsibility to him and his departure. I entered an autopsy process in my grief. The panel interview had me wondering about the aggressive response I received which did not seem to be interested in my thoughts, my distress or my humanity, or how I made sense of his departure, or what I had actually done to reach out afterwards. Why had they lost sight of me?

Mortality

Death is still a fearful, frightening happening, and the fear of death is a universal fear even if we think we have mastered it on many levels. (Kübler-Ross, 1969/1997, p. 18)

I include the next two depictions as illustrations of the shocking waking up of my denial of my own mortality, even though I thought I was present to it enough. Working with the dying provokes it.

Me – November 2015

I sit with a wife of a patient and I am listening to her describe her husband's recent and terminal diagnosis. I can feel her shock and distress. She explains how he had been monitored for the last 20 years for a blood abnormality that had the risk of developing into an acute and life threatening cancer, the reality of which she was struggling to believe. The unknowable was now here.

My heart sinks rapidly and heavily within me. I say 'fuck' to myself. A ripple of anger rises in me as I silently say to myself 'of course this woman was referred to me'. It's easier to feel angry at someone outside the room than feel angry at this woman. After the session I was thrust back more than 20 years ago to being called by my doctor after a routine blood test to come straight back to see her. Is there any leukaemia in your family she asked? No, I respond. This call started a process of invasive bone marrow, chromosome, spleen tests and a diagnosis of a blood condition that I too have been monitored for with regular haematology

appointments and blood tests for more than 20 years to ensure it has not developed into a life threatening cancer. I know something of the anxiety my patients feel. I don't appreciate the intrusive reminder today. I now question whether I have deluded myself as to why I have been so attracted to working with the dying and the bereaved.

A team member, a supervisee, and my friend dies suddenly – May 2016

I want to ring my dissertation supervisor and tell him that a team member died yesterday.

I was called by my hospice supervisor today and she asked me where I was. I immediately recognise this as a strange question. It seems strange only for a split second as she says "C" died last night. Her daughter found her in bed today. She died peacefully in her sleep."

I can't make sense of what I have just been told. I had seen her yesterday, the day of her death and two days before that. She was lively and smiling. I had dropped in to see her after her group facilitation had finished. I would often do this as I supervise the facilitators of this group.

She was wearing a beautifully coloured jacket, which I commented on and she returned the praise by acknowledging my customary black. I then noticed with her how transformed the group members seemed, the ladies were becoming more colourful as the months passed by, despite their metastatic diagnoses. I wondered with her the influence that she may be having on the group.

I had the privilege of supervising C by herself the previous week. After that session I was both moved and felt the traumatic effects of an encounter she had with a patient who believed she would be fully recovered when it was clear to C that she only had days to live. This experience reminded her of how she felt when she first came to the hospice all those years ago. She would go home and cry alone sometimes at the end of the day. I admired C's openness and honesty about the impact of the work.

I cry only when I tell my partner when he gets home. It becomes ever so slightly more real in his gaze. I feel stunned, sad and I am in shock. A thought keeps replaying for me - 'we are not supposed to be the ones that die'. My denial of my own mortality is felt full force in this moment. We all die.

C's death means I will need to attend the group to hold their grief. I feel a moment of overwhelm as I realise I will be holding the other facilitators, the group and my own grief and loss of C simultaneously. I want to be cared for in my loss too; however my role is to care for them. I imagine myself sharing my last encounter with C in the group and wonder if my joining them in our grief, with my own self-disclosure would be facilitative or would it be a hinderance? I sit on my lounge and think of her.

And then 10 days later a reflection after supervision:

I am aware now more than ever of my own mortality. We are all mortal. I question where my life is. Dad dying, my patient dying, my own losses, and my recent haematologist visit, all point towards my needing to live more fully now.

My direct exposure to death rather than just listening to the accounts of the bereaved are more piercing of my experience. I see C's face in my mind. I mostly see her smile and feel her generous hugs. Although I am shocked, I don't feel denied of sharing a final last moment. Our encounters and moments together had meaning and a sense of presence. She always made the time.

The combined effects of C and the impending death of another family member have me facing more into my own mortality as my assumptions or self-deceptions have kept me distant from its felt sense. This deception allows living but not the focus of embodied or intentional living needed to shift my stuck self into really living fully. I deflect from the realities of our existence, of my existence, the fragility of life, my own death.

I had been looking at death from a distance. Too far to actually feel its impact. Is this why I look at all the files of the deceased patients to see how old each of the patients are? Is this to soothe myself that it's not me? I am not saved from this experience. Am I at a safe distance from death by seeing the bereaved and dying? I am not.

A few weeks later:

I feel tired, overwhelmed and impotent. I am in the middle of what I think is a team split. The team are in pain over the death of C. I feel my own outrage at what I perceive to be uncaring acts towards each other.

The above two depictions point toward a renewed focus on using my death anxiety or awareness of my mortality to live more fully. I also needed a witness, someone to immediately share the deaths with, to facilitate my own shock and grief.

The painful reality of a team split gazumped this renewed focus on living. My once loving and caring team were hurt and angry. I found this unbearable. My grief and research process became centred on how to heal this wound.

Summary

My grief woke up and pursued the questions elicited above. I wanted the answer as to whether my feelings were a normal response to the loss of my patients or whether I was feeling too much due to my own relational needs being too provoked. I felt shame and the desire to hide my deeper responses due to how my grief was responded to. My initial associations wondered about whether intense transference and countertransference were provoked in death encounters, the intensity of which allowed for deeper intimacy. Or was it a joint regression of patient and therapist, which fuels infantile needs. The first option seemed relational, a joining of two humanities; the second seeded a search for my own dysfunction.

Being with my patient as she was dying shifted my focus, with the help of my supervision group, from being in the strong transference pull to be the good enough daughter, to mediating my own fear of her death so I could remain experience near to her, and to also be in my own humanity in my responses to her. Her traumatic death led me to question the inevitability of relational patterns repeating in death and to a questioning of my relational stance and whether my therapeutic goals were realistic given the circumstances. I also identified recurrent feelings of guilt and failure. Group supervision and having my work witnessed seemed important to my work.

My Dad's death, trauma, and the perceived aggressive and distancing responses I received to my grief increased my suffering. I wondered how I was going to recover myself and my relationships. This experience paralleled how abandoned and disappointed many of my patients feel. I needed my own answer to understanding why I received these responses. The question of aggressive responses continued and intermingled with feelings of abandonment, fate, guilt, and my own autopsy process after my patient left therapy suddenly. I wanted to get the answer to why I was responded to that way.

My supervisee dying provoked me into my own mortality and being reminded to live more fully. This pursuit was short lived as more aggressive responses and a team split as a result of her death meant the team suffering also increased my suffering. I needed to understand how my caring team were now hurting each other.

My questions elicited from these experiences were being asked from a place of genuine enquiry, not from a place of knowing. Although I am immediately drawn to my own associations to existing knowledge and theories, I know I am wanting and needing to find the answers to relieve my pain, to restore myself and my relationships. Although my younger regressed self at times may have feared her undoing during this time, my adult therapist self could also reflexively feel and think about what was going on. These experiences are my starting point for deeper exploration in the following chapters.

Heuristic Research Method

Method and methodology

My research used the heuristic methodology of research as elucidated by Moustakas (1990). Heuristic research is interested in finding the meaning of experience by means of the researcher investigating, analysing, and reflecting on her own experience via a systematic, disciplined, internal, creative, intuitive, immersive, and deepening explorative process. The method “seeks to obtain qualitative depictions that are at the heart and depths of a person’s experience” (Moustakas, 1990, p. 38), and then to rigorously and creatively synthesise the core themes and essence into a narrative of the experience. The methodology, which is based in phenomenology, supports this qualitative (re)search.

Philosophy and phenomenology

Heuristic research is a qualitative phenomenological research method. Phenomenology is a philosophy founded on the work of Edmund Husserl. The philosophy is interested in the immediate pre-reflective experience of the world, whilst setting aside assumptions, explanations, and constructs of objective reality (van Deurzen, 2010; Van Manen, 1990). Phenomenological research aims to “reveal the meaning within experience” (Smythe, 2010, p. 6). Heuristic research is unique within phenomenological research in that the phenomena or experience being researched is shared and is predominantly the lived experience of the researcher herself.

My research task and context of the research

My research task was to discover the meaning of my own experience of grief, as a daughter whose Dad died and as a psychotherapist working with the dying and the bereaved. The context of my search encompasses my personal life as, a bereavement counsellor, a student psychotherapist, then a psychotherapist in private practice, and a psychotherapist working in a bereavement and a hospice setting.

My experience of grief is likely interpreted through my own identity as a psychotherapist, my own adopted theories of grief, and my own assumptions of

meaning (Neimeyer, 2000), including those which still stand through the process and those which will not. Similarly, particular deaths and losses will and do have their own mediators that affect my mourning process, most significantly who the deceased person was to me, the nature of the attachment, the circumstances of the death, my previous losses and experience of grief, and my personality (Worden, 2010). All of these mediators are predominantly relevant to me. So although I am supposed to set aside my assumptions to explicate a new understanding to add to the discipline of psychotherapy, I wonder how realistic this is. My grief has its own meaning making processes.

I also know that grief and mourning is universal and has typical reactions. In searching for my answers in the sharing of other therapists, which I did immediately and intuitively, I found similarities and resonances. The resonances with the experiences of other therapists will then, by association, add to the argument that my meaning making may have some relevance to the discipline of psychotherapy as a whole, and those who practice within it.

Search for meaning and seven heuristic concepts

Moustakas's (1990) work encouraged me to enter my search for meaning fully, "introspectively, meditatively, and reflectively" (p. 11), to dwell, to doubt, to challenge, to confront, to dream, both with myself and my resonances with the experiences of others. In short, the research data/grief depictions are initially my own, and require me to be in the experience of grief in a "vital, intense and full way" (Moustakas, 1990, p.14) so as to illuminate its meaning.

The seven heuristic concepts vital to the process, according to Moustakas (1990), include: identifying with the focus of inquiry, self-dialogue, tacit knowing, intuition, indwelling, focusing, and having an internal frame of reference.

Moustakas believed the power of heuristic discovery was rooted in the concept of the tacit knowing, where understanding the essence of the whole comes from understanding the individual parts, and sensing the whole as a result of this process. He studied the work of Polyani to explicate his definitions of tacit knowledge and applied it to experience, to his concept of tacit knowing. He wrote:

experience is determined by the unique perceptions, feelings intuitions, beliefs, and judgements housed in an internal frame of reference of a person. Meanings are inherent in a particular world view, an individual life, and the connections between the self, other and the world. (Moustakas, 1990, p. 32)

This tacit knowledge is deep and continually being constructed with every new experience in an oscillatory comparison of the outer world to inner experience, and usually subliminally for a right fit with earlier experiences (Sela-Smith, 2002). “The gestalt of an experience is packaged as a structure whole and becomes part of our tacit knowledge” (Sela-Smith, 2002, p. 60), and joins the other whole experiences, sits in our unconscious and is a building block to our personal tacit knowing.

My tacit knowing will be built on and influenced with each new experience by my experiencing ‘I’; especially if it is not a feeling space fit of my previous experiences.

Importantly, for my research, Sela-Smith (2002) explained that:

it is probable that incomplete, inaccurate, or misinterpreted information will be a part of the embedded information in personal knowledge [and that] if knowledge at the tacit level is flawed, both the experience of and response to the external world will reflect that flaw. Flawed information can be transformed if an entrance to the wholes at the tacit level can be found to allow new information. (p. 61)

The source of which she proposed is our uncharted and unexplored feelings and our subjective experience. My research is guided by this knowledge.

The six phases of heuristic research – creatively adapted by my experience

The six phases of heuristic research as described by Moustakas (1990) are displayed in the **outer** circle in figure 3 (p. 21), and are described below. The inner circles depict a further understanding of my experience of the method and will be explained in the discussion section.

Initial engagement – This phase required that I identified, defined and clarified my research question which was compelling to my own experience, was autobiographical and has social value, including for my significant relationships (Sela-Smith, 2002). Given the context of my research question is as a psychotherapist, it also has relevance to the study and field of psychotherapy. Self-dialogue precipitates the plunge into the inner search for the question and often is answering a call from deep within to something which consciously or unconsciously needs exploring, clarification, or seeks completion. My question seeks subjective inner meaning and external truth (Sela-Smith, 2002). I have long been in this phase due to my own losses and lived experience of grief which can capture me without warning. The method, however, supports a more systematic and disciplined approach to understanding my experience of grief.

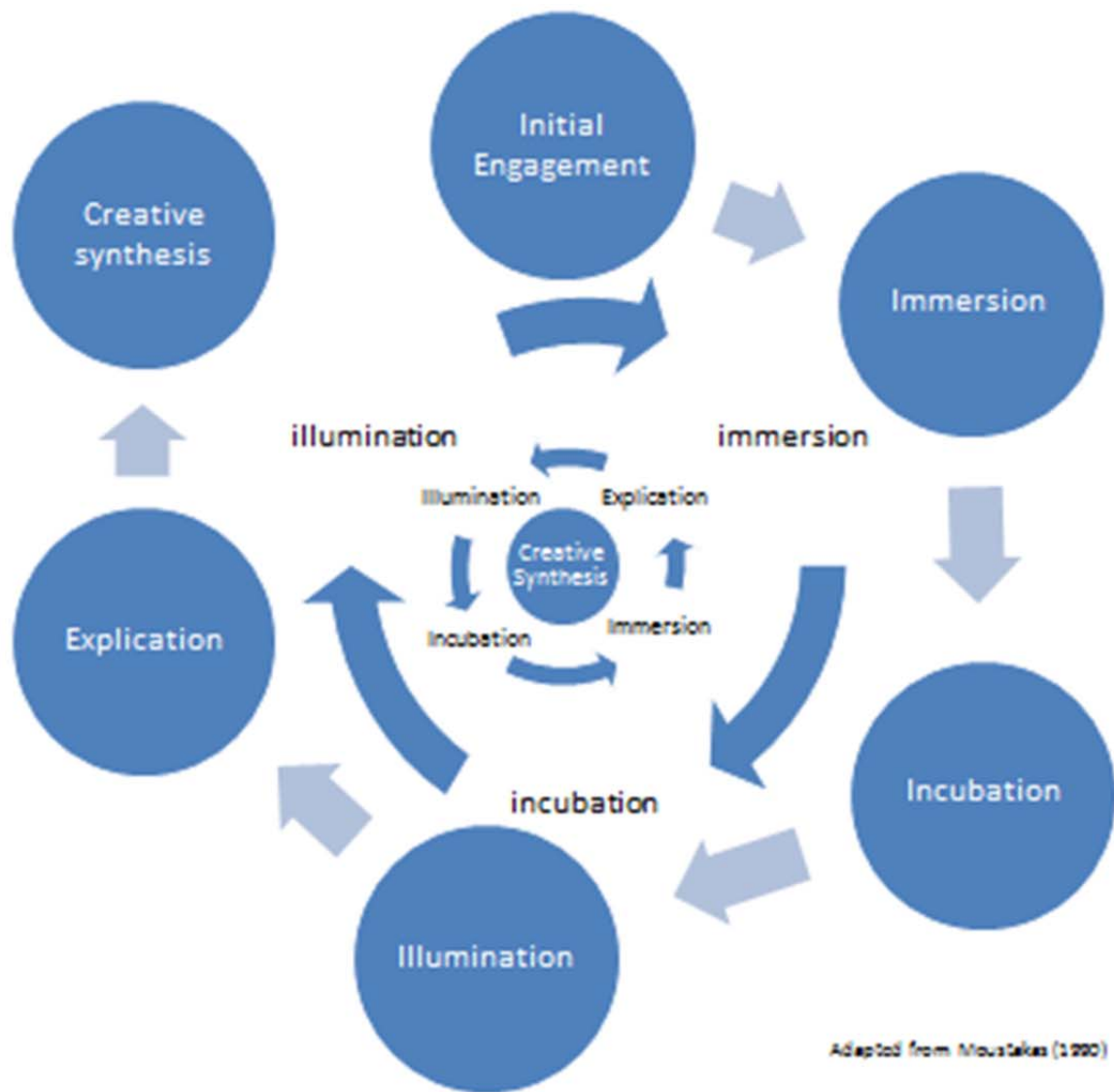


Figure 3 The six phases of Heuristic Research – creatively adapted by my experience

Immersion – This phase required me to live and become intimate with the question, both with myself, with others, and within wider contexts, in waking, sleeping and all states in which I found myself. Sela-Smith (2002) asserted with the question formed “it draws the image of the question everywhere in the researcher’s life experience” (p. 65). There is movement from inner experience, to outside stimuli and back again, usually to what still lingers in the researcher (Sela-Smith, 2002). My grief depictions capture these lingerings and oscillations with others.

Incubation – Involved a detached retreat, which allows the seeds or produce of immersion to be discovered without intense concentrated effort. This is where the tacit dimension wrestles with new depictions and reorganises meaning (Sela-Smith, 2002). I found that once I had written a depiction, I would painfully retreat to get some

buoyancy in my unconscious, which parallels grief's need to ebb to allow living. I would, however, be invited back into the depiction, into my grief spontaneously, which was readying me for its illumination.

Illumination – Is a process whereby new awareness results from the researcher's open and receptive attitude which allows her tacit knowledge and intuition to forge a breakthrough of the themes called for and searched for in relation to the question (Sela-Smith, 2002). In practice this process involved adding further narrative to my depictions and further exploration in therapy, supervision, in literature, and other sources as intuitively found.

Explication – This phase is where the illuminated themes were fully examined and comprehended to discover “nuances, textures and constituents of the phenomenon” (Moustakas, 1990, p. 31), so as to depict the major components and essence of my experience. My task was to consciously focus and attend to, in a deep examination, what was woken in me during the previous phases. This involved many oscillatory visits through the phases of immersion, incubation, and illumination.

Creative synthesis – Only once the researcher is thoroughly familiar with and has mastered the data, can the core themes and the meaning of the experience be synthesised into a narrative or creative form for others to view. Sela-Smith (2002) argued that if the researcher has surrendered to the heuristic process, then a transformation emerges, one that resonates and can be observed. My synthesis, my findings, are in chapter 4 and their implications for practice are in chapter 5.

Why heuristic? Discussion of the phases and a critique

The initial engagement with my experience of grief became more intense with my experience as a bereavement counsellor and, more recently, with the death of my Dad and the psychotherapy patients with whom I have worked. Although my stated altruistic goal is to add to the understanding of what it is like to be a bereaved psychotherapist, my drive to ‘illucidate’ the experience is initially really a personal one. From my perspective, my research method could only be heuristic. I was captured by my own grief. I needed to tend to my own experience. I needed my own answers.

I am driven to understand my own experience so as to feel less alone, to be available again to more intimate relationship, to be out of the traumatised state I often find myself in, and to feel less resentful of the needs of my more challenging patients. Ultimately I

hold the desire to use my experience to inform my empathic self and use this well, lest I unwittingly and unconsciously impose my need or healing agenda on my psychotherapy patients. Douglass and Moustakas (1985) referred to this as an effort to solve a personal problem in an effort to know the answers to my own questions. I want to restore myself to a vibrantly lived human being and, as a result, be more available as a psychotherapist.

Whilst Moustakas (1990) wanted the question to be rooted in passionate concern, important social meanings, implications and disciplined commitment, the reality at the onset is that I have been plunged into this experience, like it or not. Death came to those loved by me. My grief pervaded and changed my whole experience of myself. This is my own intimate, autobiographical and personal search. My depictions are of my own experience, and reveal my own perception of reality. I oscillate around immersion, incubation, and illumination, recursively and painfully. This is the **middle circle** in figure 3, the circle where my tacit knowledge is continually being built and reorganised by my experiences and how I subjectively understand them, and then influenced in a self-reflective intuitive process in supervision and in reviewing literature, to refuel another oscillation. The process for me is organic rather than forced, the illuminations emerge out of the process partly, I believe, due to the heuristic process and partly due to the nature of grief. Grief cycles to allow an assimilation of the full impact of the loss (Neimeyer, 2000).

I only moved to explication for the purposes of my presentation of my initial findings to my fellow dissertation students and faculty members and in writing the dissertation. The process of explication and creative synthesis required courage, concentrated effort and heartache. Staying in the earlier stages felt painful but comforting. I have felt resistance and ambivalence mostly at the beginning and at the end of the phases.

Neimeyer (2000) wrote: “The intimacy required to explore and name the multiple losses associated with any given death” (p. 90) cannot be assured or gotten to prematurely. I am both challenged to go beyond my current understanding, to stay in my grief longer; and, given my increasing depth of understanding of myself, I want to stay in the process longer before moving out too soon. The deadline of the dissertation loomed and it felt too soon. This conflict in me is in direct opposition to the heuristic process and is a critique of the method (Sela-Smith, 2002). My constant access to new grief and death situations means I have unlimited access to new depictions. My exploration will in fact never be completed.

Moustakas (1990) wrote:

The heuristic research process is not one that can be hurried or timed by the clock or calendar. It demands the total presence, honesty, maturity, and integrity of a researcher who not only strongly desires to know and understand but is willing to commit endless hours of sustained immersion and focussed concentration on one central question, to risk the opening of wounds and passionate concerns, and to undergo the personal transformation that exists as a possibility in every heuristic journey. (p. 14)

The **inner circle** (figure 3, p. 21) depicts this push against the grain to finally reach explication and a creative synthesis. I have found swimming against the tide difficult but ultimately rewarding.

Sela-Smith (2002) is acknowledging of Moustakas's contribution to research in the field of psychology by the creation and development of the heuristic method but also critical of his research. She believed, "that due to unacknowledged resistance to experiencing unbearable pain, Moustakas's research focus shifted from the self's experience of the experience to focusing on the idea of the experience" (Sela-Smith, p. 53). Her critique has given me permission to stay with the focus of my research, on the interiority of my own experience rather than shifting its application to the experience of others. "Within this interiority, feeling responses to the external circumstances combine to create meaning, and out of meaning, personalities are organised, personal and cultural myths are formed, worldviews are constructed, and paradigms are set in place" (Sela-Smith, 2002, p. 54). She asked me to surrender to my own subjective experience.

Ings (2014) suggested some disadvantages of autobiography as a research focus. He warned that this approach can turn into a non-productive ponderance on the part of the researcher, which lacks scholarly worth unless I view the transformative nature of the process as tangential rather than central. He cautioned this style of research could be critiqued as a narcissistic pursuit, the purpose of which can easily become confused and self-focused. This could render its usefulness to the discipline of psychotherapy as negligible. He also warned of the emotional cost, particularly the need to "separate critique of the manner and quality of the discourse from criticism of the self" (Ings, 2014, p. 681). I was initially seduced by these arguments, for fear of being branded over-indulgent or narcissistic, criticisms which are often used to wound a healthy self-focus, and often in hatred or envy. The psychological meaning of narcissism is used too often without its meaning being understood. Personal transformation is at the heart of an heuristic journey, it is what fuels the sustained effort required to enter the process more

fully; the meanings being investigated are central to human existence, the telling of which connects us all (Moustakas, 1990). The validity and its usefulness of my research is, however, worth considering more expansively to ensure its relevance to the discipline of psychotherapy.

Validity of the research

The validity of my research and all heuristic research cannot be measured quantitatively but must be measured by the subjectivity of the researcher herself, as she is the only one who has undergone the recursive process of analysing and judging what is significant, and therefore can answer the question: “Does the ultimate depiction of the experience derived from one’s own rigorous, exhaustive self-searching and from the explications of others present comprehensively, vividly, and accurately the meanings and essences of the experience” (Moustakas, 1990, p.32). I know the subjective truth of this and my vigilance in the process.

Lincoln and Guba (1985), who were interested in the trustworthiness of qualitative research, listed criteria that needed to be considered such as credibility, transferability, dependability, and confirmability. These criteria I have given due consideration and employed.

Credibility is enhanced by employing protocols such as prolonged engagement, persistent observation and triangulation. Transferability is enhanced by providing a “rich, thick description” (Creswell & Miller, 2000, p. 128) of what is being studied, descriptions which are dense, deep, and detailed to create verisimilitude. The intention being that the descriptions produce in the reader the feeling of the experience being described in the study. “Thus, credibility is established through the lens of readers who read a narrative account and are transported into a setting or situation” (Creswell & Miller, 2000, p. 129), and in doing so successfully enough is an indicator of whether the phenomenon of what I am describing is then transferable into other situations (Amankwaa, 2016).

Dependability is aided by transparencies of my research method and how it was employed and again by triangulation of sources. Patton (1999) suggested triangulation is not for the purpose of confirming the same result. It is an attempt to look for consistency and inconsistency which, in his view, should be considered an opportunity for illuminative deeper insight rather than a weakening of the research inquiry.

The primary triangulation sources for my research as I have mentioned, are the constant immersion into my own experience, my depictions, my long term work with the bereaved, personal psychotherapy, individual, group and peer supervision in both a general and a hospice setting, and perhaps most importantly for my feeling space resonances through the personal accounts of grief I have been reading in my literature review. I believe I have achieved and referenced my prolonged engagement in this research process and in the long term context of my bereavement work in multiple contexts.

Immersive depictions

My primary method of capturing my grief experience is self-dialogue.

I often wake in the middle of night and my grief pursues me and asks me for its meaning and associations. I drift with it. It's dark, it's quiet and I don't escape its anxiety. My attempts to get up and journal during this process usually hamper the flow of the experience and becomes too intellectual and laboured. I have learned to wait to narrate my experience later. I narrate my grief in therapy, in supervision and in group supervision, to my journal, but mostly to myself. In the early stages I also would swim, to dip in and dip out, I found floating would hold me.

I have sensitised myself to wanting to deepen my understanding of my initial questions from the perspective of clinical practice – they surface for me regularly and push in to for a search for their meaning. Although I have read widely and been influenced theoretically in leading up to being in this process, my current process is emotionally led, my research is looking for feeling resonances, rather than being intellectualised searches for the answers. I have potentially toppled my usual practice of widely reading to approach my work to soothe my anxiety, to provide new ways to think about my situation or my patients, to change my perspectives and my ways of thinking about the world. I have moved from an expert stance, to feeling first. The meanings found are embedded deeply in their relationship to my own experience and their relationship to the development of my clinical practice.

In this sense my heuristic process started with my own experience. Douglass and Moustakas (1985) suggested “heuristic inquiry begins with immersion, self-dialogue, and self-exploration, and then moves to explore the nature of others’ experiences” (p. 43). I would also like to suggest an intermediate step. The experience of grief is, at its heart, a relational one. How I am responded to effects how I experience my grief.

Via my own self-dialogue and using my intuition I follow my 'focused eye' and intuition until I find some illumination that I can breathe into that finds some relief. It is my tacit knowledge and my intuition that constantly drive me to keep searching.

My grief depiction journal documents the end results of my efforts and is organised by individuals and my grief in relation to them. As suggested, I read literature on grief and working with the dying and follow my own associations to new sources of literature. I am drawn mostly to the personal accounts of therapists, they speak to my own experience and I feel understood and soothed. I have moved from judgement, self-recrimination and pathology to compassion, humanity and mutuality. I have also read many accounts of the dying which provide me with the richest and the most poignant help in understanding my patients.

Shame, the desire to embargo my research and ethics

I constantly question the tension of writing about my grief in a full way and feeling shame in relation to my vulnerability. I feel a desire to embargo my research as a result. This has been part of my heuristic process which keeps being revisited and is in direct opposition to the open dialogue into which I was invited (Adelman & Malawista, 2013) and the surrendering to 'the I who feels' (Sela-Smith, 2002). Adelman and Malawista (2013) named part of this tension I find in me in the opening pages of their book. Therapists, although they spend hours noticing their feelings, emotional states, thoughts, identifications, transference and countertransference responses to patients, are not at liberty to share them freely. Therapists are taught to use absolute discretion about sharing their countertransference, self-disclosures and more simply the depth of their feelings in relation to patients, lest they act out their own unconscious or their own pain. And even though we have opportunities to consult with colleagues in supervision, we are often left alone in the often unbearable pain and grief. We collude with the idea that we should not expose our feelings and ourselves, we cover up. By feeling shamed about my needs being in the room I shut down and, if I do this often enough, my grief may become disenfranchised and I may shut down in the room with my patients. That would be tragic.

I now ask myself the questions: does this cover up leach the humanity and the therapeutic possibilities out of the analytic space too much? Does a privileging of avoiding our deepest rawest self and the exposure of who we are, instead of exercising our utmost professional prudence and not hiding behind our professional role, cost both

the patients and us too much? If I had worried too much about my needs being in the room with my elegant lady would I have withheld the asked for hug and kiss and denied our humanity in a poignant moment, or would I have responded to a patient, months from death, with interpreting her defensive self when she asked me not to miss her when she was gone, as she hated being a burden in her dying days. Instead I shared how I was really feeling in response: 'I will miss you', I said. I still do miss her. I miss her mostly alone.

Adelman and Malawista (2013) wrote:

There is a cost to maintaining too singular a focus on avoiding self-disclosure. A disapproving or condemnatory stance amongst colleagues could significantly interfere with our ability to share our professional losses and to learn from one another about how we bear therapeutic loss [...] bearing it alone, with the vague sense that we are feeling more than we ought to be or feeling things we cannot openly discuss with our colleagues, runs the risk of overtaxing our ability to do our work well. (pp. 4-5)

I have come to believe that this overtaxing potentially erodes my relationship with myself and others over time.

I have a moral obligation to myself to preserve my own confidentiality as self-care. I made a decision early not to censor my writing as a countertransference response to shame or feeling overly self-indulgent due to the-self-focus. I would write it with all the depth of my vulnerability, feeling responses, and inclusion of the people who provoked the most profound experiences. My first drafts would likely be more candid than the final draft. Only then would I decide what to exclude or what would cross the line of ethics, as only my own reflections of grief are available, not my family's or my patients. There is always a grey line as grief is often interpersonal. I have recursively considered and included only enough details of my patients and those in my personal world to give the reader a sense of the context of the encounter, my relationship, and particularly my grief response. My intention is to narrate my experience, not theirs. I am sensitive to protecting the confidentiality and potential for recognition of anyone referred to in this dissertation, although this has an air of impossibility especially in regards to my Dad and my family.

I have referenced Ings (2014) in my decision making process. From his perspective I need to consider both myself and those who populate the narrative told in this dissertation. This includes family, friends, patients, family of patients, colleagues,

supervisors, my therapist, and my future patients. From a patient perspective, although some are now no longer alive, this does not change my ethical stance, I will always owe them an ethical duty of care. Ings suggested conventional ethics is considered from a deontological (the end never justifies unethical research) and teleological (ends sometimes justifies the means) perspective. University ethics are aimed at protecting those who populate my narrative, not the researcher. Given my research is subjective, and my experience of the other is therefore subject to my own interpretation and their inclusion is framed non-neutrally, then the issue of ethics becomes an extremely complex issue. Ings suggested I treat all those referred to, including myself, as vulnerable and therefore discuss inclusions with those concerned where possible, but also continually reflect and debate the purpose of each inclusion for its communicative value to my narrative and its usefulness to adding to furthering research, knowledge and understanding in this area. Does the inclusion meet the teleological test, without waking up the sensitivities of the most deontological oriented?

Most powerfully I heed the work of Ellis (2007) who explored the complex relational ethics where research is autoethnographic and includes personal reflections on encounters with intimate others, including those who have died. Firstly relational ethics “values mutual respect, dignity, and connectedness” (Ellis, 2007, p. 4) and recognises that even though we may be writing about our own experience, how others interpret the encounters with others, will have implications for the other. She wrote of this genre of research and the tension of relational ethics:

Autoethnography starts with person experiences and studies “us” in relationships and situations. Doing autoethnography involves a back-and-forth movement between experiencing and examining a vulnerable self and observing and revealing the broader context of that experience. When we write about ourselves, we also write about others. In so doing, we run the risk that other characters may become increasingly recognisable to our readers, though they may not have consented to being portrayed in ways that would reveal their identity; or, if they did consent, they might not understand exactly to what they had consented. How do we honor our relational responsibilities yet present our lives in a complex and truthful way for readers? (Ellis, 2007, pp.13-14)

How would my Mum or Dad react to their inclusion and inviting others into our distress of Dad’s dying process? I can almost hear my Mum saying, ‘They don’t need to know that Bronwyn’, such is the pull to silence I often feel in my family due to shame.

Do I need to protect myself or stay with the invitation? Communicating my deepest vulnerabilities and grief means I am likely to draw criticism and disapproval perhaps

from the perspective of am I healed enough as a psychotherapist (I sometimes believe as psychotherapists we are less empathic and more critical of each other as compared to what we offer our patients), as a common countertransference to feeling helpless in death situations, or probably because I am the one still alive and those I have included cannot defend themselves (Ellis, 2007). My desire to add to the dialogue is from the perspective of revealing our basic authentic humanity, empowering the narrative of therapist grief and my illuminative discovery through this process that suffering in this work is inevitable. I want to deliberately position this research from its potential contribution to academia and to add to understanding within social contexts by being an activist (Ings, 2014). Unless I can do that with clarity and relationally with care, then there is no point potentially hurting all those mentioned in this dissertation, for all of whom I care. Everyone who appears in the dissertation matters; otherwise they would not have made the cut. The double bind is that to be able to explore my trauma, distress, and grief whilst protecting others from emotional harm and distress is, at its deepest level, an impossible task. Emotional honesty although painful can also lead to increased intimacy. I have tried to anticipate responses and discussed them directly with those I could. I have also tried to name why I may have had particular responses to my encounters with those mentioned rather than blaming my responses on the actions of others.

As a part of this process I read many autobiographical accounts of the dying and one in particular held promise at onset. Tony Judt, a Jewish historian, professor, political commentator and writer of much renown, wrote what he called *feuilletons* or light literature akin to gossip which he eventually decided to publish in a book called *The Memory Chalet* (2011). He died at the age of 62 of motor neuron disease, a cruel and tortuous death. My interest was piqued immediately as he started his book with an apology for his directness and occasional criticism of those most loved by him and his own ethical question. He was narrating his memories for his own satisfaction and mental health. He did not use 'a private censor' as a result and had hoped this did not cause offence to his family. He was trapped in a body where his limbs and eventually his voice would no longer work and, crueler still for a writer, his thinking was faster than his words could form, so communication became frustrating early on in his disease. He was alone with his mind and his memory. He would write stories in his head in the long dark hours of the night to temper and divert from his intolerable, agonising, often humiliating and helpless prison like suffering. He retraced his life, his political and

historical views, and travels, again and again with increasing complexity. He needed both the chalet as a device to store his thoughts spatially, and then be able to recall, retrace, and dictate his story the next morning. One cannot help but feel he used this book to survive his death.

After reading his book I am encouraged to be more open, courageous and forthright in sharing my feelings but I was also left wanting more from him – I wanted to know his vulnerable not his intelligent intellectual self. His intellectual prowess was astounding, admirable and, given his predicament, was probably perfected by retracing his prose again and again through the hallways and rooms of the chalet. However his intellectual writing style often detracted from me knowing him. I finished the book by googling a picture of him in an attempt to satisfy this need in me, rather than rushing to read more of his work. I am encouraged, therefore, to not become too intellectualised, lest my emotional meaning and I get lost. I am also reminded that my patients retelling their stories are like a loving, poignant, and sometimes traumatic embrace rather than an intellectual pursuit; this is what engages my being and theirs. Most powerfully though it was the detailed experiential accounts of the bereaved therapists and how they wrote about their patients in relation to their grief that helped me populate my depictions so that I could be helpful to other therapists.

What this creative synthesis is not as a result of my heuristic process

Is this a complete explication of my grief experience? It is not. I have excluded giving a full account of my shock, the trauma both leading up to and after the death of my Dad. The profound sadness and the devastation, the fear and anxiety, the guilt and the tirade of anger held back for so many years and after so many losses long gone. I do not give a full account of my sense of isolation, my constant waking in the middle of the night, my physical or my spiritual reactions. Neither do I account for the flooding of good memories held back by a painful dying process. My grief helped me renegotiate my relationship with my Dad via these good memories. His dying released me from trauma so I could be with him again.

Nor do I include the striving to build into my treatment plan for each of my patients the impact of my sudden departure and how I addressed this in each of their therapies.

It is not a complete explication of my identity, my personality, and my cultural influences which shape my unique experience of grief. I am not drawn to naming this or

working this out for myself in this lived experience. My intuition, self-awareness and judgement of my tacit knowing has not led me down these paths.

Why did my synthesis not include the above?

My grief determined what I hovered over again and again; I was in my lived experience rather than forcing myself into telling all my felt grief. I kept being drawn to what I yearned for and my relational pain and disappointments that needed healing rather than being drawn to name each feeling, as and when they appeared. It is only in the process of writing the results of my endeavours that I am naming this for myself more fully, although it is implicit.

Chapter 4

Depictions and Reflections on My Grief Response

Dying - A poem

I feel you
 I feel scared
 I feel messy
 I feel confused
 I feel intensely vulnerable and sad
 I don't want you to die
 I can't hear your kind words and appreciation
 I can't hear you say that you feel clearer from being with me
 I can't hear you say I help you
Why do I feel so different to how you experience me
Don't leave me
I won't leave you
I am in the struggle with you

Fading – A poem

I watch your light switch on to the inevitability of your death
And I watch your light go out on your soul little by little
 You fade and I cry
 You fade and I don't want you to die
 Don't go
 Don't go and leave me

Introduction

I have pondered, reflected, revisited, looked away, dipped in and out of my grief again and again, and used my own therapy, supervision, group and peer supervision, my theoretical associations and resonances found in literature in this intuitive process to make sense of my experience. I have developed my thinking and transformed my feelings in this process and the following chapter is a narration of where I have gotten to thus far. The chapter is organised by the questions provoked in me and named in chapter 2. The original depictions and my resonances with more recent and grief of old, the wounds I still carry with me, are also interwoven.

Shame and the desire to hide my depth of feeling

I did not realise the extent of how judged and shamed I felt in response to sharing my grief in relation to my elegant woman until I shared the experience again in dissertation supervision. My dissertation supervisor listened intently and responded not to the experience I had with this woman, but to how my grief was responded to, he responded to the emotional process of feeling judged. In being responded to with perceived judgement, I in turn judged myself harshly and went about searching for my own dysfunction in my responses, and potentially could have missed the therapeutic or mutuality of experience that the elegant woman and I shared. We had a moment of meeting that could be considered mutually gratifying (Maroda, 2005).

In this same exchange my dissertation supervisor noted how often I used the term 'woken up' when describing feelings I did not expect to feel, which I interpreted as silly and naive and he reframed as feelings perhaps sleeping in me waiting to be woken up in my felt experience not just sitting in my intellectual self. I had felt naïve for promising my return when her death was imminent. In learning of my elegant woman's death, I was plunged at depth into knowing she was dead, I was awoken to the essence of the experience now alive in me. Anticipatory grief in my experience never fully prepares you for how you will actually feel when death arrives.

What might these two revelations mean? Why as therapists are we perhaps quick to judge our own and each other's depth of feeling or suffering? Are our feelings more intense in death situations?

Another depiction about judgement calls to be spoken to, before moving to my findings:

I am at a party, it's late and I am speaking to someone I don't know very well. Her much beloved Mum had recently died in a nursing home and she recounted to me her grief and isolation in the months since and also the love that was given to her Mum by her caregivers. Our conversation flowed towards the death of my Dad, my work as a hospice psychotherapist, my writing a dissertation and the profound grief I feel in response to the death of some of my patients. She responded with a spontaneous 'but it's not real, the relationship is not real'. I felt deeply wounded by her response and brought our conversation to an end perhaps regrettably without letting her know why I might grieve my patients and how hurt I was by her response. I felt her dismissal of my work and my grief.

My research found its way to the writing and research of Danai Papadatou, a Greek clinical psychology professor who has written a book entitled *In the face of death. Professionals who care for the dying and the bereaved* (2009). One of the themes of her book is discussing and formulating the reality of the suffering of the care provider. She wrote: "caring for individuals who are dying, and listening to painful, chaotic, or traumatic accounts of the bereaved, is a profound experience that affects most of us and elicits suffering, aspects of which are unavoidable" (Papadatou, 2009, p. 117). She suggested we are not immune to suffering despite being knowledgeable in this field.

Health care professionals' grief is still largely disenfranchised even though it has been known since the days of Hippocrates that our suffering is in fact integral to the care of our patients. Our own suffering in response to our patients and our own personal history and wounds are woken up in this work and, if used well, can inform our empathy, sensitivity, and compassion. It is the wounded healer who has known suffering, who can feel and acknowledge their own vulnerability, limitations, and finiteness, who can examine their own fears and anxieties in death situations, who knows the impossibility of being "all powerful, all knowing, and invincible in the face of illness, pain, suffering, and death" (Papadatou, 2009, p. 116), who can then be with patients without undue anxiety. As the wounds of the healer are never fully healed; they remain to remind and inform our therapeutic wisdom, our presence and feed our continual growth. It is through our introspective, inward gazing process to tend to our own wounds, that we build a sense of humble, respectful, compassionate connection to our own humanity, which then collapses the illusion of our own mortality and our omnipotence. It is only then that we can step forth to be in our humanity and serve our patients (Papadatou, 2009).

Papadatou also asks and answers the question of why caregivers of the dying may not acknowledge this depth of suffering, and why others may react adversely to us. She suggested four reasons as to why there is a social discrimination, sometimes subtle but also sometimes crashingly overt, perpetrated by us, against us, to each other, and by society in our work with the dying.

Firstly she argued that there is a dismissal of our care which is fuelled by multiple assumptive processes. It is often assumed that it is the patients who suffer – not ‘us’, not the professionals who help them. This denial is in the professionals as well. We are also often viewed as ‘only’ accompanying the dying and the bereaved as we do not offer a cure; so what we do is often viewed as unimportant. Doing this work is stigmatised and seen as socially unappealing and therefore reacted to with distaste. Suffering is considered bad. How could I do this depressing horrible work? is a question often asked of me.

Secondly, we are idealised. We can be seduced by this idealisation as others treat us as if we are heroic or extraordinary for doing this work. This reaction, however, in turn places an expectation on us to look like we are strong, to hide our pain lest we look like we are not doing the job well. There is immense pressure to conform.

Both of the above discriminatory acts by others has a distancing effect which does not seek to understand what the work is like, and may potentially lead to our own reluctance for reflective understanding of the impact of the work. In the circumstances I receive these responses, I feel distanced from.

Thirdly, Papadatou suggested there is a negation of our own experience. Family, friends, and colleagues do not listen to our stories about death, dying and bereavement because they are often too painful or traumatising to hear. We can feel avoided as a result and in turn avoid telling of our own pain so as not to feel judged for having intense grief reactions.

Finally, and perhaps for me most importantly, she posited that there is overt aggression acted out towards us. This work elicits anxiety over death and our own mortality and is often defended against with anger and aggression. This aggression can be subtle but palpable. A suffering caregiver can be responded to with control and reprimands.

My suffering is unavoidable and inevitable in this work. I devour this book. It is compassionate, empathetic and understanding of my experience, particularly in relation

to how my grief is responded to. The four reasons given for social discrimination give understanding to why my feelings might be dismissed, distanced from, or aggressively defended against. I discuss it endlessly. I even co-facilitate a presentation of its ideas at a study day for health professionals. I feel like my experience has a voice in and through her pages.

In writing this dissertation I am exposing the most vulnerable parts of myself. I think it is this painful and sometimes shameful experience that prevents the open sharing in psychotherapeutic circles. If I show you my pain I will be branded as not coping or not professional. I believe it is the diligent effort and willingness to uncover the meaning of my countertransference which will make all the difference, not the shameful hiding of them. I am human and I want to embody my most human responses with the equally human responses of the dying. My aim is to be truly present to both myself and to be truly present to the other.

Papadatou wrote: “We are open to experience when we are “vulnerable enough” in our encounters with others” (2009, p. 183). When we are open to life and its inevitable tragedies, towards others and their tragedies, and towards ourselves whom we can know more intimately through these experiences, then it allows the unknown, and the unexpected, without us needing to question everything. We can then engage in a deeper exploration of our experiences without undue restriction of our capacity to provide effective care, or falling into the chaos of crisis situations (Papadatou, 2009).

I have permission to be human in my responses, and to not judge myself so harshly.

Trauma, how I am responded to and the pull to be in my humanity

I was drawn to reading the personal grief accounts of therapists and the trauma they felt as they speak to my own experience and I feel less alone. Underneath I have come to believe my grief was seeking connection and validation. By finding therapists who mirrored my experience it seems more acceptable to feel the way I do. This search was paralleled in the search of so many therapist accounts I read. They often reported feeling disappointed at the lack of literature.

I was particularly surprised that I found some profound meaning in Russell Carr’s (2013) *The loss of normal*, as this was his account of struggling to feel a sense of normalcy, to feel joy and a sense of connection with his family and friends after he returned from several tours of duty as a psychiatrist in Iraq and other military campuses.

Carr needed to process and integrate the emotional trauma of what he saw and the vicarious impact of listening to his patients' stories. His tours of duty changed him. He became haunted by dead, poly-traumatised, disfigured and brain injured soldiers, and by the completed suicides and the death wish of many of them. He felt shame and anger towards the violence and destruction he experienced being a part of the deployment. What he witnessed shattered his experience of himself and the world which then fore-fronted his vulnerability and his own finitude. He knew that life could change in a moment.

The disfigurement and the re-enactment of previous trauma in the dying process of my patient in a life retold, combined with the trauma of my Dad's death, and the continuing experiencing of grief in my work, alongside of feeling personally wounded and abandoned, especially at times of overwhelming grief meant, like Carr, I needed a way to process the continual input of new emotional trauma. I feel myself getting angry at the violence of cancer, and sometimes I do experience my hospice work as tending to the wounded as if I was in the trenches in wartime. Carr's process of finding an answer has helped me enormously.

Through the writing of Robert Stolorow (2007), Carr came to understand the emotional experience of PTSD. He wrote of Stolorow's work:

The effects of trauma stem from the emotional experience of the traumatic event, not the event itself. Our emotions are highly dependent on being able to process them with those around us. We have to put words to them in order to integrate them into our experiential landscape, which includes both our sense of ourselves and of the world. Symptoms of PTSD develop when a person cannot find a relational home for dealing with their emotional experiences, whether these are being minimised or outright rejected by those around them, or whether it's just too much for anyone to bear. (Carr, 2013, pp. 259-260)

Although Carr started psychotherapy, he was up against his own shame and feeling weak for not coping. He admitted that he did not share fully of his experience.

Alongside of his psychotherapy experience he began to question the intra-psychic developmental model of conceptualising trauma from earlier experiences as a child and how defences might be at play later in life which prevent the integrating the current trauma. He contended that perhaps these traumas were just plain unendurable. This concept finds a feeling match in me.

A depiction from my experience after dissertation supervision, after sharing my last moments with my long term client in a life retold in therapy:

I shared my sense of panic as I sat beside my client's hospice bed in her last days. Words were no longer possible so I sat listening to her laboured breathing. I intentionally try to review our time together but at times her breathing would resemble a death rattle and my sense of panic would increase. I didn't want her to die. I especially didn't want her to die on my watch, I wanted her 'boys' to be there, not me, I wasn't her daughter.

I return to this bedside scene often in my grief, not because of my feeling of panic, but because I was asked if I thought it was useful to my patient to have a panicking therapist beside her. This response woke up intense guilt about the possibility that I may have let her down that day beside her bed. As a therapist I needed to bracket my feelings and be there for her. My dissertation supervisor responded with something like, 'it's just a feeling, it's how you felt'.

I feel very vulnerable after reliving and sharing this moment. I was given the understanding that it was very human to have my own response. I feel liberated in being real but at the same time I know there is still a pull to be the perfect therapist in me which could hamper my capacity to provide care and seed my entering death situations chaotically.

Stolorow (2007) in his autobiographical book *Trauma and human existence* explores emotional trauma from a deeply personal, phenomenological, and intersubjective perspective. He wrote this book after the death of his wife. It is his hypothesis that emotional trauma and human existence are interwoven. The possibility of emotional trauma in each of our lives however depends on the relational context of our lives and the trauma. It is his contention that “emotional experience is inseparable from the contexts of attunement and malattunement in which it is felt. Painful emotional experiences become enduringly traumatic in the absence of an intersubjective context within which they can be held and integrated” (Stolorow, 2007, p. 47).

When a patient is dying there is a twin experience, which is not so much separate but oscillating as a whole within me. The professional one which requires me to tend to the patient as a therapist and use my countertransference and humanity in service of the patient; and also a personal experience, where I too am grieving the loss of the patient, and can experience a whole gambit of grief reactions as any person would in real connection with the person dying. Being able to express these fully in supervision without the desire to hide my feelings is my task and to have them met with attuned understanding is needed. How I am responded to can have a profound impact. To continue in this work, finding a way to be with my own grief is needed.

The isolation of therapist grief and a critique of therapist culture

Adelman and Malawista (2013) reflected that even though therapists have supervision and therapy, they are still ostensibly alone in the room with their patients, alone with a myriad of complex feelings, emotions, thoughts and responses, most of which rarely get fully and painfully exposed. “Such a sense of aloneness can be particularly palpable, even unbearable, at times of extreme grief or emotional pain” (Adelman & Malawista, 2013, p. 1), at times when a therapist is grieving. Therapist grief is solitary (Adelman, 2013a; Buechler, 2000).

A depiction after attending the funeral of my long term patient:

I felt both joy and lonely at the funeral. Seeing her life from the perspective of others and the photos of her younger well self was comforting and honouring of her life before the ravages of cancer. I liked seeing her young, vibrant and happy. The service was heartfelt. This lifted some of the trauma I experienced in her dying days and showed me a different lens to view her with. I felt closer to her again, more connected. But I also felt alone. I was nobody to anyone else here, except to the woman in the coffin. I was unable to say or share anything with anyone. I couldn't help think whether what we shared was meaningful to her, there was such love here.

Without the scaffolding of family, community support or grief rituals like funerals or the spontaneous remembering and being able to openly share with someone who knew them, therapist grief becomes an isolated, private and hidden experience (Adelman & Malawista, 2013), when in reality it is a relational one. They wrote:

Funeral rituals provide a way to contain and temper overwhelming feelings of loss and grief, to reconstitute a sense of stability and cohesion in the face of sudden changes, and to help the mourner feel held, supported, and able to put words to powerful and destabilising emotions. Such rituals, perhaps like any rite of passage, sustain the bereaved. When we are free to mourn in public and our expressions of grief, rage, and despair are understood and accepted, the process of grieving and coming to terms with loss can begin its long, gradual unfurling. (Adelman & Malawista 2013, pp. 3-4)

Houlding (2013) described similar feelings to mine sitting at a memorial service of one of her patients. She asked, “who am I – really – to you?” (p. 111). She felt invisible amongst the people she had heard so much about during many hours of analysis with her patient. She felt irrelevant to the family.

In this sense therapist grief has unique features (Adelman & Malawista, 2013; Papadatou, 2009) and impediments to openly grieving. Without access to socially sanctioned grieving rituals and with some of our own internalised doubt of who we

really were to the patient, in a dismissing of own experience, the risk is we shut down our grieving process which may lead to grief overload, complications, burnout or even loss of faith in the profession.

Analytic culture also has a part to play I believe in sending the message that I am feeling too much which inhibits my grieving openly. After the death of a patient, Sandra Buechler (2000) explored her own repeated and accumulated loss and mourning experience when analytic patients leave or die after having been in an “intimate emotional exchange” (p. 77) with her. She argued that analytic culture dictates role expectations and communicates,

sometimes in subtle ways, the emotional reactions deemed “appropriate” and acceptable. Although we might not be able consciously to formulate all the “rules”, we could probably listen to a colleague’s case presentation and agree on whether his involvement with the patient seems “excessive”. (Buechler, 2000, p. 82)

I wonder whether there are still remnants of the belief that a good analyst should only feel ‘mild benevolence’, and if they feel anything greater, fear and guilt ensues (Heimann, 1950).

This culture inhibits or interferes with normal mourning. This discourse encourages denial of our personal investment in our therapeutic relationships and the emotional impact of their loss, and encourages defensive processes towards moving nobly onto the next patient (Buechler, 2000). I am encouraged by reading Buechler, to advocate more strongly for therapists to openly reflect on their losses and to admit to how deeply they are affected by their patients. The lack of literature in the profession speaks to this discourse. If we can influence and challenge the psychotherapy culture to reveal themselves more, to advocate for the necessity and significance of this type of open communication, then we will not need to suffer alone or feel shame that we feel too much. It is my belief that, like me, this challenge will not reveal itself until psychotherapists have suffered a loss and go in search of making sense of their grief by finding the accounts of other psychotherapists which mirror their own experience.

Death anxiety and aggressive responses

My own tragedy, my Dad dying, my own need, meant I left my patients abruptly; and for most of them, given the context of my work with the dying and the bereaved, meant that the combination of the interruption to therapy, combined with knowing there was a

death in my family and the proximity of this to their own experience, meant that these circumstances would invariably provoke an enactment or transference response (Colson, 1995) which would need tending to in the therapy. I took each patient to supervision before I saw them to discuss the possibilities and how to manage each situation therapeutically. My patient in 'A sensitive soul – to live or not to live' was amongst them. Although he had experienced me as kind and caring despite his projected hated object relational world, the interruption proved fatal. He left therapy.

My panel interview in relation to this patient had me wondering about the subtle but aggressive response I received and its link to inviting others into death situations too late and how I felt like they had lost sight of me. The research of Papadatou again helped me with finding an answer.

Death severs relationships in a violent act which evokes deep suffering and frustrates the efforts of caregivers to help, often leaving feelings of anger, anxiety, hopelessness and despair. It is often the caring relationship that becomes the target of death's violence in a destructive effort to manage intolerable feelings. Working in death situations means I need to be sensitive to my own aggressive acts to manage anxiety and the aggressive acts of those whom I invite into my work. Violent acts often take the form of depersonalising or being indifferent to the caregiver without connecting to him or her personally. Violent acts, at their worst, get acted out on future patients (Papadatou 2009).

Again my panel interview could have been enduringly traumatic but for the understanding of my supervisors who knew of my care of him both during and long after the therapy ended. We, and I, spent countless hours developing my clinical understanding of him, conceptualising his treatment, reviewing verbatim and how best to communicate empathy and my therapeutic working distance. My panel was invited into the world of a sensitive young man in his 30s trying to live, but terrified of dying at the hand of chemotherapy and radiation. He wanted to discontinue treatment out of this fear and although the therapy supported him to continue with the treatment, he then was dealt a blow by facing into the possibility of death at the hands of cancer, reflected perhaps in my eyes.

When I now reflect on my panel interview, I feel some understanding and empathy for what I can only surmise was an intense countertransference response due to feeling powerless to change the outcome. This situation has been paralleled in other situations I

have been witness to and I am now curious about the psychodynamics of the response. I had at this time expected the wise elders of the profession to recognise when they may have acted out their own countertransference response at the expense of finding out what the therapist felt and had actually done. A year on, I now believe that this aggressive response happens regularly in death situations.

Working with the dying calls all therapists to be at the depths of their own maturity. Intense anxiety and feelings of helplessness and powerlessness to prevent a death are the stable diet, and containing and mediating these responses so as to maintain the ability to be curious is needed rather than being adamant about where the therapist went wrong. Curiosity can easily get sacrificed for certainty. Feeling helpless to do anything other than aggressively making the therapist see where she could have done better leaves wounds that need healing with care, empathy, and insight.

In my grief I have begun to associate these responses to how I believe therapists are treated after the death of a patient to suicide. I became interested in the dynamics of a psychological autopsy and its impact on therapists' grief, and again this led me to read the personal accounts of therapists, this time bereaved by the suicide of a patient.

Catherine Anderson (2013) explored the feelings of anxiety, powerlessness, and shame that become constant companions of the therapist, and the powerful potential for unconscious projective identification in the supervisory relationship borne from the strong feelings in the therapist in response to the primitive destructive death urges in the patient. These parallel processes risk both the supervisor and the therapist killing off their curiosity and replacing it with the unconscious pull towards certainty, concrete thinking and controlling acting out, all ineffective antidotes to the ability to tolerate anxiety. From Anderson I have gleaned that it is only through a commitment to honest, deliberate, thoughtful reflection, by both the therapist and the supervisor, especially in relation to projective processes and powerful unconscious forces around death anxiety, and through the repeated retelling to support the construction of a coherent meaning making narrative, alongside a willingness to be deeply and profoundly unsettled by our countertransference and a tolerance of the destabilising effects, that a working through of our therapeutic fantasies and our personal unresolved conflicts activated in grief, can transform us both as a therapist and as a person. This opportunity, although available to all therapists, is most powerfully activated after a death of a patient, when efforts have been thwarted.

Guilt, fate and an experience of failure

For both the patient that died and the one who left, I experienced guilt; a sense that I had let them down and a feeling of failure of not having done enough. Death and early termination intermingled in my grief in the months following the ‘three I lost’. How did this happen?

Although I anticipated both outcomes, her death and his probable leaving early, both came sooner than expected. I and we were denied the opportunity to have a long, considered and heartfelt goodbye and separation. I was deprived of the opportunity of feeling satisfied of a good death or a therapeutic outcome after a long therapy.

I wonder if our relationship cut short was enough. I was left formulating my wonderings and interpretations that could no longer be shared. The manner of her death and his departure still had meaning in the context of both their lives and our therapy. I was “compelled to make meaning out of the chaos and confusion” (Adelman, 2013b, p. 86). Limentani (1982) suggested disruptions from death can be experienced as an attack by the patient and unexpected terminations likely create painful conflicts, guilt, rationalisations and pleas of justification in the therapist.

My grieving process has included a meaning making process of what psychotherapy can achieve for the dying. I started with high hopes. I wanted to help them break free of the shackles of their dynamics and traumatic past (Adelman, 2013b). Whilst long term psychotherapy may be useful, wanted or indicated, my experience has shown that few analyses (Guntrip, 1969) particularly in this context can be taken that far. Taking clients to the depths of themselves to emerge reborn at a time when they are being ravaged by cancer, are often regressed and in need of their defences, is unlikely. The old adage of people dying as they have lived proves true in my experience.

Adelman (2013b) asked herself the question of whether fate could be analysed, what had she missed in the analysis of a patient who died suddenly. She suggested “those twin reactions were spun together from feelings of responsibility, on the one hand, and, on the other, [her] profound sense of loss of [a] meaningful and unique relationship” (Adelman, 2013b, p. 83). This reminds me of bargaining and guilt that often strives to work out what went wrong, feelings of which seek for you to have done something different, then fate may not have stepped in, then she may not have died and he would not have left, in a magical wish for their return.

Denial, death anxiety, and my own mortality

Some denial of our own mortality is needed in psychic life. Most of us, however, seem to hold the assumption that we should have a long life and die at an old age, having lived a full, happy and vital life. Sometimes these assumptions get shockingly revealed.

He died. As head of the bereavement service I am given all files of the patients who die so I can contact their families to see if they need our support. Today I was given the husband's file (see depiction titled 'Me – November 2015'). I usually review each file to see what condition each patient died from, their age, did they survive a long time or die quickly, how did they access our service, did we help or did they get missed? I am curious from a professional view point, but I also know I often search for identifications for myself and those I love. My heart particularly breaks for our patients in their 30s and 40s who die leaving young children and a future un-lived life. My last visit to the haematologist left me with the message that I am likely to have a shorter life expectancy even if my condition does not progress to leukaemia or if I need a bone marrow transplant. I often see bone marrow transplant patients at the hospice and they look like the walking dead. Like grey ghosts. I'm terrified.

I cannot un-know my diagnosis and the implications for my future health. I carry a wound from this self-awareness, the fear of my own mortality, a death anxiety (Yalom, 2008). This anxiety for me sits in the background of my awareness. I barely feel its presence. I am not ruled by it. In times of grief and overwhelm I am thrust into death anxiety's ghostly clutches. Yalom (2008) might call the file letting me know the patient who died an awakening experience. Awakening a depth of perception which has a transformational quality, the depths from which I feel disappointment of my yearned for vibrantly lived life.

Bronnie Ware (2012) in her autobiographical account of her time spent being a carer for the dying described how she was personally transformed by hearing their death bed regrets. The most common regret was not to have "lived a life true to themselves" (Ware, 2012, p. 30); they had lived a life of what they thought was expected of them by their parents or partners. Her patients implored her to be brave enough to live her desires and bare the disappointment of others, lest she risked living a life without soul. She was urged to make those changes before it was too late.

Yalom (2008) referenced the work of Heidegger to describe a shift from the everyday to an ontological appreciation of *being* in the miracle of the world when you are more likely to be aware of your existence, and your mortality. It is here that anxiety primes you to make changes. From this ontological place "you are prompted to grapple with

your fundamental human responsibility to construct an authentic life of engagement, connectivity, meaning, and self-fulfillment” (Yalom, 2008, p. 34). Death anxiety, used well, gives us the focus to live each day more fully and helps us re-organise our priorities, to spend our time prudently. Death anxiety need not destroy us unless we cannot look away from its omnipresent stare.

Kübler-Ross (1969/1997) believed that every patient needs to use denial as a buffer against the reality of death so other less radical defences can be mobilised, and before partial acceptance can replace it. She suggested denial is used more so at the beginning rather than at the end of a life threatening illness, when isolation is used more often. A patient will usually drift in and out of knowing, and she urged those caring for the dying to perceptively and sensitively listen and allow the patient his/her denial, so that health and illness, mortality and immortality can be talked about “as if they were twin brothers permitted to exist side by side, thus facing death and still maintaining hope” (Kübler-Ross, 1969/1997, p. 54).

In the context of my work and the ever present tug of knowing and not knowing of the death of each of my patients, my felt experience of this in the countertransference and the tension of when to tend to hope in a patient and when to look death in the face, is an experience which sticks a finger in the wound of my own mortality, I wonder if this work is good for me. This hurts.

Society also colludes with denial and has shut down from death. Dying is done behind closed doors, death is hidden away (Ware, 2012). This means families like mine and the families I work with are wholly unprepared for the inevitability of death, and often make heroic efforts for treatment which often act as self-torture and increase the suffering in the last months of life. This is especially heartbreaking and repeats my family trauma.

Countertransference, team splitting and survival

How individuals working within teams manage their grief, distress, anxiety, and suffering can be different. My difference was excruciatingly revealed in the months following our colleague’s death. My preference is to go towards the pain, to grieve, to prioritise taking care and acknowledging our own distress, to uncover the unconscious dynamics, so that we could continue to be available to our patients. Being a

psychotherapist means I value this explorative process. The reality is that not everyone does.

I keep wondering if I will survive the team. It's not the patients work that I find the most distressing, it's the subtle and not so subtle wounding I receive by being part of the team. The unconscious desire to do more to manage our distress keeps getting acted out against each other.

When I first started working in the hospice environment the countertransference dynamics I was most present to were a combination of there is not enough time and the intense pressure to do more in response to patient distress and need. Life and death situations created urgency. This sat alongside of experiencing the team as caring and loving. As a new team member I fed off this energy as I was eager to learn the nuances of being a psychotherapist in death situations. I felt intense countertransference responses to my patients so felt the pressure to respond therapeutically well and tend to my own distress, but I also wanted to be a valued team member. I quickly had a full diary of patient appointments and group commitments. I felt satisfied that I was on the road to becoming a sensitive and competent psychotherapist for my patients. I would juggle my time generously and flexibly extending my hours before and after office hours and into lunch hours.

A few years on, I no longer feel eager to satisfy the pull to do more or to say yes to all requests. I feel tired, wounded, and hurt. I have increasingly become more boundaried to protect my empathetic self and, in doing so, I have felt less understood in response. I have felt defensively responded to. I feel resentful and angry, not at the patients, at the team dynamics. Over time I have gently and carefully challenged team members when they have booked patients to see me under the projective pull of patient distress without asking my availability, which has resulted in my patient load threatening my capacity and potential burnout. The culture is one of self-sacrifice and charitable giving. In making these challenges I am aware that I am putting my team membership under threat as it is becoming increasingly clear that death trumps everything. The culture has been organised and constellated around managing anxiety. As long as I can come to terms with, and surrender to, the group rules and norms to how the organisation has developed to protect itself in death situations, then I will be accepted. If I cannot accept or transgress these rules by challenging the unconscious, I will be rejected (Papadatou, 2009).

In the absence of team supervision there is not a place to explore the unconscious team dynamics and my desire to increase the understanding of how an outwardly caring organisation does not care for its team when acting out this countertransference is not being met. I feel the pressure to be silenced so as not to be further wounded and to remain good and seen as 'caring'. This dynamic would mean I need to work harder to mediate my hurt, to make the perpetration against me okay. I do not want to do this again. My own family drama is being repeated in the team. I will need to either learn to continue to say no more often and bear the responses and mediate the desire to remain good or decide that if the organisation does not want to hold the desire to explore the individual and group unconscious processes then I may need to leave. My relational history and my own traumas have left me too thin skinned and vulnerable.

It is clear that my own vulnerabilities threaten to get in the way of team dynamics and need working through. Colson (1995) suggested that when there is a major loss or trauma then we should "expect an exacerbation of central neurotic struggles and disturbed relationship paradigms, no matter how thoroughly such conflicts were experienced and examined" (p. 468) in our own therapy. I was in danger of becoming my sister standing shaking my fists and yelling at the parents as to what they needed to do to take care of us. I had temporarily lost my empathy for my team. There is a familiar feeling of despondency in me. If I act out my despondency then I will act out an abandonment.

Tom Main (1957) in *The ailment* wrote of the basic need in those who care for patients for their treatment to be responded to well and for the patient, therefore, to feed the satisfactions of the carer. If there is a frustration of these hopes, especially after long, diligent and devoted care, then only the most mature of us do so without ambivalence towards ourselves and our patients, the consequences of which can be dire.

Main (1957) wrote:

If human needs are not satisfied, they tend to become more passionate, to be reinforced by aggression and then to deteriorate in maturity. With sadism invading the situation, together with its concomitants of anxiety, guilt, depression and compulsive reparative wishes, until ultimate despair can ensue. We need not be surprised if hopeless human suffering tends to create in ardent therapists something of the same gamut of feeling. (p. 129)

Team dynamics can deteriorate to being fed by unconscious primitive behaviours aimed at either manic treatment behaviours or if the patients are recalcitrant, and therefore our

distress is recalcitrant, “treatments tend, as ever, to become desperate and to be used increasingly in the service of hatred as well as love; to deaden, placate, and silence, as well as to vivify” (Main, 1957, p. 130). Like a nurse can use sedatives to silence patients, unconsciously to silence her own anxiety, a therapist can use a self-reflective countertransference response to justify an intervention “to escape from their own distressing ailment of ambivalence and hatred. The temptation to conceal from ourselves and our patients increasing hatred behind frantic goodness is the greater the more worried we become” (Main, 1957, p. 130).

After the death of our colleague, my distress and outrage increased and could not be ignored the more I noticed how patients suffered from ill-advised but well intentioned decisions by team members whose grief perhaps challenged their empathy and capacity. I noticed distressed colleagues retreat behind closed doors after their pain was met with dismissive behaviour. It is my belief that in the overwhelm of a death situation we became destabilised and some of the unresolved tensions were revealed. The most distressed therapists and facilitators left in this process, but I am relieved to say that like Main’s group of nurses, we have entered into a group supervision process. Although it is in its infancy, it is beginning to reveal “old unsettled interpersonal scores [...] private ambitions, omnipotent therapeutic wishes, guilts, angers, envies, resentments, unspoken blamings, alliances and revenges” (Main, 1957, p. 132) – we are making some headway. My feeling silenced and fear of retribution has ebbed, the process feels positive enough to ward off my despair. Research stresses that “effective care of the carers transcends simply the individual carer’s personal strengths or coping capacities. The work organisation [...] retains major responsibility (Doka, 2006, p. 6). They have answered this responsibility.

Moral imperatives, saving patients, and intense countertransference responses

In my experience with working with the dying and their families you can often get drawn into the crisis, into the transference relationship and feel all the intensity of feelings that go with it. Crisis situations often forge strong bonds quickly (Doka, 2006). You can become another protagonist in the life and death drama, which amplifies countertransference feelings. I have come to appreciate that allowing the drama to capture me more fully, by allowing my omnipotent fantasies some airtime, these processes inform empathy and a fuller understanding of what matters most. If I can accept the inevitability of the patient’s death, without the need for denial made much

harder by the projective pull of the transference situation, then I can help them in their decisions about their deaths and alleviate unnecessary suffering. The following paragraphs provide a guide through my experience of coming to appreciate my intense countertransference feelings rather than viewing them as distressing challenges to my competence.

I start with the visceral feel of being in the death contexts before giving the illuminative process. Kalanithi (2016) wrote about death situations:

At moments, the weight of it all becomes palpable. It was in the air, the stress and misery. Normally, you breathed it in, without noticing it. But some days, like a humid muggy day, it had a suffocating weight of its own [...] trapped in an endless jungle summer, wet with sweat, the rain of tears of families of the dying pouring down. (p. 78)

I have the repeated experience of breathing in fresh air as I leave the hospice building. It comes as a soft flowing rush of relief. I usually stop and close my eyes and show my face to the sun. I feel fed in these moments and I promise myself to go for a walk at lunch time so I can have this feeling during the day. I have promised myself this many times, and I have not once done this in nearly three years. Once I am in the intensity of the day, I am swept into tides of needing to do more, in not enough time. I was being swept up in the suffering of families the closer to the death they became. My perspective of my therapeutic function at this time was changed forever after reading: *When breath becomes air* by Paul Kalanithi (2016).

This book is a devastatingly poignant account of his work as a doctor and as a patient. He wrote the book as he was dying. Although he was a doctor, he believed that it was not his job to save his patients. We all die. He fiercely believed in the moral dimension of his work and set about reading literature to understand and illuminate the experience of being human. The most useful fodder for moral reflection he discovered was his direct experience in forging relationships with his patients and their suffering. He was interested in knowing what made life meaningful to each of his patients, both before life threatening illness and in dying. It was only this information that could populate and generate moral opinions to inform decisions and recommendations about treatment. Judgement calls in life and death situations could not be made just on knowledge or intelligence, moral clarity was borne from understanding his patients. He reflected:

At those critical junctures, the question is not simply whether to live or die but what kind of life is worth living. Would you trade your ability-or your mother's-to talk for a few extra months of mute life? (Kalanithi, 2006, p. 71)

This stance asks how much suffering is endurable? If you can no longer do the things that make life meaningful, when is death preferable or kinder? Figenshaw (2016) viewed this as compassionate decision making which flies in the face of death.

Kalanithi (2016) came to this eloquent realisation in the following account:

I had started in this career, in part, to pursue death: to grasp it, to uncloak it, and see it eye-to-eye, unblinking. [...] intertwining life and death. I had thought that a life spent in the space between the two would grant me not merely a stage for compassionate action but an elevation of my own being [...] I began to suspect that being so close to the fiery light of such moments only blinded me to their nature, like trying to learn astronomy by staring directly at the sun. I was not yet with the patients in their pivotal moments, I was merely at those pivotal moments. I observed a lot of suffering; worse, I became inured to it. Drowning, even in blood, one adapts, learns to float, to swim, even to enjoy life, bonding with the nurses, doctors, and others who are clinging to the same life raft, caught in the same tide. (pp.81-82)

I have some feeling resonances with the idea of being close to the suffering of patients, sometimes unnecessarily at the hands of heroic treatments which potentially rob patients of their quality of life. Kalanithi's words create an enormous shift in my experience of myself as a therapist. It is also my moral responsibility to discover what makes my patients' lives meaningful and to help them at those pivotal moments to determine what course of action might facilitate this: it is not to save them.

In death situations patients and their families are confused and do not understand the full significance of the tragedy unfolding. They painfully want a full recovery to what was. At these times only health care professionals can hold the reality more fully about an impending death or the likelihood of further treatment being futile or even death inducing. In my experience this can be an incredibly difficult task, as it is during this time that you are in the depths of a death-induced intense transference relationship and the concomitant gambit of countertransference responses and grief. Examining all of the transference and countertransference responses, including the oft ferocious pull to deny death, to be the saviour, to be the loving daughter, which informs my empathy, must be worked outside of, as these feelings can collude with denial and invite a long and painful, possibly treatment-tortured death. Kübler-Ross (1969/1997) believed that a patient's need for denial was often present in similar proportions to the doctor's need of

it. Tending my own death anxiety and the need to defend against a patient's death means I will be able to have these discussions without undue anxiety or despair.

At these pivotal moments doctors and hospice teams, although pulled by the families to be recruited into the fight against death, could play a part in being death's ambassador (Kalanithi, 2016). If I am to hold on to being good and provide earnest perfectionist care, the move to challenge patients and their families into the reality of how they might be increasing their suffering by letting them know of the impending death has seemed cruel. I have felt like an executioner. My experience with my Dad's death, of not being able to relieve his suffering, if not brought to conscious awareness may unconsciously influence or lead me to presume what the right thing to do is based on my own projected values onto their situations (Figenshaw, 2016), especially as the occurrence of so many deaths creates a crucible of intense and viscerally felt grief. I do not want the patient to die either. My task is not to crush hope or to collude with the unrealistic to avoid despair, but to be with the patients where they are, to hear, to strive to understand with curiosity and respect, their lived experience and help them make sense of their values and priorities, and little by little help them be with the reality of their situation whilst conscientiously, and with self-awareness, bracketing my own values (Figenshaw, 2016).

It seems to me that Roger's (1980) facilitative conditions or attitudes of empathy, unconditional positive regard and congruence, which encompass respect for patients' agendas and gives consideration to their own intimate knowledge of themselves that will be revealed in the therapy (McWilliams, 2011) are a prerequisite in this work.

The following depiction woke up in me the realisation of the benefit of allowing my omnipotent fantasy airtime:

I am in group supervision and I am discussing a young family, the father of which is dying. I am allowed the latitude to really feel into how I experience the family and in all my omnipotent strivings to help them.

It feels like the family is headed for a massive car crash. The father is at the wheel, he is in angry denial of his impending death and how his actions may contribute to his unconscious sabotage of potentially time giving treatment. It seems like the worse kind of denial where he is not looking after himself enough during chemotherapy, so the possibility of a life giving transplant is unlikely. He is angrily lashing out, yelling at the Mum and not allowing her to let the kids know he might die soon. They are all terrified. They don't have their seat belts on. In the crash the father will surely die, the young children will be thrown from the car and will be strewn all over the road. They will live, but will never fully recover from their injuries.

I let myself enter more fully into the drama. I tell my group I want to be in the driver's seat, I want to push the Dad out and slow the car down by applying pressure to the breaks. I want to buckle the kids in and help the Mum to let them know where we are headed. I let my omnipotent self be heard fully on the car radio. I am resigned to the father dying. I am not resigned to watching the car crash. I can easily name my anger for the father and I am asked where my anger is in relation to the mother. I feel the need to save the children.

By getting some 'blood' on me in the transference relationship, by letting my desire to save this family be felt and heard, I was simultaneously released from the responsibility. As a psychotherapist my task is to name the dynamics as I understand them and the mother's job is to consider the resonances of truth within her, and choose what is right for her based on her own values, even if it increases their suffering. I cannot choose for her. I tend to my responsibility guilt as it is never far away; the rest is up to the other.

The most humbling thing I learned from Kalanithi is the following: I had believed that death anxiety used well means you had an opportunity to be focussed on living more fully doing the things that really mattered in a much re-ordered and prioritised life. I have the privilege of relative health to do this. But if death has already cast its ghostly shadow and treatment has sucked your energy from you, if you are in the unremitting crisis of ghastly side-affects. If your life has collapsed and disintegrated, then the moral responsibility to your lived life is at best temporary; what is left is only what is possible in a very shut down existence. My task is to tend to and ease, but not eradicate patients' emotional, physical, social, and spiritual pain. That may be impossible. The cruel realisation of living life to the fullest often comes too late. There is a tangibly different tension in facing your mortality when death is close. Time changes pace.

My need, patient need, and mutuality in psychotherapy

Medicine requires doctors to live the oath of putting patients' needs and interests first, above their own. Doctors and interns who are asked to work enormous hours to prove themselves, to make the grade, seem to me to be living a rite of passage that the previous cohort had to endure and survive. If they do survive and make the grade, then, and only then, can they cut back on their hours, breathe a little and feel justified at flogging the next lot, and perhaps become callous to their suffering. This culture needs a political voice to advocate for change, as this ongoing practice does not support the life force of the doctors. If we continue to justify this ongoing practice as the doctors living their 'calling' in life, then nothing will change.

There are parallels to this dynamic in hospice work which is influenced by the medical model, and is added to by its own organisational myths (Papadatou, 2009). The myth of benevolence and self-sacrifice, of putting patient needs before therapist need, is felt by me in this work. I want to advocate for therapist suffering to be acknowledged. I want to advocate for change. I am not arguing antithetically, but for both and. We need to take care of the caregiver, so we can take care of the patients.

A recurrent theme in my work with the dying has been feeling shame over feeling too much or the presence of my own humanity or grief, challenged as my own needs. I believe I am vulnerable to making too much of this feedback due to my own sensitivity and irrational guilt, of having any of my needs met and perhaps in response to the impossibility of being self-sacrificing without engendering anger and resentment over time. Maroda (2005) has written about the gratification of therapists' needs being a legitimate part of a mutually beneficial relationship, and acknowledges this is still the subject of controversy in the profession, perhaps in response to a denial of how needy we actually are. She is clear, and I am clear, that any inappropriate pursuit of the satisfaction of my own narcissistic needs is to be avoided. She contended therapists should realistically assess their own motivations for doing this work and their own mental health. In the current age of relational therapy or the two-person approach, which includes conversations in literature emphasising mutuality and the "inevitability of the analyst's participation as a human being" (Maroda, 2005, p. 372) and their personal involvement, then guiding principles are needed to make good decisions about therapists' affective disclosures to patients. Maroda suggested that the seeking of this gratification should ideally be patient rather than therapist sought, the dynamic of which should be viewed over time to review the mutual beneficence to both parties. She encourages analysts to be freer with themselves. This requires judgement, self-analysis and self-awareness.

Ellen Pinsky (2014) asked the following questions in her grief after her analyst died: "Who are you to me? Who am I to you? (p. 1). Perhaps in our work, especially with the dying, who they are to us, should be prudently reflected on and answered with the patient. Like a therapist can ask at a funeral, as I did in my own grief, who was I to my patient, patients and clients in general also often ask, mostly to themselves, if they really matter to us. Just as I would encourage my patient's family members to say what matters when a family member is dying, so as to live without any regrets of love

whispered too late, I am encouraging myself to let the patients know who they are to me, before it is too late. It is not a time to deny or withhold our humanity.

Pinsky (2014) seems particularly reproachful of the profession for not being a good guardian of therapists and patients, given the analytic space exists to promote extraordinary intimacy, for not shepherding its flock to consider mortality more often, given grief and love are so entwined and is present in the therapy couple. Although she is writing from the perspective of a patient, there is a parallel for me which agrees with the notion, that if we deny the impact of patient death or termination on the therapist, by not writing about it, by shunning discussions about it, in examples of dismissal, countertransference hatred, motivated forgetting or denial, then the profession is abrogating its responsibility to the care of its bereaved flock. Talking about therapist grief matters.

Chapter 5

Implications for Practice and My Concluding Thoughts

Dead - A poem

I need you to know I am grieving

I need you to know I have been in the struggle to care for them as best I could

I need you to know I feel their loss

You need to know I will feel and relive the therapy, my regret and guilt will address how I could have been more helpful

So I need you to hold your anxiety about being invited into a death after the fact. I need you to hold your judgement about what could have been done better

I ask that you be with me first, to understand, to feel how I struggled to give them what they needed, feel into my plight, my loss, then you can challenge me so I can grow

If you remind me of the difference I made, I ask that you pause to check that I heard it, that I heard and felt your acknowledgement of me

Be with me first

Introduction

Through my grief, my dissertation and the heuristic method I have been working initially unconsciously on my philosophy of practice which will now be informed by my own lived experience. My grieving process has sensitised me to a deeper and nuanced understanding of grief that will inform my empathy and clinical practice with the dying and the bereaved. In this chapter I will discuss my need for a place to mourn my patients and how trauma in death situations calls for twinship in my own therapy and supervision relationships, and also in my patient relationships. I will reveal what I discovered about myself, my guilt, and my own mortality. I discuss what may be needed by me to continue on this work. I continue with some thoughts about what I am called

to further heuristically research both for myself and the profession, and some final concluding comments to summarise my synthesis.

A therapists approach to dying and grief - new understandings

When I work with the dying, given the uncertainty and the possibility that this could be the last time together, I work in the moment, with immediacy and responsiveness. Immediacy and responsiveness can be interpreted in a number of ways and along a continuum, depending on your theoretical orientation. Classical psychoanalysis privileged abstinence and neutrality, which would require me to bracket from the encounter my countertransference feelings and my own idiosyncratic personality (McWilliams, 2004). More contemporary psychodynamic approaches might favour insight and interpretation of conflicts and defences. With the relational turn, however, the emphasis changed to include the subjectivities and past relational phenomena of both the therapist and patient. Through to a real response between two human beings or a stance where the relationship with all its history, transferences and counter-transferences are allowed, and worked with sensitively with the patient.

I do not want to be an analytic experience distance caricature of a therapist who challenges the denial rather than be with the patient's humanity. Equally I do not want to sacrifice the psychoanalytic theories which help frame and understand what might be going on. Nor do I want to be a therapist racked with her own needs to make a difference whose therapeutic goals are thwarted by death and dying.

My clinical stance will now include relational moments of meeting that matter. The real in the moment, positive or negative countertransference withstanding, moving from the intellectual to the emotional, from trauma and chaos down to deeper emotional attunement. To a stance where both therapist and patient matter. Where they are more likely to know that they matter to each other.

I am called into the depths of my capacity to approach patients, death and dying despite my fear and denial. Responses which idealise, diminish, or aggressively reject pain or experience, all of which do not seek to understand the experience of grief, which call for a defensive response, need further illumination so as to not act out what cannot be beared in the patient's experience or in mine.

Through my work with the dying and the bereaved I have come to fervently believe that the criticisms of a Rogerian or a person centred stance, particularly around its

inactiveness of just being a kind listener or “de facto passivity” (Quinn, 1993), either have not put it in the context of a complex, comprehensive and considered dynamic formulation, character style diagnosis and treatment plan or appreciated how hard it is to empathetically sit with a dying client. This is the most active and emotionally hard work from an empathetic stance, particularly in relation to strong countertransference responses, that I have experienced.

Patients who are grieving are likely to feel alone, scared and abandoned by those around them, not always because there is not anyone around them. What is needed is someone to step towards them by being available to their pain with compassion, kindness, openness and the ability to bear their aggression, anxiety and pain, and to understand the agony is exacerbated by those who they believe should be there for them and cannot be.

The more we can be real and authentic with our patients in these moments, “the more engaging, dramatic, and alive the treatment relationship comes to feel” (Adelman, 2013b, p. 83). Interpretations are only accepted, after all, if they are genuinely given in the depth of the relationship (Adelman, 2013b). The mutative power of therapy is in the affective bonding and emotional understanding of being understood in the transference relationship, in the affective longings mobilised and attuned to, in an emotional attachment relationship (Stolorow, 2007).

Working in an open hearted near relational way, in the chaos of powerful unconscious forces around death means I am more likely to be profoundly unsettled by my countertransference and my therapeutic fantasies, which will more likely activate my own relational traumas and conflicts. These forces are natural, inevitable and vital to the work (Doka, 2016). I need a place to reflect on these tensions and to grieve in an often repetitive retelling of them so I can build and emerge with a coherent meaning making narrative of my therapeutic approach.

A place to mourn

There is a need for a place to mourn the loss of my patients openly and fully, to seek to really understand and make meaning of the experience and the relationship. This includes mourning not only the loss of the bond with the patient but also the therapeutic goals unrealised for both the therapist and the patient. I have found group supervision to

be the most helpful and soothing perhaps paralleling the social context that grieving is usually processed in, within a family.

With the previous discussed relational stance, and the mutuality of mourning, this place to mourn first starts when still in relationship to the patient, as the patient is dying. I am giving myself permission to be freer with the patient, if indicated, felt and elicited. We will mourn together.

Most importantly the grief process resides in my own experience. The process feels much like the heuristic method itself. It is immersive, subject to incubatory retreats, receptive to awakening illuminations, explications and a synthesis that continues to transform my experience of myself and my relationship to my patients.

This experience has also shown me that this place to mourn needs to be resilient to defending against my own shame, dismissal, idealism and reparative efforts and death's provocations of denial, aggressiveness and violence.

Therapist grief, trauma and the work

The proximity of the loss of my patients to my Dad's death, and to my registration process as a psychotherapist, meant their losses likely had a more profound impact on my grief (Houlding, 2013). The death of my patient in 'a life retold' will always hold a special place in me. She was my first long term client to have died. This was also no doubt influenced by what could not be said with my Dad before he died a month later. My grief of my 'sensitive soul' was influenced by my previous losses and the strong desire to help this young man which was thwarted.

It is also true that emotional trauma is an existential given due to our human condition, our finitude, we are "siblings in the same darkness" (Stolorow, 2007, p. 47). Stolorow came to this synthesis through his grieving. He was searching to feel deeply understood, he longed for 'twinship'. He referenced this term from the work of Heinz Kohut, and applied it to the reactive longing he felt in relation to "emotional trauma, with its accompanying feelings of singularity, estrangement, and solitude" (Stolorow, 2007, p. 49). He longed to form a connection with someone who knew the same darkness. He wrote:

Although the possibility of emotional trauma is ever present, so too is the possibility of forming bonds of deep emotional attachment within which devastating emotional pain can be held, rendered more tolerable, and, hopefully,

eventually integrated. Our existential kinship-in-the-same-darkness is the condition for the possibility both of the profound contextuality of emotional trauma and of what my soul-brother, George Atwood, calls “the incomparable power of human understanding”. (Stolorow, 2007, p. 49)

I am searching for this twinship and kinship in my personal, psychotherapy and supervisory relationships, so as to feel understood and emotionally attuned to; to find a relational home to be able to process and integrate the emotional trauma, particularly as a bereaved psychotherapist and in response to my reactive need to be taken care of due to my grief. This explication means that how I approach my own psychotherapy and supervision will be forever changed. I will also consider twinship as a treatment approach to the reactive longing due to emotional trauma of my dying and bereaved patients, if this longing is in the space between us.

A model of supervision

I have discovered that in this work I am more humanistic in my approach, without sacrificing my psychoanalytic perspectives. What does this mean? Integral to my need is an oscillation between tending to and recognising how my own dynamics are woken up in the intensity of death situations and also a need to now include myself and the patient as a focus in supervision.

My future supervision, therefore, needs to integrate my grieving process, and given my understanding of the likelihood of an aggressive response if invited into a death situation after a death, also optimally includes the entirety of the therapeutic relationship with the patient. My grief and my guilt call for attuned and sensitive understanding which honours my loss of the patient, honours the patient and holds a self-reflective autopsy process that will hopefully help future patients and my own development. Like actual autopsies which determine the cause of death and find evidence for what was going on for the person in the moment of death, akin to finding an undigested morphine pills in a stomach which suggests a person died in pain (Kalanithi, 2016), I too am sifting through the evidence of our shared last moments and my own feeling resonances. Dying and grieving can lift the veil of defences long held and now overwhelmed to reveal the most vulnerable and private inner world, stripped bare. I gain entry to their sacred place, and I gain entry into my scared place, perhaps in a mutual regression critical for depth therapy (Maroda, 2010). The evidence of this psychological autopsy is not just scientific information on the psychodynamics of the patient, it puts me in connection with who they are and their pain in the moment of their death, and who I am

in my own pain. Autopsies from this perspective are anything but an impersonal objectified cutting open of a cadaver (Kalanithi, 2016).

I am drawn to notice parallels in this research and the process of how I am in supervision and, therefore, can take counsel from what academia says about supervision for autobiographical research. Tenni, Smyth, and Boucher suggested (2003) the criticality of supervision being a professionally intimate and high trust relationship, rather than being distant and objective. A supervisor is responsive to the emotions and impact of the work, and brings proportion and reason to the “vulnerable edge of [my] courageous inquiry” (Ings, 2014, p. 690). The supervision inquiry from this lens not only develops my professional self as a psychotherapist, but draws into close proximity my development as a person. A supervisor’s humanity and authenticity will be valued and privileged over his/her interpretive prowess, although I will appreciate the intellectual and emotional pursuit of this as well.

This immersive process has proven to be invaluable both from an illuminative perspective and in knowing myself in a fuller sense. From multiple perspectives, professional, personal, and ethical, I have come to believe that working with the dying requires the following reflective and supervision formats to sustain my work: ongoing individual psychotherapy, individual supervision which holds both myself and the patients at the core, group and peer supervision to hold a place for my grieving, and lastly group supervision for the team, both to explore and uncover unconscious dynamics provoked through death anxiety, and to foster empathy for each other. Peer supervision, which lacks an authority figure and therefore lacks a protagonist to feeling judgement of what the ‘right’ way to do psychotherapy is, has allowed a freer exploration of myself in relation to the dying.

Know thy self

We must have some understanding of our own blind spots, shame and what we find disturbing about ourselves, lest our contempt for these parts of ourselves enter our therapy rooms and wreak havoc on our ability to be empathetic (McWilliams, 2004). Countertransference can help or hinder treatment and requires in every therapy that the therapist gains insight into their own unresolved and unconscious conflicts (Hinds, 2004), especially when exacerbated by his/her own losses (Colson, 1995).

According to Maroda (2010) in deeper engagements with patients our own emotional themes, primitive feelings will be woken, and with the mutuality of influencing each other, the capacity for both therapist and patient to repeat the past is likely. Thus, it is incumbent on the therapist to discover and be aware of his/her vulnerabilities. No amount of therapy, however, will prevent therapists from the powerful and sometimes destabilising psychological forces that enter the “inter-subjective emotional fray” (McWilliams, 2004, p. 63). I feel this to be a truism especially in death situations. The intensity of both my grief and my countertransference responses to death and dying, and the continued exploration of them in this heuristic process, has deepened my understanding of myself. Grieving and death situations have opened a doorway like no other I have experienced to knowing myself more intimately. My grief has allowed this illuminative depth process and transformation possible.

Know thy self – My tortuous guilt

My solution to alleviate my own suffering, as is common for therapists given the predominance of depressive character styles (Hyde, 2012; McWilliams, 2011), is an introjective one. My family history contributed to my developing depressive character dynamics. I am attuned to loss and sadness to grieve both my own and the intergenerational losses of my family. I seek closeness, connection and intimacy, and resist loss. I feel and express guilt more readily than anger (McWilliams, 2011). In order to survive in my family I needed to be ‘good’. The shadow side is that it created obstacles to integrating my ‘bad’ self, and a more healthy freedom to be an empowered, forthright and uncensored creative being who can speak her emotional self (Klein, 2012). I am also a twin, for me there is always an ‘other’.

Barbara Klein (2012) suggested that being a twin means that we are often on a lifelong journey to recreate the intimacy and intensity of the twinship relationship, in our friendships and in our intimate relationships, which may overburden these relationships. The twin bond is both an affectional and caregiving one (comfort provided for and with) and also an attachment bond which is primary to how I experience myself and others. The bond is tenacious, protective and means I will be forever connected to my sister. Klein suggested that twins are born married and cannot get divorced. A unique strength as a psychotherapist, as a result of being a twin, is, I believe, a greater capacity for intensity, intimacy and attuned sensitivity – I will stay the course. The challenge will be to look after my own self care if the intense need of a patient engages with my ‘married’

and overly responsible self, as this self cannot 'divorce' and separate without considerable anxiety and grief. I am warned to be careful about patients becoming my surrogate twin (Klein, 2012).

Judy Hyde's (2012) both personal and professional research into why therapists choose this career gives voice to a hypothesis that their increased capacity for empathy, interpersonal sensitivity, perceptiveness and insight into distress is seeded in their own distress both personally and interpersonally from their families of origin. Their own survival, triumphs, and awareness of psychological problems coupled with intellect attracts us to being psychotherapists but potentially gives salve to our woundedness and our own unmet psychic needs. Depressive character psychotherapists Hyde argued, with reference to the thoughts of McWilliams (2011), "try very hard to "good" (p. 245), "often handle their unconscious dynamics by helping others" (p. 246) to keep their destructive anxieties and guilt at bay, hear criticism more readily than compliments, and are more likely to attribute therapeutic success to the strivings of their patients and any failures to their own limitations. Repressed negative affects such as anger and aggression if heavily defended against can lead to a psychotherapist who is self-sacrificing or selflessly giving. Depressive psychotherapists are, from Hyde's reckoning, 'the guilty good' of wounded healers. Working in death situations, being of depressive character, and being a twin is like a painful perfect storm for me. My patients die and leave me to my guilt.

Klein (1937) has helped me to really take up my relational space without feeling overwhelming remorse about the impact, to seek a balance between love, guilt and reparative wishes and my own aggression and hate. My continued and on-going developmental task in therapy and supervision is to individuate and to set healthy boundaries. I have come to realise through this process that my increased sense of responsibility does not allow both myself and patients to stand more fully in our own vitality, potency, responsibility and identity.

My own mortality

A poem

Too busy working

Too busy proving myself

Get busy being

Get busy being loved and loving

Get busy becoming known to me and others

The decision to continue with this work

Being a psychotherapist in death situations satisfies my need to do work that matters. The intensity in dying creates an intimacy and perhaps a chaos which satisfies a need in me to be needed at a time where I can also feel honoured to know the dying in profound ways. For those who want to be companioned in their dying process my history has given me the empathy, the sensitivity, and the strength to stay until the end and grieve when they are gone. There are potential rewards, satisfaction and enrichment both from being in respectful relationship with the dying, to ourselves, our personal relationships and to our future patients. Papadatou (2009) believed literature has been too focussed on the hazards of working with the dying whilst neglecting the benefits which temper the distress and the potential for burnout.

To continue in the work, however, I need to be able to mediate the losses and the suffering. My Dad's death left me with fear, a need to be looked after and, as my depictions portray, some painful experiences where my feelings were not held and understood and I felt let down again and again by those whom I believed should be there for me.

Although I offer intimacy and the ability to be known by another, I am not fully known in this process. Unless I can create a life where I can be fully known first by myself and others who are curious and wish to know me more in my personal life, then this is a faux one sided existence. Although my work offers me self-validation, approval and acknowledgement, to live a life where I work too hard, if the focus is too other oriented, to sacrifice my lived life for the dying is also not the way. I can feel my identity changing. A mutuality of relationship has been found to be needed by me via this heuristic research. Grieving and writing this dissertation has had me sacrifice family

time to my own process, to patients and I hear my dangerous mutterings to myself that there will be time later to reconnect more fully to those who matter.

Further call to heuristic research

I could not illuminate all that I wanted to in this process. I am still called to deepen my awareness and understanding of the following:

Long term psychotherapy with the dying – Given the context of my work is within a hospice setting which accepts patients from diagnosis rather than just end of life care, and medical advances mean patients often live longer, then prolonged illness and the concomitant anticipatory mourning and intense grief reactions will more likely result in traumatic stress for therapists (Doka, 2006; Rando, 1993) due to the length and depth of the relationship. This means I will need to identify my own specific strategies for self-care, and to assist with adaptation to the loss of patients who will die whilst still in therapy with me (Doka, 2006). I am particularly drawn to what might promote resilience (Rutter, 1987) in my work.

In regards to my own mortality – I heed the argument of Pinsky (2014) for therapists to act with integrity by challenging their denial of their mortality and to own their limitations, and if possible prepare their patients for their death by taking responsibility for their future bereaved patients. What would that mean to be a good shepherd to my patients?

For the discipline of psychotherapy I would like to see further discussion on:

Continuing bonds – The ghost of Freud still feels near. Neutrality, withdrawal of attachment, bracketing of countertransference feelings and hiding our deeper feelings and needs, hiding who we are, keep us in the paradigm of pathology and not in the realm of real relationship so important to psychotherapy outcomes. The theoretical shift by grief and psychoanalytic theorists from withdrawal of attachment to a changing and continuing bond to what is lost, perhaps needs to be infused into discussions about future theoretical and relational stances, particularly discussions of mutuality in psychotherapy and the reality of therapist grief as a result. From my findings, supervision groups could engender greater vulnerability in psychotherapists and exploration of what mutuality of relationships in psychotherapy means in practice, which also could foster empathy for fellow psychotherapists, particularly when feelings and fantasies are intensely inevitably activated in grief.

Concluding thoughts

To suffer is part of the human condition.

The writing of this dissertation has been an incredibly difficult experience. I have had to intentionally stay in this immersive pain of grief long enough to explicate and synthesise its riches. To convey the experience in words has felt most often tortuous.

I feel empathy, care and love for my patients, their families and my own suffering. Even in their deaths, they are still alive in me. Death does not end relationships. They continue on as long as I continue on. They are alive in these pages, in the work and in relationship to me, and in my companioning others in their dying process in the future. They still influence me.

Is it brave to reveal my humanity in this way or is it an opportunity to influence myself and others in this work? Kalanithi (2006) chose to be brave and continue to influence a new generation of people who care for the dying. Or, as Pinsky (2014) suggested, is it a reproachful call to the profession asking for an emotional context in the profession which can hold attuned understanding and the breaking down of the dismissal and denial of death's impact on therapists and their patients? I am asking psychotherapists to reveal themselves more in their grief, to enter into open communication so as to support normal mourning. I am also asking for theorists to include the reality of therapist grief in their conceptualisations of the therapeutic relationship. Ultimately, I believe that underneath it all my exploration of my grief was an attempt at seeking deeper connection. I felt understood by reading the accounts of other therapists and that is the value of my research to me, and to anyone who may find solace in reading my experience.

Being bereaved left me feeling alone, isolated, and abandoned. I struggled, maybe in an attempt at seeking atonement, to connect to either who had been lost or to those who remained in my world. The suffering that ensued was often affect filled and stimulating to those who I asked to respond, to take care of me, to understand me. This created an environment of either attunement or mis-attunement, and perhaps continuing trauma as a result. It was also the fodder for a deeper understanding of myself. Finding a relational home and context for my emotional trauma that is inevitable in my work with the dying, so that my emotional experiences can be understood and integrated into a coherent meaning making narrative, is needed in both my professional and personal life. Having

a personal life which supports living fully matters, otherwise this work is too hard and painful. It is the emotional moments of meeting in relationship, personally, with patients, with humanity, with what matters, in profound moments that reconnect me with myself and everything, that connect me with what living more fully actually means.

I will continue to struggle, to strive and to learn from each patient and hopefully they will learn from my experience. It is absurd, if not insane, to try to be a 'good' therapist. It is more realistic, and hopefully more valuable, to be a real human therapist. I have no doubt, as I reflect on my patients who have died or who have left, they know that I cared deeply for them and I gave them an opportunity to be known by me. What I offer is an opportunity to be understood, felt, accepted, loved, challenged, witnessed, seen, held, to be real. To laugh, to cry, to have someone be near their pain, confusion and despair. They know they mattered. I gave them I hope more than the gift of my presence.

As I end this writing process, I have come full circle, I feel as I did when I began. I feel a reactivation of the anxieties of guilt, fear and persecution within me due to my critique, and I fear an aggressive response. My fear lacks the intensity it once did. I am curious, compassionate and also a little despondent at being back with Klein, like visiting an old wound with a kind hug and a gentle knowing.

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