Death in the Life and Work of a Therapist

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'Listen, I'm a psychologist, I can handle that...just let me see her...please!' I shouted with all my strength as two male nurses struggled to stop me from entering the room where my partner's body lay. Less than an hour ago I had witnessed the most horrific car accident and had held her head as she breathed for the last time. As the ambulance arrived and the firemen dragged her body out of the ruins, the only sedative that the human organism can produce was beginning to abandon me... Denial was now turning into desperation and my consciousness was initiating its attempts to integrate the loss of my partner of three years. Even though I was convinced that by stating my status of mental health practitioner I would be allowed to say goodbye for the last time, my pompous declaration appeared to have no effect on the hospital staff and all I could do was to watch what was happening like a convict whose sentence is to watch his worst nightmare over and over and over again without even being able to close his eyes ...

Bereavement and Mental Health

As mental health practitioners, bereavement is a common issue that we are often invited to help our patients with. Thanks to Elisabeth Kubler-Ross (1969, 1975), Collin Murray Parkes (1972) and other pioneers who have provided us with invaluable information through their writing and research, psychotherapists and counsellors are today able to draw from a satisfactory number of resources in order to effectively support their clients and assist them in returning to their everyday life relatively unharmed. These resources however, appear to be rather limited when it is the mental health practitioner who is faced with the experience of death and loss.

At the time of my loss, I was serving the Hellenic Medical Corps as a psychologist. My duties included counseling large numbers of newly recruited soldiers on a daily basis. Bereavement was a common issue presented by these soldiers and in many cases I would find myself in a position of suggesting their 'discharge' for a minimum period of

six months in order to allow them to grieve. After six months the soldiers would be re-assessed and would often be sent home for another six months, or perhaps even longer. In my mind the procedure was clear cut when it came to these soldiers, or anyone else suffering from bereavement: offer support and ensure that the individual does not return to their duties –life, work, post etc - unless they feel and are well over their grief. Even then, be prepared to sustain the support and perhaps suggest another period of leave. Bereavement appeared like this severe bone fracture, which took a certain amount of time to heal, and it hurt when touched. It could even leave a permanent scar or limp and that was perfectly understandable when it came to others! Socially acceptable definitions were OK when it came to people or clients ... somehow, though, I was not sure if they were OK when it came to me - and the mental health professional in me in particular!

At the time of the accident I had less than two months left to complete my national service. In addition to the sympathy leave, I made use of whatever leave I had left. This meant that I had little chance to observe the direct manifestation of my loss in my client work. A lot of questions remained unanswered and I was hoping that my Postgraduate training would answer most of them through its teaching, reading, case studies and any other form of learning involved in a 3 year psychotherapy training –and a humanistic-orientated one in particular-. Even though I was offered the opportunity to work on my grief, mostly in my own therapy but also with the precious support of my training colleagues and tutors, the subject of 'The Effects of Bereavement on Psychotherapists and their Client Work' was not once mentioned in any of the suggested reading, never formed part of the taught syllabus and was never the theme of any case study. My need to explore the subject and share my knowledge with my colleagues did not subside. Two years ago I began my MSc on Humanistic Integrative Psychotherapy and gave myself the opportunity to begin looking at some of the issues that had haunted me for almost four years.

The Study

My research was carried out using qualitative methodology and Grounded Theory in particular. It consisted of interviewing six humanistic psychotherapists who lived and worked in London and had been bereaved while in practice, using an open-ended, structured questionnaire, and then transcribing the recorded data in order to extract the recurring themes. This method would fall under the category of analysis known as 'interpretive', since the data makes itself known to the researcher through their interpretation. Therefore the only method of testing the objectivity (known as 'credibility' in field research) of the findings is to share them with several colleagues but also with the participants themselves. My credibility check has revealed that the assumptions put forth by me are appropriate and sound and that the methodology was aptly used to derive the findings that are about to be presented in this article. By no means does that mean that they are either conclusive or absolute; on the contrary, they indicate that the subject would benefit from further research and a larger sample.

The Management of Bereavement

The therapists interviewed and the literature search yielded some common themes. I felt that it was important to explore both the personal and professional management and impact of death, since this agreed with my humanistic philosophy of 'wholeness' and also allowed for a most useful parallel to be drawn; the parallel between a psychotherapist as a mental health professional and as a person. The themes which appeared most often may provide a lead into some commonality. But it is worth mentioning that in no case was any theme shared by all participants. In cases where I felt that my own experience of bereavement resonated or significantly clashed with the derived themes, I have made mention of it.

It appears that following bereavement psychotherapists usually tend to take some time off work. The duration of leave and the reasoning behind it however appears to vary tremendously. Six weeks was the longest leave mentioned and the need to support themselves and their family the most recurrent reason. Personal therapy was amongst the ways that therapists chose to support themselves, its effectiveness varying from *'...not a very successful one...'* to *'...that was quite helpful...'*. A number of therapists also mentioned that their professional knowledge around death and bereavement provided a valuable resource, which helped them reflect on the loss. Even more interestingly -and despite the fact that humanistic therapists do not tend to follow 'models'- most of the participants resorted to a psychological theory to assist them throughout their loss. As an example, some decided to separate their work from their personal lives as suggested by Srtroebe and Schut (1999). At this point I must say that this deeply resonated with my own experience of bereavement, since I remember trying to come up with the answers from any available publication, ranging from 'On Death and Dying' to 'Tibetan Philosophy on Life After Death' and I immediately entered individual therapy -which I personally did not find very useful at the time, perhaps because I was unable to focus on anything or simply because I was not with the right therapist. These feelings of uncontained desperation, experienced by most of my participants and myself are echoed by Wilber in his book 'Grace and Grit', where the bereaved psychoanalyst tries to compromise with the idea of his wife's terminal illness:

'Where was the denial and repression when I really needed it?' (Wilber, 1991: 179)

Today, five years later, I find that I have been able to address my loss in therapy and I no longer read about death to come up with answers but simply to increase my ability to reflectively enhance my understanding of it. The factor, which I feel, mostly contributed to this transformation was time.

In terms of drawing support from their environment, most therapists reported that colleagues who were also friends appeared to be of vital importance throughout their grief. It can be inferred here, that situations such as training, professional bodies and mental health settings may serve as a context which results in a high level of intimacy between mental health practitioners. The nature of the work and sharing may also be said to create situations that other people are less exposed to. This particular factor is, in

my opinion, a distinguishing characteristic between the loss of a psychotherapist and, for example, the loss of a marketing executive. I clearly remember spending a lot of time around colleagues who were also friends at the time and even though I received a lot of support from family and other friends, the opportunity to communicate my loss to a colleague often helped me see things more clearly and recollect myself. On the other hand, one could argue that the exclusivity and perhaps the frequently unspoken emotional supremacy assumed by mental health professionals, may lead to a healing 'self-fulfilling prophecy'. Whichever the case, there appear to be a number of resources which are more available and more frequently used by therapists than other people.

Having briefly looked at how therapists managed their loss on a personal level, I will now focus on some of the ways that the participants dealt with their loss within their practice. The most integral cornerstone of maintaining a healthy relationship with clients appeared to be supervision. One of the participants recalled how she related with her supervisor in order to ensure that she did not contaminate the therapeutic process:

'I spoke to my supervisor and consulted her immediately and actually had a much longer session in supervision with her, firstly just after my father died and I also negotiated with her that if I had clients or counselors, you know, that I felt really wobbly with, I could phone for extra support'.

It is worth noting that supervision was emphasized mostly by less senior practitioners and not mentioned at all by the two participating supervisors in the study. One could probably assume that a senior practitioner will be in less need of supervision than a junior practitioner, however I could not help but wonder whether it had not been mentioned because they did not consider it important or because they did not feel they needed their supervisor's support! One of these senior practitioners who reflectively shed some light on my puzzlement made the following remark:

'As one who's been sitting in the therapist's chair for thirty odd years, ehm...inevitably there is a sort of numbness...that takes place...so for a more senior practitioner, he will want to look at that numbness'

The same two senior practitioners were also the only two who did not hesitate in receiving bereavement related referrals after they returned to work, since they strongly believed that *'...we get the clients we need'.*

Disclosure has been an issue that has been the center of debate for several decades in psychotherapy. Generally speaking, psychoanalytic practitioners appear to consider that a 'blank screen' will facilitate the therapy process, whilst humanistic practitioners appear to be more flexible. The literature I reviewed appeared to suggest that the decision to disclose is a strictly individual choice. Rodman, in his book 'Not Dying', which explores his bereavement around his wife's death writes about disclosing to one of his patients:

'It would have been impossible for her therapy to continue if I did not disclose that information' (Rodman, 1977:78)

On the other hand, Marina Vamos presents four case studies of her work with clients during her bereavement and concludes that:

'Even in retrospect, I find it difficult to be certain whether my patients

should have been informed of my loss and if so, in how much detail, at what time and by whom.' (Vamos, 1993:304)

All but one of the therapists interviewed, reported to have disclosed their grief to their clients. This may in a way support the notion that humanistic psychotherapists are more flexible in disclosing to their clients than other schools of therapy. One of the therapists even reported that the disclosure had played a significant part in the course of therapy:

'He had a breakdown and I worked with the breakdown and part of that involved being more available to the relationship ... so I held him during the breakdown and cried with him and I shared some of my own material ... I also shared with him some of my own bereavement ...'

It is worth mentioning that the above practitioner holds many years of experience as a supervisor, trainer and supervisor and even though I dread at the thought of every therapist following that example, it is my opinion that it portrays the potential of true humanistic practice as well as the fact that bereavement may also serve as a facilitating factor in the therapist's idiosyncratic style. At the same time the decision not to disclose the grief to any clients, made by one of the therapists, was based on the fear of a switch in the therapist-client roles and will be examined further in the next section, since it would fall under the category of 'Impact of Bereavement'.

The Impact of Bereavement

One of the most significant lessons that I acquired from my experience of loss was that for a very long time after the event, my profession played very little role when I had to face my emotions of pain, loneliness, anger and desperation. As I mentioned earlier, therapy, books and any other method that I tried in order to lessen my suffering were unable to soothe my pain during that period. The emotions expressed by the therapists I interviewed, deeply resonated with my memory of those first few months and events such as 'temper tantrums', being physically sick, sleepless nights etc, validated the notion that when faced with such devastating events, mental health practitioners do not differ significantly from anyone else. The social stereotype of the therapist who challenges and confronts her clients and herself in order to promote a strong sense of individuation, appears to become a mere caricature in moments of such extreme pain. One of the therapists recollected how she felt after she lost her husband:

'If...if it's done one thing to me and I always think about it...about the ultimate aloneness of life. And I think that bereavement really brought that home to me, that ultimately you are alone in your body...'

It is worth mentioning that at present the same therapist is actively involved in her professional life and carries out activities such as going on holiday, meeting with friends and leading what would be considered a normal life. It appears, once again, that when the extent of the loss is so devastating, the most crucial healing factor is time.

However, when it comes to a therapist's professional life, time may not be as available as it is in their personal life. The impact of the loss will inevitably manifest itself in the consultation room and clients should not have to contain or be exposed to the consequences that bereavement

has on their 'care-taker'. Following bereavement, the return to the consultation room may present the wounded healer with a significant challenge. Most of the therapists interviewed, and particularly the ones who had suffered the loss of a significant other, such as a partner or a parent, expressed doubt with regards to their ability to ever return to the healing profession. A relationships therapist said that:

'... the immediate aftermath was, I thought, 'I can't possibly go back to doing people's relationship programs, because it just seems just so inappropriate".

Even though fear and self-doubt were evidently present, one of the participants presented me with an interesting 'negative-case'. He reported that despite the loss and pain he experienced, the loss of his grandmother provided him with the opportunity to work with client groups that he had never worked with before. His loss had allowed him to resolve some of his inner conflicts related to sexual abuse and according to him, improved his therapeutic skills, his availability to clients and range of issues he could deal with such as sexual abuse and bereavement issues that he had never before treated. This view is shared by Martin Silberberg (1995) who describes similar consequences on a professional and personal level in his book 'On the Death of my Father: A Psychoanalyst's Memoir'. According to Silberberg, his analytic framework but also his personal issues were dealt with immediately after his father's death:

'It was like making peace with the Oedipal Conflict' (Silberberg, 1995:69)

None of the therapists I interviewed reported to have interrupted their practice, despite the inevitable doubt and hesitation, which was displayed. However, a general position displayed by half of the participants was that their loss distanced them from their practice. The loss of enthusiasm was vividly recalled by one of the therapists:

'I am watching the blank pages on my diary ... there are only two or three clients ... I am trying not to drop it, you know, or let it go ... ehm...it's funny ... just losing it ... losing my enthusiasm, my energy'

Another therapist mentioned how her own loss cast a shadow on the issues of her clients and forced her to distance herself from her work.

'I sort of just stood back and operated it'

The contrast of reactions with regards to the involvement in the work appeared to be very sharp. The three therapists who did not distance themselves from their work, reported a significant increase in empathy:

'I felt in certain sessions there was a level of empathy reached that was almost new to me...ehm...and it was quite facilitative, I think'

Having been unable to examine my own processes in my client involvement after my loss and not having detected any particular determinants of grief which may account for this deep differences, I cannot offer any logical explanation around the reactions of the therapists I interviewed, except that it is possibly a uniquely individual reaction how bereavement impacts on the therapist's involvement in their client work. There appeared however to be a correlation between an increase in empathy and intense feelings of sadness. All three of the therapists who reported an increase of their empathic attunement, also made significant mention of sad emotions arising during the sessions. One of

these participants wondered how transference and counter-transference dynamics were implicated in the consultation room:

'I would think 'Have they triggered?' you know ... Iguess something ... something you know! A place where I'm easily kind of swayed and I feel quite emotional or am I actually emotional because of what they've brought?'

Markedly, the same therapist was the only one who chose not to disclose the loss of his sister to any of his clients and also explicitly commented about the risk of a switch in the therapist client roles. This concern was shared by most of the participants but no one felt that it had actually taken place or hindered the therapeutic process. Givelber and Simon, in their article 'A Death in the Life of a Therapist and Its Impact on Therapy' write about the risks of transference phenomena, which may pose a threat to the therapeutic relation during a therapist's bereavement:

'A problem can arise when the therapist unconsciously (or in part consciously) designates one of his patients to be the replacement for the lost object' (1981: 148)

Most psychotherapists would agree that the processes taking place in the consultation room usually reproduce and represent actual life processes. If this notion is right, then, equally, a therapist's professional cosmos and the learning acquired from it could hold identical value and weight in the course of their existence outside their practice. The conclusive notion, which could be inferred from this theory, is that therapists are not that different from their clients and that they are affected by their experiences in a way similar to all human beings, including their clients. This view was shared by all my participants (including myself, since I was by definition participating in the study). Even though everyone indicated that their experience of loss had greatly brought to the foreground that *'we (therapists) are human too'* one therapist's comments appeared to capture and summarize what I felt a large part of this research was about:

I have learned a lot about the appropriateness of therapists' disclosure and therapists being in touch with their own process and the relation to client work, has widened my understanding of therapists' self support and about the mutuality of client-therapist and therapists needn't pretend it's different.'

Overview

Before presenting the reader with a brief overview of the findings, I must once again emphasize that the breath of the study does not lend itself to conclusive answers. In addition, the determinants of grief (such as the relation to the deceased, time elapsed since the loss, circumstances of death and more) were not integrated into this article due to time and space constraints. Needless to say, that the determinants of grief could be and have been, the focal point of other studies. (Parkes, 1972).

The majority of the participants, including myself, reported to have taken some time off work after their loss. They also resorted to personal therapy, which did not always successfully contain their desperation, and supervision, which ensured that complications in the consultation room could be monitored and avoided, as a means of supporting themselves and their practice. There appears to be no

prescribed amount of time in order to recuperate from the loss and that the bereaved therapists can decide on its duration according to their individual needs.

The compassion of colleagues and psychological knowledge played a significant role in terms of self-support. Disclosure, which did not pose a threat in the cases that it was applied, and bereavement-related referrals, which were accepted by two of the participants, appeared to be a major concern for therapists, some of who also reported an increase in empathy correlated with feelings of sadness within the sessions. In terms of emotions experienced on a personal level, the participants reported desperation and loneliness to be the most overwhelming ones.

A decrease in involvement and an impaired professional image seemed to be a natural effect immediately after the loss, though it was by no means inevitable. In addition, upon returning to work, a fear of switching roles with the client was experienced, but also dealt with, by most participating therapists, even though it did not present an actual hazard for any of them. Finally, the reciprocity in the client-therapist relation and the fact that therapists face similar issues in similar ways to their clients during times of crisis was a notion that was admitted indisputably by most therapists interviewed.

Further Feading

Colson, D. B. (1995) *An Analyst' s Multiple Losses: Countertransference and Other Reactions.* Contemporary Psychoanalysis 31:3: 459-478: USA.

Dickenson, D., Johnson, M. & Katz, S. J. (2000) *Death, Dying and Bereavement.* Sage Publications: London.

Givelber, F. & Simon, B. (1981) *A Death in the Life of a Therapist and Its Impact on the Therapy.* Psychiatry 44:5: 141-149: USA.

Glaser, B. G. & Strauss, A. L. (1967) *The Discovery of Grounded Theory.* Aldine Publishing Company: Chicago.

Kubler-Ross, E. (1969) *On Death and Dying.* Tavistock Publications: Great Britain.

Kubler-Ross. E. (1975) *Death: The Final Stage of Growth.* Prentice Hall: USA.

Lewis, C. S. (1961) *A Grief Observed.* Faber & Faber: UK.

Parkes, C. M. (1972) *Bereavement: Studies of Grief in Adult Life.* (3rd Edition, 1996) Routledge: London

Persons, R. (1990) *Psychotherapist and Widower.* The Psychotherapy Patient 6:3/4: 71-80: USA.

Prochaska, J. O. & Norcross, J.C. (1983) *Psychotherapist's Perspectives on Treating Themselves and Their Clients for Psychic Distress.* Professional Psychology: Research and Practice 14:5: 642-655: USA.

Rodman, F.R. (1977) *Not Dying.* Random House: USA.

Silberberg, M. (1995) *On the Death of My Father: A Psychoanalyst's Memoir.* Edwin-Mellen Press: UK.

Vamos, M. (1993) *The Bereaved Therapist and Her Patients.* American Journal of Psychotherapy 47:2: 296-305: USA.

Walter, T. (1999) *On Bereavement: The Culture of Grief.* Open University Press: Philadelphia

Wilber, K. (1991) *Grace and Grit.* Gill & McMillan. Boston

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