Portfolio Volume 1: Major Research Project

Psychological Therapists' Experiences of the Death of a Parent in Childhood

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Abstract

Research examining psychological therapists' personal experiences of bereavement is limited, despite existing research and anecdotal accounts indicating its profound impact on the self and therapeutic practice. Situated in the context of existing literature on wounded healers and the use of self in therapy, the aim of this qualitative study was to examine the experiences of psychological therapists who experienced the death of a parent in childhood. Seven psychological therapists from a range of professions and therapeutic modalities participated in semi-structured interviews exploring how this experience impacted them personally and professionally, in their therapeutic work with clients. Using interpretative phenomenological analysis, three master themes emerged: *A loss beyond words*; *Navigating in a strange landscape*; and *Something lost, something gained*. These themes reflected how the impact of the parent dying was experienced throughout participants' lives, from childhood through to adulthood, and into their psychotherapeutic practice. Areas of convergence and divergence between these findings and previous theory and research are discussed, particularly with respect to literature on grieving and the self of the therapist. Implications for therapeutic practice, supervision, and training are highlighted, including the importance of self-reflection and supervision in facilitating the use of self, and the value of therapeutic training incorporating self-of-the-therapist work.

Introduction

This research explores the experiences of psychological therapists who experienced the death of a parent during childhood, attending to the impact of this on them both as people and as therapeutic practitioners. It is a qualitative study utilising interpretive phenomenological analysis (IPA; Smith, Flowers, & Larkin, 2009). This chapter will be structured as follows. First, there will be discussion of the language used in this thesis, followed by a statement of my epistemological position and relationship with this research. This will be followed by an overview of the topic area, summarising relevant theoretical and research literature, followed by a more focused systematic review of the literature concerning psychological therapists' experiences of bereavement. Finally, the rationale for the current study will be presented with respect to its relevance to clinical practice and research, followed by a statement of the research aims and questions.

Terminology and Language

As an IPA study, which takes an idiographic approach, close attention to language is important (Smith & Osborn, 2007). Where appropriate (e.g., when quoting participants in the Results section), participants' language will be presented verbatim. In addition, some key terms that are used throughout the thesis are defined as follows.

Psychological therapist: This term is used to refer to people who practice psychological therapy, who have completed a professional training in the practice of one or more psychological therapies, and who work therapeutically with clients. This includes (but is not limited to) clinical and counselling psychologists, systemic family therapists, psychodynamic and psychoanalytic psychotherapists, and cognitive-behavioural therapists. For brevity, the term *therapist* will generally be used.

Client: This term is used to refer to people who have received therapeutic services from psychological therapists. There are differences of opinion regarding this terminology (e.g., Simmons, Hawley, Gale, & Sivakumaran, 2010). Whilst no term may be perfect, and all terms elicit connotations unlikely to be agreeable to everyone, the term *client* is used here because of personal preference, and because it was the term most frequently used by participants.

Death: There are many euphemisms in the English language for death (e.g., Rawlings, Tieman, Sanderson, Parker, & Miller-Lewis, 2017); however, these will be avoided, with the terms *dead*, *died*, or *death* being used instead. The terms *loss* and *lost* may be also be used when emphasising the absence or loss of the person that died, as appropriate. Many participants expressed experiencing significant emotional pain as a result of the dead parent not being openly spoken about. Therefore, euphemisms are consciously avoided as a way of not further contributing to silence and avoidance of this topic.

Childhood: The term *childhood* is used to refer to the period of 0 – 17 years of age. This is consistent with the legally accepted definition of a child in the UK (NSPCC, 2019), as well as the United Nations definition (OHCHR, 1990).

Parent: This term is used to refer to someone's mother or father, whether biological or adoptive. When referring to specific participants, their preferred terms will be used to describe their family relationships (e.g., "mum's partner", "step-father").

Lastly, where appropriate, elements of this thesis are written using the first-person perspective to emphasise my presence, actions, and thoughts as researcher. The third person is used in other areas so that the participants, and the research itself, remains centred. This is consistent with the spirit of IPA, with Smith et al. (2009, p. 109) noting: "Remember the I and the P of IPA; IPA is a joint product of researcher and researched. You are attempting to capture something of the lived experience of your participants but that inevitably invokes interpretations on your part".

Epistemological Position

> "Are cows pink?". "No," says the positivist, "they are black and white or brown – and sometimes combinations, thereof." But to those who have had direct experience with cows know that they can be pink. We have seen them. At sunset, when the sky over a Wisconsin field is rosy and glowing, cows are pink. At that moment and in that particular context, the description of pink for cows is really true. This is phenomenology. (Dahl & Boss, 2005, p. 63)

This research takes a phenomenological approach, where there is less concern with “external reality” or what is “factually accurate”, but rather emphasis is placed on how participants subjectively experience their world and meaning-making (Harper, 2011). With regards to the experiences of participants, the view held in this research is that “although experience is always the product of interpretation, and is therefore constructed, it is nevertheless ‘real’ to the person who is having the experience” (Bailey, 2011, p. 41). At the same time, I acknowledge that an active process of interpretation is taking place, both at the level of participants’ interpretations of their experiences, and also at the level of the researcher, in drawing my own interpretations of the participants’ interpretations (the *double hermeneutic*; Smith & Osborn, 2007).

My Relationship to this Research

A part of what draws me to this research are questions arising from my own experience. I am both a trainee clinical psychologist, and someone who has experienced the death of a parent in childhood. Whilst my relationship with my mother – both her presence and her absence – has changed over time, I feel the impact of her death quite profoundly, both in my personal life and professional context. I carry her with me, and when clients meet with me, they meet with her too. As a relatively new therapist, I wonder how my experiences influence my practice with clients, particularly families, young people, and women and girls who have been similarly bereaved of a mother. I have a desire to produce research, which is currently lacking, that could further elucidate aspects of these experiences, both for myself and other therapists in a similar position: to understand what is common and what differentiates the experiences of therapists bereaved in this way as children, as a means of aiding reflection, uncovering blind spots, and considering ways of drawing on this experience in service of clients.

Overview of the Theoretical and Empirical Context of this Research

Prior to a more focused systematic review of the literature concerning therapists’ personal experiences of bereavement, I will summarise relevant literature in the broader area, to situate this research in its wider context. I will begin by reviewing the concept of the wounded healer and the use of the self in therapy, followed by a brief overview of literature on bereavement, which, due to its size and scope, will be limited to literature concerning experiences of parentally bereaved children.

The Wounded Healer

The concept of the *wounded healer* refers to the idea that people can draw on their own experiences of woundedness in helping to heal the wounds of others. This concept is thought to have existed for at least 2500 years (Zerubavel & O'Dougherty Wright, 2012), with roots in shamanism and ancient Greek mythology (Kirmayer, 2003). More recently, the archetype of the wounded healer was first referenced in modern Western psychotherapeutic practice by Jung, who believed that "diseases of the soul" were the best form of training for healers (Daneault, 2008). Interestingly, Jung's perspective on this shifted over time, with Zerubavel et al. (2012, p. 483) describing, "in his early writings, Jung described therapists' personal struggles as a contamination that must be eliminated, using the metaphor of a surgeon's clean hands, yet later in his career, his conceptualisation shifted, and he wrote that 'only the wounded physician heals' (Jung, 1963, p. 134)".

In illustrating the concept, Jung (1951) drew upon Greek mythology: specifically, the story of Chiron, a centaur grievously injured by an arrow shot by Hercules. Being a god, Chiron was immortal, but as his wound never healed, he had to live with his pain. In learning to live with and accept his own pain, Chiron helped others learn to do this too, becoming known as a legendary healer, finding ways of working alongside his wounds. At the heart of the concept is the idea that "wounded" and "healer" are not dichotomous, but rather that woundedness is something that healers can draw upon in service of healing (Zerubavel et al., 2012). The wounded healer is not able to heal *in spite* of his or her wounds, but *because* of them.

Whilst much has been written about wounded healers from a theoretical perspective, there has been relatively little research in this area. Relevant research can be broadly clustered into two themes: (i) studies examining personal experiences and motivations that draw people to practice psychotherapy; and (ii) studies examining the impact of therapists' wounding experiences on their practice.

Personal Experiences and Motivations to Practice Psychotherapy. A body of research has focused on experiences influencing therapists' career choice. Wounding experiences in childhood, such as early experiences of loss, seem to be common for psychotherapists (Farber, Manevich, Metzger, & Saypol, 2005; Zerubavel et al., 2012).

In interviewing therapists about their personal and professional histories, Barnett (2007) found that early loss experiences, including parental absence or death, were present in the childhoods of all nine psychodynamic and psychoanalytic therapists interviewed. She noted that "without exception, [participants] had experienced periods of loneliness in childhood. They had felt different to and apart from their peers in various ways" (Barnett, 2007, pp. 264-265). Relating this to their career choices, she reflected that "counselling and psychotherapy are solitary professions, but they do afford the opportunity for human contact … thereby avoiding loneliness" (p. 265). This theme of connection was also highlighted by Sussman (1992), in research on career choice motivations in psychotherapists. Fourteen therapists were asked, "What would you guess might be the most common unconscious motivation of your average colleague?". Answers often reflected themes of desiring meaningful and intimate connection, and wanting to feel affirmed and affirm others. However, it is important to recognise that these studies have used small, self-selected samples of psychodynamic or psychoanalytic therapists, limiting the generalisability of the findings.

Nonetheless, there is some evidence to suggest that psychotherapists may be more likely than people in other professions to have had wounding experiences in early life. Fussell and Bonney (1990) compared childhood experiences of 42 male psychotherapists and 38 male physicists with equivalent years of educational and professional experience. Relative to physicists, psychotherapists were statistically significantly more likely to report, during their childhoods: greater parental absence, greater caretaking responsibilities, and feeling unhappier. A further self-report questionnaire study (n = 2963) found that compared to women in other professions, female mental health workers reported higher rates of childhood trauma (including physical and sexual abuse), bereavement, and parental mental health difficulties in their family of origin (Elliott & Guy, 1993). Additionally, Murphy and Halgin (1995) found that relative to social psychologists (n = 53), clinical psychologists (n = 56) were more likely to report difficulties during childhood within their families (e.g., parental absence or death, abuse, neglect, family conflict, physical and mental health problems, being a young carer). Interestingly, these experiences were not reported as particularly influential to the career choice of most participants. More recently, a study (*n* = 3577) examining therapists' motivations found that in response to the question, "To what extent do you feel that your development as a therapist has been influenced by the motivation to explore and resolve your personal problems?", 48% of respondents answered "very much" or "much", with only 16% answering "not at all" or "slightly" (Orlinsky & Rønnestad, 2005). With respect to these differing findings, one explanation may be that differences in questionnaire design could have influenced the extent to which participants could meaningfully explore complex issues such as career choice. Moreover, social desirability bias could have influenced responding: therapists may have felt reluctant to express motivations relating to resolving or understanding personal issues.

The Impact of Therapist Woundedness on Clinical Practice. Several studies have examined the impact of various wounding experiences on psychological therapists and their practice, including therapist experiences of physical illness (Counselman & Alonso, 1993) and cancer (Lee, 2016), difficulties in their family of origin (Racusin, Abramowitz, & Winter, 1981), psychological struggles (Telepak, 2010), eating disorders (Costin & Johnson, 2002), and divorce (Johansen, 1993). Positive impacts on practice included increased empathy, patience, and understanding; and negative impacts included difficulties with the therapist remaining emotionally present, over-identification, and projection (Zerubavel & O'Dougherty Wright, 2012). In the area of alcohol and drug addiction, Zerubavel and O'Dougherty Wright highlight that lived experience of addiction is common and/or preferred for the therapist, acknowledging that "the wounded healer is recognised for playing a distinctive role as a provider" (p. 483).

Nonetheless, it is interesting to notice that whilst there is some research on therapists' personal experiences of the kinds of events which often bring clients to therapy, this research is limited: only a small number of studies have examined therapists' personal experiences of wounding life events. This may simply represent a gap in the literature, or it could reflect a reluctance of professionals to own the same wounded status as the clients that they serve. Indeed, Martin (2011, p. 10) has argued that "for many therapists, woundedness is a hidden secret. This deceit is sometimes masked as 'professionalism'". Given the extent of theoretical literature concerning wounded healers and the self of the therapist, it is noteworthy how little attention this topic has received in empirical research.

The Self of the Therapist

Whilst the wounded healer concept focuses on drawing upon personal wounds in service of clients, ideas around the *self of the therapist* have been developed to demonstrate how practitioners can use the self in therapy more broadly. Whilst the wounded healer has tended to receive most attention in psychoanalytic literature (Miller & Baldwin, 2013), the self of the therapist is a concept that has flourished most within systemic family therapy (e.g., Andolfi, 2014; Aponte & Kissil, 2014; Satir, Banmen, Gerber, & Gomori, 1991), where therapists are seen as “unavoidably part of the system as participant observers” (Cheon & Murphy, 2007, p. 5).

For example, in the Satir model of family therapy (Satir et al., 1991), Virginia Satir strongly advocated for the use of the therapist’s self in therapy, and this formed a significant part of her training programmes (Lum, 2002). She emphasised the importance of congruence, believing “therapists will not become congruent if they neglect to work through their own issues because of discomfort, avoidance, resistance, or denial … therapists model the possibility of how to stay more connected with themselves” (Lum, 2002, p. 182). Focusing on how therapists can use personal struggles in service of clients, Aponte’s person-of-the-therapist model (Aponte, 1982) proposes that all therapists have a “signature theme” relating to their woundedness, suggesting:

> …however “resolved” we may be, we all carry within us in some form another our own core issues (signature themes) that colour how we see, feel, and function … it is critical for therapists to get hold of that “wounded” part of themselves, and learn to work with and through their signature themes to consciously and purposefully utilise them for their therapeutic tasks. (Aponte & Kissil, 2016, p. 162).

Thus, therapists’ wounds are not seen as hindrances; rather, they have potential to greatly facilitate therapists’ ability to empathise with and differentiate from their clients (Aponte & Kissil, 2014). However, within family therapy, there are differences of opinion in how the self-of-the-therapist is conceptualised. Whilst some identify the self as an important source of humanity which increases therapists’ sensitivity and contributes positively to the therapeutic relationship (Cheon & Murphy, 2007), others believe that the self may compromise the therapist’s ability to work effectively unless issues are “worked through” or "resolved", with the idea that "therapists cannot facilitate developmental change in clients that exceed the therapist's own limits" (Blake Horne, 1999, p. 386).

Nonetheless, research on the self of the therapist is extremely limited (Lum, 2002). Thus far, it has tended to be organised by the "common factors" versus "specific factors" debate in family therapy, around whether general factors or model- or therapist-specific factors contribute to therapy outcome. However, most reviews in this area point to not just a lack of research, but also significant deficiencies in the quality of studies (e.g., Sexton, 2007; Simon, 2006).

Bereavement and the Death of a Parent in Childhood

One particularly powerful wounding experience, which is common for both therapists and their clients to experience, is the death of a loved one. When someone dies, the impact on those still living can be profound and indelible. Experiencing a significant bereavement can engender changes in one's identity, sense of self, and existential understanding (Broadbent, 2013). Whilst death is an inevitable part of all of our lives, childhood bereavement, and specifically, the childhood experience of a parent dying, is a more unusual experience that can bring about some different challenges. Data from a cohort study of approximately 11,000 people born in 1970 in the UK suggest that one in 20 (4.7%) young people will have experienced the death of one or both parents by the age of 16 (Parsons, 2011).

The death of a parent in childhood represents not only an emotionally traumatic event, but also the loss of a significant relationship through which young people are able to explore their identity and define themselves in terms of contrast and continuity with parents (Tyson-Rawson, 1996). The interaction between development and bereavement is highly complex, with studies demonstrating impacts in a range of areas, including psychological functioning, relationships, and identity development (e.g., Balk & Vesta, 1998; Cerniglia, Cimino, Ballarotto, & Monniello, 2014; Schultz, 2007; Tracey, 2011). Nonetheless, there is much still to be learned about the impact of parental death in childhood (Schultz, 2007). However, as Tyson-Rawson (1996) argued when writing about the death of a parent in adolescence,

> …it would be impossible to say that the experience of parent death leads to any single outcome. Rather, the experience of loss during this stage of the life cycle is unique to this

> period, and its outcome is isomorphic to the complexity and richness of adolescence itself. (pp. 156-157).

Systematic Review of Relevant Literature

In order to locate research particularly relevant to the topic of this study, a systematic review was conducted to identify research concerning therapists' experiences of personal bereavement and the impact of this on therapeutic work with clients. Despite the current study focusing on therapists who experienced the death of a parent in childhood, I decided to conduct a broader search about therapists' experience of personally significant bereavement more generally, due to the limited existing research.

The search was conducted across nine bibliographic databases in October 2019. Via the University of Hertfordshire, searches were performed in Scopus, APA PsycArticles, and PubMed. Via NHS England Open Athens, searches were performed in Health Databases Advanced Search (searching PsycINFO and EMBASE) and EBSCO Host (searching MEDLINE, MEDLINE Complete, CINAHL, and the Psychology and Behavioural Sciences Collection).

To identify relevant articles, a search strategy was developed to retrieve records containing keywords relating to both (i) psychological therapists and (ii) bereavement. To inform this process, titles and abstracts of papers previously identified as relevant were examined in order to identify common words that would capture these papers in a database search. Several pilot searches were evaluated in developing the final search strategy, which met a good balance between efficiency and inclusivity. The search strategy is presented in Appendix A.

The procedure for the systematic review was as follows, with a flow chart depicting the study selection procedure presented in Figure 1. Search results were exported from bibliographic databases and imported into reference management software, and duplicate records were removed. Titles and abstracts were screened according to the inclusion and exclusion criteria in Table 1, and then the full texts of the remaining articles were evaluated against the criteria for inclusion in the review.

Inclusion criteria	Exclusion criteria
Published in the English language	Focused on bereavement in professional context only (e.g., client suicide)
Reporting original peer-reviewed qualitative or quantitative research	Personal reflection or anecdotal account (i.e., not research)
Participants are psychological therapists	
Focused on psychological therapists' personal experiences of bereavement (i.e., relevant topic area)	

Table 1. Inclusion and exclusion criteria for the systematic review.

After duplicates were removed, a total of 1464 articles remained. Following screening of titles and abstracts, 1423 articles were excluded, and 41 articles remained for full-text screening. Of these, four articles met the criteria for inclusion in the review. The reference lists of these articles were hand-searched to check for any further articles that met criteria.

Given the limited number of original research articles focused on the topic of psychological therapists' personal experiences of bereavement, I decided to provide a detailed summary of these four articles, as well as a summary of themes emerging from the 12 articles identified as personal reflective accounts following full-text screening (i.e., articles otherwise relevant to the topic area that were not research studies).

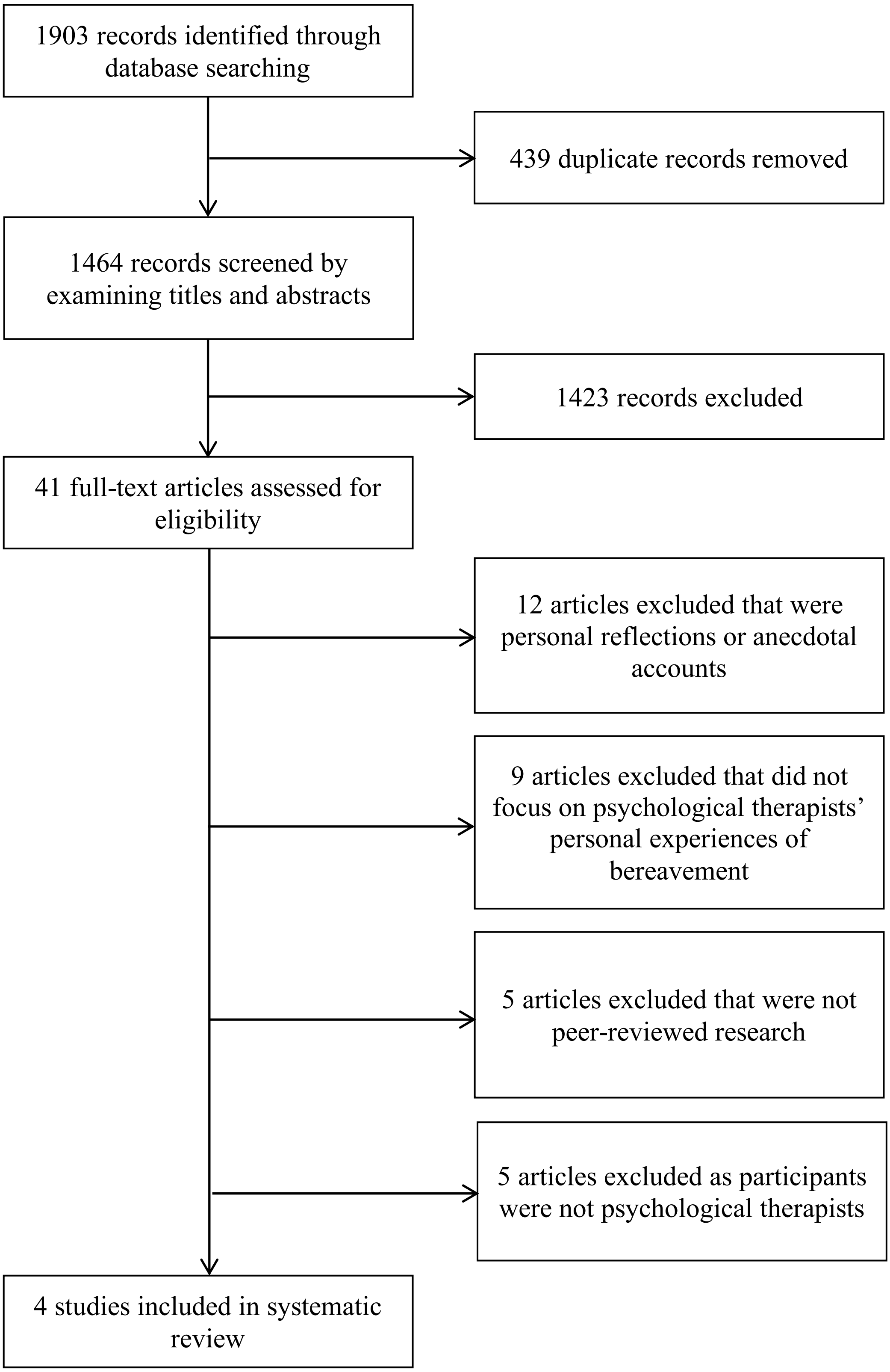

Figure 1. Flow chart for the study selection procedure.

Overview of Literature

Prior to detailed discussion of the methods and findings of the four studies identified in the systematic review, a brief overview of their aims and scope is given below. A summary of each study is presented in Table 2.

There were three qualitative studies and one quantitative study. The quantitative study, which was conducted in the USA using postal questionnaires, examined correlations between bereaved therapists' sense of grief resolution, and client ratings of therapist empathy, credibility, working alliance, and session depth (Hayes, Yeh, & Eisenberg, 2007). The three qualitative studies were conducted in the UK, and all examined experiences of trainee or qualified therapists who had experienced a significant bereavement, either whilst or before working as therapists. Two of these studies focused on the personal experience of loss, as well as the impact on therapeutic work (Broadbent, 2013; Kouriatis & Brown, 2013) and used IPA; whereas one focused more on the personal experience of loss, and to a lesser extent, how it impacted the experience of psychotherapy training (Stewart & Thomas, 2018), using heuristic inquiry.

In terms of the types of bereavement examined across the four studies, three did not restrict either the type of bereavement (other than it needing to be personal and significant), or the timing (whether it occurred in childhood or adulthood, or whilst working as a therapist). However, one study (Stewart & Thomas, 2018) had a more specific focus, exploring female psychotherapy trainees' experiences of maternal suicide in adulthood. The methods and results of these studies will now be discussed in greater detail.

Author(s), year published, location	Participants	Research design and method	Key findings	Strengths and limitations
Hayes, Yeh, & Eisenberg (2007) USA	69 therapists who had experienced death of a loved one, and 69 of their clients (i.e., 69 therapist-client dyads). Therapists working from a range of therapeutic modalities. Mean time since therapists' bereavements was 15 years.	Correlational study using self-report questionnaires, examining relationship between therapists' "grief resolution" and client ratings of therapist empathy, credibility, working alliance, and session depth. Questionnaires sent to therapists specifying bereavement therapy as an area of speciality, as identified through various online databases. Eligible therapists instructed to pass further pack of questionnaires to their next bereavement therapy client.	Greater therapist empathy (as rated by clients) associated with (i) therapist reporting more "resolved" grief, and (ii) therapist reporting less current distress about missing their loved one.	Strengths: Examined experiences of client in addition to experiences of therapist, examining concept of "wounded healer" from client's perspective. Limitations: Issues with generalisability of findings due to low response rate from therapists, and some clients not returning questionnaires. Limited range of scores of clients' ratings of therapists (mostly rated very positively).
Broadbent (2013) UK	4 humanistic therapists who had experienced a close family (child, parent, or spouse) bereavement before or during their work as therapists.	Qualitative study (interpretive phenomenological analysis) using semi-structured interviews. Interviews explored participants' personal experiences of bereavement and the impact of this on their therapeutic practice.	Four master themes of (i) bereavement as a unique experience, (ii) re-learning the world, (iii) personal and professional synergies, and (iv) impact on therapeutic practice.	Strengths: Study allowed for broad exploration of a range of different bereavement experiences in an open-ended manner. Limitations: Participants were limited to therapists working from a humanistic modality only.

Kouriatis & Brown (2013) UK	6 therapists who had experienced significant personal loss (including but not restricted to bereavement). Therapists working from a range of therapeutic modalities (3 integrative, 2 psychoanalytic, and 1 systemic).	Qualitative study (interpretative phenomenological analysis) using semi-structured interviews. Interviews invited participants to reflect on their personal losses and the interaction with their therapeutic work.	Three master themes of (i) the grieving therapist, (ii) hindrances in grieving, and (iii) impact of loss on therapeutic work, including advancements and challenges.	Strength: Research method and interview structure allowed participants to speak more freely about a range of experiences of loss that felt relevant to them. Participants worked from a range of therapeutic modalities. Limitations: Research participants were mostly known to the researchers personally, potentially influencing what they may have felt comfortable disclosing.
Stewart & Thomas (2018) UK	2 final-year integrative psychotherapy trainees whose mothers died by suicide, plus researcher with her own personal experience of this.	Qualitative study (heuristic inquiry) using unstructured interviews. Interviews were conversational in nature as per recommendations for heuristic enquiry.	Five main elements were identified: (i) it's not just about the suicide; (ii) the pain continues – attachment, abandonment, and fear; (iii) left with all the unprocessed feelings – "the shit"; (iv) trigger after trigger – complicated experiences of psychotherapy training; (v) a catastrophic loss that no-one "gets".	Strengths: Analytic method allowed for rich and detailed exploration of the phenomena. Limitations: preliminary, exploratory study with very small sample size of trainees only. Restricted to suicide bereavement (which is aim of study), but findings may not speak to other kinds of bereavement. Focused primarily on personal impact rather than influence on therapeutic work.

Table 2. Summary of studies included in the systematic review.

The Personal and Professional Impact of Bereavement on Therapists

Just three peer-reviewed studies have examined the impact of bereavement on therapists' personal and professional selves. The first of these studies was by Broadbent (2013), who explored bereavement experiences of four humanistic therapists. In semi-structured interviews lasting between 45 minutes and two hours, she focused on participants' personal experiences of bereavement and the impact this had on their therapeutic practice. All participants were women, aged between 35 – 55 years old, who experienced a significant bereavement (of mother, daughter, or spouse) either before or during their time practising as therapists. Although the causes of death were not specified, three of the four bereavements were described as "traumatic".

In her IPA analysis of the transcribed interviews, Broadbent identified four master themes, which she contextualised within the framework of time, recognising the evolving process of grief, and change over time in personal and professional development. The first theme, *bereavement as a unique experience*, reflected both the emotional impact of the bereavement (e.g., different emotional responses, how grieving changed over time), as well as how the bereavement impacted participants' sense of self and social identity (e.g., feeling supported or let down, feeling stigmatised). The second theme, *re-learning the world*, focused on adjustment to life following bereavement, including processes of personal growth and reconstruction of the sense of self following loss. This theme also reflected experiences of "being heard and witnessed" in this process by others. The third theme, *personal and professional synergies*, reflected how participants integrated their personal experiences of bereavement with their therapeutic role, and the value of supervision in facilitating this. The final theme, *impact on therapeutic practice*, reflected the significant impact that participants' bereavements had on their work with clients, and how this changed over time with respect to their own personal and professional growth. This theme also reflected participants' feelings around self-disclosure with clients.

In drawing these themes together, Broadbent (2013) concluded that whilst bereavement undoubtedly affects both the personal and professional lives of therapists, a sense of movement along one's own journey of healing is critical in enabling therapeutic support of others. She states,

> …in order to draw upon the 'touchstones' … of their own experience in the service of their clients, therapists need to have arrived at a place in their own healing process that enables them to facilitate an empathic therapeutic relationship with clients whose material may have personal resonances. (Broadbent, 2013, p. 270)

In facilitating this process, Broadbent (2013) emphasises the importance of continuing personal and professional development, as well as good-quality clinical supervision.

The second study examining therapists' personal experiences of loss and the relationship with therapeutic work was conducted by Kouriatis and Brown (2013). In semi-structured interviews lasting up to one hour, participants shared information about a loss or losses they deemed personally significant, and elaborated on the relationship between these loss experiences and their therapeutic work. Six therapists were interviewed (four male, two female), from a range of white ethnic backgrounds (white British, white European, and white Irish). Three therapists were described as integrative, two were psychoanalytic, and one was family-systemic. In terms of professional experience, the mean duration of practice was 15 years, with a range of five to ten years. As the authors intended participants to determine what losses were personally significant, participants spoke about a diverse range of experiences. All spoke about at least one kind of bereavement (parent's death, spouse's death, client's suicide, personal therapist's death) but other forms of loss were also discussed (e.g., relocating to a new country, having a child diagnosed with schizophrenia, relationship break-ups, a parent having dementia). Although the authors did not explicitly share the age at which bereavements occurred, it appears that the majority occurred when participants were adults, working in therapeutic practice, although one participant spoke about the death of her father in her late teens.

Like Broadbent (2013), Kouriatis and Brown (2013) used IPA to analyse interview transcripts, identifying three master themes: *the grieving therapist*, *hindrances in grieving*, and *impact of loss on therapeutic work*. The first theme, *the grieving therapist*, reflected participants' experiences of grief and coping. Participants spoke about different ways in which grief was experienced across psychological, physical, and relational domains. Coping experiences also varied, with participants identifying support from others, carrying on or taking breaks from work, seeing clients, and making sense of their loss, as things that were helpful. The second theme, *hindrances in grieving*, reflected obstacles that some participants experienced in grief. Some were described as arising from others (e.g., losses not being recognised by others, not finding others supportive), whereas others were described as originating from the self (e.g., avoidance of grieving, not recognising own needs). The final theme, *impact of loss on therapeutic work*, reflected different challenges and advancements that participants perceived as arising from their loss experiences. Challenges included participants feeling emotionally vulnerable in therapeutic work, and over-identifying with clients. Advancements included an increased ability to "walk alongside" clients and give space to their experiences; increased empathy, insight, and awareness; and increased confidence and bravery as therapists.

In addition to highlighting diverse ways that therapists experience loss and grief, Kouriatis and Brown (2013) suggest that their study highlights the significance of personal loss experiences in therapists' professional practice, in light of the numerous ways in which these experiences impact therapeutic work. As such, they argue for the value of further research in this area, given its relevance to clinical practice. With respect to their finding about risks of over-identification with clients, they also emphasise the importance of research with therapists working with clients who have had similar loss experiences.

The third study examining therapists' experience of bereavement was conducted by Stewart and Thomas (2018), focusing on female trainee psychotherapists whose mothers had died by suicide. Adopting a heuristic inquiry approach, the first author drew on her own experience of maternal suicide, synthesising this experience with those of two participants: two female integrative psychotherapy trainees who experienced maternal suicide during their twenties. Both participants completed unstructured interviews lasting approximately two hours.

Findings were presented within a narrative framework, with five themes identified across the three stories (of the first author and both participants). The first theme, *it's not just about the suicide*, reflected the sense that suicide was just one part of the picture, with other difficulties existing within family relationships beforehand. The second theme, *the pain continues – attachment, abandonment, and fear*, referred to experiences after the bereavement, reflecting difficulties in trusting others and fearing abandonment. The third theme, *left with all the unprocessed feelings – "the shit"*, reflected intense and overwhelming feelings that had previously been swallowed, but were now experienced as indigestible. The fourth theme, *trigger after trigger – complicated experiences of psychotherapy training,* referred to challenges during training, such as emotional responses to client work and course endings, and relational difficulties with tutors. The final theme, *a catastrophic loss that no-one "gets"*, reflected participants' deep pain about the irreplaceable loss, feeling misunderstood and alone.

In exploring the implications of these findings, Stewart and Thomas (2018) highlighted the importance of trainers of being sensitive to issues that people bereaved by suicide may have in experiential groups, particularly regarding trusting others and feeling misunderstood. They also recommend that training institutions are aware of additional support that these trainees may need, showing consideration to the emotional challenges of endings for this group. Lastly, they draw attention to the lack of research in this area, highlighting the value of further research, using alternative qualitative and quantitative methods, that explores experiences of bereaved therapists.

The Impact of Therapist Bereavement from Clients' Perspectives

The final study identified through the systematic search was a quantitative study by Hayes et al. (2007), aiming to explore countertransference in bereavement therapy by examining correlations between clients' experiences of bereavement therapy and bereaved therapists' grief. The authors used online databases to identify 500 therapists specialising in bereavement, who were posted details of the study and questionnaires. Questionnaires were returned by 128 bereaved therapists, who were asked to give questionnaires to their next bereavement therapy client: of these, 69 clients returned questionnaires. Therefore, the final sample was 69 therapist-client dyads.

To assess therapists' grief resolution, therapists completed the Present Feelings subscale of the Texas Revised Inventory of Grief (TRIG; Faschingbauer, Zisook, & DeVaul, 1987). This was a 13-item subscale assessing "thoughts, feelings, memories, opinions, and attitudes" about grief in the present day (Fachingbauer et al., 1987, p. 120). Due to the breadth of this scale, Hayes et al. (2007) performed a factor analysis and proposed a two-factor solution, with items loading onto an "Acceptance" factor (the degree to which respondents felt acceptance of the death and their associated feelings) or a "Missing" factor (the degree to which respondents missed the deceased person). To assess clients' experiences of bereavement therapy, clients completed the Empathy subscale of the Barrett-Lennard Relationship Inventory Form (BLRI-E; Barrett-Lennard, 1962) to measure their perceptions of therapist empathy; the Counsellor Effectiveness Rating Scale (CERS; Atkinson & Carskaddon, 1975) to measure perceptions of therapist credibility; the Working Alliance Inventory – Short Version (WAI-S; Tracey & Kokotovic, 1989) to assess perceptions of the therapeutic relationship; and the Session Evaluation Questionnaire-Depth (SEQ-D; Stiles, & Snow, 1984) to assess perceptions of the depth of their therapy sessions.

Multiple regression analyses were conducted to examine correlations between therapists' "Missing" and "Acceptance" scores, and the client-rated variables. Only one statistically significant association was found, which was between therapists' "Missing" scores and clients' perceptions of therapists' empathy (BLRI-E scores). The more therapists indicated that they were missing their deceased loved one, the less likely they were to be rated as empathetic by their clients. Therapists' "Acceptance" scores were not statistically significantly associated with any client-rated variables.

Hayes et al. (2007, p. 351) suggested that if therapists' "emotional energy is tied up in an unresolved personal issue such as grief, clients may perceive therapists to be less available and understanding". They suggest the finding that therapists who have "resolved" their grief about missing a loved one are more likely to be rated as more empathetic by clients is consistent with the wounded healer hypothesis: "Losing a loved one and working through the emotional pain of missing that person can serve as a basis for enhanced empathy with clients who are also dealing with the death of a loved one" (p. 351). Recognising methodological limitations, the authors highlight clinical implications, suggesting that attention should be paid to the degree to which therapists feel "resolution" of their personal issues, particularly when working with clients experiencing similar difficulties. However, as the "acceptance" aspect of therapists' grief was unrelated to all client-rated variables, and the "missing" aspect was uncorrelated with some client-rated factors such as the therapeutic alliance, this suggests that the picture here is not entirely clear. Further research would help elucidate the relationship between therapists' bereavement and clients' experiences.

Critical Evaluation of Study Quality

The quality of studies included in the review was evaluated using the quality assessment guidelines developed by Elliott, Fischer, and Rennie (1999). Whilst these guidelines place particular emphasis on assessing factors contributing to good quality qualitative research, the authors recognise that both qualitative and quantitative research share commonalities when it comes to good research practices. As one of the four identified studies was quantitative and three were qualitative, this tool allowed for efficient evaluation and comparison of all studies together against some of the same indices. Appendix B contains a summary of the evaluation of the studies against the Elliott et al. (1999) guidelines.

In summary, all studies were deemed to contribute in a meaningful way to the knowledge base and were generally clear in presentation style. However, Broadbent (2013) was less clear in stating her research questions and contextualising her study alongside relevant theory and existing literature, and Stewart and Thomas (2018) did not adequately specify how their findings could link back to theory and existing research. Nonetheless, all qualitative papers were deemed to have good coherence and resonance.

On the whole, methods used in the four studies were suitable for the articulated aims, and were mostly specified in a way allowing for adequate replication and evaluation. However, questions could be raised about aspects of the method utilised by Hayes et al. (2007), who purportedly investigated countertransference in bereavement therapy. The authors used quantitative questionnaires to examine client-rated factors about the therapist and therapy process, alongside therapists' own ratings of their "grief resolution". The authors operationalised this measure of "grief resolution" as "countertransference", explaining that "therapists' reactions to clients may be adversely influenced by therapists' unresolved personal conflict" (p. 346). Arguably, this operationalisation is overly simplistic and not adequately reflective of the concept of countertransference (Hayes, Gelso, Goldberg, & Kivlighan, 2018), potentially undermining conclusions drawn from the data. Moreover, Hayes et al. (2007) used questionnaires from the 1970s and 80s to operationalise their variables; it is possible that newer measures may have been more appropriate to evaluate factors (such as the working alliance) in contemporary psychotherapy. Furthermore, whilst Stewart and Thomas (2018) gave a detailed overview of the different phases involved in heuristic inquiry, specific examples of what they did at each stage were only given for certain phases of the method. As such, methodological details were ill-specified at times, potentially hindering readers in their evaluation of the study's credibility.

Most studies clearly articulated details of how ethical responsibilities towards participants were fulfilled. However, Hayes et al. (2007) did not provide information about the informed consent procedures for their client participants, only explaining that therapist participants "were asked to give a packet [of questionnaires] to the next client with whom they were addressing grief issues" (p. 349).

All three qualitative studies had issues with adequately situating the sample; that is, giving sufficient descriptive and contextual information about participants (Elliott et al., 1999). Participant ages or age ranges were missing from some studies (Kouriatis & Brown, 2013; Stewart & Thomas, 2018), as were participant ethnicities (Broadbent, 2013; Stewart & Thomas, 2018). Whilst all studies provided information about therapists' preferred modality, some also gave information about therapists' degree of experience (Kouriatis & Brown, 2013; Stewart & Thomas, 2018); however, information about length/level of experience was omitted from one study (Broadbent, 2013).

In terms of the degree to which authors of the qualitative studies "owned their perspectives" (i.e., recognised and disclosed their own values, interests and assumptions that could influence their understanding of the matter under study; Elliott et al., 1999), two studies explored these issues (Kouriatis & Brown, 2013; Stewart & Thomas, 2018), but one study (Broadbent, 2013) did not contain any reference to what drew the author to the research, or discussion of personal and/or professional experiences that could influence interpretation of the subject matter.

On the whole, the qualitative studies were reasonably good at grounding interpretations in examples from the data. However, one study (Stewart & Thomas, 2018) made less use of examples, tending to use only brief phrases as quotations, and only relatively few of these. For example, one participant was only quoted four times, with two of these quotations being brief phrases of only a few words.

Synthesis of Personal Reflective Accounts

In addition to the four peer-reviewed published research articles identified by the systematic review, 12 further published articles (book chapters and journal/magazine articles) were identified, which were reflective accounts written by therapists with personal experience of significant bereavement. A summary of key details from these accounts is included in Appendix C. These were not included in the main review as they did not report any formal research (conducted either with other participants, or with themselves using an approach such as autoethnography). Nonetheless, given the limited research that exists to situate the current study in its context, key themes from these reflective accounts are presented below, which were generated following a brief thematic analysis (Braun & Clarke, 2006). After reading through each reflective account to become familiar with the content, a written summary was produced to provide a condensed overview of key points raised in each account. Next, these summaries were reviewed together to identify broader themes that appeared across multiple accounts. These themes were then reviewed against the original accounts to check for fit, and were refined or adapted as necessary, before being labelled and illustrated as follows.

The Lived Experience of Bereavement and Grief. All accounts explored, at least to some degree, the experience of bereavement for the authors as people (as opposed to in their therapeutic roles), but some accounts placed particular emphasis on exploring personal experiences of bereavement unrelated to professional context (e.g., Allphin 2018; Chasen, 1996; Galgut, 2013). Speaking about her mother's suicide during her childhood, Allphin (2018) reflected on the impact of responses from others in the aftermath of her mother's death, referring to the "silence [her] family kept around the suicide" (p. 643) and the difficulty that people had in attending to her emotional needs because of their own struggles: "dissociated caregivers teaching dissociative skills" (p. 644). Many authors also described changes in grief experiences over time (e.g., Callahan & Dittloff, 2007; Chasen, 1996), or grief increasing at significant milestones (e.g., Galgut, 2013). For example, Galgut (2013) reflected on how her experience of grief after her mother's death was not linear ("16 months after her death, in some key ways I am struggling even more than I was when she first died", p. 22). A number of authors also reflected on developing an increased understanding of psychological experiences associated with grief, for example, understanding how childhood bereavement can lead to a desire to feel in control ("I wanted desperately to have nothing change, ever again", Warshaw, 1996, p. 209), and the experience of intense emotions such as anger (e.g., Allphin, 2018; Callahan & Dittloff, 2007; Warshaw, 1996).

Integrating the Experience of Bereavement into Professional Identity. Regardless of the age at which the bereavement occurred, all authors spoke of their experiences integrating their experiences of bereavement into their identity as therapists. Murray-Swank (2019) described significant challenges in working towards this integration ("struggling through a dark room, trying to find a way through, but uncertain about how to navigate the territory", p. 189). Both Murray-Swank (2019) and McDonald and Grau (2019) spoke of difficulties finding and utilising support from colleagues to assist with this process. Warshaw (1996) described using personal therapy to help with this process of integration. Some authors who experienced bereavement earlier in life recognised this as directly motivating them to become a therapist (e.g., "I wanted to turn my own tragic loss into something meaningful", Osband, 2016, p. 113).

The Challenges and Benefits of Being a Bereaved Therapist. All authors reflected on advancements and challenges that their experiences of bereavement gave to their therapeutic practice. A major theme common to many accounts was an increased sense of empathy and connection with clients (Chasen, 1996; Colson, 1995; Galgut, 2013; Horwell, 2019; McDonald & Grau, 2019; Osband, 2016; Rosenfeld, 2016); for example, Galgut (2013, p. 21) expressed, "I'm not sure where this supersized empathy comes from, but it seems to be born of an emotional rawness in me which, if I can contain it adequately, I can use to good effect". Chasen (1996, p. 9) spoke of increased empathy for feelings of despair following the accidental death of her 12-year-old son: "now I fully understand why the thought of suicide is so very comforting". This increased capacity for connection was described by Horwell (2019, p. 161) as, "Listening. Not like before. Listening. As if the volume's turned up". Other authors reflected on empathy having two sides, with Osband (2016, p. 113) reflecting, "whereas at times [the bereavement] enables me to empathetically relate to my patient, there are also times when it interferes" (Osband, 2016, p. 113).

A further identified benefit concerned therapeutic lessons learned from personal experiences. For example, following the accidental death of her 13-year-old daughter, Osband (2016) gained an appreciation that "grief is a process, not a problem to be solved" (p. 122). Galgut (2013, p. 22) reflected on how personal experiences informed professional understanding of "madness", saying, "I have also taken comfort from my own belief that these 'mad' states are actually a very normal response to extreme trauma". However, several authors reflected on the challenges of working close to their own experiences, with Osband (2016, p. 122) stating, "when the face across the room reflects my own, I need to be particularly alert to my desire to be helpful". Others reflected on heightened sensitivity to certain therapeutic situations; for example, Allphin (2018) spoke about patients leaving therapy, and how this stirred feelings of rejection, mirroring feelings from her mother's suicide.

Several therapists reflected on the mutuality of healing between themselves and their clients. Osband (2016) shared an example of her client who also had a child die in an accident, who asked of her, "this happened to you too, didn't it?" (p. 118), reflecting on how this shared experience helped her client trust her more than if she were a "blank screen". Chasen (1996), who also experienced the death of her child, also reflected on this experience of mutual healing, quoting Lord (1995, p. 79), "you want to know how to overcome despair, I will tell you. By helping others overcome despair". Horwell (2019) reflected on the idea of bracketing (Husserl, 1931), suggesting that therapists are "inevitably unable to 'bracket' [their] loss", instead proposing, "if we approach our work with the attitude that it is not *if* our loss enters the unconscious intersubjective domain, but *how* it manifests, we open up the possibility of harnessing our vulnerability for greater connection and healing potential" (p. 159).

Self-Disclosure about Personal Experiences of Bereavement. Many accounts discussed issues of self-disclosure, both with clients and colleagues (Chasen, 1996; Colson, 1995; Galgut, 2016; McDonald & Grau, 2019; Murray-Swank, 2019; Osband, 2016; Rosenfeld, 2016). Chasen (1996) reflected on the impact of clients knowing about her young son's death, both in terms of the therapeutic relationship and the process of therapy. For example, speaking of a female client dealing with fertility problems, she wrote, "we … talked about her plans for adopting a child and whether she feared she couldn't share her happiness because of my loss" (Chasen, 1996, p. 14). Galgut (2016) spoke of how self-disclosure can be used to validate and give reassurance:

> …if a client of mine is struggling to cope with the loss of a parent and feeling the burden of pressure not to be too upset after a certain period of time … if I as their therapist can say,

> "well, look, my mother died and I'm struggling too – it's a huge thing", that in itself can be very reassuring and a relief and can ease some of the distress they are feeling. (p. 22)

Some authors shared concerns: for example, Colson (1995, p. 469) was concerned that some of his clients knowing about his wife being terminally ill would experience this as an "'unfair' intrusion into their analyses".

What Helps the Bereaved Therapist. Several authors who experienced bereavement whilst working as therapists highlighted the importance of good-quality supervision (Chowdhury, John, & Nanavaty, 2019; Colson, 1995; McDonald & Grau, 2019; Rosenfeld, 2016); for example, Rosenfeld (2016) spoke of the benefits of having a period of supervision without seeing any clients as a way of supporting her back into therapeutic work following the death of her husband. Several authors also valued personal therapy (Colson, 1995; Galgut, 2013; McDonald & Grau, 2019; Warshaw, 1996). When a bereavement occurred relatively recently, authors offered different perspectives on working whilst grieving: some found therapeutic work to be a refuge ("continuing to conduct analysis served as a temporary refuge from turmoil"; Colson, 1995, pp. 467-468; "at least for the time that I was in session, I could escape a little from the horror of what my life had become", Chasen, 1996, p. 7), and others found that taking time away from client work was valuable (e.g., Galgut, 2013; Rosenfeld, 2016). Referring to the unpredictable trajectory of grief over time, Galgut (2013, p. 23) spoke of the need to be sensitive to "recognising when I need to take time off".

Implications for Clinical Practice and Research

As there is so little research in this area, it is wise not to overstate the clinical implications of the existing knowledge base. Nonetheless, reviewing research evidence alongside personal accounts highlights the significant impact that bereavement has on therapists, both personally and professionally. The literature demonstrates different ways in which therapists integrate personal experiences into their therapeutic work, how they draw upon these experiences in service of clients, and areas of advantage and challenge that bereaved therapists recognise in connection with personal experiences.

As such, implications for clinical practice concern the importance of practitioners reflecting on these issues as a means of better integrating the personal with the professional, allowing personal experiences to become a resource for therapeutic practice. Moreover, acknowledging the challenges experienced by some therapists working towards this aim, the literature also highlights the importance of good-quality training and supervision to support this. Lastly, given the richness of this topic area and fruitfulness for therapeutic practice, this review emphasises the importance of further research exploring the personal and professional impact of bereavement in therapists.

Conclusions

This systematic review on therapists' personal experiences of bereavement identified only four relevant published research studies. However, the review was limited to English language studies: further research may be available in other languages. Two IPA studies highlighted that bereavement and loss had a range of significant impacts on therapists as people and in therapeutic practice. However, neither study focused on the experiences of therapists bereaved in childhood, and one was conducted with humanistic therapists only. A further hermeneutic inquiry study of trainee psychotherapists maternally bereaved by suicide gave rich accounts of the personal impacts of this experience; however, this study focused less on the impact on therapeutic work, possibly because participants were currently in training. Finally, a quantitative study demonstrated that the more therapists reported distress associated with grieving a loved one, the less likely they were to be rated as empathetic by clients; however, other variables relating to therapist grief were unrelated to client perceptions. As such, the conclusions from this study are not entirely clear and the authors recommend further research to help elucidate things further.

In the absence of a more substantial body of research in which to situate the current study in context, 12 further reflective accounts by therapists with personal experience of bereavement were reviewed. These accounts provided some rich data on the experiences of individual therapists, both in terms of the personal impact of bereavement and the way it influenced therapeutic work. Nonetheless, whilst these accounts provided valuable context and could help inform the design of future research, individual testimonies are not intended to substitute for research in this field.

Aims and Rationale for the Present Study

Drawing on the wounded healer and self-of-the-therapist literature, the aim of this study was to examine experiences of bereaved therapists who had a parent die in childhood, focusing on the personal and professional impacts of this experience. As previously emphasised, research in this area is extremely limited. This has been acknowledged in a review of this area (Kouriatis & Brown, 2011), where the authors argued that studies on how therapists' loss experiences affect them personally and professionally would be a helpful area for future research.

Other than studies examining bereavement in a professional context (e.g., client suicide, Darden & Rutter, 2011), only one study has examined the impact of a specific kind of personal bereavement (maternal suicide during adulthood, Stewart & Thomas, 2018), and no published studies have specifically examined therapists who experienced the death of a parent in childhood. As discussed previously, this represents a different challenge, because the loss also represents the end of a relationship through which the young person can develop and explore their identity (Tyson-Rawson, 1996).

Although it is evident that a gap in the literature exists, it is important to explore why this may be a helpful gap to fill, particularly with respect to potential implications of the research. A crucial starting point involves reiterating that experiencing a significant bereavement, such as the death of a parent, can have a great impact on *any* individual's self: their way of being, thinking, and relating to others (Broadbent, 2013; Kouriatis & Brown, 2011). Given the extent to which the therapist's self affects the therapeutic work with clients (e.g., Aponte & Kissil, 2014), research on significant life experiences is of clinical utility, as it can help facilitate therapists' reflection on personal struggles and how they can draw on these in service of clients.

It can be further argued that research examining the impact of specific events, rather than wounding experiences generally, is helpful. Wounds come in many forms and stem from different experiences including loss, marginalisation, abuse, ostracism, family and relationship conflict, spiritual crises, and physical illness. Just as these wounds reflect different kinds of human experiences, how these wounds are understood, reflected upon, and used by therapists in service of clients may be quite different.

Indeed, developing the argument of why research stimulating reflection in practitioners is of clinical utility, self-reflection on the part of the therapist is a powerful (and arguably, essential) tool in effective psychotherapy, the importance of which has been consistently emphasised over many decades and across multiple theoretical traditions (e.g., Freud, 1957; Satir & Baldwin, 1983). The term *reflection* implies “a ‘bending or folding back’, like a ray of light … one reflects light and focus within, taking time to look more deeply, and pulling back to discover a wider view” (La Torre, 2005, p. 85). Studies of both psychotherapists (e.g., Gale & Schröeder, 2014) and other health care professionals (e.g., Paget, 2001) demonstrate that reflection on the part of the practitioner is associated with improved outcomes for clients.

Lastly, rather than restricting participation to certain professions, this study aimed to examine experiences of therapists from a range of traditions, for two reasons. First, given the lack of research in this area, and that one of the two most relevant existing studies was conducted with humanistic therapists only, a study of relevance to practitioners more broadly is helpful, not least because parental death in childhood is, in itself, quite a specific experience. Second, diversity amongst the trainings of participants may invite interesting similarities or differences in terms of how participants draw upon experiences in therapeutic practice. As part of the study’s rationale concerned producing research that could facilitate self-reflection, introducing some diversity amongst participants’ experiences may be beneficial to this.

Research Question

Following from the aims and rationale outlined above, the research question for the current study is as follows:

How do psychological therapists who lived through the death of a parent in childhood experience this personally and professionally, in their therapeutic practice?

Method

Design

The research question was examined by way of a qualitative approach, using semi-structured interviews, for three reasons. First, the question necessitated an approach that enabled participants to reflect on their experiences, and the personal meanings and implications of these experiences. Qualitative approaches can allow participants to speak about experiences without too much restriction, insofar as they relate to the research question. Second, as an under-researched area, qualitative designs are particularly helpful when researching phenomena that have received little prior research attention (Barker, Pistrang, & Elliott, 2002). Lastly, with respect to my epistemological position, I was not attempting to establish a singular "truth" or gather data to accept or reject a null hypothesis; rather, I was more concerned with participants' experiences and the meanings ascribed to them, highlighting patterns of convergence and divergence across different accounts.

Interpretive Phenomenological Analysis

I chose to use IPA to address the research question for several reasons, reflecting IPA's phenomenological, hermeneutic, and idiographic underpinnings (Smith et al., 2009). First, the aims of IPA were consistent with the study's aims: to get an insider's perspective (Conrad, 1987) through in-depth accounts of highly personal experiences, where there may be commonality and difference between participants (Smith & Osborn, 2007). *Phenomenology* is the study of experience from a first-person point of view (Woodruff Smith, 2006), and with this underpinning, IPA researchers recognise that "the complex understanding of 'experience' invokes a lived process, an unfurling of perspectives and meanings, which are unique to the person's embodied and situated relationship to the world" (Smith et al., 2009, p. 24).

Second, as this study aimed to explore participants' experiences they perceive and interpret them, this is well suited to IPA, as "the main currency for an IPA study is the meanings particular experiences, events, and states hold for participants" (Smith & Osborn, 2007, p. 53). This reflects *hermeneutics*, the philosophy of interpretation, since IPA studies are concerned with how participants make meaning from experiences. Moreover, IPA acknowledges the active role of the researcher in trying to get close to participants' inner worlds (the "I" in IPA), thus recognising the role of the researcher's own interpretations of participants' interpretations (the *double hermeneutic*). Given my connection with the phenomena being studied, choosing a method that recognises both participants' processes of interpretation (hermeneutics), and the researcher's processes of interpreting these interpretations (the double hermeneutic) seemed particularly important.

Third, as the study aimed to examine individual experiences of therapist participants, this fitted well with IPA's idiographic roots. *Idiography* can be described as a concern with the particular (Smith et al., 2009), in contrast with many approaches in psychology that are *nomothetic* (i.e., making general claims, or identifying laws applicable to particular populations). As such, IPA involves in-depth analysis of individual cases, understanding experiences as they are perceived by a particular person, in a particular context (Smith et al., 2009). As one aim was to produce research to facilitate therapist self-reflection, the idiographic focus of IPA was felt to be beneficial in stimulating reflection through in-depth exploration of individual experiences.

In addition to the qualities of IPA that make it particularly appropriate for this research, it is important to consider its limitations. One criticism relates to its reliance on language, with concerns reflecting both practical aspects (e.g., whether participants can adequately articulate their experiences), and philosophical aspects (e.g., does participants' language describe their experience or construct it?) (Smith & Osborn, 2007; Willig, 2013). With the first concern, although everyone may have experiences beyond the realm of language, for the participants in this study, it was felt that they may be particularly skilled with using language to express complex psychological experiences.

Regarding the second concern, there are other qualitative approaches which focus on this aspect, deconstructing the way language is used (e.g., discourse analysis; Willig, 2013), however, this kind of deconstruction is not the aim of IPA, and neither does it fit with the research question. Although one could argue that examining the way in which discourses are constructed is one method through which to examine meaning-making around a particular experience, IPA is more concerned with examining idiographic experiential accounts, rather than critically analysing the construction of those accounts themselves (Smith et al., 2009). Moreover, Smith and Osborn (2007) argue that there is a connection between how people talk about their experiences, and their thoughts and emotions relating to those experiences. Therefore, through closely examining the way in which participants speak about experiences, it is possible to gain some shared understanding of how phenomena are experienced from their perspective.

Participants

Recruitment

Participants were recruited by purposive sampling, a non-random sampling method that "involves identification and selection of individuals or groups of individuals that are proficient and well-informed with a phenomenon of interest" (Etikan, Musa, & Alkassim, 2016, p. 2). IPA studies tend to use purposive sampling because "participants are selected on the basis that they grant us access to a particular perspective on the phenomena under study … they 'represent' a perspective, rather than a population" (Smith et al., 2009, p. 50).

The majority of participants (six) were recruited through online advertisements: postings on social media channels for psychological therapists, or e-mail advertisements to members of therapists' professional bodies (see Appendix D). One participant was known professionally to one of the supervisors and was recruited through referral.

Inclusion and Exclusion Criteria

To be eligible for the study, participants had to meet the following inclusion criteria (there were no exclusion criteria).

- Be a qualified psychological therapist (e.g., psychotherapist, psychologist, family therapist) with appropriate accreditation from a professional body;
- Practice psychotherapy as part of their professional role;
- Have experienced the death of one or both parents before age 18.

IPA studies tend to have fairly homogenous samples, although the degree of similarity between participants can vary. The rationale for this is that by establishing some degree of uniformity within the sample, it allows for exploration of psychological variation between participants, examining patterns of convergence and divergence (Smith et al., 2009). If the sample is too diverse, examining these patterns would be far too complex, particularly given the reasonably small sample sizes required for good-quality IPA analysis.

I felt that these inclusion criteria afforded some homogeneity without being too restrictive: given the lack of research in this area, it made sense to approach the topic more broadly rather than stipulating a more specific focus (e.g., only examining certain kinds of parental bereavement; only maternal or paternal deaths). Nonetheless, I decided to limit participation to qualified therapists rather than trainees, as I felt that professional maturity may enable participants to give richer accounts of their experiences, perhaps being more able to recognise and articulate the effects of their bereavements on their practice.

Participant Information

In total, seven participants were recruited, each completing an interview approximately one hour long, consistent with the recommended sample size for IPA studies conducted as part of professional doctorates by Smith et al. (2009), who recommend four to ten interviews. A sample size of seven was felt to strike a good balance between allowing for breadth and difference, improving the rigor of the research, whilst also not compromising the opportunity to perform the in-depth analysis required for IPA.

Demographic information and pseudonyms for the participants are presented in Table 3. With respect to pseudonyms, I wanted to give participants the opportunity to select their own pseudonym, because of how emotionally significant names can be. Participants expressed that they appreciated being given this opportunity; five participants offered a pseudonym and two indicated that they were happy for me to choose.

All participants were female, and from a white (British, European, or other white) ethnic background. Ages ranged from early thirties to early sixties, with most participants being in their thirties or forties. Time since therapeutic qualification ranged from within the last few years to over twenty years. Four participants were clinical psychologists, one was a cognitive behavioural therapist, one was a systemic family therapist originally trained in social work, and another was a therapist with training in couples and systemic psychotherapy.

Name	Sex	Age bracket (years)	Ethnicity	Therapeutic profession	Time since qualifying as a therapist	Preferred model(s) of psychological therapy
Emily	Female	30 - 34	White British	CBT therapist	< 5 years	CBT (cognitive behaviour therapy)
Alice	Female	30 - 34	White British	Clinical psychologist	< 5 years	Integrative (CBT, acceptance and commitment therapy (ACT), compassion focused therapy (CFT))
Blossom	Female	40 - 45	White Other	Clinical psychologist	10 – 15 years	Integrative (narrative, systemic)
Sandy	Female	40 - 45	White British	Clinical psychologist	10 – 15 years	CBT within integrative approach
Laura	Female	35 - 39	White British	Clinical psychologist	5 – 9 years	Attachment based, psychodynamic
Joanna	Female	35 - 39	White European	Social worker, family therapist	10 – 15 years	Systemic family therapy
Rowan	Female	60 - 65	White British	Therapist (couples therapy and systemic training)	20 – 25 years	Systemic, attachment, psychodynamic

Table 3. Participant demographic information and therapeutic professional background.

A summary of information about the circumstances of the parents' deaths is presented in Table 4. Five participants experienced their mother dying, and two experienced their father dying during childhood. Deaths occurred when participants were between three and 14 years old. Four parents died due to illness, two due to accidents, and one due to suicide. Rowan's other parent (her mother) had died relatively recently, but all other participants' remaining parent was still alive.

Name	Parent that died	Cause of death	Age of participant when parent died (years)	Other parent still alive now?
Emily	Mother	Accident	6	Yes
Alice	Father	Suicide	7	Yes
Blossom	Mother	Illness	7	Yes
Sandy	Mother	Accident	3	Yes
Laura	Mother	Illness	13	Yes
Joanna	Mother	Illness	14	Yes
Rowan	Father	Illness	12	No

Table 4. Details of the bereavements experienced by participants.

Ethical Considerations

The study received ethical approval (Appendix E) prior to data being collected. Participants were provided with the ethics protocol number and details of whom they could contact if concerned about any aspect of the research. The study was designed and conducted in accordance with the British Psychological Society's code of ethics (BPS, 2014), and pertinent ethical issues are addressed below.

Informed Consent

Interested potential participants were given the Participant Information Sheet (Appendix F), containing information about the purpose of the study; what participation involves; possible benefits and disadvantages of participating; and information about confidentiality, data storage, and dissemination of results. Contact details of the research team were provided, and people were encouraged to ask questions. People wishing to participate were asked to sign a consent form (Appendix G) to give written consent prior to the interview.

On the interview day, the researcher went through the Participant Information Sheet again, to ensure participants' understanding and to give further opportunity for questions. Prior to the interview, the researcher sought further verbal confirmation that people were still willing to participate, reiterating that consent could be withdrawn at any time, with no obligation to complete the study.

Confidentiality and Data Management

As participants belonged to the same professional network as the research team and target audience for publications arising from this research, this was felt to increase the risk that peers may identify participants. To address this, steps were taken to ensure anonymity. Pseudonyms were used, and potentially identifying data were reported in a format giving generalised rather than specific information: reporting ranges for age and time since qualification; reporting therapeutic profession rather than specific job title; reporting cause of parental death in broad terms (e.g., illness). Descriptions of participants in the form of "pen portraits" were not included to further protect participants' anonymity.

Participants were informed that if there were significant concerns about the wellbeing and safety of participants or others, it may be necessary to breach confidentiality by informing others outside of the research team to access help, but this would usually be discussed with participants at the time.

Steps were also taken to maintain confidentiality in managing data, with identifying information being stored separately from audio recordings and transcripts, in a secure password-protected environment. Participants were told that recordings would be destroyed after the principal investigator's degree is conferred, signed consent forms would be destroyed after five years, and interview transcripts would be destroyed ten years after the date of any publications arising from the research.

Participants were informed that the study's findings would be presented in a thesis as part of the principal investigator's Doctorate in Clinical Psychology, and that the research team and thesis examiners may view anonymised interview transcripts. They were also informed that the research, including participant quotations, may be reported in public presentations or documents, but that their anonymity would be preserved (e.g., through ensuring interview extracts were not identifying).

Lastly, all but one participant (who was referred to the study by one of the supervisors) only had contact with the principal investigator, and no-one else in the research team. As such, as an additional safeguard, the principal investigator did not reveal participants' identities to the research team. Despite obtaining consent to share identifying information within the team, ultimately, it was felt unnecessary for the supervisors to know the identity of participants, and as such, anonymity was further preserved in this respect.

Potential Distress

In asking participants to reflect on their parents' deaths, it felt relatively likely that the interview could cause distress. However, when expressing interest in participating, people were given detailed information about the topics that would be covered, including the circumstances of their bereavement, and their emotional responses to the death, both at the time and up to the present day. Since participants received explicit information about interview content, it was felt that they would be in an informed position to choose whether or not to participate. Moreover, participants were informed that they did not have to answer any questions they did not wish to answer, and could discontinue the interview and withdraw from the study at any time. Following the interview, the researcher took time to debrief with participants, hear about how they found the experience, and answer any additional questions. A debrief sheet was available which contained details of further organisations participants could contact for emotional or bereavement-specific support (Appendix H).

As this project holds personal resonance, I was also conscious of my own emotional wellbeing. My personal view is that I do not find my distress associated with this topic to be bad or something to be avoided, and neither is it unwelcome. I also believe that my willingness to remain emotionally present helped me to be a better interviewer and a more sensitive qualitative researcher. At the same time, to do justice to the research and participants' experiences, it felt important to be aware of my own emotional responses, and to look after myself. For example, I would intersperse more emotionally intense activities with more "neutral" activities. This is similar to approaches taken by other insider researchers when researching topics that may be emotionally painful (e.g., Stewart & Thomas, 2018).

Data Collection

Development of the Interview Schedule

A semi-structured interview schedule (Appendix I) was developed by the principal investigator, in consultation with the primary supervisor (an experienced IPA researcher), an IPA researchers' group (see Quality Assurance section), and the IPA literature (e.g., Smith et al., 2009). For example, various iterations of the interview schedule were tested in mock interviews with other members of the IPA researchers' group for feedback at different stages of its development. The researcher also sought consultation from the first participant, whose interview served as a pilot (see Consultation with Research Participants section). Semi-structured interviews are particularly appropriate for IPA as they allow the researcher to follow lines of enquiry from their research question, whilst also having the flexibility to modify questions in light of responses, allowing for richer exploration (Smith & Osborn, 2007). Smith and Osborn (2007, p. 59) note that "the respondent shares more closely in the direction the interview takes … respondents can be perceived as the experiential expert on the subject and should therefore be allowed maximum opportunity to tell their own story".

The schedule began with closed questions collecting demographic data and information about participants' bereavements. The researcher and primary supervisor deliberated about whether to collect this data verbally or through pre-interview questionnaires, but it was ultimately decided to do this verbally. It was felt that beginning the interview by asking participants some easy-to-answer questions may help build rapport and familiarise participants with the interview process, prior to moving onto more challenging questions. The interview schedule contained three sections, which captured data relevant to all elements of the research question:

- How the experience of the parent's death impacted the participant personally;

- How the parent’s death may have influenced choice of career;
- How the parent’s death may have influenced therapeutic practice.

In the first section, questions concerned the circumstances of the bereavement, and the emotional and practical impact of this experience, both at the time and in the present day, reflecting on any changes. In the second section, participants were invited to give a brief overview of their educational and professional history. Questions concerned their understanding of what influenced their career choices, and whether they considered there to be any links between these choices and earlier experiences. In the third section, participants were invited to reflect on being a therapist with this experience of bereavement, any challenges or strengths associated with this experience, and any things the experience had taught them. Finally, participants were asked whether there was anything else that felt relevant which had not been discussed. The schedule was used in a flexible manner, allowing the researcher follow the lines of participants’ thinking (Smith et al., 2009). For every question, the schedule contained prompts that could be used, which either rephrased the question, or offered several alternative routes that participants could take.

The ordering of sections in the schedule was intended to reflect meaningful chronology, both in terms of time (speaking about earlier life experiences first), and identity (everyone experiences being a person before they experience being a “professional”). Nonetheless, the researcher and primary supervisor discussed the potential difficulty of the schedule beginning with what was likely to be the most emotionally arousing section (focusing on the death of the parent and its emotional impact). After further discussion with the IPA researchers’ group and the participant consultant, it was felt best to begin with this area, as it represented the “heart” of the experience, making it difficult to explore other areas without establishing this context. Moreover, all participants were made aware of the interview content and order of sections beforehand, so this would not be unexpected.

Interview Procedure

Participants were offered a choice of face-to-face or online video interview. Participants’ geographical locations meant that only one participant opted for a face-to-face interview, with the remaining interviews being conducted online. Interviews lasted around one hour or just over an hour, although more time was allowed for one participant who had English as a second language.

With respect to online video calls, this technology is becoming more popular for research interviews (e.g., Salmons, 2015), and whilst it has some disadvantages (e.g., difficulty detecting subtle non-verbal cues), there are various benefits (e.g., accessing a wider pool of participants). Despite initial concerns that the online medium may make it harder to build rapport, after the first few moments of each call, the process felt comfortable and not significantly different to in-person interaction.

After reviewing information about the study and checking with participants that they were happy to proceed, the researcher shared details of the interview structure and approximate timings, whilst also emphasising that as a semi-structured interview, there was some flexibility. This information was shared to orient participants to the interview process, with hopes that this would feel reassuring and containing. Additionally, a brief introduction was given at the start of each interview section, to punctuate the change in focus prior to continuing the questions (see Appendix I for approximate wordings). It was hoped that this punctuation would further assist with orienting participants to the process and rhythm of the interview.

During the interview, prompts were used if participants had difficulty with questions. Follow-up questions were also used to gather additional information about interesting or significant things that were not elaborated on (e.g., “Can you say some more about that?”). Occasionally, if something appeared confusing or ambiguous, a brief summary was given to check understanding (e.g., “Earlier on, I think I heard you say [summary] – have I understood that correctly?”). This enabled the researcher to verify their comprehension without straying into the territory of analysis or interpretation (Smith et al., 2009).

With regards to researcher self-disclosure, several participants asked about my motivations and connections with the research topic. I was happy to share this information, but I reflected beforehand on the advantages and disadvantages of different choices around disclosure - such as whether to tell all participants or only to share if asked, and when to give the information (Smith et al., 2009). Ultimately, I decided to share information with participants if they asked me, but only after the interview. I was mindful of not wanting to set up any comparative dynamics around the shared experience that could bias responding (e.g., participants feeling pressure to present their experiences in a particular way).

Consultation with Research Participants

In developing the interview schedule and other aspects of the project, I sought consultation from a member of the population I wished to interview (i.e., a psychological therapist who experienced the death of a parent during childhood). My pilot interview with this person was included in the analysis as substantial changes were not made to the interview schedule.

I arranged an appointment in which to interview this person and consult with her afterwards about aspects of the research process, seeking feedback on a number of areas. First, I asked about her experiences of being recruited to the study (study advertisement, consent form, information sheet). Second, I asked for feedback about the interview schedule and process itself (e.g., whether questions felt clear and relevant; whether anything important was missed; the order and pacing of questions). Lastly, we discussed how she had found me as a researcher, and the process of participating generally (e.g., impressions of my contact with her, the process of arranging the interview).

The consultant's feedback was valuable in highlighting what was experienced positively and giving suggestions for improvements. For example, we discussed the order of the interview sections, and the appropriateness of starting with asking about the circumstances of the parent's death and the emotional impact of this. The consultant felt that in consenting to participate, she knew this would be a major part of the interview and was not concerned about beginning the interview in this way. Whilst it is important to recognise that other participants may feel differently, feedback from a later participant was similar: she preferred this order as she expected to become tearful during the interview when discussing her parent, and did not want to "hold in" her emotions for a prolonged period.

Whilst I did not formally consult with other participants, I allowed time for everyone to provide informal feedback on the research process. This allowed me to continuously monitor participants' experiences to ensure their comfort; seek feedback on interaction with me in case I could improve experiences of subsequent participants; and check I was not systematically missing important areas from my interview schedule.

Data Analysis

Interviews transcripts were analysed using the IPA steps proposed by Smith et al. (2009). Specific choices made with respect to the analyses conducted in this study are outlined below.

Analysis of Individual Transcripts

The process of IPA begins with detailed analysis of individual transcripts. To ensure an idiographic focus, analysis of each transcript was completed in full prior to working on subsequent transcripts. Interviews were transcribed right before analysis, which helped to keep participants' voices in mind, with a vivid memory of rhythm and tone. Transcripts were read and re-read to aid immersion, without trying to perform any analysis at this stage.

To prepare for analysis, transcripts were transferred into a Microsoft Word template (see Appendix J for an example transcript excerpt with analysis). The template was in landscape format with three columns. The transcript was in the middle column, with the left column for initial exploratory comments, and the right column for emergent themes, mirroring the process of pen-and-paper IPA (Smith et al., 2009). Initial comments were categorised into descriptive, linguistic, and conceptual comments (represented by plain text, italicised, and underlined comments respectively). After making initial exploratory comments, the right column was used to note emergent themes, working at a higher level of abstraction and reducing the level of detail, whilst still retaining the richness and complexity of the data (Smith et al., 2009).

The next stage involved identifying patterns across emergent themes and developing superordinate themes. All emergent themes from the right column were copied into a new file in chronological order, and duplicate themes were deleted. If too many emergent themes were present due to retaining excessive detail, I went through an iterative process of reviewing the theme list, noticing patterns of similarity, making adjustments to reduce themes into more abstract concepts, then checking whether adjusted themes reflected the data, updating the themes in the right column beside the transcript accordingly. After settling on the final emergent themes, these were arranged into clusters of related concepts, giving each cluster a name to represent the superordinate theme concepts (see Appendix K for an example). This process was repeated for each transcript.

Analysis Across Transcripts

The final stage involved searching for patterns across interviews, whilst trying to retain IPA's "dual quality", in which idiosyncrasies of individual experiences are highlighted alongside higher order themes shared across multiple accounts (Smith et al., 2009). I created a list of superordinate themes from all interviews, and attempted to cluster these using a similar approach to the one used with individual transcripts, creating a label for each cluster to represent a master theme. I met with my supervisors to discuss this process in detail, arriving at a final set of master themes and subthemes which I felt captured the essence of participants' experiences, holding in mind patterns of similarity and difference.

Quality Assurance

Various steps were taken to conduct the study in accordance with guidelines for good-quality qualitative research (e.g., Yardley, 2000). Several steps to improve quality have been outlined previously, including: providing a detailed overview of relevant literature and following robust ethical procedures (sensitivity to context); providing a detailed account of the method, along with a transcript excerpt and accompanying analytical comments for independent evaluation (transparency); and discussion of experiences and motivations that drew the researcher to the topic area (reflexivity). I would like to draw attention to additional procedures which contributed towards improving the quality of the research, organised under some of the quality criteria proposed by Yardley (2000). The criteria from Elliott et al. (1999) were previously used to allow for evaluation of both quantitative and qualitative research studies together as part of the systematic review; however, the Yardley (2000) criteria were selected for this evaluation, where it was not necessary to consider applicability to quantitative studies, since they placed greater emphasis and exploration of quality criteria specific to qualitative research.

Commitment and Rigour

An important element of good-quality qualitative research concerns commitment to the topic, methods, and analytic process. Fundamentally, IPA is an iterative rather than linear process, and I attempted to remain committed to this throughout. An example of this concerns my process of referring back to audio recordings. I listened carefully to the recordings several times at the beginning of the process, as Smith et al. (2009) recommend. However, I returned to them at various stages of the analysis, often to listen to sections where I felt uncertainty with respect to tone, emotion, or meaning. This immersion helped me feel more connected to participants' accounts, and helped to resolve things which felt ambiguous in textual form alone, helping to improve the credibility of my analysis. I also annotated transcripts where I had found sections of audio particularly powerful or emotive, recognising that these passages may be valuable when looking for quotations to represent themes.

A further commitment to IPA was demonstrated by how I aimed to retain an idiographic focus during individual transcript analysis. For example, I had experimented with the qualitative data analysis software NVivo (QSR International, 2020), but as this is not specifically designed for IPA, it retains previously used codes in a library, encouraging users to re-apply these codes across multiple transcripts. I felt seeing codes applied to other interviews would be distracting and discourage bracketing between interviews. Naturally, whilst there were common themes across interviews, starting with a new Microsoft Word file for each transcript meant I was not tempted to intentionally repeat codes or themes between transcripts, allowing me to experience each interview as distinct in its own right by keeping analyses separate.

Coherence and Transparency

A further aim in qualitative research concerns coherency, which in part describes "the 'fit' between the research question and the philosophical perspective adopted, and the method of investigation and analysis undertaken" (Yardley, 2000, p. 222). Regular consultation with my primary supervisor and an IPA researchers' group helped to improve the coherency of the research design and analysis. For example, when working on my interview schedule and analysis, I presented work to colleagues for critique, and their thoughtful and challenging questions enabled me to find ways to improve the coherency of the project (e.g., considering the fit between the research aims and interview schedule; the credibility and interpretative depth of my analysis).

An additional feature of good-quality research is transparency. Embedded within this should be openness on the part of the researcher(s) about aspects of them that could affect the qualitative research process, such as experiences and motivations that could shape their approach. This can be referred to as researcher self-reflexivity (Yardley, 2000). To this aim, I have been open about various aspects of myself that could influence the work, such as my epistemological position, and my personal connection with this topic. There were various additional processes of self-reflexivity I used throughout the research. For example, I wrote in transcript margins or in my personal notes when I experienced strong resonance with participants' experiences. Rather than ignoring it, this helped me acknowledge and give space to reflect on the resonance, writing down thoughts and emotional responses, and sometimes discussing this with supervisors or other colleagues. This also helped me with "bracketing" my experiences (Tufford & Newman, 2010): by attending to my own responses, I felt more able to be with the voices of my participants, attending fully to their experiences.

Reading about the concept of insider researchers in qualitative research (e.g., Ellis-Caird, 2017; Gair, 2012) and exploring research conducted by "insiders" further assisted with self-reflexivity. For example, early in my research process, I spent time reading the thesis of a previous trainee clinical psychologist from my programme, who conducted an IPA project exploring a kind of bereavement she had personally experienced. It was valuable to reflect on challenges pertinent to insider research, such as how to ensure the research remained accessible and relevant to "outsiders" (Ellis-Caird, 2017), and how my empathy for the shared experience might influence the way I approached the analysis.

Results

In this chapter I will present findings from analysis of the seven interviews. Through this process of analysis and interpretation, three master themes were developed (Table 5). The remainder of this chapter will focus on describing these in detail, using interview extracts to illustrate and provide evidence for the credibility of the interpretations.[1] Whilst these themes reflect common features from all accounts, it is also important to recognise areas of similarity and difference between participants, and the researcher's role in offering one possible interpretation of how participants experienced these phenomena. It is also acknowledged that this analysis does not capture every experience shared during the interviews, but rather focuses on those most relevant to the research question.

Master theme	Subtheme
A loss beyond words	The dynamics of grief (Re)arranging life The intensity of silence Feeling lost
Navigating in a strange landscape	The ebb and flow of loss The evolving relationship with the parent that died Connection
Something lost, something gained	Becoming a therapist Drawing on the self in therapy Supporting therapeutic use of self

Table 5. Summary of master themes and subthemes.

A Loss Beyond Words

This master theme reflects participants' childhood experiences of a parent dying. It addresses ways in which they experienced grief around the time of the bereavement, and perceptions of how the death impacted their early lives. The theme title reflects the quality of this experience as feeling somewhat beyond words – reflected in the difficulties participants

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[1] In this section, everything presented in quotation marks or block quotes is a direct participant quotation.

and their families had in speaking about the dead parent, the intangible sense of difference that the experience engendered, and the emotional enormity of what happened.

The Dynamics of Grief

In elevating a direct quotation from Sandy to this subtheme's title, it reflects the use of "dynamics" to describe grief, both as an adjective (of change and motion) and, in the musical context, as a noun (loudness and quietness, intensity and calm). Some participants spoke directly to the emotional intensity of sorrow.

> Once you start crying … it was hard to stop. So it, it was devastating. (Rowan)

> Massive, massive impact really, obviously, as you'd expect, and I think made worse … by the fact my dad never ever spoke, so you have this massive, just gap, of [voice trembles, pauses] this person, who's this person that you've lost. (Blossom)

For some, other strong emotions were also vividly present in the aftermath of the death. Rowan recalled feeling intense anger on the day of her father's funeral, which she describes as being "not allowed" to attend. Sometimes the anger was towards people remaining in her life; at other times, the target of the anger was less clear, perhaps being towards the father who left her by dying, or anger at the bitter unfairness of her situation.

> I do remember being very angry, coming home on the day of the funeral … towards all the people in the house, feeling, "What, what are you doing here?" … as if I could scream at them, "He was my dad" … "Why are you here? It was, it was my dad", and people not recognising how important he was to me, really. And then, at other times … I used to go outside and just run down the fields. You know, literally run as fast as I could, and I think, probably, I'd be feeling cross. I might be cross towards my brother, or I'd, but I'd just be aware of feeling cross. (Rowan)

Several participants recalled difficulties with remembering their grief experiences around the time of the death: for some, this was perhaps due to how traumatic the experience was and how painful it was to remember. This was more pronounced for certain participants such as Alice, whose father died by suicide.

> I don't have very strong memories of him. I think that's partly because I've pushed him away. (Alice)

For Sandy, her lack of memory of grieving related in part to her being three years old when her mother died in an accident. This gave a disorientating quality to her experience, feeling painfully lost in this search for the emotional impact, the lack of memory perhaps feeling like an additional loss.

> Not having that direct memory … there's always a sort of a question of, well, has it affected me? How has it affected me? It must have done, but I can't feel it, except when I talk about it now. And so sometimes, there's a bit of searching for the impact, you know, trying to, trying to feel it, because it's just, it's like, how do you miss something you don't remember ever having? (Sandy)

For some, difficulty in remembering grief was associated with disconnecting from emotions. Alice spoke of her family role being to “keep things nice and calm”. These perceived expectations may have led to her attending less to her own feelings, trying not to take up emotional space in the minds of others.

> My natural style was to kind of like not get too emotional, not be needy. Make sure that all the adults are okay, really. So yeah, I shut down those emotions pretty quickly. (Alice)

Rowan also spoke of perceived expectations about what her response should be when told of her father’s death – this tension perhaps representing the balancing act of being “from a line of women who cope”, whilst also not wanting her love for her father to be underestimated.

> I can remember vividly coming home from walking the dog … and my mum saying, you know, "Daddy's died". And my brother was in front of me, and he started crying. And I remember thinking, "I better cry, or they'll think I didn't love him". (Rowan)

Grief tended to be recalled most emotionally, and most vividly, in the context of how it was witnessed in others. Perhaps this was because of difficulty putting their own emotional experiences into words, or perhaps because seeing the grief of loved ones was more tangible and vivid, a deeply painful witnessing of others’ suffering.

> Joanna: Our family was ruptured. My father was very sad … I saw my father going through a very hard stage. … I saw that it was eating him. I heard him. I heard him cry at night. [crying]
>
> Interviewer: Did you cry together as a family, or was it separate?
>
> Joanna: Separate.

Participants witnessed different manifestations of grief in those around them. Sandy recalled her grandparents' anger and disappointment following the death of her mother (their daughter). It seemed as though the "horrific" dynamics of this grief felt particularly damaging for Sandy – coping not just with the sudden death of her mother, but the deeply painful impact on relationships, saying, "it's defined what's happened to our family".

> [Long pause, then speaking through tears] It was impossible to talk to them, because … their grief was so, so overwhelming, that I couldn't, you couldn't ever be the person to bring it into the room, because it was so painful. … Their grief came out as anger, and blame. They blamed my dad, it was all his fault. They managed to convey perpetual disappointment in me and my sister for, we would have been different if she'd been there. (Sandy)

(Re)arranging Life

Participants spoke of the ways in which life changed following the death of their parent. There was a sense of life changing profoundly (i.e., *rearrangement* – a revision of what had gone before), alongside a sense, for some, of carrying on as normal (i.e., *arrangement* – making things orderly).

Many experienced substantial disruptions to almost all areas of life (e.g., home, school, relationships), contributing to feelings of instability and unsteadiness. Emily recalled a legal dispute between her relatives about who would look after her following her mother's sudden death.

> My grandparents were hideously bereaved and there was a big court case in the end over who was going to look after us. … And whilst living with my grandparents, we had to move our cats there, and everything … so we were there for a few months … whilst it was all going on.

> My grandparents were always lovely to us, but it was these questions, “Who do you want to live with?”. They were arguing hideously around us, and it was really awful. Eventually we went to live with my dad, so we then moved schools. (Emily)

Joanna spoke of the speed at which her life changed, which in part, contributed to the surreal quality of the experience of her mother dying:

> It was like a film. It was like a film. I don't know if the other people told you, but for me, it's like a film. (Joanna)

In recalling the changes, memories of speed and fastness evoked connotations of things rapidly slipping and falling away from Joanna’s grasp, perhaps mirroring the process of her mother’s rapid deterioration in health.

> It went very fast…I remember the day after, the Thursday, someone was at the door … and I opened it, and then there were people … they gave us some helping materials … for sick people. "You're too late, she's gone." ... I, we forgot to ring them, but it was the day afterwards. So it went very fast. And that is the main thing I remembered for my father, for everyone, it went very fast. (Joanna)

Juxtaposed with these profound changes, for some, was a sense of carrying on as normal. Several participants described returning to school with no interruption.

> The next morning, I was sent to school, and it was, just seemed bizarre, you know, to be going into school as usual. But actually, nothing was normal anymore. (Rowan)

Alice described her choice to go to school “the next day”. Of this decision, Alice expressed, “That's something I always feel quite ashamed of saying”, perhaps feeling out of step with cultural expectations around mourning. At the same time, not wanting to draw attention to grief may have felt culturally encouraged – perhaps leaving participants in an awkward position of neither wanting to draw attention to their pain, nor wanting to be judged as insensitively ignoring it. This sense of not drawing attention to things and “carrying on” was also expressed by Blossom, who described returning to school after her mother’s death:

> I don't think anybody said anything, or at least if they did, maybe they did, I don't know. But … nobody really mentioned it. And we just sort of carried on. Which was basically the pattern for the rest of my childhood. [laughs] We just carried on and nobody spoke about it. Oh... [sigh]. (Blossom)

Several participants, in particular Laura and Joanna, spoke about the positive impact of support from others. Joanna spoke of the "warm memories" of her friends around her mother's illness and death – "just hanging out … not doing something spectacular", inviting her swimming and for bicycle rides. Through this continued closeness, and a willingness to be alongside her in her grief, perhaps Joanna felt able to continue amidst the sorrow of what had happened.

The Intensity of Silence

Many participants experienced a powerful and painful silence within their families when it came to talking or sharing emotions about the death of their parent. For many, the impact of this silence was felt intensely, throughout most or all of their lives. For some, it felt as though the silence was almost as painful as the original loss, preventing a continued sense of knowing, connectedness, and remembrance of the dead parent.

Speaking of the silence around her mother, Sandy described how "my dad met someone else, and I think that stopped a lot of conversation about her". Describing how her mother's photograph was once "up all over the house", Sandy recalled that "the pictures disappeared, and it became a silence". The impact of this was enormous: in the context of her mother dying when Sandy was so young, this silence seemed to act as a barrier to continued connection.

> I think the silence around it has been the biggest impact. … That silence has been crushing over the years, just like really paralysing, and really omnipresent in every relationship and really, really difficult to break through. I have in, in some cases, with some family members, managed to break through some of that, and it's been really, it's been a really positive, painful, but really positive experience … I've managed to speak to my dad, but it's always so uncomfortable. It's just incredibly difficult. He gets upset and then he can barely tolerate being upset, and I can barely tolerate him being upset, so it becomes [large sigh, voice emotional] really, really difficult conversation. (Sandy)

Blossom expressed missing the “ins and outs” and the “little bits” of her mother because of the silence in her family, and like Sandy, recognised how pain prevented people from speaking. It was as though for some families, the intense grief may have felt like all they could bear, hence avoidance of further conversations that would stir emotion, and connecting with previous ideas around the pain of witnessing others’ suffering.

> My dad basically never really spoke about my mum again, pretty much. He didn't tell us any fun stories, or anything … I sort of recognise now that he couldn't. But equally that meant a lot the family followed his lead. (Blossom)

Some participants spoke of a family culture around emotions that preceded the bereavement. For example, Alice spoke of being from “quite a repressed family, really”, with the silence around her father reflecting “a trauma that people went through that they just couldn’t bear to speak about”. Laura described a “cheerful” family culture, perhaps experiencing tension between her desire to sometimes talk about her mother, but not wanting to initiate painful conversation that could perturb this culture. With respect to this, perhaps Laura put others’ wishes first.

> We don't talk about a great deal, as a family. My dad and my brother are … very cheerful types that like to kind of not dwell on sad things … same with my nan, you know, realising that, it felt like when I would want to talk about her that, you know, as if I was causing them pain by doing so, you know, like they really would just wish I wouldn't. (Laura)

For many participants, a further consequence of silence was a lack of information about their parent. For some, this also concerned the circumstances of their death, but for many, this was experienced as a loss through not having a robust sense of knowing and feeling connected with the dead parent.

> I have a-, a sort of almost like a gap. Like, a just, a nothingness. (Sandy)

> It's a bit, one of those things where you just think, "How do I not know all this stuff?", but I don't, unfortunately. (Blossom)

Alice reflected on how her father’s death was “never properly explained” to her:

> The word suicide has literally never been spoken in my family, nobody's ever told me what happened, it's something that I pieced together … somewhere in my adolescence … it started to just make sense that people don't just get into cars and stop being able to breathe. (Alice)

Lacking an explanation and the opportunity to talk was perhaps linked with Alice's mode of coping – pushing down her emotions and focusing on others, perhaps because the idea of grappling with something like this, alone, would feel too overwhelming.

Feeling Lost

All participants described some sense of feeling lost, alone, or different following their parents' deaths. In some respects, this difference was quite literal – some spoke of being the only one, or one of a small number within their peer group with this experience. The salience of this difference was sometimes highlighted through ordinary, day-to-day events – such as Emily's experience of her school's celebrations of Mother's Day.

> Every Mother's Day at school they all made cards and things like that, and I used to sit there and make a card for my cat. [sigh] Which [laughs] my poor cat. My dad would be like, "Ok, we'll put the cat card up". So yeah, I think it was really hard at school. (Emily)

Many participants spoke about the ways this sense of difference manifested more subtly, in relationships with others – reflecting feelings of their own and others' awkwardness, self-consciousness, tentativeness, and feelings of disconnection.

> No-one really knew what to do with us or how to speak about it or how to be. (Emily)

> When I started doing clinical training, like, struggling to like, have a lot of memories of how I was afterwards, and messaging one of my school friends, and saying, "What was I like?", and she was just like, "You just absolutely didn't want to be different, you didn't want to talk about it, you just wanted to be normal, you wanted everyone to treat you like everyone else". (Laura)

> I felt like the only person where there was real sadness in my family. And so I felt quite separate from my peers when I was a kid … When I came to piece things together, I think I

> went through certainly times in my adolescence where I struggled with anxiety and depression that wasn't really – again, given my family style – wasn't really acknowledged. (Alice)

Alice's example reflects how her deep sorrow led to her feeling alone and distanced from others, perhaps having no sense of where to begin in talking about her feelings around her father's suicide. Rowan expressed a similar sense of feeling out of step and emotionally different from her peers:

> Maybe that's why I felt different to everybody else, there was something really major I was dealing with, and they were just, you know, having fun, just being teenagers. (Rowan)

Similarly, whilst Joanna expressed great warmth towards her close friends that remained beside her, she nonetheless experienced deep loneliness. Acknowledging, "I'm a big talker, but I don't share that many emotions, deep emotions", perhaps Joanna's lack of sharing her grief contributed to this sense of feeling alone.

> Despite of all the people who helped us, and always being there, I felt very lonely … Suddenly, it was different. Suddenly… [beginning to cry] (Joanna)

A couple of participants sought comfort from dreams and fantasies, perhaps to steady themselves amidst the trauma of their loss. Sandy described her childhood understanding of her mother's sudden death being "based on myth and false memory", with her current understanding "being a work of many layers". This sense of feeling lost and uneasy about this lack of clear narrative comes across in Sandy's reflections:

> Even as I relay the facts to you now, I'm not confident that they're real. (Sandy)

> It's all a bit fake. And I feel slightly like I'm talking about somebody else. (Sandy)

Blossom spoke of having a fantasy that her mother "had killed somebody and gone to prison … and that she would come back". This seemed protective, allowing Blossom to live with hope rather than face an unbearable reality.

> I suppose now that was my way of protecting myself from the pain, even though I was also going through the pain … I remember crying myself to sleep at night, and not going to share that with anybody. … I think it just allowed me to think she was coming back, and … that she wasn't gone forever. Just, that just seemed too horrible and final, and we hadn't had … a chance to say goodbye. … I don't know when I had to … let go of it … I suppose I probably always knew that it wasn't true. Because why would you tell someone their mum's dead? You know, but it, I suppose it allowed me something to protect from that horrific pain. [voice trembling] (Blossom)

Blossom reflected on childhood dreams after her mother’s death, where during sleep she would dream of her whole family, with her mother still there, still alive. These dreams seemed like a refuge from the pain of her waking life, enabling her to continue that sense of childhood innocence, sheltering her from pain and chaos. The comfort she took from these dreams is reflected in how Blossom felt when they ceased.

> One day I woke up, and I decided that I was too old to dream about that kind of thing anymore. And I never dreamt about her again. And that was a massive loss, I think. [voice trembling, tearful] So you can hear in my voice [laughs], that was a massive loss. And I don't know why I never dreamt about her again, I sort of decided that was it. [crying] I don't know if that's the time I realised that she wasn't coming back. (Blossom)

Navigating in a Strange Landscape

This master theme focuses on the experiences of participants in navigating life after their parent’s death, using the metaphor of travelling through a strange, surreal, and unfamiliar landscape. In contrast with the previous theme that focused on childhood experiences that were proximal to the original loss, this theme reflects the process of navigating adult life, up until the present day.

The Ebb and Flow of Loss

In reflecting on how the early loss of a parent was felt during participants’ adult lives, there was a powerful sense of it having a non-linear, meandering quality that shifted and evolved over time. Milestones also punctuated this experience, where the parent’s absence felt particularly salient.

For Emily, whilst she spoke of thinking of her mother every day, she recognised times when the loss felt particularly “raw again”: often associated with anniversaries and major events, where the absence of her mother felt conspicuous.

> I remember actually when I graduated from uni, that … my dad was really upset that he was like, “Your mum would be really proud”. … So those events, where you see everyone with their parents, or like, you know when your friends are getting married with their mum, the mother of the bride, all this stuff … it’s really obvious that it’s missing, you know? (Emily)

Laura reflected in a similar way about the absence of her mother at major milestones in her life. For Laura, this may have also connected with painful childhood memories of feeling different as a result of her bereavement.

> It's the things that, you know, remind you of being in that different situation to other people. (Laura)

Whilst some participants alluded to a tension between the joy of a happy event and the sorrow of their parent not being there to share it with them, Joanna reflected on this more explicitly with respect to becoming pregnant with her first child. For her, it was though there was both a sincere joy right alongside a deep sorrow. Joanna chose to face this courageously through her choice to give her daughter a part of her mother’s name.

> I didn't want to admit that I was going to be sad because I've lost my mother. So when I was nine months, preparing myself, "I don't want to be sad, it's okay, it's already 20 years, I can do it”. … Because illness is more destructive than pregnancy, so why would I be sad? And I'm not, and I wasn't sad. It was a very happy time for my husband and me. We had a healthy baby and I had a joyful pregnancy. So why? But I missed her. And I missed also in other little things. And every time my father gave us the mission command, "Seize the day, try to appreciate the little things” … I also felt the strength from that mission, but I also felt the sadness from... she couldn't. She now can't feel the little things … so it's appreciating and missing. (Joanna)

Two participants in particular – Laura and Joanna – spoke about deeply painful experiences of subsequent adulthood bereavements of women who were mother figures.

Laura spoke of her grandmother's death, which felt "devastating" to her – "a bigger deal for me than most people losing their grandparents", because of her grandmother being a maternal figure – a "surrogate mum". Joanna spoke of the loss of her "second mother" – her mother's best friend – which had a profound impact on her, perhaps stirring many feelings from her childhood loss. Like Joanna's mother, her "second mother" also had terminal cancer.

> Grief is always complicated. But sometimes I get confused in my grief because it's so strange. Sometimes we wonder, am I now sad because of my mother or am I sad because of [her]. So sometimes, it's difficult to know when, when I'm sad for who. (Joanna)

Aside from specific milestones, many participants reflected on the ebb and flow of grief, sometimes experiencing strong swells (with Alice talking about how grief "hit" her, and Blossom saying how it was "hitting me in the face … like waves"), and at other times, being subtler (described as "ripples" by Sandy, Blossom, and Alice). Despite this ebbing and flowing, a feature of many accounts concerned the permanence of this loss:

> The loss, a loss of whatever it is, or whoever it is, doesn't just stop, and you don't just get over it. It is entwined in all of your lives. (Blossom)

> You're not just bereaved at a certain point, it hits you at different times over your life. (Alice)

There were differences in how participants related to this ongoing sense of loss. Speaking in the context of her therapeutic role, but perhaps connecting with her outlook on life more generally, Laura spoke of her bereavement:

> It's about not letting it define you. (Laura)

Sandy spoke of feeling the loss "more and more and more and more as time has gone on", but did not experience this in a negative way. Perhaps because she felt emotionally disconnected from the loss during childhood, developing a connection felt heartening.

> At first [it] was a bit troubling, because you think, "Why am I getting worse? Why am I feeling worse about this?". Like, the more distance I travel, you know, it's like the wrong correlation, I'm feeling worse about it. … But at a certain point, I just sort of thought, "Well, I have to just lean into that", and actually, almost started to welcome feeling the impact

> because, I think in a way, it made me feel a bit more normal. Like, it's normal to feel sad that your mum died, right? And I would just talk about it like it was matter of fact, like, I would say, when I was a kid … kids ask you about your mum, right? "Oh, what does your mum do?", "Oh, my mum's dead", you know, you have that conversation, like a million times. ... People would say, "Oh, I'm sorry"; I'd say, "Oh, it's okay, I don't remember her, it doesn't matter". … That was all I could access about it, was that I didn't remember it, so it, it sort of didn't count. … So actually, it came a point where I welcomed that emotional distress. (Sandy)

Several participants reflected on other emotions shifting and changing over time – reflecting the multi-layered, meandering quality of the loss experience. Blossom noticed emerging feelings of anger towards her parents:

> I've been quite angry at her, and my dad, for not preparing us, and not leaving us anything, you know, like you see in all the movies where people write letters and all this sort of stuff. (Blossom)

For Alice, her anger related more to others' silence about her father's suicide ("I wouldn't say like day to day, I'm really affected by loss, but the aftermath of that loss"). Developing psychological knowledge during training perhaps amplified and sharpened her feelings of anger and injustice.

> When you're training, you sit in circles and talk about your feelings all the time, and you sit in supervision and talk about attachment, and you work in CAMHS, and that I really started to feel angry, like really, really angry. And I had a really difficult relationship with my mum for a few years that hasn't quite recovered. (Alice)

The Evolving Relationship with the Parent that Died

All participants spoke about shifts in their relationship with their dead parent over time: feeling the loss of a person as well as a parent; through their own maturation leading to identification with the parent; through becoming a parent themselves.

Several participants spoke about how an increasing appreciation for the parent as person led to them missing them in a different way over time. A number of participants appeared particularly moved when discussing this – perhaps because this additional loss of the adult relationship with their parent felt like a painful and unanticipated loss that had slowly come into focus over time.

> She's been an absence … like a big gap, I've been teetering on the edges trying to get in, to see more …before I missed a mum, and now I miss a woman. [voice trembles] And who was she? And I miss that woman, do you know-, as well as the mothering. (Blossom)

> It is a kind of mourning, because … it's that kind of opportunity where, like, when you become an adult, you appreciate your parents more, and you have a different kind of relationship with them. (Laura)

Connecting with this, a number of participants had significant and unanswered questions about their parent. This, too, felt like an additional layer of loss – never being able to resolve those questions.

> I quite often sort of wonder … what would she think of me now, as an adult, would she like me as a person? (Laura)

> Would I like her? Would we get on? Is she like me? (Blossom)

Several participants spoke of identifying with the dead parent. Three reflected on becoming the age their mothers were when they died. This identification seemed to highlight a new angle to the loss: for example, recognising the horror of an untimely death from the parent's perspective; feeling driven to make the most out of life; making sense of a swell in grief.

> It's awful to think that she died only a tiny bit older than me … it's horrendous. So like, I always want to know that I've done the best that I can, that I've had the most fun that I can, that I've eaten all the best food, do you know what I mean? (Emily)

> I passed the age that she was when she died, and that was a big thing. You know, I've calculated that down to the day. So I knew exactly what day it was, that I was, you know, 36 and 7 months or whatever, and x days. So I, and I got to that point, and I was like, "Wow, I'm really young, this is a bit shit, isn't it? Like, imagine dying now." (Blossom)

> I didn't know that she'd died a month before she was 27. And I became so preoccupied with it that I got a copy of her birth certificate. And I realised that she'd died at exactly the same age I was, then. It suddenly made sense that, okay, somewhere in my head, I knew that, and that's why I've been really reviewing the experience, and searching for it, and asking a lot of questions, and feeling a lot more of the emotional impact, which was quite shocking to like, look at it and think, "Fuck, I'm basically exactly the same age as she was." (Sandy)

Several participants, who were parents themselves, reflected on the impact of becoming a parent, and the new light this shed on their evolving relationship with their loss. For Joanna, longing for her mother intensified when she had her first child. She recalled an occasion when her usually quiet baby was unable to settle, and a swell of missing her mother that rose within her.

> That was the night that I went crying, crying, because… [crying] I miss my mother. And I never felt it during the pregnancy … but I missed my mother. [crying] ... And then I called [mother's best friend], and I just cried. And she said, "I was waiting for this day". [crying] So I didn't have to explain. (Joanna)

Experiencing motherhood also made Joanna feel deep sorrow for missed opportunities to talk with her mother when she was still alive. Her ability to identify with her mother's position seemed to bring a fresh sense of pain to the experience.

> I remember, one time she, she tried to talk about it [her illness/death]. And I was afraid of the conversation, and I waved it away. She wanted to thank me because I was doing lots of housekeeping work. And she wanted to thank me because she, she was very, appreciating that. And I heard her. I heard that she was going to ask me some things. And I waved it away, I went away. … And a few weeks later, she was not able to talk about it anymore, because she had too much pain. [Interviewer: How does it feel, remembering that now?] Painful. [crying] Because now I'm a mother and I can [sigh] value the talks that I have with my children, and when they wave it away, I'm, I'm... I think, "Ah, she, she tried, and I waved it away". [crying] (Joanna)

For Sandy, the relationship between becoming a parent whilst having lost a parent manifested in intense existential dread of the possibility of further loss. Perhaps her very real experience of utterly unexpected and sudden death brought the reality that people can die at any point into sharp focus.

> Every single day, it's in my head, that something will happen to them, something will happen to me, something will happen to my husband, that the same history is going to repeat itself in some way. … That means an enormous amount of anxiety. … That is a struggle even now, like I sometimes just think, "I don't, I don't know how I'm supposed to live with this". I don't know I'm supposed to go about my daily business with this level of fear about, about our family being struck by something like that again, you know? (Sandy)

For Blossom, as well as feeling she had to "second guess" parenting because of feeling "I didn't have any mothering beyond seven", she also identified with her child self through her own children, recognising – from a different perspective – what she had lost when her mother died.

> My children turned the age I was, well my oldest did, and that was again, like, "Look at this child, how, what, what if I wasn't here? What would she do?". … I guess also, they're older. They don't need me as much. And yet, they still need me massively. So I think there's that, you see what you've lost, what you had lost, again. (Blossom)

Connection

Linking with the previous subtheme of *The Intensity of Silence*, this subtheme reflects participants' ongoing struggles with silence in adulthood, and their attempts to break those silences through connection. These attempts seemed to be both about seeking closer relationships with other family members (navigating the strange landscape together, as fellow travellers), as well as continuing the relationship with the dead parent as life goes on – sharing stories and emotions as acts of remembrance and connectedness.

Almost all participants referred to significant difficulties in speaking in a meaningful or emotional way about the dead parent to other family members. This difficulty seemed long-standing for many, although there were differences between participants in terms of how they related to these conversations. Referring to the profound sense of silence she experienced during childhood following her mother's death, Sandy expressed:

> It's hard to ever quite get out of that silencing. It's like, I don't want to be silenced about it, but it's not instinctive for me to talk about it, it's difficult sometimes, I feel like I'm talking about somebody else. (Sandy)

It seemed challenging for Sandy to break this habit of silence that became entrenched in her family culture, despite feeling herself that it was deeply damaging. Emily, too, appeared to wrestle with this difficulty of doing something differently when it came to silence, recognising an "emotional boundary" between her and her father, when it came to discussing her mother:

> I find it easier with some people than others, for example, my dad, I still find it hard to talk about her … I wouldn't sit down for example and say "I wish she was coming to the wedding". I would just never say that to him, because that's like an emotional boundary that we haven't crossed. You know, and we were really close, and like, I know that he's thinking that, he knows that I'm thinking about it, but we'd never say that. (Emily)

However, Joanna identified changes over time in her feelings around sharing her grief. It was as though experiencing the death of her "second mother" (her mother's best friend) helped her and her father to do things differently – despite finding the sharing of tears difficult, they had learned to share more with one another this second time around.

> I still cry alone. But I share in words … my worries. I think [my father] now knows what is going through my mind. And sometimes he shares his as well. But... [pause] I find it difficult to share my tears with him. [pause] Because of erm, because of what happened to [her "second mother"], we learned that we now can do it. … Because she was ill, and we had to do it all over again. We learned now that it was better to share some worries. But it was difficult. It was very difficult. (Joanna)

Many participants reflected on connections with living family members and the way these had been affected over time by both silence and/or talking about the loss of the parent. For Blossom, difficulties in talking about her mother, following perception of her father's example of silence in their earlier lives, engendered a sense of emotional distance between her and her siblings in adulthood. It was as though not having sufficiently broached this “taboo” topic made Blossom feel as though there was a barrier to greater closeness in these relationships.

> I would say we're quite close, but in some ways we're close, but distanced, because we don't really speak about it. And we do, and yet we do. So I have spoken, especially to my sister, a bit more, but I, it is something I want to do more … but … it's just, that has driven a wedge, I think. And whilst we're quite close and one way we, it's, it's been something that's been, I want to say a taboo-, well, yeah, it was a taboo, really, you didn't talk about her, that was it, she became a taboo, and you didn't speak about her. (Blossom)

Connecting with this idea of taboo, Laura spoke of a similar family rule when it came to speaking about her mother:

> It's still this kind of unwritten rule in the family, like, [whispering] best not to dwell on it. (Laura)

For Laura and Blossom, as well as several others, there were continued concerns about upsetting others – with the feeling that through avoiding these topics, one can also avoid further distress. Laura, particularly, reflected on challenges discussing “flawed” aspects of her mother, and difficulties in their relationship before her death – to share this with her father and brother, she felt “I feel like I would be spoiling their idea of her”.

> I think it was just all so sad. It was like, "what is there to say?". Yeah, and I think it's made us quite kind of conflict avoidant, as a family, so that we can't really bear to see each other upset. …. We protect each other quite a lot. (Laura)

> We all get upset, this is a problem, because we haven't ever spoken about her that much, we always just get upset the minute we start talking about it, so it's quite difficult. (Blossom)

Alice and Sandy highlighted challenges in relationships associated with silence. Alice reflected on continued feelings of anger towards her mother as a result of her mother’s silence about her father’s suicide – “I don't see my mum an awful lot, and we have had it out this year”. Sandy spoke of how the aftermath of her mother’s death affected the family’s connectedness – as though the complex and painful experiences of grief, anger, and silence over the years had come together to impose huge strains on relationships, which felt irreversible.

> It's not like one of those things where it, "Well it brought everyone together", and it didn't, it just drove everybody apart. [sigh] That sounds, that sounds worse than it is, it didn't drive everyone apart, it drove some people apart. And it put, I think, immovable barriers between others. (Sandy)

Something Lost, Something Gained

Drawing on the rich and deeply personal experiences reflected in the previous two master themes, this master theme illustrates the synergy between the personal and the professional by focusing on participants' lives as therapists. It reflects the process of becoming a therapist, their use of self and personal experience in therapeutic work, and reflections on experiences that support the therapeutic use of self in service of clients.

Becoming a Therapist

All participants recognised a connection between personal experiences and their choice to become a psychological therapist, with patterns of similarity and difference in how experiences influenced career choices. In addition to the bereavement experience connecting with the choice of therapeutic work, other experiences that related to this were significant too, and there was diversity amongst the kinds of experience that drove professional interests. Several participants spoke about how personal experiences led to professional curiosity about families and relationships.

> I'm really interested in like, family secrets and family stories. … I'm very conscious of what people don't know or haven't been told. Like, you know, gaps in people's stories, I'm always really curious about, and I think because of my own experience of things not being shared with me. (Alice)

Rowan described how her interest in therapeutic work stemmed from counselling she sought after her divorce – which she recognises as linked to experiencing her father's death.

There was something about Rowan's process of unpicking this experience and patterns in her own life through personal therapy that led her to feel inspired to pursue this career.

> I had counselling, and that's when I started to piece together the death of my father, and the fact that that sense of disappointment in my husband when he became a father, he wasn't the same sort of father that I expected. (Rowan)

Sandy recognised a motivational shift – noticing how the things that originally drew her to pursue a therapeutic career were not the same things driving her interests over time. Initially, understanding and sense-making seemed a powerful pull for Sandy into her profession – linked with her own experience of feeling lost and lacking a clear narrative following the death of her mother. However, later on, it became about "the work itself".

> …[it] was about just wanting to make sense. I wanted to feel it in a way that I could understand, and just know what it was. And that's what I was struggling with. And that's why I wanted psychology to help me do at the start. And I think that's probably also a bit of my job that I enjoy the most, is the formulation. It's like, when people just have this thing that's too big, that's too complicated, they can't put it together, they can't grasp it and understand why … that's the bit I love. That's the bit that I really, it gives me huge amounts of satisfaction to be able to go, "Oh, okay, I get it. I get it!". (Sandy)

Others spoke of personal qualities which drew them towards their career, or made them well-suited to the work. Alice described having "a compulsive caring quality that was born in my childhood" which she felt "leant itself into going into some kind of helping profession". Perhaps in childhood, this may have made it hard for Alice to get her emotional needs met, but in adulthood, this may have made her a particularly sensitive and compassionate therapist. Laura joked about the relationship between her choice of career and her mother's death – and whilst said in jest, also said something about her continued connection with this experience and its influence in her professional life.

> I sometimes kind of joke with other psychologists that … my brother, for example, he's obviously dealt with the death much better than me because he's just got a normal job. [laughs] (Laura)

A couple of participants spoke openly about wanting to move their life in a different direction, somehow, through their choice to work as a therapist. Emily reflected on her preference towards embracing the nuance and unpredictability of therapeutic work – after being raised in a "very male … straight down the edge" environment after her mother died.

> I've lost every female figure. … I think it made me more understanding of people's difficulties … And I think maybe that rigidity made me want to not be in a rigid… (Emily)

Sandy reflected on how her choice to work therapeutically was partly inspired by the wish to not re-live patterns from her childhood. It was as though this vocation enabled Sandy to keep this hope and inspiration for her own family alive.

> … for my own family now, not my family above me, my family below me, like, "It can be done. It doesn't have to be, it doesn't have to be the same, the same template". … It doesn't have to go the same way. … You can drive your experience in a different direction. And I think probably being in the role of being in therapy with other people … you live that a bit more. (Sandy)

Drawing on the Self in Therapy

Participants reflected on their use of self in therapeutic work – how they were able to draw upon experiences from their own lives in service of their clients. Whilst participants all shared the childhood experience of a parent dying, how this experience shaped therapeutic practice was rich and varied.

All participants recognised an increased capacity for empathy stemming from their own experiences of suffering. Some recognised the ways in which the universality of suffering transcended other differences: through the shared experience of pain, they were able to feel deep empathy and connection with their clients.

> … having kind of a personal experience of kind of [sigh] loss, and particularly loss in very traumatic circumstances … facilitates a bit of a bridge between me and these people whose lives are so different from mine. (Alice)

For many, this kinship in suffering enabled deeper feelings of compassion. The external experience did not have to be the same; rather, the internal, psychological experience was where the connection and commonality was felt.

> I’ve always been I guess, different in that respect, to other people. … Maybe it is just about understanding difference. Understanding being the odd one out, or lost, or alone, or feeling there’s no-one. (Emily)

> … perhaps because I've been through that, it might help me see that for everybody that whatever they're bringing to therapy, you know, is touching that worst time for them. Touching a struggle, touching some sort of loss or change … or emotion … they've got something in their life that they just can't manage. (Rowan)

All participants recognised the value of learning from personal experience – beyond what was taught in therapeutic training – and the profound impact this has on informing their work. Life seemed to teach deeply valuable lessons that participants were able to draw upon in service of clients.

> I realised that I am a person that works from my belly and not from the things I learned. … It's not in the books, eh? [laughs] (Joanna)

> It's as important as … everything I've learned through training, the technique and stuff, it's just, just a feeling of how to be with people that comes from this experience that I've had. (Alice)

Others reflected on the ways in which personal experience provided a rich illustration of clinical theory that greatly enhanced their understanding of therapeutic training.

> One of the things that my own experiences have demonstrated very powerfully to me, that I then hear in families, is that family script stuff, about what happened to us, why it happened, what kind of family we are, what kind of family we can be, or can't be now, that this has happened, all that stuff that constrains the dynamics in a family system after awful event. I don't think I would have any grasp of the power of that, if it hadn't been from witnessing it, and growing up with it all, all over the place. ... In terms of systems theory, that, that is

> something that I think I feel the impact of, and can make better theoretical sense of, and use better with families, because of the experience I've had of it. (Sandy)

However, there was variation in how participants connected with this idea of drawing on the self in therapy. Laura, who was in the process of considering a career change away from therapeutic work to improve her work-life balance, felt unconvinced as to whether her experiences had enhanced her therapeutic work.

> Whether it makes me a stronger therapist, I don't know … there's so many factors that would play into that, and I probably believe mostly it's about the kind of relationship and the dynamic with the people you meet with which … isn't necessarily related to whether you've had this loss or not. [pause] I'm not sure about that one. [pause] I think, you know, that I feel like maybe it would be a nice way to package it up? Kind of nice story to tell yourself, that like, "Oh, it's made me stronger", that kind of thing, that, but that maybe that's a way of trying to put a silver lining around it. (Laura)

However, many participants identified strengths gained from their experiences, which manifested in different ways. For example, having experienced her father taking his own life, Alice recognised how she had become a therapist who felt confident in working with acutely suicidal people.

> I don't get very upset and worried when people talk about being suicidal. And people who are suicidal appreciate that. They don't want to hear someone freak out on the other end of the phone when they call the duty worker and say, "I'm having thoughts about taking my own life", they want to hear someone say, "Tell me about it". And I can do that. … Maybe going through the process of training and my own therapy, and learning a lot about myself, I've come to not feel very, I don't feel responsible for other people anymore. (Alice)

Alice and several other participants also reflected on feelings of strength that they had gained from living through early experiences of vulnerability and pain.

> There's this narrative that, you know, "You have to be resilient". And well, why? Who says that being vulnerable isn't part of being resilient? I'm resilient because I know that I’m really vulnerable, I think. And that's, that's come from having lost a parent, I think. (Alice)

> I've just got a bit of inner strength, I think, you know, to stand alongside people and just hold the space for people. (Rowan)

> I feel really proud of how I've turned out. Like, you know, I think I'm quite normal. I hope I'm quite normal [laughs]. And, and strong, and like, you know, I can do the job that I do despite these experiences. (Emily)

Nonetheless, many participants could connect with areas of vulnerability in their therapeutic practice, stemming from personal experiences. For some, these issues related to over-identifying with younger clients, which sometimes felt detrimental to therapeutic work.

> I found it very difficult to separate her experience from mine. (Alice)

> I definitely used to come at it from a child's perspective, and like, always be siding with a child in therapy in a sense. And that's definitely changed … I used to be very much like, "Yeah, you don't have to tell your parents any of this, your parents don't need to know". I'd be surprised when parents wanted to know what their children were talking about. And very much be like sort of on the side of the children. (Blossom)

Other times, vulnerability related to the emotional impact of the work – where the emotional resonance could have a detrimental impact on the therapeutic process.

> Is there some kind of switching off to death in, you know, in that I experience in people, that's hard for me? (Laura)

> … that's a strength for me, in terms of having a very real therapeutic relationship. … But at the same time, that is also the difficulty, because that brings up my own emotions, that makes me a bit more vulnerable, that makes me want to work a bit harder, and then maybe that takes some responsibility away from the patient. (Emily)

Several participants acknowledged the importance of attending to the self – being reflexive in therapeutic work, rather than neglecting or ignoring the personal.

> Family therapy education taught me what you have to do with your belly. Why is your belly now worrying? If the people don't give you any words that are worrying. Why is that?

> Because you are busy with something else, or is it because the family is avoiding things? (Joanna)

> We can get into trouble, can't we, if we worry too much about using our self and our experiences with other people. And I think if we try to never do that, we will do it accidentally. If we do it with thought, and consciously, then we'll probably do it helpfully, but it does require you to have a certain management of your own stuff in order to be able to do that. … I don't think we have to be perfect on it. … It can be live, I think it can be raw, we just have to be thoughtful. (Sandy)

Supporting Therapeutic Use of Self

Participants reflected on various things they encountered which enhanced their ability to draw on the self and personal experiences in service of clients – identifying both internal and external resources that could support them in this work. One idea from several accounts concerned the importance of identifying emotional boundaries – both with respect to client work, and the choice of broader work setting.

> You really need to know what you lost. I think that's the main thing. You need to know what's yours and what's other people's. (Blossom)

> I took it to my supervisor, and I just said, "I can't do this". … I think that was me recognising my personal boundary, that you know, actually this is going to make me too vulnerable … I am not going to be able to be a good therapist to this person if I can't contain my own emotions. (Emily)

> I would probably still struggle to work specifically around bereavement and children. … I would struggle to... I don't know whether I could keep my own stuff where it needed to be, enough? I don't feel like it would be unsafe for me anymore, in that, "Oh my god, I'm going get overwhelmed by someone's story and have a meltdown". But I'm not sure, like from a professional point of view, whether it would just be asking too much of myself, to every day, visit material, and be the right psychologist I need to be for the person I'm working with, and have my own stuff managed efficiently. (Sandy)

Two participants spoke about taking a break or moving away from therapeutic work, recognising the importance of attending to their own wellbeing. Joanna described taking a two-year break after experiencing the death of her “second mother”. It was as though the intensity of this personal pain left her feeling exhausted, doubting her abilities, and less motivated to want to sit with others’ sorrow.

> After the second experience [of bereavement], I quit helping people. I quit my job. Because I was tired of sadness. … I didn't believe in myself, because I didn't believe that I could make a difference for people because I was so sad ... And I went for, looking for an administrative job …. And I thought it was okay, because I don't have to investigate in, in my belly. I don't have to investigate in my, in deep connection with people, I just have to be. I don't have to take care of relationships anymore. Hah! [laughs] Not true! But yeah. I was stubborn. And I needed it for two years. (Joanna)

For Laura, the death of her grandmother – a maternal figure – contributed to her evaluating her work-life balance, and the impact of stress. At the time of the interview, Laura was considering whether she wanted to continue therapy work, having just started a part-time role in a different sector. Previously, she had two part-time therapeutic roles, one of which was in staff support:

> It almost feels like the universe was kind of conspiring to make me talk about burnout and the signs and symptoms and how important it is to look after yourself. (Laura)

> So I was kind of working the hardest I've ever worked, like stress nearly every day, and then my nan died, and I was like, "What the hell am I doing?". (Laura)

Some participants identified the importance of checking in with themselves to examine the psychological impact of therapeutic work, particularly when working in areas of emotional resonance. It was as though the flip side of participants’ deep capacity for empathy was an increased vulnerability to feeling emotionally exhausted and overwhelmed.

> I need to always be able to check in with myself and say, “Is this too much right now?”. (Emily)

Many participants highlighted the value of personal therapy. Whilst some acknowledged reservations and feelings of vulnerability, personal therapy seemed to support participants in being more open to embracing resonance with clients and drawing on the self, without becoming overwhelmed.

> I kept thinking, "I should go to therapy, I should go to therapy". And I just, at the time, I didn't have enough support around me. So I've done it since, and I think I left it too late. [laughs] But I got an awful out of it. … I feel like I can empathise with people without going, sitting in my car at the end of the day and feeling really harrowed. (Alice)

Finally, many participants recognised the value of open and reflective discussion with supervisors and colleagues. Participants varied in the extent to which they felt connected with people they could talk to about using the self in therapeutic work – but many identified opportunities for open reflection with others as important.

> It's just being sure that you have a solid, well, it doesn't have to be your supervisor necessarily, but a person, a relationship with someone, that you can reflect upon this stuff with. Because I think it's the thing that makes the difference is about having awareness about it. … What has the danger of making you a less good therapist is when you're blind to it, or you, you know, it's kind of something that you can't see, or can't reflect on, or talk about when it comes up in the work. (Laura)

> I'd love to have the opportunity actually to think about those things with other people. I don't think I've ever met another therapist that has openly told me anyway, that they've had the same experience. (Emily)

Discussion

In this chapter I will discuss the findings of this research, beginning with a brief summary of the results as a whole and how they connect with and extend the existing evidence base, followed by more focused discussion organised by the three master themes identified in the previous chapter, highlighting links between these findings and the theoretical and empirical literature. Critical evaluation of the quality of the study will be presented, followed by discussion of the implications of this research, and suggestions for future research. Some final personal reflections will be shared, followed by the study's conclusions.

Taking all three master themes together, the results demonstrate how for the psychological therapists in this study, the experiences of being bereaved of a parent in childhood had a profound impact, in both personal and professional contexts. Whilst the first two themes focused more on personal experiences and the third theme focused more on professional experiences, one can nonetheless observe threads of connection that run across all three themes. One connecting thread reflects the idea of growth over time, which is first represented in the second master theme, *Navigating in a strange landscape* – reflecting participants' experiences of their ebbing and flowing relationship with loss and the dead parent over time, primarily in personal contexts. This notion of growth over time appears again in the final theme, *Something lost, something gained* – reflected in the ways participants reported journeys of change and growth in their professional contexts, such as how their motivation to practice therapy shifted over time, and their journeys of integrating personal experiences into professional identities. This connects with existing literature on posttraumatic growth (Tedeschi & Calhoun, 2004), reflecting how a major traumatic life event and subsequent experience of profound suffering can lead to positive growth across multiple intra- and interpersonal domains.

A further powerful thread connecting all master themes was the experience of silence, and associated feelings of difference and isolation. The emotional silence about the person that died was experienced most noticeably by participants in their personal contexts (both during childhood and in the present day), but also connected strongly with their professional lives, both in terms of career choice (for some participants), and their relationship to silence around this topic in the course of their work. It was noteworthy the way participants chose a career in which their practice of therapy could be said to reflect the opposite of this silence (i.e., choosing a career where talking about emotions is central), with this connection being explicitly highlighted by some participants. Some participants also reflected on encounters with professional silences around their personal experiences, and challenges associated with navigating this (e.g., speaking about their loss with supervisors and colleagues). This finding about silence represented a relatively novel finding with respect to the studies discussed in the systematic review about therapist bereavement, where silence was not emphasised as such a strong feature of those accounts. Nonetheless, this does connect with some existing literature which has explored the role of silence following bereavement in the general population (e.g., Baddeley & Singer, 2010; Jalland, 2013). Continued exploration of this theme, along with other prominent findings, will now be presented with in-depth discussion of the three master themes in turn.

A Loss Beyond Words

This theme connected with the element of the research question concerning the personal impact of therapists' experiences of the death of a parent in childhood, focusing on experiences during childhood. Participants discussed the emotional impact for themselves and their loved ones, as well as impacts on their day-to-day lives, and the effects of these changes in both psychological and relational contexts. A powerful universal theme was that whilst the death had, quite expectedly, an enormous impact, events in the aftermath of the death – and specifically, families' responses to the death – had a profound effect on participants' emotional experience of the events. The most pronounced difficulty for participants seemed to be silence – a struggle experienced in many families to speak of the person that died, and to share grief openly with one another. This connects with work from Imber-Black (1998) and McGoldrick (2011) on family secrets, recognising the impact of that which is hidden on emotional processes and relationships within the family system. Whilst there were differences between participants in the degree to which loss was shared and spoken of communally – for example, Joanna, who spoke of how, just hours after her mother had died, "the house was full of friends" – all participants recognised a major difficulty, for themselves and others, in speaking of and sharing deeper emotions. In addition to this sense of silence, a further theme common to all accounts were feelings of difference and disorientation in the aftermath of the death. Often juxtaposed with a surreal sense of things carrying on as normal, were profound feelings of difference. This difference seemed to be felt both internally, with respect to participants' former lives (things never feeling the same again), as well as externally, in terms of participants feeling different to others, somehow set apart and distanced from their peers.

In reflecting on areas of similarity and difference, it was powerful to observe the degree to which some similar elements – in particular, silence and feelings of difference – resonated strongly across all interviews. This was in spite of considerable diversity amongst the nature of bereavement experiences – for example, the age the participants were when their parent died, whether it was the mother or father, and the cirucmstances of the death (e.g., sudden or expected). Previous research on parental death in childhood has emphasised the uniqueness of each individual experience (Tyson-Rawson, 1996), arguing for the impossibility of suggesting any single outcome given the heterogeneity of experiences. Whilst this may be true, it may also be true to state that whilst experiences can appear totally different on the surface, they may, at a deeper level, share more in common than initially recognised. For example, whilst participants who experienced the sudden death of a parent reported of feelings of shock, it was interesting to recognise that those who experienced a parent's protracted decline in health still felt shock, too, when that parent died, even though on the surface, to an external observer, it may have appeared predicable.

Without diminishing the uniqueness of the individual, perhaps there is something about our shared humanity that transcends some of this difference. This is not to say that significant differences in responses to bereavement were not seen in this study – as highlighted previously, differences were certainly there. It is more of a suggestion inspired by this data that whilst there may be temptation to see individuality and uniqueness as a metaphorical full stop when it comes to developing further theory and research – to just say, "Everyone's different!", and leave it at that – it can be powerful to look deeper and try to recognise areas of commonality and patterns, too. It is also important to emphasise that identifying similarities across experiences need not result in rigid psychological models in which people are crudely meant to fit. Rather, the findings of this research speak to the value of recognising the shared alongside the idiosyncratic.

Considering the phenomenon of silence following bereavement, one can identify parallels between experiences of participants in this study, and previous research and reflective writing. The analysis by Broadbent (2013) on therapists' bereavement and loss experiences proposed a theme – "being heard and witnessed" – reflecting the importance of grief being heard, and conversely, the detrimental impact of grief remaining "unwitnessed". Allphin (2018) wrote of painful silence around her mother's suicide – perhaps connecting particularly closely with experiences reported by Alice about her father's suicide. Allphin (2018) conceptualised this silence as having a dissociative quality – which perhaps reflects some participants' experiences of silence in this study. Indeed, many accounts referred to silence having the function of avoiding emotional pain – and thus, silence being in some respects dissociative – as participants expressed that bringing the pain of the loss "into the room" (in Sandy's words) felt too much for them and others to bear.

It is also interesting to refer back to the parallel silence, identified in the Introduction, that exists within the therapeutic profession with respect to wounded healers and therapists' personal experiences of trauma. In their literature review on wounded healers in mental health, Zerubavel and O'Dougherty Wright (2012) reflected on "dialogue and silence" in this area, highlighting the lack of research and discussion of this topic:

> …it is often only alluded to, or given a brief mention that pales in comparison to the depth that other topics have received … reference to the wounded healer is often set apart structurally from other material, appearing in the epilogue or afterword (Zerubavel & O'Dougherty Wright, 2012, p. 484).

They suggested various reasons for this silence, including ideas around stigma (e.g., (e.g., Tay, Alcock, & Scior, 2018), fears about gatekeeping in therapeutic professions, and the unpredictable trajectory of the wounded healer's recovery. Evidence from this study suggests a further reason: that people working as therapists may have learned powerful lessons about silence within their family of origin. As such, it may be that the therapeutic profession is a mirror of the family contexts of those within it. In Sandy's words, "It's hard to ever quite get out of that silencing".

This master theme also highlighted ways in which participants felt different and distanced from others. Some, like Joanna, experienced profound loneliness, despite having friends around them. Others, like Rowan, found it hard to relate to peers after their bereavement. Existing theory concerning bereavement and loneliness offers a way to understand this. Riches and Dawson (2000) proposed the concept of *intimate loneliness* – the phenomenon of feeling uniquely alone in grief despite being surrounded by others. Communication difficulties are thought to contribute to this: “Bereavement can drive apart those who normally would be expected to give support, isolating individuals from their most intimate relationships” (p. 4). Although Riches and Dawson (2000) were writing about child death, their assertions regarding the impact of bereavement could equally apply to parental death in childhood: specifically, that it “fundamentally threatens this sense of who we are. It wipes out many assumptions about the future and shakes the permanence of our relationships.” (p. 5). Both the silence, and the unsettling shaking up of life, may partly explain why participants felt alone and different to others following their experiences.

Moreover, considering these experiences in light of participants’ current professional contexts, connections can be drawn between experiences of separation and difference, and their choice of career. Previous literature has highlighted a relationship between these kinds of early experience and the choice to become a therapist – hypothesising that a career that centres meaningful connection with others may appeal to those who experienced painful feelings of difference during childhood (Barnett, 2007; Sussman, 1992). This study suggests that for some, these professions may appeal, in part, because they give something wished for earlier in life.

Navigating in a Strange Landscape

Connecting with the previous theme concerning the personal impact of parental death during childhood, this theme reflected the personal impact as participants navigated their adult lives. Parallels can be made between this theme and the “re-learning the world” theme by Broadbent (2013). A powerful theme across all accounts concerned the way in which participants’ experiences of grief and loss had a non-linear quality that ebbed and flowed over time. Many identified milestones that punctuated their lives, reflecting on how these events shone a light on their loss, or how meanings of these events were interpreted in the context of the absent parent. A further element of this navigating process concerned the ways in which as participants aged, they began to identify with the dead parent. This was most pronounced for women in the study who had lost mothers. Becoming the same age or living beyond the age of the parent when they died gave a powerful new angle to the loss (also highlighted by Edelman, 2006a), as did the experience of becoming parents themselves. For women whose mothers died, this latter experience had a significant emotional impact: feeling the loss of their mother to guide them in new motherhood, and experiencing pain through identifying with the mother role and recognising their loss from that perspective, connecting with existing literature on “motherless motherhood” (Edelman, 2006b). Lastly, this theme also reflected participants’ ongoing experiences of connecting with others with respect to this loss. Many acknowledged an ongoing struggle with silence around the dead parent; however, some reflected on progress in feeling able to connect and share emotions with loved ones.

This study highlighted the ways in which participants experienced grief over time: despite areas of difference, all accounts demonstrated its meandering, non-linear trajectory. An obvious point of comparison in the theoretical literature is the famous Kübler-Ross “stage model” of loss, which describes five stages: denial, anger, bargaining, depression, and acceptance. In earlier iterations, the stages are described as tending to occur in a particular order (Kübler-Ross, 1969); however, subsequent revisions have emphasised that they are not necessarily experienced in sequence (Kübler-Ross & Kessler, 2005). This research certainly supports the notion of grief “stages” not being experienced in succession, and instead, connects more with the work of Neimeyer (2001), who emphasised that ongoing meaning reconstruction and continued symbolic bonds with the deceased person are at the heart of the grieving process. Connections can also be made with the work of White (1988), who suggested that rather than only emphasising the notion of “saying goodbye” (when there is, of course, much to say goodbye to, including the person’s material existence), it can be more valuable to explore “saying hello” – as a means of reclaiming a relationship with the person that died.

Aside from arguments about the non-linear quality of loss, the most salient feature of the findings not captured by the Kübler-Ross model concerns the relational aspects of grief. Primarily, the Kübler-Ross model conceptualises loss in terms of individual experience. However, these findings suggest that there are powerful aspects of grieving that are experienced and shaped in a profoundly relational and social context (e.g., Walsh & McGoldrick, 2004). This is not just limited to how experiences of loss and grief are shaped by family culture (e.g., the impact of silence; whether grief is communal or private), but also the broader feelings of strangeness, alienation, and difference that participants reported experiencing in their social contexts. These aspects of the loss experience seemed profound for many participants in this study; thus, models which neglect the social and relational experience of grief appear not to do justice to this phenomenon.

Further developing the idea of participants as navigators in a strange landscape, suggestions can be made about ways this may influence therapeutic practice. By experiencing a parent's death in childhood, participants could be said to be losing a compass, something that helps orient them in childhood and beyond. As adult therapists, perhaps these are people who can allow themselves to do this navigating work with clients, lingering and exploring the strange landscape rather than rushing onwards from A to B. Perhaps these people become therapists who are more used to, and not so scared, of this kind of navigating work in therapeutic practice. Indeed, this idea is consistent with several participants' accounts; for example, Rowan speaking of being able to "be alongside" with an "inner strength". It also connects with Alice's reflections on feeling comfortable "sitting with" a client who experienced the death of her father some time ago:

> My supervisor … I remember [her] being like, "Why now? What's going on now?". I think everybody else was very, very worried about this girl, and thought, "There must be something else going on". And they were all trying to find the answer and look underneath and find some secret she's not telling us, and I was like, "Why can't it just be what it is, what she's saying?". It is something that we do, services do, we like to kind of really understand and put things into boxes and make sense, but … it's not something you can really put into words why something might affect you at a particular time. … Sometimes it just does." (Alice)

This idea also connects with theoretical work by Olfhof (2017), who reflected on the idea of conceptualising life, and psychotherapy, as a nomadic journey. He describes this process of nomadic navigating as follows (Olthof, 2017):

> Nomadic in this sense means peripatetic, in motion, becoming and moving in a particular direction. … Nomadic thought seeks to release thought from the straitjacket of the Logos and give it back its liberty, vitality, beauty, and difference: all the paths are opened up again, and the beaten – not to say time-worn – paths can be abandoned. New stories can come into being and tales told about alternative routes. (p. 7)

It is possible to appreciate how experiencing one's own strange landscape following the death of a parent may help people to become therapists particularly skilled in enabling others to travel in this nomadic way. With these experiences, therapists can connect with recognising how important it is to stay as long as is necessary in a particular place in the landscape, and not too move on too quickly. These therapists may feel particularly able to hold space for clients to linger and meander in their own landscapes, to have a good look around.

A further aspect of this theme concerned some participants' experiences of identifying with the dead parent. These participants were women who had lost their mothers, although it is worth noting that only two participants – Rowan and Alice – had experienced their fathers dying. Various experiences of identification – for example, through becoming the mother's age when she died, or through becoming a mother – have also been identified in studies examining maternally bereaved women's experiences. Through interviews with adult women who experienced the loss of their mothers, Edelman (2006a) highlighted ways in which women continued to identify with their mothers throughout life. Similar to participants in Edelman's research, several participants in this study found both joy and pain in this changing process of relating to their mothers over time. Some had unanswered questions, and a number reported ongoing wondering about the lost relationship with the woman, as well as the mother. This latter theme of "missing the mother as woman" that developed for some participants later in life connects with ideas from systemic theory about the process of renegotiating the adult relationship with the parent – giving up the need to be parented and forging a new relationship with the parent as a person (Williamson, 1991), a process often initiated in the third or fourth decade of life. Perhaps some of the pain associated with this experience relates to this feeling like a further loss – a previously unanticipated loss of the opportunity to develop and experience a relationship with the mother, as fellow adults.

Something Lost, Something Gained

This theme addressed the element of the research question focusing on the professional impact for therapists of being bereaved of a parent in childhood. Participants spoke of their journeys towards becoming a therapist, and ways in which their personal histories influenced their choices. Whilst all participants recognised connections between their career choices and childhood experiences, there was considerable diversity amongst which experiences were influential, and how meanings taken from these experiences fed into professional interests. For example, when faced with the phenomenon of silence in their family of origin, some participants, as adult therapists, felt a strong curiosity about family secrets, whereas others felt drawn to encouraging open speaking about emotions. A further important element of this theme concerned ways in which participants used the self in therapy, drawing on personal experiences in service of clients. Participants highlighted feelings of increased empathy, alongside other strengths and learnings from personal experiences that contributed to their therapeutic work, although one participant questioned whether her experiences led to therapeutic advantages. Participants also identified vulnerabilities in their therapeutic work associated with their personal experiences – for example, over-identification with clients, similar to the findings of Kouriatis and Brown (2013). Lastly, this theme reflected participants' understandings of things that supported therapeutic use of self, recognising how supervision, personal therapy, and self-reflection helped them with utilising personal qualities and experiences in service of clients.

These findings connect strongly with self of the therapist literature. For example, Satir et al. (1991) emphasised the importance of therapists remaining deeply aware and connected with their own experiences, such that they are able to model to clients this process of remaining congruent and connected with the self. This resonates with experiences of some participants in this study. For example, Rowan's process of supporting clients with their own self-reflexivity was scaffolded by her experiences of growing to understand her own context.

> With my dad dying, and then learning what I've learned about myself, that whole process … self-reflexivity … I can use that to help clients understand themselves, understand what their context is, and what's led them to be the way that they are … thinking in terms of the meaning of things in context, that they're in. And I've, I've done that, a lot of that work for myself. And it's always ongoing. (Rowan)

The findings also connect with Aponte's work on using therapists' personal wounds (Aponte & Kissil, 2016). Participants spoke of connecting with personal pain and drawing on it in ways that benefitted the therapeutic process. From Sandy's experiential understanding of dynamics that constrain family systems as a result of the "crushing" and "paralysing" silence in her family after her mother's death, to Alice's sense of calm compassion in working with acutely suicidal clients following her own father's suicide – participants seemed to draw on these experiences in powerful ways that enhanced therapeutic practice. In terms of further literature on the self of the therapist, these findings also connect with the work of Ellenwood and Brok (2012) on how different therapeutic roles, which are developed in one's family of origin, can be utilised to move beyond therapeutic impasses, and the work of Haber (1990) on how personal “handicaps” can, through a rigorous process of training and self-reflection, be able to be utilised as a “capability” in therapeutic work.

A further theme present in many accounts concerned personal suffering increasing feelings of empathy and connection with clients. The experience of suffering helped to transcend other differences – described by Alice as “a bridge” between her and her clients. This connects with the work of Nouwen (1979) on wounded healers:

> Making one’s own wounds a source of healing, therefore, does not call for a sharing of superficial personal pains but for a constant willingness to see one’s own pain and suffering as rising from the depth of the human condition which all men share. (p. 88)

These findings also resonate with ideas from Yalom (2003), who described clients and therapists as “fellow travellers” – “a term that abolishes the distinctions between “them” (the afflicted) and “us” (the healers)” (p. 8). It is noteworthy that participants’ feelings of increased empathy and connection was not limited only to clients who had experienced similar events. Perhaps recognising the common humanity can help explain why, even when working with “people whose lives are so different” (in Alice’s words), participants felt able to connect.

Parallels and distinctions can also be made between these findings and research examining motivations to practice psychotherapy. In Barnett’s (2007) study, therapists reported feelings of loneliness and difference during childhood, and Barnett hypothesised that therapeutic practice may thus be attractive as it offers intimacy and connection. Whilst many participants in this study described feelings of separation and difference, they did not explicitly connect these experiences with their desire to become a therapist. Therefore, whilst this hypothesis may be plausible, it may not ring true, in a conscious way, for participants in this study. In terms of alternative motivations, Farber et al. (2005) hypothesised that people receiving reinforcement in childhood for behaviours such as listening and providing emotional support may be driven to practice psychotherapy. This may resonate for some participants, such as Alice, who recognised a relationship between her “compulsive caring quality that was born in [her] childhood”, with practising psychotherapy therefore feeling like a “natural step”. However, this experience was not universal, suggesting that this motivation may apply to some but not all therapists. Perhaps the most noticeable departure from previous research was the finding that for many participants, their childhood experiences gave them a strong interest in understanding humans: in suffering, flourishing, and in relationship with one another. Although not emphasised in previous research, this seemed significant for many participants in this study. Whilst for some, an element of this interest concerned wanting to make sense of their own experiences, there was a deeper and more general curiosity that the practice of psychotherapy seemed to satisfy.

Lastly, it is valuable to highlight findings concerning factors participants found helpful in supporting therapeutic use of self. Several accounts emphasised the benefits of good-quality supervision and/or talking openly with colleagues. This was consistent with Broadbent (2013) and Kouriatis and Brown (2013), where supervision was identified as helping therapists to synergise the personal and professional. Several participants alluded to the value of connecting with other therapist colleagues (not just supervisors), as well as experiencing struggles with professional silence, perhaps feeling shame or stigma around sharing personal wounds in professional contexts. Connections can be made with the use of group supervision in Aponte's person-of-the-therapist training model, reflecting on the value of experiencing supervision in a group context (Aponte & Kissil, 2014):

> The group allows the individual trainee to see the humanity of every other trainee, who like their clients and themselves, struggles with life. It helps remove the shame that blinds us to our flaws and vulnerabilities, provides the support of empathetic colleagues, and facilitates the ability to observe self by seeing ourselves as others see us. (p. 8)

Critical Evaluation of Study Quality

In evaluating the quality of this study, its strengths and limitations will be considered. One strength concerned the diversity within the sample, in terms of differences in type of psychological therapist, or circumstances of bereavement. These various perspectives gave richness to the data, whilst still keeping the focus of the study on the shared experience of being bereaved of a parent in childhood. Nonetheless, it was interesting that participants tended not to speak much about experiences particular to their therapeutic profession, instead reflecting more broadly on their practice of psychological therapy. It is possible, however, that the design of the interview schedule did not encourage participants to reflect in this way, and one could argue that more could have been made of the fact that the study was conducted with different types of psychological therapist, by having questions specifically exploring these differences. However, this was beyond the scope of the research question (since the question was not "How do different types of psychological therapists make meaning of this experience?"), and indeed, IPA is best suited to studies where there is some homogeneity between participants and a focus on what is shared, rather than research questions explicitly examining between-participant differences. One could further argue that if there were major differences between professions in terms of how experiences were understood and integrated into practice, a schedule such as the one used here, with open and exploratory questions, would allow participants to illustrate these differences in their responses. As such, perhaps participants not generally raising profession-specific issues, or making very different meanings of their experiences as a result of their professional group, suggests that their profession did not drastically influence the way they made sense of experiences.

A further consideration relating to the sample concerned how all participants were women, despite recruitment procedures not specifically targeting female participants. To speculate on reasons for this, one probable influence is the phenomenon of psychological professionals tending to be female (e.g., Morison, Trigeorgis, & John, 2014). Another explanation may relate to sex-specific socialisation, and the inclination towards or away from talking about emotional experiences. Masculine socialisation may make men less inclined to participate in research with a focus on talking about emotional responses to life experiences. Whilst male psychological therapists work in a profession where speaking about feelings is central to their work, one could also argue that regardless of profession, these men are not immune to cultural messages based on sex stereotypes and expectations (e.g., Oranksy & Marecek, 2009). Regardless of the reason for the lack of male participants, it is likely that the sample being all female has shaped the findings, particularly as women in the study discussed experiences pertaining to their female sex (e.g., the impact of becoming a mother when one's mother has died). As such, the lack of male participants means that their experiences are unfortunately missing from the findings of this research.

It is also important to acknowledge limitations with respect to the sample size and potential sampling bias. With respect to sample size, whilst the number of participants was well within the recommended amount for IPA studies of this nature (Smith et al., 2009), the small sample limits the extent to which these findings can generalise more broadly. Nonetheless, it is important to recognise that generalisability is not the goal for IPA research;

instead, the aim is to produce research with rich resonance that can allow understandings to transfer across situations (Tracy & Hinrichs, 2017). A further issue concerns whether the sampling strategy may have introduced bias in terms of who was drawn to participate. For example, therapists identifying less with the experience of being bereaved in this way, or therapists currently experiencing significant emotional distress, may have been less likely to volunteer. Therapists who had reflected more on this topic, or those who felt a better sense of integration between this aspect of their personal experience and their professional practice, may have been more likely to participate. It is important to acknowledge the impact that this may have had on the findings – for example, with respect to experiences of drawing on the self in therapeutic work.

A further point of evaluation concerns the tension embedded in the research question itself – balancing rich accounts of personal experiences before participants became therapists, with deep exploration of their professional experiences as therapists, in light of these personal experiences. It was important not to forget when focusing on personal experiences, that the research question was concerned with experiences of parental bereavement during childhood *in people who now work as therapists*, rather than *in people generally*. At the same time, in designing the study, it felt critical to include a thorough exploration of personal experiences, because reflecting on participants' use of self in therapy and how they draw on personal experiences is impossible to interpret without an understanding of their personal contexts. In examining the personal and professional in parallel, a further level of complexity was introduced through participants varying in the extent to which they recognised connections between the personal and professional, possibly due to the extent of previous reflection on these matters. However, in IPA, the researcher offers their interpretations of participants' accounts, and bolder interpretations may involve making connections between areas that participants may not have explicitly linked. Inherent in this process is acknowledgement from the researcher that interpretation is taking place, and recognition that whilst interpretations may be credible, alternative credible interpretations could also be offered. I attempted to use the Discussion to further reflect on relationships between personal experiences and therapeutic practice, particularly when discussing the two themes relating to personal experiences, as a means of holding in mind that these are personal experiences of people *who now work as therapists*.

Adding to the previous point regarding the way in which this research explored how people who work as therapists experienced the death of their parent in childhood in both personal and professional contexts, it was noticeable that during interviews, participants tended to be able to give richer accounts when speaking about their personal contexts, perhaps finding it harder to speak about how the experience was understood in their professional context. This could reflect difficulties inherent to the choice to research an area that may be less “storied”, alongside an area that participants may be very familiar with and used to speaking about. There is not an obvious methodological solution to this difficulty, particularly with a study using IPA, where one wishes to explore how participants make sense of their personal experience, rather than excessively “prompting” them in a given direction. Nonetheless, this is mentioned here such that the impact of this can be recognised, insofar as participants may have felt less able to give as rich accounts when speaking about how their personal experience of bereavement was experienced by them in their therapeutic work. In itself, it is also interesting to consider why this may be less “storied” for some participants, particularly considering previous discussion regarding professional silences in this area.

A further area for evaluation concerns the decision not to perform member checking of the analysis – that is, sharing the analysis with participants and requesting feedback, as is done in some qualitative methods to attempt to improve credibility. During interviews, I performed member checks in some sense as occasionally, if something felt ambiguous, I checked my understanding with participants to see if it fitted their intended meaning. However, when it came to analysis, I deliberately chose not to perform member checking, as it can be argued that it is inappropriate for IPA research. Morse et al. (2002, p. 16) argued that “member checks may actually invalidate the work of the researcher and keep the level of the analysis inappropriately close to the data”. As IPA researchers are concerned with developing interpretive accounts of experience, member checks are incompatible with the subjectivity inherent in IPA’s epistemological position (Gauntlett et al., 2017). Instead, I shared passages of transcripts and my process of coding and developing themes with my supervisors, to check that my interpretations were credible and grounded in data.

An additional consideration with respect to the analytic process concerned the challenge of trying to balance representation of all participants in the analysis whilst avoiding the temptation to include too many quotations – something which IPA researchers caution against as it can give the impression of being defensive of one's interpretations and remaining too close to the data (Smith et al., 2009). Some participants were unusually eloquent in their expression, which may have led to slight oversampling from these participants – even though two quotations may have said broadly the same thing, one may have captured the essence in a more concise or emotive way. As such, this may have compromised the degree to which readers were able to appreciate the generality of the claims (Smith et al., 2009) – reflecting an underlying tension between the proportional sampling of quotations and the evocative quality of the analysis. A further consideration with respect to the sampling of quotations concerned the choice not to share specific clinical examples given by participants to illustrate their use of self in their therapeutic work. I chose to omit these quotations for reasons of client confidentiality, whilst acknowledging that the choice to exclude this material may have led to the third master theme being less well-illustrated by vivid clinical vignettes of how the self was used in therapeutic work.

Lastly, an area for reflection concerns my decisions around sharing my "insider" position with participants. I chose to disclose my personal connection with this research to participants only if asked, and only after interviews had taken place. My rationale was that I was concerned that hearing about my experiences before having the opportunity to speak about their own might colour or shape the way in which participants shared their experiences. Given the nature of IPA research, I wanted to hear of their experiences in terms of the personal meanings they had ascribed to them, without them feeling overly conscious of my experiences as listener. My concerns were: How might their telling of their experiences have been affected if our bereavements were very different, or very similar? Might participants assume I "get" certain things I do not get? After completing the research, I reflected on whether my choices regarding self-disclosure may have led to some opportunities being missed. For example, quite understandably, some participants felt a little self-conscious initially – they may have relaxed more quickly had they known we had this shared experience (Dwyer & Buckle, 2009). Moreover, participants might have withheld thoughts or experiences that felt stigmatising – particularly in the context of them being qualified therapists and me being in the position of trainee – because they may have felt concerned about judgment from an "outsider". As such, whilst I do not consider my decision about self-disclosure to be a limitation as such, it is nonetheless worth reflecting on potential losses and gains from taking this stance.

Implications

In considering the findings of this research, it is possible to identify implications for therapeutic practice; supervision and professional teams; and training and continuing professional development. One particularly powerful reflection from this research concerns the value of therapists being able to draw on the self in therapy, recognising, in the words of Joanna, the power of working from the belly as opposed to just from the books. This research highlights what a powerful resource the self can be for therapists – leading to many possibilities in terms of how this can be used in service of the client and the therapeutic relationship. In proposing the following implications, it is important to recognise differences amongst psychological therapists both in terms of profession and clinical training, with respect to the different ways in which they consider personal experience as something which can be used as a therapeutic tool. For some professions, the use of self and personal experience is of central importance, and for others this forms a much less substantial component of training and practice. These recommendations are written broadly, with the acknowledgment that their applicability and suitability will vary as a function of these professional differences.

Implications for Therapeutic Practice

This research highlights the value of self-reflection – not just in bereaved therapists, but in all therapists, regardless of modality or profession. Rather than marginalising one’s own experiences, or considering personal pain as something that must be “worked through” and “resolved” prior to working with clients, given the power that the self can have in therapeutic work, therapists should be encouraged through a process of ongoing self-reflection, in order to facilitate continued professional development. Therapists may be accustomed to doing this at points of difficulty (e.g., when something feels “jarring” or “stuck” in therapeutic work); however, this research highlights the value of self-reflection far more broadly, as something to do throughout one’s therapeutic career, rather than something attended to primarily at the start or during training, and then forgotten about. Bereaved therapists are particularly encouraged to reflect on how their grief can ebb and flow over time, in the context of their own maturation and in interaction with milestones in their personal lives, and to consider how their changing experience of grief may influence and interact with their therapeutic work.

In addition, as participants identified personal therapy as beneficial to themselves both personally and professionally, therapists who have experienced the death of a parent may benefit from seeking therapy themselves. Many trainee therapists seek personal therapy during training, but it is recommended that therapists continue to engage with personal therapy when it is helpful, particularly given the fluctuating nature of grief over time.

Reflecting on the non-linear trajectory of grief and loss, and recognising the relational and social aspects of this experience (e.g., the power of silence; feelings of difference and separation), a further implication concerns therapists recognising the different ways that people experience loss over time – both for themselves, and in their clients. Participants in this study had experienced the death of parents at least several decades ago, and yet the impact was still felt profoundly in their lives – for some, almost more so than in the immediate aftermath. For anyone working therapeutically with bereaved people, this emphasises the importance of exploring the trajectory that loss has in people's lives, not assuming that if the loss was distal in temporal terms, that it will also be distal for people in a psychological sense.

Implications for Supervision and Professional Teams

This research highlights the negative impact of silence and taboos, both in personal and professional domains, with an implication for professionals being to consider ways to respond to, and if appropriate, disrupt these silences. Several participants recognised a taboo in the therapeutic profession, suggesting that therapists may feel uncomfortable speaking about personal experiences in connection with therapeutic work, feel anxious about their competency being called into question if they reveal woundedness, or feel worried about being seen to "centre themselves" by exploring the influence of the self in therapeutic work. Since these findings highlighted the value of openness, it is important to reflect on how to further encourage this within the profession. For example, professional teams may benefit in reflecting on their team's culture with respect to integration of the personal and professional, and whether they could benefit from collective thinking and discussion around therapeutic use of self. Therapists may also benefit from forming or accessing professional networks connecting therapists with particular life experiences (similar to groups already existing for therapists based on factors such as sexual orientation or ethnicity), to encourage peer support, reflection, and collective learning about drawing on these experiences in service of clients.

Recognising the emotional impact of therapeutic work, particularly when using the self, it is essential that those in positions of responsibility, such as supervisors and managers, attend to therapists' wellbeing. This research highlights the importance of sensitive supervision, which makes room for the self of the therapist, and gives space for discussion of the emotional impact of the work, without fear of judgment and shame. The research also orients supervisors to themes that supervisees bereaved of parents may encounter, to help facilitate supervisees' personal reflection around the self of the therapist.

Implications for Training and Continuing Professional Development

These findings suggest that integrating self-of-the-therapist work into therapeutic training may be very valuable. Some psychological professions place more emphasis on this than others, and even within professions there is considerable heterogeneity in terms of the extent to which there is training on the use self in therapeutic work, depending on the particular course. Thinking of my professional context, is there something that clinical psychology could learn from other professions where self-of-the-therapist work is more established within the therapeutic training? For example, as previously highlighted, there are some excellent ideas from the field of systemic family therapy (e.g., Haber, 1990). Clinical psychology programmes may benefit from considering how to develop self-of-the-therapist training, sharing wisdom from across disciplines. Every student coming to a training programme brings with them a wealth of personal experiences – not just of bereavement, but of all sorts of things – and if training programmes neglect to train students in how to draw on these personal experiences in service of clients, this powerful therapeutic resource is likely to be underutilised with clients.

Recommendations for Future Research

Considering the findings, strengths, and limitations of this research, along with its wider implications, several avenues for future research in this area are suggested as follows. It may be useful for other researchers to know that amongst participants in this study, in the context of personal and professional silence, there was a sense that it felt important to approach and speak openly about these topics, such that researchers should not feel dissuaded from researching this and other “sensitive” areas.

- Examining the impact of self-of-the-therapist training. What is the impact of training on the use of self in therapy on therapists’ practice? Does this training help therapists to be more reflective around their use of self? Does this reflection translate into the therapy room, in ways that appreciably benefit therapeutic work with clients?

- Examining how the self of the therapist is understood and utilised across different therapeutic modalities and professions. In a study designed to compare and contrast different modalities or professions, how do different therapeutic practitioners relate to the use of self? Do their understandings and preferences arise from formal training or personal inclination? Does the modality that the therapist comes from make them more inclined, or less inclined, to draw on the self and personal experience in service of clients? Is the therapist’s use of self epistemologically incompatible with some therapeutic modalities?

- Examining personal and professional impacts of childhood bereavement in therapists from different contexts. The participants in this study were all female and of white European heritage, which is likely to have shaped their experience of the phenomenon under study. What can we learn from the experiences of therapists with different cultural experiences, for example, being male, or from other countries?

- Examining the role of other significant life experiences on the self of the therapist. Considering the professional impacts identified in this study, are these specific to parental bereavement in childhood? What is the impact of other major life experiences, and are there areas of commonality and/or difference?

- Examining the impact of therapists that purposefully draw on the self and personal experiences in therapy, from the perspective of the client. How do clients experience therapists who consciously work in this way? Do they appreciate a difference between therapists that purposefully draw on the self, and those who report not attending to this in their practice? What is the effect on the therapeutic relationship, from the client's perspective?

Final Reflections

Despite coming into this research feeling that I was relatively well-acquainted with the process of grieving and loss, I learned so much through hearing participants speak about their personal experiences. At the same time, I was struck by some quite uncanny similarities – it was surreal and yet deeply comforting to hear a participant share a thought or emotional experience that they had, which I also recognised in myself, and yet had never heard another person speak about. In my therapeutic work, I would like to consider how I could translate this experiential learning into something of benefit to clients – perhaps thinking about how I could work more with groups (of staff or clients), rather than just working with individual people and individual families, recognising the impact of collectively sharing experiences in giving comfort and reducing feelings of shame and emotional distance.

Certainly, this research has taught me much about grief and love. I have a sense of how they meander together in my own life, but to recognise how these things weave through the lives of others in so many different and varied ways was deeply moving. I have taken from this an increased understanding of the importance to be sensitive to these differences with clients – in the words of Joanna, to be sensitive to "the little things", whatever they may be.

In exploring the themes of silence and connection in this research, I have thought about how humbled I was by participants' willingness to share their stories and tears with me. So rarely do we get to see beyond the so-called "professional" faces of our colleagues. This research has helped me to recognise the tremendous value of therapists being willing to reveal some of the personal – enabling conversations that stimulate reflection on therapeutic work and the ways in which we can draw on our personal experiences in service of clients. It requires generosity and courage, and I would like to think more about what I can personally do to perturb professional silence and create a culture of greater openness about what we carry with us from our own experiences.

The process of using IPA has made me appreciate how it is a method deeply suited to researchers who also practice psychological therapy. The double hermeneutic in IPA has a beautiful parallel in the process of psychotherapy. IPA has inspired me to refocus my attention towards this multi-layered and iterative process of interpretation and meaning-making in my therapeutic work, recognising “the space between” (Flaskas, Mason, & Perlesz, 2005), and the significance of differentiating my meaning-making from the meaning-making of the people with whom I work.

In working on a study relating to the use of self in therapy, this study has also enhanced my appreciation for drawing on the self in research. I have always been drawn to conducting research with personal resonance, and I think the same is probably true for many researchers, particularly in the social sciences. The self of the researcher matters: much like the therapist, the researcher is not a neutral scientific instrument there to robotically follow prescriptive procedures, they are a living, breathing creature full of love, longing, pain, wisdom, and vitality. It is a great shame to marginalise the richness that humans bring to the research process in psychology. This research has encouraged me to embrace the humanity in the research process, celebrating the contribution of the researcher’s inherent subjectivity, whilst also respecting and recognising the vast contribution that the development of formal research methods – both qualitative and quantitative – have contributed to our understanding of psychology.

Conclusion

This research aimed to examine the experiences of psychological therapists who experienced the death of a parent in childhood, and the impact that this had on them both personally and professionally. Through interpretive phenomenological analysis of interviews conducted with seven psychological therapists, the profound impact of this experience throughout participants’ lives was illustrated: from childhood, through to adulthood, and into their psychotherapeutic practice. Contributing to a small but growing body of research examining the experiences of bereaved therapists, this research improves understanding of this personal experience, and the rich and diverse ways in which therapists draw on the self and lessons gained from life in service of the clients with whom they work. As an IPA study, the idiographic nature of this research means that rather than aiming to broadly generalise these findings, the intention instead is to develop a deeper understanding of this phenomenon.

As such, it is hoped that readers of this research gain insight into these experiences in a way that will stimulate personal reflection, inspiring them to be open to the creative ways in which the self can be used – in all its warmth, humanity, sorrow, and joy – to enhance the therapeutic endeavour.

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Appendix A: Search Strategy for the Systematic Review

Terms relating to profession	Terms relating to bereavement
psychologist*	[2] [3] bereave*
psychotherapist*	
psychoanalyst*	
family therapist*	
psychological therapist*	
systemic therapist*	
[1] cognitive behaviour* therapist*	
person centred therapist*	
analyst*	

In order to be included in the search results, records had to include at least one of the terms from the "profession" column, and the one search term from the "bereavement" column. To appear in the search results, the search terms had to appear in the title, abstract, and/or keywords of the article.

[1] Search included both British English and American English spellings of behaviour/behaviour.

[2] Several pilot searches were run with other words relating to bereavement, including "death" and "loss", but these terms were excluded because of high numbers of irrelevant articles (e.g., "cell death", "loss of sensation") that were too diverse and numerous to exclude with NOT Boolean operators. The term "grief" was not used as whilst it tended to capture the same articles as the "bereavement" search term, it also generated large numbers of irrelevant articles (e.g., studies of grief therapy with bereaved clients). The term "mourning" was also not used as this tended to capture articles focusing on social expressions of grief and cultural customs around bereavement.

[3] Pilot searches were attempted to restrict results to studies only examining therapists' *personal experiences* of bereavement. However, I decided to use a broader search strategy, recognising that this may have been a less efficient strategy (generating more articles to screen), but being more conservative and inclusive (less likely to exclude relevant articles).

Appendix B: Study Quality Assessment

Guideline	Hayes, Yeh, & Eisenberg (2007)	Broadbent (2013)	Kouriatis & Brown (2013)	Stewart & Thomas (2018)
Publishability guidelines shared by both qualitative and quantitative approaches				
Explicit scientific context and purpose	✓	✗	✓	✓
Appropriate methods	✗	✓	✓	✓
Respect for participants	✗	✓	✓	✓
Specification of methods	✓	✓	✓	✗
Appropriate discussion	✓	✓	✓	✗
Clarity of presentation	✓	✓	✓	✓
Contribution to knowledge	✓	✓	✓	✓
Publishability guidelines especially pertinent to qualitative research				
Owning one's perspective	n/a	✓	✗	✓
Situating the sample	n/a	✗	✗	✗
Grounding in examples	n/a	✓	✓	✗
Providing credibility checks	n/a	✗	✓	✓
Coherence	n/a	✓	✓	✓
Accomplishing general vs. specific research tasks	n/a	✓	✓	✓
Resonating with readers	n/a	✓	✓	✓

Note. Quality assessment guidelines developed by Elliott, Fischer, and Rennie (1999).

Appendix C: Summary of Key Details from Personal Reflective Accounts

Author(s), year published, title	Nature of bereavement	Life stage at time of bereavement(s)	Type of psychological therapist(s)
Callahan & Dittloff (2007) Through a glass darkly: Reflections on therapist transformations	Death of baby in late stage of pregnancy	Adulthood	Clinical psychologists
Horwell (2019) The transformative process of the bereaved therapist	Death of mother (accident), father (illness), and aunt (suicide)	Childhood and adulthood	Psychotherapist
McDonald & Grau (2019) Challenge and growth through bereavement during graduate training	Death of parents (illness)	Adulthood, during therapy training	Trainee psychotherapists
Chowdhury, John, & Nanavaty (2019) Impacts of challenging life experiences on professional development in graduate trainees	Death of family members (unspecified cause)	Adulthood, during therapy training	Trainee psychotherapists
Murray-Swank (2019) The cracks where the light gets in: Exploring therapist transformation following the loss of a family member to suicide	Death of close family member (suicide)	Adulthood	Clinical psychologist
Allphin (2018) An unhealable wound: Left by suicide	Death of mother (suicide) and father (unspecified)	Childhood	Psychotherapist and Jungian analyst
Osband (2016) Ghosts in the consulting room: Bereavement, grief, and the therapist	Death of adolescent daughter (accident)	Adulthood	Psychotherapist
Colson (1995) An analyst's multiple losses: Countertransference and other reactions	Death of wife (illness) and mother (illness)	Adulthood	Psychoanalyst
Rosenfeld (2016) A therapist at sea	Death of husband (illness)	Adulthood	Psychotherapist
Galgut (2013) Continuing to work after my mother's death	Death of mother (illness)	Adulthood	Psychotherapist
Chasen (1996) Death of a psychoanalyst's child	Death of son in childhood (accident)	Adulthood	Psychoanalyst
Warshaw (1996) The loss of my father in adolescence: Its impact on my work as a psychoanalyst	Death of father (illness)	Childhood	Psychoanalyst

Appendix D: Study Advertisement

Advertisement for Posting Online

Are you a psychological therapist who experienced the death of one or both of your parents during your childhood?

We are seeking participants for a research study which aims to understand psychological therapists' experiences of the death of a parent or parents in their childhood. In particular, we are interested in exploring the impact of this experience on therapists both personally and professionally (e.g., in their therapeutic practice).

The study is open to anyone who practises psychological therapy (e.g., psychotherapists, psychologists, family therapists), and who is fully qualified and registered with an appropriate professional body (e.g., AFT, UKCP, HCPC, BABCP, BCP), who experienced the death of one or both of their parents before the age of 18 years old.

Participation is entirely voluntary and involves taking part in an hour-long interview, either in person or through online video chat (e.g., Skype).

This study has been reviewed by the University of Hertfordshire ethics committee (LMS/PGR/UH/03874) and is being conducted as part of my Doctorate in Clinical Psychology.

If you would like more information about the study, please e-mail Rosie Kingston (Principal Investigator) on r.kingston@herts.ac.uk

Advertisement for E-mails

Hello,

I am a third-year trainee clinical psychologist at the University of Hertfordshire. I am conducting a research project examining the experiences of psychological therapists who experienced the death of one or both of their parents during their childhood, and the impact this has had on them personally and professionally (in their therapeutic practice).

Participation in the study would involve taking part in a semi-structured interview with me, about one hour long, either in person or remotely (e.g., via Skype), depending on what is convenient and preferable for each participant.

I am hoping to speak with therapists from a range of professional backgrounds (e.g., clinical and counselling psychologists, family therapists, psychotherapists), and I am specifically wishing to interview people who are fully qualified and practicing therapy as part of their professional role. Participants would also need to have experienced the death of one or both of their parents before the age of 18 years old.

I am hoping that this study will be able to contribute to a small but growing body of research examining the self of the therapist, as a means of facilitating reflective practice and consideration of the ways in which we can use these sorts of life experiences in the service of our clients.

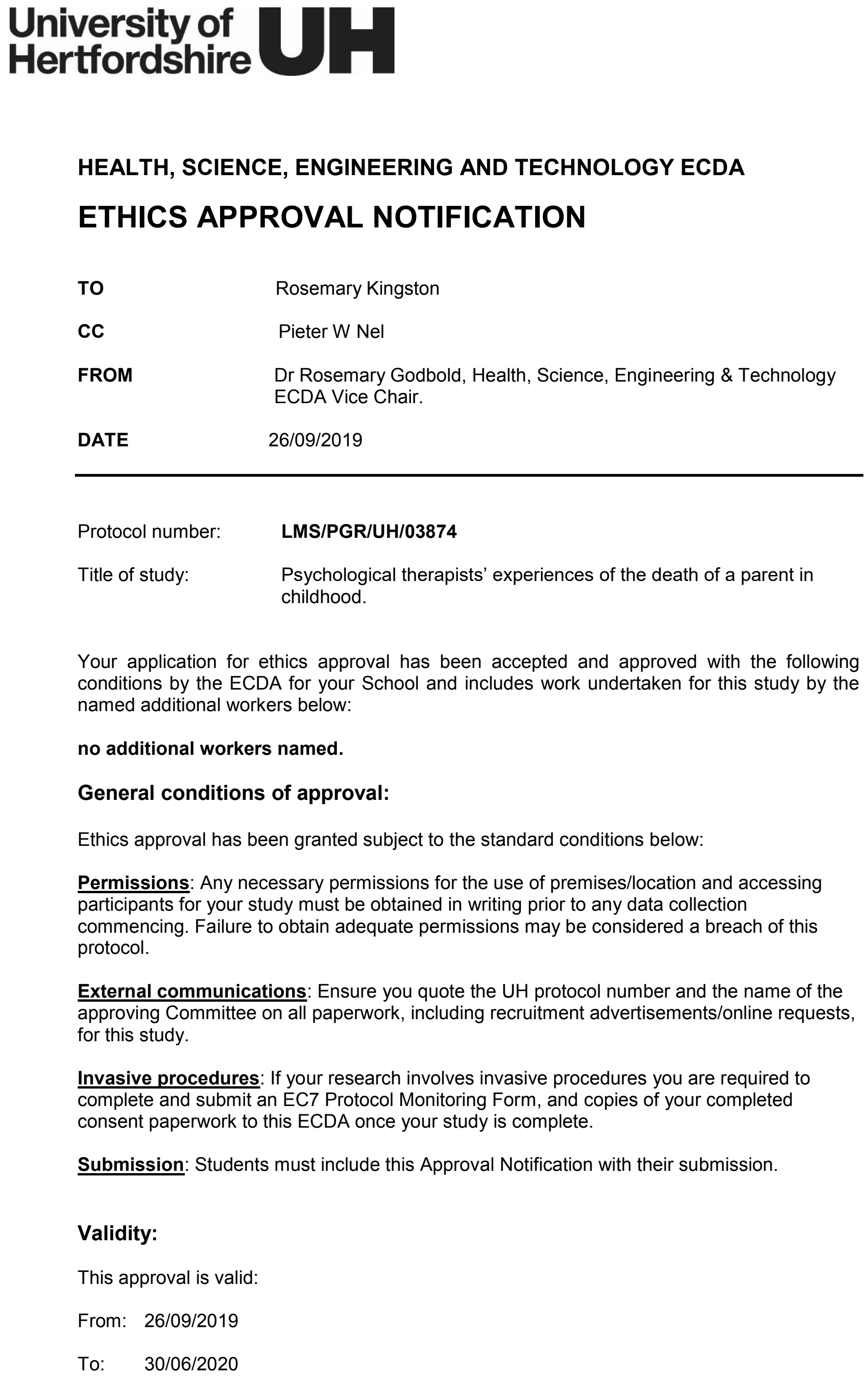
If this sounds like something you might be interested in, it would be great if you could contact me via e-mail at the address below, and I will be happy to send through some more information. I would also be very grateful for anyone wishing to pass on details of this study to colleagues who they feel might be interested in talking more with me.

Thank you very much for your time.

Best wishes,

Rosie Kingston
r.kingston@herts.ac.uk

Appendix E: Ethical Approval Confirmation



University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Rosemary Kingston
CC	Pieter W Nel
FROM	Dr Rosemary Godbold, Health, Science, Engineering & Technology ECDA Vice Chair.
DATE	26/09/2019

Protocol number:	**LMS/PGR/UH/03874**
Title of study:	Psychological therapists' experiences of the death of a parent in childhood.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

no additional workers named.

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 26/09/2019

To: 30/06/2020

Appendix F: Participant Information Sheet

Study Title: Psychological therapists' experiences of the death of a parent in childhood

Introduction

We would like to invite you to participate in this research study. Before deciding whether you wish to participate, it is important that you understand why this study is being conducted, and what taking part in the study would involve.

Please take the time to read the following information carefully, and discuss it with others if you wish. If there is anything that is not clear, or you would like any further information to help you decide whether or not you wish to take part, please do not hesitate to get in touch using the contact details at the end of this document.

What is the purpose of this study?

The aim of this study is to understand psychological therapists' experiences of the death of a parent or parents in their childhood. In particular, we are interested in exploring the impact of this experience on therapists both personally and professionally (e.g., in their therapeutic practice).

Who are the researchers involved in this study?

The principal investigator for this study is Rosie Kingston, Trainee Clinical Psychologist at the University of Hertfordshire. The primary supervisor is Pieter W Nel at the University of Hertfordshire. The secondary supervisor is Greet Splingaer at Rapunzel Therapy Centre, Belgium.

Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part, you will be given a copy of this information sheet to keep, and you will be asked to sign a consent form. Agreeing to participate in this study does not mean that you have to complete it. You are free to withdraw at any stage, without giving a reason.

Who can take part in this study?

To be eligible to take part in this study, you must fulfil all of the following criteria:

- Be a qualified therapist (e.g., psychotherapist, psychologist, family therapist) with accreditation from a professional body (e.g., HCPC, UKCP, AFT, BABCP, BCP, etc)
- Practice therapy with clients as part of your professional role
- Have experienced the death of one or both of your parents before you were 18 years old

What does participating in the study involve?

If you decide to take part in the study, you will be invited to talk about your experiences in an interview with Rosie (the principal investigator), who will contact you to arrange a convenient time for the interview. Interviews may take place in person (Hertfordshire area) or remotely, over online video chat (e.g., Skype). Rosie will begin by talking with you about the research study and check that you understand the information on this sheet. You will have the opportunity to ask any questions you may have about the study. If you wish to continue, you will then be asked to sign a consent form to show that you are willing to participate.

If you are happy to continue, you will take part in an in-depth interview about your experiences, lasting up to 1 ½ hours. The interview is semi-structured, which means that it will be guided by some set topic areas and questions to be covered. To begin with, we will gather some brief background information about you and the parent or parents who died during your childhood. The main part of the interview will ask you about your experiences in three key areas. First, we will talk about the impact of your parent's death on you personally, both when you were younger and in the present day. Next, we will discuss how your parent's death may have influenced your choice of career. Finally, we will talk about how the experience of your parent dying may influence your therapeutic practice. The interview will audio-recorded, so that at a later date it can be transcribed for analysis of the data.

What are the possible disadvantages of taking part?

Talking about death, bereavement, and your emotional responses to these experiences can be upsetting. You may find it distressing to think about some of the questions in the interview. If you find that any aspect of the interview is too upsetting or uncomfortable for you, you are welcome to ask to move on from certain questions, take a break, or stop the interview and withdraw from the study. Rosie will also check in with you to see if you are finding the interview manageable or if you wish to take a break or stop. When the interview ends, Rosie can provide you with some information about further support, if you feel you require it.

What are the possible benefits of taking part?

This study aims to increase understanding of how psychological therapists have experienced being bereaved of a parent early in life and the ways in which this may influence their practice with clients. We hope that this study will also be helpful in facilitating the reflective practice of other therapists who may have had similar experiences. It is possible that some participants may find the process of being interviewed on this topic in a research context facilitates their own personal reflection, and they may find this beneficial.

Who will know that I have participated?

Only the research team immediately involved in this study will know about your participation. That team comprises Rosie Kingston and Pieter W Nel from the University of Hertfordshire, and Greet Splingaer from Rapunzel Therapy Centre in Belgium.

How will my information be kept confidential?

All information about you that is collected throughout the course of this research study will be kept confidential. Your name and any other personally-identifying information will be kept separate from your audio-recording and transcription of your interview, and any identifying information will be removed from your transcript. Your consent form, which will contain your name, will be kept in a locked filing cabinet at the University of Hertfordshire.

A transcription service, approved by the University of Hertfordshire, may be used to transcribe your interview. If a transcription service is used, the transcriber will be made to sign a confidentiality and non-disclosure agreement. Any audio recordings sent to the transcription service will be anonymised.

In rare cases, it may be necessary to breach confidentiality if there are significant concerns about the wellbeing and safety of participants or others. In such cases, it may be necessary to inform others outside of the research team to access help. This would be discussed with participants at the time.

What will happen to the results of this study?

The findings of this study will be written up into a thesis as part of the principal investigator's Doctorate in Clinical Psychology. Anonymised transcripts of interviews may be viewed by the research team and the examiners of the thesis.

The findings of this research may also be reported in public documents or presentations (e.g., journal articles). In any public documents or presentations, anonymised quotations from interviews may appear. Participants will be kept anonymous in any report, publication, or presentation, with care being taken that you cannot be identified from any extracts from your interview.

What will happen to my data?

The audio-recording of your interview, and the transcription of your interview, will be stored electronically, in a secure password-protected environment. The audio-recordings of your interview will be destroyed after the principal investigator's degree is conferred, which is due to be in late 2020. The transcription of your interview will be kept for 10 years after the date of any publications arising from this research. Your consent form will be stored in hard copy at the University of Hertfordshire in a locked filing cabinet for up to 5 years, after which time it will be destroyed under secure conditions.

Has this study received ethical review?

This study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. The UH protocol number is LMS/PGR/UH/03874.

Who can I contact if I have any questions?

If you have any questions or would like to discuss anything further, please get in touch with Rosie Kingston, using the contact details at the end of this document.

What should I do if I am interested in taking part in this study?

If you are interested in taking part, please contact Rosie Kingston using the contact details below. If you are not interested in participating, you do not need to do anything. Thank you very much for reading this information and considering taking part in this study.

Contact Details

Principal Investigator:	**Primary Supervisor:**
Rosie Kingston	Pieter W Nel
E-mail: r.kingston@herts.ac.uk	E-mail: p.w.nel@herts.ac.uk
Telephone: 01727 286322	Telephone: 01727 286322

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Hertfordshire
AL10 9AB

Appendix G: Consent Form

Psychological Therapists' Experiences of the Death of a Parent in Childhood
(UH Protocol No. LMS/PGR/UH/03874)

Please tick each box to indicate your agreement with the following statements.

☐ I confirm that I have read and understood the Participant Information Sheet, and I understand what participating in this study will involve.

☐ I have had the opportunity to ask questions, with any questions being answered to my satisfaction.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.

☐ In giving my consent to participate in this study, I understand that an audio-recording will be made of my interview, and a verbatim transcription of this will be made.

☐ I understand that the results of this study may be presented or published.

☐ I agree that anonymised quotations from my interview may be used in any reports, presentations, or publications arising from this study.

☐ I understand how information relating to me (data obtained from the interview, data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

Participant Name: ____
Participant Signature: ____
Date: ____

Principal Investigator Name: ____
Principal Investigator Signature: ____
Date: _______________________________________

If you would like feedback about the results of the study once a report has been completed, please provide your e-mail address below.

E-mail Address: ____

Appendix H: Debrief Information for Participants

Study title: Psychological therapists' experiences of the death of a parent in childhood

Thank you for taking the time to participate in this research project. Through exploring your experiences, we hope to increase understanding of how being bereaved of a parent early in life may influence psychological therapists both personally and in their therapeutic practice. Further, we hope that this research study will be helpful in facilitating the reflective practice of other therapists who may have had similar experiences.

The information that you have provided will be kept confidential and your anonymity will be preserved in any publications or presentations arising from this research. For full details of how your personal data will be used and stored, please refer to your copy of the Participation Information Sheet given to you before your interview.

We hope that you have found participating in this study to be a useful experience. If taking part in the study has caused you distress, you may find it helpful to make use of immediate sources of support, which may include family, friends, GP, or therapist/counsellor.

If you would like further support, please find below the details of some organisations that may be useful.

Your GP

Please consider contacting your GP if you feel that you could benefit from psychological support. Your GP should be able to signpost you to local NHS services.

Samaritans

This is a free and confidential helpline available 24 hours a day, 7 days a week, for anyone experiencing emotional distress.
Freephone: 08457 90 90 90
Website: www.samaritans.org

Cruse Bereavement Care

The Cruse helpline offers emotional support to anyone affected by bereavement. The helpline is open Monday to Friday, 9.30am to 5.00pm (excluding bank holidays), with extended hours on Tuesday, Wednesday, and Thursday evenings, when the helpline is open until 8.00pm. They also offer in-person support (e.g., one-to-one sessions, groups). For more information about local Cruse services in your area, please visit their website.
Freephone: 0808 808 1677
Website: https://www.cruse.org.uk

Winston's Wish – Adults Bereaved as Children Peer Support Group

The child bereavement charity, Winston's Wish, offer a peer support group on Facebook for adults bereaved as children. For more details, please see the website below.
Website: https://www.winstonswish.org/adults-bereaved-as-children/

If you have any further questions or would like to be informed about the outcome of this study, please contact Rosie Kingston by e-mail (r.kingston@herts.ac.uk).

If you have any complaints or concerns about any aspect of the study, you can contact Dr Pieter W Nel (Principal Supervisor) by e-mail (p.w.nel@herts.ac.uk), and/or write to the University's Secretary and Registrar (please see the Participant Information Sheet for details).

Thank you again for your participation in this study.

Appendix I: Interview Schedule

Introduction

The aim of this research is to explore psychological therapists' experiences of the death of a parent in childhood. The interview will take around an hour, and I will be audio-recording it, so it can be transcribed at a later date. To begin with, we will start by gathering some background information about you and the parent who died in your childhood. The main part of the interview will then ask you about your experiences, roughly in chronological order, in three key areas. First, we will start by talking about the personal impact of your parent's death, beginning with how it was experienced by you at the time. Next, we will talk about how your parent's death may have influenced your choice of career. Finally, we will talk about how the experience of your parent dying may have influenced your therapeutic practice in the present day. We can spend around 15-20 minutes on each of these three areas.

A note on language: I intend to use the language that participants use to describe things wherever possible; for example, using the term they use to describe the parent (e.g., dad/father/their name), their choice of word to describe death (e.g., died/passed away/lost), and their way of describing their occupation (e.g., therapist, psychotherapist, psychologist).

Section 1. Participant and Background Information

Before we begin the main part of the interview, I would like to briefly ask for some general information about you.

1. How old are you?

2. How would you describe your ethnicity?

3. What is your job title?
    Prompt: *What do you prefer to call yourself professionally?*

4. How would you describe your theoretical orientation for your therapy work?
    Prompt: *For example, systemic, CBT, psychodynamic, integrative…?*

As this research is about the experiences of psychological therapists who had a parent or parents die during their childhoods, I would like to ask you for some background information about that, before we get into the main interview.

1. Can you tell me which of your parents died when you were a child?

2. How old were you when they died?

3. When did they die? (how many years ago, or date)

4. (If just one parent died in childhood) Is your other parent still alive now?

5. Why were you interested in participating in this research study?

   Prompt: *What are your hopes? Is there anything in particular you feel is important we talk about today?*

Section 2. How Experiencing the Parent's Death Affected Participants Personally

I would like to start by asking you about the experience of your parent(s) dying when you were young, and the way this may have affected you personally, both at the time of their death and in the present day.

1. Can you tell me a bit about how your mother/father died?

   Prompt: *Can you give me a brief history of what happened before/after their death? How did they die? How did you find out?*

2. If you think back to that time when your parent died, can you tell me about how it affected you?

   Prompt: *What did you think, feel, do? What was the impact on you emotionally, practically?*

3. Has your understanding of the impact of your parent's death changed over time?

Prompt: *Have you noticed changes in what you think/feel about their death? Have you experienced the impact of their death differently over time?*

4. Thinking now of the present day, can you tell me about how you are affected by your parent's death now?

Prompt: *What is it like for you now, to have had your parent die when you were young? How do you experience that loss now? How do you feel/think about it now?*

Section 3. How Experiencing the Parent's Death May Have Influenced Choice of Career

I'd like to talk a bit about your life after your parent died, with respect to when you were making choices about your future career as a therapist.

1. Can you give me a brief overview of your educational/professional history, of how you came to work as a therapist?

2. How do you think the death of your parent may have influenced your choice of career?

Prompt: *What is your understanding of why you chose this career?*

Section 4. How Experiencing the Parent's Death May Influence Therapeutic Practice

Now I would like to invite you to think about the present day and ask some questions about how experiencing your parent's death may have influenced your therapeutic practice.

1. What is it like to be a therapist who has gone through the experience of a parent(s) dying when you were young?

Prompt: *Do you think the experience of your parent(s) dying has influenced the way you practice therapy? How/what has been affected? How might your practice be different if you had not had this experience?*

2. Are there times when you have found it helpful/a strength to be a therapist that had a parent die when you were young?

Prompt: *Has it ever felt like an advantage to have had this experience? Has it ever felt helpful?*

3. Are there times that you have found it difficult/hard to be a therapist that had a parent die when you were young?

Prompt: *Has it ever felt like a hindrance/handicap/disadvantage? Has it ever felt unhelpful?*

4. Considering what you may have learned from the experience of your parent dying, are there things it has taught you as a therapist?

Prompt: *Any things that you may not have learned without this experience? Things you may not have learned from your professional training alone?*

5. What would you say/what advice would you give to other therapists about how they might draw upon these experiences in their therapy work?

Prompt: *What might you say to a fellow therapist earlier on in their career who had a similar experience to you? What might be helpful to others in a similar position?*

Closing Questions

1. Is there anything else that feels important or relevant that you would like to talk about?

2. How has it been to be asked and answer these questions?

Appendix J: Example of Analysed Interview Transcript

Appendix K: Example of Clustering Emergent Themes into Superordinate Themes

Loss – of mother, of memory, of communication, of relationships

The intensity of grief
Silence
Lacking information
Emotional barriers to talking
Fractured relationships
The event defining the family
Let down by memory
Sense of detachment

Constructing a story to steady oneself and piece together what was lost

Instability
Feeling out of control
Fear of being overwhelmed by trauma
Trying to construct a narrative
Trying to make sense
The use of fantasy
Sense-making as healing

The maturation of grief

Becoming ready to grieve
Change in relationship to grief over time
Welcoming emotional distress
Identification with mother
Anxiety of motherless motherhood

Professional choices drawing from personal contexts

The construction of narrative about career choice
Shifting motivations for career choice
Choice of client group
Personal/professional distance
Sense of safety
Impact of motherhood on professional identity

The use of self in therapy

Drawing on own experience in therapy
Using her wounding experiences as a guide to support others
Understanding of psychological theory enhanced by lived experience
Increased capacity for compassion
Recognising the parallels in pain to transcend difference
Driving experience in a different direction
Holding ambition and hope for clients
Value of experiential understanding of trauma
The importance of conscious use of self in therapy
Importance of self-reflective and self-reflexive practice

Gifts from therapy

Gaining inspiration and hope from clients
Therapy as mutually beneficial
Understanding of lived experience enhanced by psychological knowledge