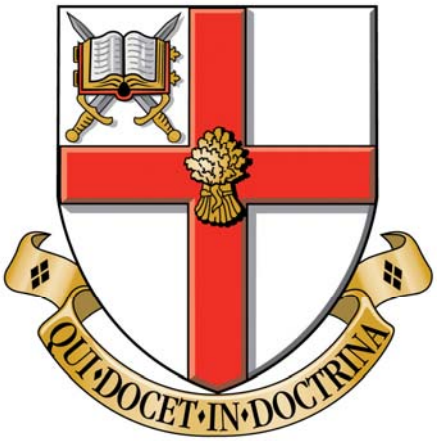

A QUALITATIVE EXPLORATION

OF

GRIEVING COUNSELLORS' MONITORING

OF

FITNESS TO PRACTISE

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ABSTRACT

This small-scale qualitative study explores grieving counsellors' monitoring of their fitness to practise. The data was collected from seven co-researchers using semi-structured interviews and analysed using the constant comparative method. Analysis of the data suggests that grief experiences before counsellor training were formative in the development of the participants' philosophical approach to life and loss. Following their loss all participants made a personal exploration of their fitness to practise prior to meeting with their supervisors. When the deaths were in old age and/or expected counsellors resumed practising within a month. Counselling during anticipatory grief was helpful as was practising following their losses and this is consistent with the Dual Process of Coping with Bereavement (Stroebe & Schut, 2001). Experiencing grief in practice appeared to have a positive impact on personal and professional development.

DECLARATION

This work is original and has not been submitted previously in support of any qualification or course.

Signed

Pamela Helen Johnson

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LIST OF ABBREVIATIONS

BACP	British Association for Counselling and Psychotherapy
BABCP	British Association for Behavioural and Cognitive Psychotherapy
CRUSE	Cruse Bereavement Care
DPM	Dual Process Model of Coping with Bereavement
FtP	Fitness to Practise

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CHAPTER 1
INTRODUCTION

1.1 INTRODUCTION OF THE PERSONAL AND PROFESSIONAL CONTEXT

Early in my Master of Arts in Counselling Studies programme, I thought my research would be concerned with grief and later decided to contextualise it in counselling practice. My personal history brought "the core of the problem into focus", (Moustakas, 1994:104) and it is appropriate that I provide the relevant autobiographical detail (Moustakas, 1994).

My interest in bereavement and grief counselling arose following my mother's death, which occurred prior to counsellor training. I coped well supporting her during her terminal illness but the intensity and duration of the emotions following her expected death took me by surprise. I had taught loss and grief in relation to childbearing during my work as a midwife teacher but this prior knowledge had not prepared me for the experiential learning that was to come. Recently retired I was already experiencing a loss of identity, status and usefulness and bereavement added to these emotional difficulties. On reflection, I wondered had I still been in employment whether this would have provided some distraction from my grief (Stroebe & Schut, 1999).

Four years later, towards the end of my training with Cruse Bereavement Care (Cruse) a friend, whom I had supported during her terminal illness, died from a similar condition to my mother. After her death, when supporting her only adult child and

during supervised practice with Cruse clients, I found that listening to the grief narrative of others evoked the re-emergence of bereavement related issues (Raphael, Middleton, Marinek & Misso, 1993; Machin, 2009). This occurred most markedly when the loss experiences were similar to my own (Worden, 2009). I continued to work with Cruse clients and accessed personal therapy to address my re-emerged bereavement related issues. My involvement with Cruse continued for eight years during which I obtained a Diploma in Counselling. Assessing and monitoring fitness to practise had not been addressed during either my Cruse or Diploma in Counselling training.

Cruse is an organisational member of the British Association for Counselling and Psychotherapy (BACP) and its members adhere to The Ethical Framework for Good Practice in Counselling and Psychotherapy [The Ethical Framework] (BACP, 2010). During my time with Cruse, two volunteer counsellors temporarily withdrew from client work to attend to their own grief following the deaths of family members. I thought this was a wise decision, as though the caseloads of Cruse volunteers are usually small they consist entirely of grieving clients. Worden (2009) offers the caution that working with the grief of others is not the place for a counsellor to deal with a recent major bereavement of their own.

On entering the community of qualified counsellors and working with a wider range of presenting issues, I became increasingly aware that the underlying causes of many are grief related (Bowlby, 1980; Parkes, 2006). In my experience, this is not always immediately evident, thus making it difficult for grieving counsellors who wish to avoid working with grief and loss issues of clients. I started to wonder how grief affected

counselling practice. The death of a loved one, as well as personal disablement due to illness or accident, may affect therapists' ability to handle clients' needs appropriately. While there is reason to hope that therapists will respond with good judgement, it is a mistake to assume making a sound decision will be easy (Guy, 1987).

The Ethical Framework (BACP, 2010) encourages practitioners to monitor their fitness to practise (FtP) for which it offers only a minimal definition and no guidelines on how this is done (Raffles, 2006). It suggests, "if effectiveness becomes impaired...they should seek the advice of their supervisor, experienced colleagues or line manager" (BACP, 2010:8). Raffles (2006) discusses the possible use of questionnaires, rating scales, referral for psychiatric or psychological assessment, and the difficulties, delays and expense incurred in accessing these. She concludes there is a case for the development of an 'awareness based approach' to a practitioner's assessment of FtP and recommends this be incorporated into practitioner and supervisory core training programmes.

1.2 THE FOCUS, AIMS AND SIGNIFICANCE OF THIS STUDY

Guy, Stark and Poelstra (as cited in Guy, 1987) in a survey of therapists found that approximately 20% had experienced the death of a loved one in the previous three years. Most bereaved people experience dysphoria, disrupted social and occupational functioning, cognitive disorganisation and health deficits during the first year following their loss (Bonnano & Kaltman, 2001) to which counsellors are not immune. Counsellors who have had grief experiences are likely to re-experience them in their empathy and identification when working with the grief of clients leading

to possible enmeshment (Raphael et al, 1993). Some may have feelings of incompetence (Theriault & Gazzola, 2006).

My study is confined to those counsellors who have grieved the loss of a loved one while in practice. My primary aim is to discover how grieving counsellors monitor their FtP and whether grief experience and counsellor training is helpful during this process. Informed by Raffles research, I was also interested to know if a tool to assess FtP had been available, how helpful my co-researchers thought this might have been.

It is not my intention for my findings to be prescriptive but to add to the limited but growing body of knowledge on FtP issues. My findings may be of interest to counsellors, supervisors, trainers, trainees and managers of counselling services. Machin (2009) suggests that organisations should consider staff reactions to loss and their ability to cope. Undertaking the study will contribute to my professional and personal development and be pertinent if in the future I undertake supervision or experience a further loss.

1.3 MY FITNESS TO CONDUCT THIS RESEARCH

I have experienced a major bereavement, trained with Cruse and later obtained a Diploma in Counselling. I have experience in working with bereaved clients of Cruse, in primary care and in private practice. Parkes (1995) considers such training and experience desirable when undertaking bereavement research. My core counsellor training was based in brief psychodynamic therapy, which is particularly relevant for grief and loss issues (Raphael et al, 1993). Though a novice researcher, I have

undergone training in counselling research methods. I have received ethical approval from the University of Chester to undertake the study for which I have a designated research supervisor. As a member of BACP I adhere to the Ethical Framework (BACP, 2010) and the Ethical Guidelines for Researching Counselling and Psychotherapy (Bond, 2004). As a member of the British Association of Behavioural and Cognitive Psychotherapy (BABCP), I abide by the organisation's Standards of Conduct, Performance and Ethics in the Practice of Behavioural and Cognitive Psychotherapies (2009). I have contextualised myself within this research to allow the reader to recognize the influence of my experience of the phenomenon under investigation and the existence of any potential biases (Etherington, 2004).

In this small-scale qualitative study with a non-emergent design I used a phenomenological approach and semi-structured interviews with a purposive sample of seven co-researchers with the aim of discovering how grieving counsellors monitored their FtP. The data was analysed using the constant comparative method as described by Maykut and Morehouse (1994).

In the next chapter, I review the literature relevant to this study. The research design and methodology are presented in chapter 3. The findings of the study are presented in chapter 4 and discussed in chapter 5. The conclusions drawn from this study are in chapter 6 together with recommendations for practise and suggestions for further research.

In the context of this study:

Bereavement refers to the death of a loved one

Grief refers to the personal experience of the anticipated or actual death

Grieving and mourning synonymously refer to the process through which a person moves when anticipating or adjusting to death of a loved one

Counsellor, psychotherapist, therapist, and practitioner are used interchangeably

CHAPTER 2
THE LITERATURE REVIEW

2.1 THE LITERATURE SEARCH

A literature search enabled me to identify a possible gap in the literature, a focus for my research, a suitable design for my study (O'Leary, 2005) and to update my knowledge on bereavement and grief. Undertaking a literature search prior to a phenomenological study has the potential to bias the researcher's findings (McLeod, 2003). However, a research proposal with a literature review was a course requirement for formative assessment. As there appears to be a paucity of literature regarding grieving counsellors' monitoring of their FtP, it is unlikely that bias will arise from this source.

I undertook manual searches of the library at the University of Chester to obtain texts on bereavement and grief. The BACP website was used to locate relevant articles in its journals and to access the organisation's information sheets. I searched the on-line databases Cinahl Plus, PsycARTICLES, Psychology and Behavioural Sciences and Science Direct. Various computations of the key words counsellor, therapist, psychotherapist, health professionals, and fitness to practise, grief and bereavement in conjunction with Boolean operators, truncation and wild cards were used to obtain literature subsequent to 1990. The use of the term health professional accessed helpful literature from the field of nursing and medicine. Electronic databases were used to access material noted in reference lists of published work, a snowball technique (Ridley, 2008) that I found most helpful. I accessed some journal articles and books from the British Library and

contacted the authors of two unpublished doctoral dissertations, both of whom generously provided electronic copies. I found limited literature on the grief experiences of counsellors and their monitoring of FtP. During the course of my interviews, I realised that I needed to return to my literature review as some co-researchers spoke about anticipatory grief, the possibility of which I had not foreseen.

2.2 INTRODUCTION TO THE LITERATURE REVIEW.

As there are distinct issues involved in this research, the literature review is presented in a thematic manner as suggested by McLeod (2003) under the following headings:

- Bereavement, grief and mourning
- Grief: the impact on the practice of counsellors
- Grief the impact on the practice of health professionals
- Ethics and FtP

2.3 BEREAVEMENT, GRIEF AND MOURNING.

The review is confined to an exploration of grief as a normative process in adult life and does not consider specific types of bereavement. The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994) regards the death of a relative or close friend as a stressor, the consequences of which are usually predictable and normative.

Because the literature on bereavement, grief and mourning is vast, I have confined this review to some historical material, which together with more recent theories

Stroebe & Schut, (1999, 2001) have integrated into a Dual Process Model of Coping with Bereavement (DPM).

The contextual factors shaping the grief experience are variously described as determinants of grief (Parkes, 1996), internal and external circumstances (Lendrum and Symes, 2004), or mediators of mourning (Worden, 2009).

Western cultural beliefs and assumptions about the normality of intense distress, depression, detachment and recovery after a major loss arise from psychodynamic theory and attachment theory. Despite the lack of supporting evidence, these beliefs and assumptions continue to influence the expectations of those who grieve and the evaluation of them by others (Silverman & Wortman, 2001). Most bereaved individuals experience dysphoria, disrupted social and occupational functioning, cognitive disorganisation and health deficits during the year following their loss (Bonanno & Kaltman, 2001). Regarding reactions to grief as symptomatology has led to the medicalization of bereavement (Stroebe & Schut, 2001).

Many theorists describe complicated grief reactions for which little agreement exists regarding definitions (Bonnano and Kaltman, 2001; Parkes, 2007) and there is a lack of agreement about the duration of grief (Schuchter & Zisook.1993; Wortman & Silver, 2001). However Worden (2009) claims when a person can think of the deceased without pain and regains interest in life, mourning is moving toward completion and “for many, 2 years is not too long” (page 77). Anniversaries

of the death (Parkes, 2010) or of events important in the relationship with the deceased may re-awaken painful memories (Raphael, 1984).

Grief includes the emotional response to the impending as well as the actual death of a loved one. It encompasses coping, interaction, planning and psychological reorganisation with recognition of losses in the past, present and future (Rando, 2000a). The anticipated death of the elderly in whom there is a gradual fading of bodily functions may be viewed as a 'natural' death (Raphael, 1984). Forewarning may facilitate the acceptance of the inevitability of an impending death making it less of a shock when it happens (Parkes & Weiss, 1983).

Attachment theory reduces the emphasis on the psychoanalytical concepts of psychic energy, forges links with cognitive psychology, is compatible with neurophysiology and developmental psychology (Bowlby, 1980). It remains highly significant to the understanding of grief and loss (Lendrum & Symes, 2004; Machin, 2009; Parkes, 2006; Raphael, 1983; Worden, 2009). The human infant has an innate tendency and a basic need to form relationships. Separation anxiety is expressed when the mother figure is out of sight or unresponsive. Apathy and despair follow prolonged or permanent loss. Learning influences this instinctive behaviour and leads to the development of 'internal working models' about the parents, the self and future relationships (Bowlby, 1973). Patterns of attachment established in childhood influence attachments in adulthood and the experience of grief (Bowlby, 1980; Parkes, 1991).

Bowlby and Parkes described phases of grief pointing out the similarities in the responses of adults to the loss of a partner and children's responses to separation from their attachment figure (Parkes, 2006). These phases and those described by Collick (1986), Sanders (1989) and others, though not by intent became prescriptive for normal post death grief as did the description by Kubler-Ross (1969) of the stages through which a terminally ill person passes when anticipating their own death (Worden, 2009). Hunt (2004) reminds us that prevailing medical models of the grieving process are expert led and mourners may search them in an attempt to locate their position in the process. These medical models do not acknowledge the agency and wisdom of the mourner. Hunt (2004) cites Parkes' view that people grow through loss experiences and her study confirmed this.

The concept of stages or phases suggests a passive linear progression through grief which Worden (2009) challenges and presents a task model of mourning. These tasks suggest the mourner needs to take action, are not necessarily addressed in order, though the definitions do suggest some ordering (Worden, 2009). While this model is suggestive of the need for 'grief work', the fourth task reflects a departure from Freud's (1917/1957) claim that the function of mourning is to relinquish the survivor's attachment to the dead.

Attachment theory is usually considered to reflect detachment from the deceased, However Bowlby (1980) in the final volume of his trilogy wrote, "it is precisely because they are willing for their feelings of attachment...to continue that their sense of identity is preserved and they become able to organise their lives along lines they find meaningful" (1980:98). Later Attig (1996) and Shuchter and Zisook

(1993) suggested the bereaved find ways to continue their relationships with the deceased. Klass, Silverman and Nickman (1996) argue we have been educated to expect a period of disengagement from the lost loved.

Recent bereavement literature includes concepts from trauma and stress theory (Bonanno & Kaltman, 1999; Parkes, 2006; Worden, 2009). Acute grief is a traumatic stress response to the actual or impending severance of a meaningful attachment. There may be doubt about the ability to cope with cycles of intrusion and avoidance of distressing thoughts (Rando, 2000b) with a gradual reduction in the intensity of each phase as the longer-term memory structures gain consistency with more recent information (Horowitz, 1986).

Whilst acknowledging these earlier works and those of numerous other thanatologists, Stroebe and Schut (1999) are critical of a linear progression through grief, the focus on intrapersonal aspects and the failure to explain how the bereft cope. The DPM is an integration of existing grief theories and the cognitive stress theories of Folkman & Lazaraus, Horowitz and Lazarus & Folkman (as cited in Stroebe & Schut, 1999). The DPM identifies loss-orientated stressors that include intrusions of grief, the breaking or relocation of bonds/ties. The restoration-orientated stressors are similar to the psychosocial transitions (Parkes, 1996) and involve attending to life changes, establishing a new identity, role, relationships and the avoidance of grief. At times, the bereft will take respite from both processes and attend to everyday activities such as spending time with friends, watching television or attending to chores; there may be no choice but to care for others or to earn a living. The DPM postulates oscillation between the two

processes is a dynamic coping mechanism and acknowledges the benefits of denial, providing it is not extreme or persistent, rather than the detriments as in the psychoanalytical tradition. Unlike theories based solely on grief work, the DPM takes account of gender and cultural differences and the social context of grief. It suggests various possible outcomes in the adjustment to bereavement, e.g. personal growth (Tedeschi & Calhoun, 1995) and meaning making (Neimeyer, 1995).

Stroebe and Schut (2001) extended their DPM drawing on positive meaning making (Folkman, 2001) and negative appraisals (Noel-Hoeksema, 2001). The oscillation between negative and positive affect and (re)appraisal is an integral part of the coping process occurring during both loss and restoration processes. Working through grief includes rumination that enhances the negative affect of grief but is important in coming to terms with loss. However, positive appraisals sustain the coping mechanism. This introduction of differing pathways through grief into the DPM model allows for the appreciation of the idiosyncratic nature of the experience (Stroebe & Schut, 2001)

2.4 GRIEF: THE IMPACT ON THE PRACTICE OF COUNSELLORS

Even though therapists have had training and possibly experience of helping clients with bereavement and grief issues, if the event occurs in their own lives, they will experience many of the same consequences. Remaining in or an early return to practise may be motivated by a fear of loss of income and referrals. Grieving practitioners may avoid discussion of certain client issues because of fear of re-awakening their own sorrow that might result in ‘breaking down’ in front of the

client (Guy, 1987). During grief, therapists may perceive increased vulnerability, be more directive, limit their investment in therapy, be more technique dependent, be self-critical and feel incompetent (Theriault & Gazzola, 2008). However current personal loss experience can also deepen empathy heightening the ability to identify with the pain of clients, providing a perspective on life helpful in assisting with adjustment to their own loss and clients to theirs (Guy, 1987; O'Connell, 1999). The death of a loved one is a personal crisis that may lead to loss of FtP but can lead to "new insight and personal development" (Raffles, 2006:117). Personal life events used competently can be illuminating and instructive in a counsellor's work (Skovholt & Ronnestad, 1995).

During early grief, Evans (2003) lacked the necessary psychological and emotional energy to assist clients to address their problems. She was salaried, took sick leave and though still grieving, resumed clinical work six months after her loss feeling more confident in supporting others express their grief. After resuming work a week following her mother's death and ten days following that of her husband four months later Lambert (2003) withdrew from voluntary work and saw private clients less frequently. She was extremely tired and aware that her needs might intrude on those of her clients However, Lambert felt her counselling relationships benefited from increased creativity. When faced with the terminal diagnosis of her son Hargrave (2003) knew she was not FtP in addition to wanting to care for her son. Five months after her son's death Hargrave, though still grieving, feeling she needed structure in her life, returned to employment but did not counsel. Evans, Hargrave and Lambert all seemed to rely on tacit rather than

explicit knowledge. None mentioned the Ethical Framework but all commented on the support of their supervisors.

2.5 GRIEF: THE IMPACT ON THE PRACTICE OF HEALTH PROFESSIONALS.

Nurse managers, experiencing personal grief found it possible but difficult to support clients, families and staff in a similar situation, thought it necessary to know when personal limits are met and to seek help for self and others (Poole & Giger, 1999). This situation is similar to that of grieving counsellors. However, nurses face serial patient deaths and find themselves in conflicting roles. There is an expectation of them to support patients and families while also experiencing their own grief. By valuing patients and families as fellow human beings, relationships become reciprocal and transcend the purely professional aspect. Personal growth often resulted from the experience of patient deaths (Gerow, Conejo, Alozo, Davis, Rodgers & Domian, 2011).

Health professionals perceived the death of a child as unjust but acquired meaning when close relationships with the children and their families existed (Papadatou, Bellini, Papazoglou & Petraki, 2002), together with conditions that allowed for a dignified death when a hoped for cure was not possible (Papadatou, 2000). Physicians may perceive a loss of professional goals while nurses grieve for the lost relationship with the child and family (Papadatou et al, 2002). A health professionals' model of grieving proposed by Papadatou (2000) expressed as rules provides safety by giving health professionals permission to express grief but suggests the need to move away from it. Regulation of this fluctuation occurs through the identification of the time, place and ways in which to express grief and

access support. This model, which is healthy and adaptive, allows the delivery of competent care to other children and their families. It identifies expected grieving behaviours in the work place and invites educators of health professionals to encourage their students to recognise personal loss and grief needs.

2.6 COUNSELLING ETHICS AND FtP.

Ethics are rules or principles of behaviour (Chambers, 2011). The Ethical Framework (BACP, 2010) is non-prescriptive and encourages ethical mindfulness (Gabriel & Casemore, 2010). It offers only minimal definition of FtP, which could be explicated, however FtP is individualistic and no set of guidelines could address each practitioner's idiosyncratic situation (Raffles, 2006). The Ethical Framework describes the ethical principles informed by the values of counselling and the desirable moral qualities of practitioners. The latter are important to clients and many have an ethical component (BACP, 2010).

Counsellors are personally responsible for decisions regarding their FtP, which in best practice follow consultation with supervisors or managers (BACP, 2010, Dale, 2010). Supervisors have a duty to tell supervisees if they consider them unfit to practise and may end the supervisory relationship but they have no jurisdiction about supervisees' right to practise (Dale, 2010; Raffles, 2006). Deciding on FtP is an ethical dilemma "where there are competing obligations" (BACP 2010:4) when considering how best to simultaneously meet the needs of clients and those of the practitioner. Two case histories of counsellors affected by bereavement are used to illustrate an ethical decision making process in the BACP information sheet "Am I Fit to Practise" (Dale, 2010).

In Raffles' (2006) study participants, "trusted their own process through self-evaluation and in some instances through consultation with supervisors" (page 143). However, "in times of *disablement,* ability to self-regulate is most likely to be impaired" (Raffles, 2006:196). As a result of her study, BACP commissioned Raffles to write an Information Sheet on FtP for Independent Practitioners, parts of which may be relevant to all practitioners.

2.7 SUMMARY OF THE LITERATURE REVIEW.

In this chapter, I have reviewed the literature on normal grief in adult life and described some of the historical theories integrated into the DPM, which suggests adaptive coping involves confronting the reality of loss, but not relentlessly. Tasks that are concomitant with the loss of a loved one also need attention. The DPM allows for positive outcomes of grief and the introduction of pathways into the model indicates the idiosyncratic nature of the experience (Stroebe & Schut, 2001). Next, I considered impact of grief on counselling practice. The limited literature on grieving counsellors' assessment and monitoring of FtP led me to explore nurses' grief and a suggested health professionals' model of coping with grief (Papadatou, 2000). The review concludes with an overview of counselling ethics and an ethical decision making process for assessment of FtP Dale, 2010).

CHAPTER 3
METHODOLOGY

3.1 PHILOSOPHY AND RESEARCH DESIGN.

Having decided on the topic of my research I then considered what it was that I wanted to discover. I wanted to know whether previous experience of grief and counselling training helped grieving counsellors to monitor their FtP rather than the decisions they made. I was then able to arrive at a working title for this study and was attracted to a qualitative study. Following the guidance offered by McLeod (1999) I examined the philosophies and methods of both the quantitative (dominant) and qualitative (alternative) paradigms after which I read many qualitative studies which increased my understanding of the later enabling me to make an informed choice.

The quantitative approach to research recognises that one event causes the next in a unitary reality but by carefully dividing and studying the parts the whole can be understood. The researcher is positioned outside the research while seeking an objective view relating to one time and place (Maykut & Morehouse, 1994). Quantitative research instruments are rigid. Questionnaires and/or interviews with standardised questions or rating scales limit the responses to predetermined categories (Patton, 2002); the resulting numerical data is subject to mathematical analysis and statistical tests to assess the validity of the findings. This paradigm is suitable for large scale studies that may include a control group, is seen as scientific and producing credible results (Denscombe, 2010).

The qualitative paradigm recognises multiple realities with interconnected socio-psychological constructs, views the world as complex with events shaping each other but only tentative explanations for one time and place are possible. Data collection is predominately by questionnaires and/or interviews using open ended questions during which the researcher is a participant observer. Qualitative researchers use a small number of participants; the data consists of the words they use to describe their experience and subsequent actions. This paradigm employs an inductive analysis of the words used by the participants to discern patterns of meaning and the findings are presented as propositional/outcome statements (Maykut & Morehouse, 1994).

Quantitative methods did not seem appropriate for this study as my research question has no definitive answer, hypothesis to test, single truth to be established or quantifiable findings to be discovered. Therefore I chose a qualitative approach as grief is a unique experience that occurs in the context of current life events; in this study that context is counselling practice. Grief is an unique phenomenological experience shaped by multiple determinants including earlier life and loss experiences. I consider my approach to this research is consistent with the focus of enquiry, my core training in brief psychodynamic counselling and later in cognitive behavioural and solution focussed therapies.

Qualitative research is based on a phenomenological position (Maykut and Morehouse, 1994) with a focus on trying to understand the meaning of events have for the people being studied (Patton, 2002). I decided not to create a bricolage to avoid becoming confused. I wanted to learn more about the topic of enquiry and

qualitative research in the process (McLeod, 2003). Due to the limitations of time and resources, I used a non-emergent design and was aware that theoretical saturation would not be reached. However, a non-emergent design can produce important findings and suggest the direction of further research (Maykut & Morehouse, 1994). The use of a single method of data collection meant that methodological triangulation was not possible. I used a small sample to facilitate face to face interviews, to avoid being swamped with data and the possibility of being unable to analyse it with sufficient sensitivity and depth (McLeod, 2001).

In the role of a human instrument (Lincoln & Guba, 1995) I was "connected to the topic of investigation both intentionally and philosophically" (Maykut & Morehouse, 1994:28). Aware of my tacit and explicit knowledge, experience, skills and biases, my aim was to be an empathic perspectival observer while trying to understand the co-researchers' experience. The word *perspectival* includes but is not limited to the researcher's perspective (Maykut & Morehouse, 1994). Tacit knowing is an act of indwelling by which we gain access to new meaning (Polanyi as cited in Maykut & Morehouse, 1994). To analyse my data I used the constant comparative method adapted from grounded theory, as described by Maykut & Morehouse (1994:127-149).

3.2. DEFINING MY SAMPLE.

As it is not possible to identify all those counsellors who have grieved, stratified or random sampling was not appropriate. Therefore I chose to use purposive sampling which is a feature of qualitative research (Lincoln & Guba, 1985) and suitable for an

exploratory study of a little researched topic (Denscombe, 2010). I established a set of criteria to ensure I obtained an 'information rich' sample for in depth study (Patton, 2002).

My co-researchers were required to:

- hold a Diploma in Counselling or a higher relevant qualification.
- be a member of BACP or BABCP to ensure the co-researchers' awareness of the need to monitor their FtP. for self-care and supervision.
- be in regularly supervised practice.
- be able to access personal therapy in order to be able to address any bereavement related issues that may resurface as a result of participating in the study.
- be two years post a major bereavement that had occurred during their practice.
- consider their bereavement issues had been sufficiently worked through to allow them to participate in the study

I was mindful that Worden (2009) suggests that when a person can think of the deceased without pain and regains interest in life, mourning is moving toward completion and "for many, 2 years is not too long" (page 77).

3.3. LOCATING THE CO-RESEARCHERS

A poster (Appendix 1) to invite willing participants indicating the title and purpose of the study and my contact details was distributed at counsellor networking groups with

a request for it be ‘snowballed’ to colleagues, supervisors and supervisees. I sent posters to local counselling organisations with a covering letter (Appendix 2). Advertisements were placed in the BACP journal ‘Therapy Today’ (Appendix 3). All responses were by telephone or email. Many of those who responded were very recently bereaved and therefore did not meet my inclusion criteria. It took longer than I expected to secure the sample and I became rather despondent. I decided not to commence my interviews until I had a sample of six. Those respondents able to verbally indicate they met the inclusion criteria were sent a pre-interview questionnaire (Appendix 4), an information sheet (Appendix 5) and covering letter (Appendix 6). When I received the completed questionnaires confirming all inclusion criteria were met I contacted my co-researchers to arrange the interview. The arrangements were confirmed by letter (Appendix 7) with which I sent two copies of the University of Chester’s Consent Form for Audio-taping Interviews (Appendix 8) and a Co-researchers Interview Guide (Appendix 9).

Table 1 shows the profiles of the co-researchers all of whom were able-bodied, female Caucasians with ages ranging from forty-seven to sixty-seven years. It had been my intention to limit my sample to six. For personal reasons of the sender, the return of one completed pre-interview questionnaire was delayed. I thought it only fair to include her as well as another person I had located in the interim.

TABLE 1: THE PROFILES OF CO-RESEACHERS

CO-RESEARCHER	**A**	**B**	**C**	**D**	**E**	**F**	**G**
Diploma (D) or higher relevant qualification.	D.	D. MA,	D. MA.	D. MA.	D.	D. **1**	D.
Years since the latest bereavement in practice	3	5	5	6	5	3	2
BACP/BABCP member	BACP	BOTH	BACP	BACP	BACP	BACP	BACP
Regularly supervised	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Access to therapy	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Worked through bereavement issues	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Employed (E), self-employed (SE) or volunteer (V)	E	SE	E & SE	SE	SE	V	SE
Person lost	Adult Child	Mother	Mother and Husband	Mother	Husband	Mother	Mother
Theoretical orientation	Person-centred	Person-centred CBT	Integrative Psycho-sexual	Person-centred Psycho-sexual	Person-centred	Person-centred	Person-centred
Special interests	Mental Health	CBT Medico-legal Supervision	Relationships Psycho-sexual Therapy Training	Relationships Psycho-sexual Therapy Training	Student counselling Training	Mental Health	Spirituality Stress and Anxiety Supervision

1 The pre-interview questionnaire for co-researcher F correctly indicated that she held a Diploma in Counselling. However, during the interview it became evident that at the time of her bereavement she had completed her training, had submitted her portfolio for assessment and was still counselling at her placement. Following discussion with my research supervisor I decided to include her data as she had been assessed as competent to commence her placement and thus was accountable for her practice.

3.4. DATA COLLECTION

I rejected the use of questionnaires and/or interviews with standardised questions because they limit the responses to predetermined categories (Patton, 2002). However they have the advantage of making the analysis easier but the data may lack depth and could bias the findings toward the researcher's view (Denscombe, 2010).

Interviews provided the co-researchers an opportunity to check they understood what was being asked and for me to check my understanding of their responses and made it easier to deal with ethical queries or any adverse emotional response of the co-researchers (McLeod, 1994). I lacked experience in working with groups and telephone interviewing. I was aware that unstructured interviews allow interviewees maximum control (Denscombe, 2010) but as a novice researcher I chose to use individual semi-structured, face to face interviews. These would help keep the interviews focussed while allowing some flexibility, achieve consistency across the interviews and make efficient use of time (Patton, 2002). A structured format seemed like using a questionnaire face to face with the co-researchers.

The interviews were audio-taped "to capture the actual words of the person being interviewed. The raw data of the interviews are the actual quotations spoken by the interviewees" (Patton, 2002:380). I considered the costs of travelling and time involved in transcribing the audio-tapes worthwhile for the increased richness of the data I was hoping to obtain (Denscombe, 2010; McLeod, 1999).

The formulation of my interview questions proved difficult as I had not found any prior research on my topic of enquiry to guide me. Initially I relied on my own knowledge to make a list of open-ended questions (Patton, 2002) I am indebted to two colleagues who not only afforded me the opportunity to practise interviews with them but also for the many helpful comments they made regarding the refinement of the questions.

The first question asked about grief experience prior to counselling training, the intention of which was to ease the co-researchers into an interview on a sensitive topic. I then asked how helpful this past experience or counsellor training had been at the time of the co-researcher's most recent loss. This was followed with enquiries regarding their practice, assessment and monitoring of FtP following bereavement. I included a question about the possible use of a tool to assess FtP which was a secondary interest. The final question asked if there was anything else that the co-respondents would like to say in order to 'wind down' and close the interview (Denscombe, 2010; O'Leary, 2005). I prepared a Co-researchers' Interview Guide (Appendix 9) and an Interviewer's Guide with prompts regarding the interview procedure (Appendix 10).

I wanted my pilot interview to be with a counsellor unknown to me and I undertook this with someone who had expressed an interest in the study but who had been bereaved before commencing his training placement. All other inclusion criteria where met. I provided this counsellor with an information sheet, an interview guide and obtained a signature on a consent form for audio-taping a pilot interview which

indicated the data would not be used in my dissertation (Appendix 11). The pilot interview lasted 45 minutes following which we both thought the content, conduct and duration was appropriate. I was beginning to feel more confident about commencing the study.

All interviews took place within a period of eight weeks and at a venue of the co-researcher's preference. Prior to commencing an interview I allowed fifteen to twenty minutes to establish rapport and trust, during which I introduced myself, gave brief details of the background and purpose of the study, answered any questions and expressed my appreciation for my co-researcher's participation (O'Leary 2005). I ensured two consent forms had been signed by both parties and we each retained a copy. The co-researchers were reminded that they could stop the tape at any time and withdraw from the interview. I stopped the tape during one interview when I noticed the co-researcher was becoming distressed. After discussing the situation, when she had regained her composure, she expressed her wish to continue.

Though not a person-centred counsellor I am aware of and adopted the principles of that approach during the interviews to encourage the engagement of the co-researchers who would then be more likely to give authentic and constructive responses. However I was conscious of the need to avoid developing a therapeutic relationship (McLeod, 1994). I consider such an approach essential to the fostering of the co-researcher's self-perception "as a collaborator in the research process" (Maykut and Morehouse 1994:98).

After the formal ending, I asked the co-researchers for their reflections on the experience of being interviewed as a means of debriefing. After the debriefing, I collected socio/demographic information that had not emerged during the interview to characterise the co-researchers and further my understanding of their experience. The collection of this information was delayed until after the interview as I wanted the co-respondents “to become actively involved in providing descriptive information as soon as possible instead of becoming conditioned to short answers, routine responses to uninteresting categorical questions” (Patton, 2002,353). Finally, I suggested the co-researchers seek supervision or personal therapy if any residual negative material emerged.

I did not take notes during the interview as I thought this may make it difficult to listen attentively and I wanted to be able to observe any facial clues that might suggest that the interviewees were finding the process uncomfortable. I did however make journal entries following the interviews. While some co-researchers appeared to want to stay ‘in the moment’ others seemed to have found receiving the interview guide prior to our meeting helpful. They were well prepared with carefully thought out responses. Consequently four interviews were of only thirty minutes duration while others were over an hour during which participants explored personal detail. I thought it appropriate to allow this as it was clearly important to the interviewees but it has been edited as it may have made the participants identifiable and it had no relevance to this study.

3.5. ANALYSIS OF THE DATA

I used the constant comparative method of data analysis, an inductive method, characteristic of qualitative research (Glasser & Strauss, 1967: Lincoln & Guba, 1985: Maykut & Morehouse (1994) and suitable for a small-scale exploratory study (Denscombe, 2010). This method, using a rigorous analysis, aims to understand more about the phenomenon under investigation. Propositional statements are developed and the description of what is learnt stays as close as possible to the feelings, thoughts and actions of the research participants (Maykut & Morehouse, 1994).

Strauss and Corbin (1990) describe three approaches to data analysis from which I chose the second. Their first approach is purely descriptive and the third requires a high level of interpretation for the purpose of theory building which was not the intention of this exploratory study. Some interpretation is necessary during the development of propositional statements and I acknowledge that my counter-transference may have influenced the process. Maykut and Morehouse (1994) purport the perspective of a qualitative researcher is somewhat paradoxical. The qualitative researcher needs to be tuned-in (or indwell) to the meanings of the experiences of co-researchers and at the same time have an awareness of the possible influence of their own bias and preconceptions may have on what one is trying to understand. Therefore during the analysis I engaged in a process of 'epoche' bracketing off my subjective perspective. I followed the procedure for the constant comparative method of analysis described by Maykut & Moorehouse (1994).

Preparation of the data. I listened to each recorded interview twice before transcription. When typing the interviews, to ensure anonymity I gave each co-researcher an identifying code. Each transcript was printed on to different coloured paper to aid visual identification.

Unitizing and coding the data. During a careful re-reading of the transcripts I drew a line above and below units of meaning indicating in the margin where each was located in the text. The code T/A.5 indicates the data comes from page 5 of transcript A. In the margin I also wrote a word or phrase to describe the essence of each unit of meaning. The units of meaning were then cut from the text and attached to index cards. While unitizing the data I noted on a discovery sheet (Appendix 12) recurring words, phrases and themes combining any that overlapped. The data analysis then continued as depicted in the following diagram and as fully described in Appendix 13.

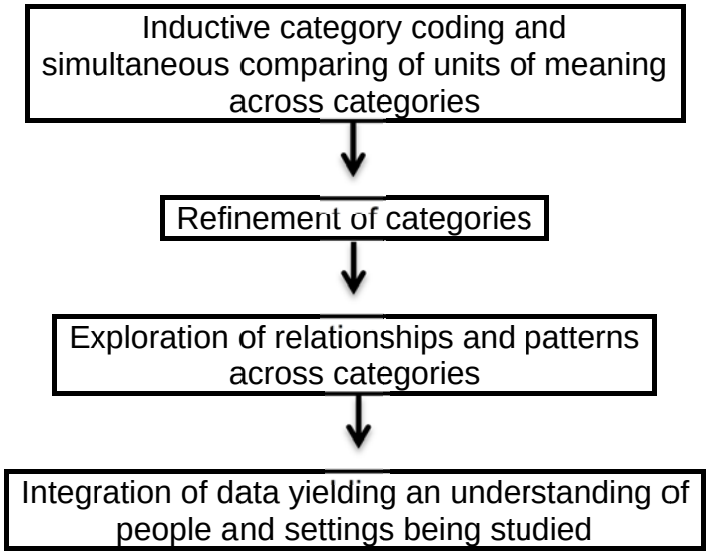

Diagram 1: THE CONSTANT COMPARATIVE METHOD OF DATA ANALYSIS
(Maykut & Moorehouse, 1994:135)

Following the data analysis I decided to modify my working title as assessment of FtP is a continuous process. Therefore I decided to replace the word *assessment with monitoring* in the final title.

3.6. ETHICAL CONSIDERATIONS

Throughout the planning and conduct of my research and writing of this dissertation I gave particular attention to informed consent, confidentiality and the avoidance of harm. Informed consent requires fulfilment of three criteria: competence, provision of adequate information and voluntariness (McLeod, 2003).

Competence. I consider practising counsellors with a Diploma in Counselling and membership of BACP or BABCP to be competent.

Provision of adequate information. The information leaflet (Appendix 5) aims to fully inform potential co-researchers' about the research, the risks entailed, confidentiality and the contact details of my research supervisor. In order to avoid a dual researcher/counsellor relationship and to enable participants to address any negative consequences that might arise, they were required to be receiving regular supervision and have access to personal therapy.

Voluntariness. All co-researchers gave written consent which was checked verbally and recorded at the commencement of each interview. No incentives were offered to encourage participation. I sent a copy of the interview guide to the co-researchers

prior to the interview as part of a 'process consent' procedure (Bond, 2004; McLeod, 1999). My anxiety regarding the impact of any withdrawal of consent late in the preparation of this dissertation caused me to limit withdrawal from the study to two months following the interview. I am aware that this is contentious. McLeod (2003) considers that "it is impossible to design ethically neutral research' (p. 167).

Confidentiality. I am the only person who has access to the interview audio-tapes which I personally transcribed removing identifying information and stored them securely. During the data analysis I realised that some participants could possibly be recognised in other ways. Therefore I made minor alterations to some details to avoid this and decided not to reveal the gender or number of children. I discussed these alterations with my research supervisor and we thought they would not affect the findings of the study.

My overriding ethical concern was the avoidance of harm to my co-researchers Bond, 2004). The inclusion criteria discussed in section 3.2 by implication indicate the main exclusion criteria, the intention of which was the avoidance of harm. The participants had been advised of the potential for the re-emergence of grief related emotions on the information sheet. I was aware that this risk also pertained to me but considered the risk minimal as I meet the same inclusion criteria as the co-researchers.

I had initial concerns regarding dual relationships with three research participants:

1. Prior to enrolling on the M.A. programme when undertaking a free-standing module I had been in the same cohort as one co-researcher The possible topic of

my research had not been discussed and I was unaware that she had been bereaved during practice.

2. I had known one co-researcher in a previous professional capacity, was unaware that she was a counsellor and had had no contact with her for seventeen years.

3. I had had an isolated supervision session with one co-researcher when my regular supervisor was unavailable.

Following a discussion with my research supervisor I decided that these concerns could be appropriately managed and refer to them here for reasons of transparency and critical reflexivity.

Participants in a bereavement study by Cook and Bosley (1995) though not counsellors, thought the interview experience interesting and felt that they had helped others by their participation. I aimed to foster a similar beneficence for my participants by referring to them as co-researchers and stating "together we will be adding to a body of knowledge" on the information sheet. Some participants' comments suggesting this had been achieved are contained in an extract from my journal (Appendix 16).

3.7. PROVISIONS FOR TRUSTWORTHINESS

The term trustworthiness refers to the believability of the findings of a qualitative research study (Lincoln & Guba 1985) From the many aspects of the research

process that provide evidence of trustworthiness, Maykut and Morehouse (1994) recommend the following to novice qualitative researchers:

Multiple methods of data collection.

When the findings of a mixed method study corroborate the results are more believable. A mixed method approach which resulted in divergent findings would requires time and resources to address (Denscombe, 2010) which I did not possess; furthermore as this is a first study I thought it prudent to endeavour to use one method well.

Building an audit trail.

I have provided a detailed description of the background to and purpose of the study, the selection of the sample, data collection and analysis which together with my research journal will allow the reader to consider whether the findings are believable (Maykut & Morehouse, 1994).

Working with a research team

Team members serve the function of 'peer debriefers' and help to keep others honest (Lincoln & Guba, 1985). This research was undertaken as part of a Master of Arts course which required me to be a sole researcher. I did consider having an outside person to periodically walk through my work looking for evidence of bias (Maykut and Morehouse, 1994) but decided to rely on a rigorous conduct of the study, transparency and critical reflexivity and allow the readers to decide whether any bias exists (McLeod, 2001).

Member checks

All participants were offered a transcript of the interview and invited to comment whether it accurately reflected their experience. They had been advised that they could amend, edit or withdraw the transcript up to two months following their interviews. Two co-researchers requested copies, and both agreed the transcripts accurately reflected their experience. All agreed to be contacted if there was anything I needed to clarify and I contacted three. One co-researcher expressed her wish to read the study when completed.

3.8. LIMITATIONS

Due to the limits of time and resources that led to the choice of a non-emergent design no attempt was made to achieve either a homogenous sample or one with maximum variation. All participants were female and there was a dominance of person-centred counsellors. The sample lacks gender, ethnic and cultural variation. However, the study is contextualised within the culture of counselling. The absence of males and ethnic minority representation could possibly be explained by the under representation of both groups in the counselling population. The reluctance of some males to express emotion and their predominantly restoration orientated way of coping with bereavement (Stroebe & Schut, 1999) offers a further possible explanation for their non-representation. Counsellors experiencing the loss of their mothers dominate as do those who were self-employed. A larger sample may have achieved greater variation and possibly theoretical saturation but with the disadvantage of a larger amount of data that could have been difficult to analyse in

the time available. Working as part of a research team would have minimised any bias and facilitated the use of a larger sample.

The use of a single method means that methodological triangulation was not possible but there is triangulation of data sources (Denscombe, 2010). Qualitative research may be criticised as being subjective but Lincoln and Guba (1985) argue the researcher, the researched and the audience all bring a perspective to the topic of enquiry which Patton (2010) suggests is a form of triangulation.

An important reason for undertaking this research was to develop my research skills. My inexperience as a researcher as a limitation cannot be overlooked but I have tried to reduce the impact of this by:

- reading numerous qualitative studies on counselling
- obtaining ethical approval prior to commencing
- being critically reflexive (Etherington. 2004; McLeod, 2001)
- having my work overseen by an experienced research supervisor
- following the guidance offered in the texts of experienced researchers.

CHAPTER 4
THE RESEARCH FINDINGS

4.1 SUMMARY OF THE MAIN THEMES AND OUTCOME STATEMENTS.

I explored the relationship of patterns across the eighteen revised categories and arranged them into six themes with outcome statements. This process required lengthy periods of immersion during which some categories moved between themes and others stood alone. I had now achieved an integration of the data that provided an understanding of grieving counsellors' monitoring of their FtP.

The word limit did not allow for all units of meaning to be included but a complete list of units of meaning for the sub-category 16 can be found on page 94 and for sub-category 18 on page 96.

A table summarising the themes and sub-categories is shown on the next page.

TABLE 2: SUMMARY OF MAIN THEMES AND SUB-CATEGORIES

THEME	SUB-CATEGORIES
1.0 Previous grief experience shaped counsellors' philosophical approach to life and loss.	
2.0 Grieving counsellors perceived their training as helpful when monitoring their FtP.	2.1 Self-awareness and personal development 2.2 Monitoring FtP 2.3 Self-care 2.4 Specific bereavement training
3.0 Counsellors' phenomenology of grief in relation to their practice was idiosyncratic.	3.1 Time out of practice 3.2 Self-exploration 3.3 Supervision 3.4 The Ethical Framework 3.5 Working was helpful when grieving 3.6 Anniversaries
4.0 Grieving counsellors had dilemmas	4.1 Concern for clients 4.2 Personal disclosure 4.3 Breaking down in sessions 4.4 Finances 4.5 Dilemmas of an individual nature
5.0 Grief enhanced personal and professional development	
6.0 Counsellors were sceptical about the value of a tool to assess FtP	

In the detailed presentation of the themes that follows:

- T-A5 indicates the unit of meaning came from the actual words spoken by participant A as they appear on page 5 of her transcript.
- **R** indicates the researcher's words
- (IMR) indicates that identifying material has been removed
- … indicates the respondent paused or was struggling to find the right words
- (---) indicates parts of long quotations have been omitted

4.2 PRESENTATION OF THEMES AND OUTCOME STATEMENTS.

THEME 1: Previous grief experience shaped counsellors' philosophical approach to life and loss.

Deaths in old age were an expected part of life and viewed as normal especially if they occurred at home. In direct contrast a child pre-deceasing a parent is out of the natural order. Each loss was a unique experience with no right way to grieve.

- *I do remember as a child, grandparents dying and various neighbours dying and it was part of our cultural norm that you would actually go and … um … see the body at rest in their home and you would say a prayer for them so it was something that was in our culture and part of the normal … um … cycle of life.* *T-B1*
- *Everybody loses their grandparents and I suppose I had friends around me that were going through similar experiences at a similar age … um … so it felt pretty normal … although sad.* *T-F10*
- *My mum's death was expected, she was 97.* *T-G6*
- *My grandmother had died and my other set of grandparents had died. They all died at home as well which made it much more normal. They were a grand old age so it wasn't a great trauma to me.* *T-D1*

Referring to her loss in practice D said

- *I suppose when people live to they're 94 before they die you're ready for it. (IMR) So I think we were all quite relieved that she wasn't suffering anymore and we could all get on with our lives.* *T-D6*

- *Get on with life because it is so precious and there is no point in someone not living their life. They (the deceased) have not got a choice about whether or not they are going to live their life, I do.* *T-C3*

- *You've just got to get on … to just move forward … got to keep moving forward.* *T-C5*

- *Death is part of life. Just get on with it.* *T-D6*

From past experience C knew

- *It was OK to be grieving … um … and I also knew that the pain would pass, because it does and I know that from my training I know that from my own experience* *T-C3*

A's father died at a young age when she was 11, her mother died at 83. Referring to how she coped said

- *Quite differently obviously because I was at different stages of my life* *T-A1*

When referring to the loss of her adult child, A said

- *When your (IMR) dies at (IMR) it tips all the rules out of the window because this is out of the order of things so I think those other losses, I can't compare them.* *T-A2*

C and E expressed their belief that every loss is unique and is grieved differently.

- *Each of these (bereavements) has been very, very different (---) … um … and so everybody else's and I don't think that there is a right way to do grieving.* *T-C6*
- *Every loss is different because that's my experience and I dealt with the grieving in a different way … um … (---) there is no right way and that everyone is different, everyone has a different time-scale for how they manage that as well.* *T-E1*

THEME 2: Counsellors perceived their training as helpful when monitoring FtP during grief

Sub-category 2.1

Self-awareness and personal development in training was viewed as helpful when bereaved in practice.

- *Training helped me deal retrospectively with my growing awareness of myself. I could lie to rest a lot of ghosts around my mother and our relationship.* *T-A2*

- *The whole process of growing into a counsellor and then four or five years that I worked since my training brought me to the place I was when (IMR) died. Of course it had an impact, but I don't think I could tease out a particular … and say that dealing with that in training really set me up and prepared me for (IMR)'s death.* *T-A3*

- *All the self-awareness training that we did in terms of looking after self, how we would do that in whatever circumstances and acknowledging what was going on for me, acknowledging my feelings and being open to that, exploring that for myself.* *T-E2*

Prior to the loss of their mothers C and G had considered their relationships with their mothers during their personal development.

- *During my self-development I had … perhaps been grieving for the mother that I wished I had but never had had, so when the person who was my mother died oh yes, I felt the loss and there was some upset but it wasn't the devastation that it might have been.* *T-C2*

- *Having been through my own therapy and looked at my own issues, and … um, I guess just being more self-aware, and yeah I guess having you know looked at my relationship with my mother in therapy and personal development.* *T-G1*

Sub-category 2.2

Training promoted counsellors' awareness that monitoring FtP was a continuous process and not confined to the experience of grief.

- *I had that before I even started counselling, I think I got that from my (IMR) … that your fitness to practise was always something that you were very aware of and monitoring and it was emphasised in my counselling training.* *T-B2*

- *In systemic terms … taking a metaposition to myself and looking about … looking at what I'm doing and … um … and working reflexively and reflecting on my part in things and what I might be bringing into the room and all of that (---) which is obviously nothing to do with bereavement but is what one is doing in the normal course of working it is that that's useful.* *T-C5*

- *Whatever somebody brings it might be rattling on something which is a bit close to you so you know that … I don't see that as anything different.* *T-C7*

- *It is hugely important for… um … therapist to be aware of what's going on for them at any given time because there may be many other events in life that can have a huge reaction.* *T-E7*

- *Something we were taught to do in training was to step outside of the session and look at the session not only from the client's perspective or how you understood that, but also from your perspective and how you've experienced it and what was going on for you and how you, what you were feeling or what emotions it raised for you. T-F20*

- *We were certainly told what might affect our fitness to practise, like you know, when personal issues might get in the way. T-G2*

- *When we might need to refer on and how we might do that. T-G3*

Sub-category 2.3

Training encouraged counsellors to consider their self-care.

- *I know myself quite well and I know when I need to take a break and I know … I'm very conscious of it, so yes my training did help me. T-B3*

- *The self-awareness training that we did in terms of looking after self, how we would do that in whatever circumstances. T-E2*

- *I don't know whether it was the training or our tutor in particular, was very big on the idea of self-care and making it a priority (---) it has stuck with me to make it a priority. T-F13*

- *We were actually trained to say "It's equally important that you're in a good place otherwise you can't work safely." T-F14*

Sub-category 2.4

Specific bereavement training was minimally helpful.

Some counsellors found the input on bereavement in training helpful when

experiencing a personal loss in practice.

- *I did my project in my Certificate Course on bereavement (---) so yes at some level there is an intelligence there about death and dying and the aftermath but there is no emotional intelligence in the moment and … it changes minute by minute in … certainly in the early stages. But I couldn't hook my emotional experience onto a process … that's the training. But certainly the cognitive process oh yes. T-A3*

- *It's that unpredictability … that something can just catch you. Now in a session I can stop that, I can hold the tape, but then I have to rewind it afterwards. It wouldn't go away until I've grieved again and experienced it and I know I have to do that , I know I mustn't stop myself from that because of my training … you know it's that sort of learning the helps me deal with it. T-A9*

- *I knew that the pain would pass, because it does and I know that from my training.* *T-C3*

C did not think her training prepared her for personal loss and has strong feelings on the topic.

- *The counselling training has helped me with endings, but it hasn't helped me with loss, not with personal loss.* *T-B1*

- *Bereavement and loss, personal loss, should be included in any training because the majority of people who train as counsellors especially are mostly middle-aged women who will have elderly parents who more than likely will experience a loss of a parent in the time that they are practising and I think it is...I think there is a duty of care for the trainees to have this training.* *T-B6*

THEME 3: Counsellors' phenomenology of grief in relation to practice was idiosyncratic.

Sub-category 3.1

The majority of grieving counsellors only took a short break from practice.

The duration of counsellors' absences from practice seemed to be influenced by their past experience of loss, their philosophical approach to life and circumstances surrounding the death.

The deaths of the mothers of B, D, F and G were expected.

- *I cancelled all my appointments for three weeks.* *T-B3*

following which B reduced her practice

- *The rest of that year I kept my practise at a reduced rate.* *T-B3*

- *I decided that I wouldn't take on any bereavement cases for six months.* *T-B3*

- *I gave people appointments every fortnight rather than every week so I really lowered my practice. I, also for two months didn't take on any new clients.* *T-B3*

D's and G's mothers were over 90 when they died.

- *Following my mum's death I did take a month off seeing clients.* *T-D4*

- *I think I just took two weeks out.* *T-G4*

- *I had about, I think three weeks off work as far as I recall.* *T-C4*

Counsellor F counselled throughout her mother's two year terminal illness

- *I went back to work after two weeks.* *T-F10*

For counsellors A and E the circumstances of their loss influenced the time out

- *He'd been ill for several years before he died (IMR) so I lost the man I married several years before he died, so I do believe there was an on-going grieving process long before he died. The day he died I'd been told by the consultant that he would have to go into a home (---) and I knew that was one thing he absolutely dreaded … um … so for me in a strange sense there was actually a huge sense of freedom when he died (---) I went back into personal therapy and did a lot of work on that… about my guilt around this feeling and have I cared for him well enough (---) I think it was more ethically I felt I needed to have a break from my work (---) I was functioning really well, I was very sad but I decided to have a two month break.* *T-E2/3*

Counsellor A lost an adult child and was employed

- *I actually went back to work after a month but I didn't counsel for eight months.* *T-A4*
- *I answered phones; I dealt with things because I was a senior counsellor so I could go back in some capacity to work in that environment.* *T-A5*

Sub-category 3.2

Counsellors made a personal exploration of their FtP following their loss.

- *It felt the right thing to do because my mind set was in the … you've just got to get on … to just move forward … got to keep moving forward.* *T-C5*

- *My conviction about my understanding of myself and what I was capable of what was right for me was OK for my clients.* *T-C5*

- *It was that asking myself why am I doing this, why am I … you know you don't need to go back. You can take as much time as you want, they've (agency) told you that, so why are doing this and really checking out that it wasn't either just for the client or just for me.* *T-F15*

- *Knowing that I have just worked with this client for twenty odd weeks and my mum was dying for all those weeks and I'd been working with her issue over her dad dying so I kinda knew that I was OK with it. The only difference was that my mum had actually died now.* *T-F16*

Two counsellors found that returning to non-counselling duties aided their assessment of FtP.

D's mother died in the month of August and said:

- *I was a bit nervous going back to teaching (counselling) at the end of September but then I have a mortgage to pay and really just have to get on with it and then having tested the water by talking to students without breaking down, having lumps in my throat I knew then that I was ready to do the next step which was seeing clients.* *T-D4*

- *That was kind of my litmus test during those eight months that I was continuing to do up to fifteen assessments a week. I did hundreds of them. So it was kind of a fair analysis really of where I was with my grieving and how safe I would be to share clients' experience.* *T-A5*

Sub-category 3.3

Counsellors found supervision supportive when grieving.

All counsellors were regularly supervised and valued their supervisors support. They sought supervision at the time of their loss clearly aware that grief had the potential to affect their FtP. Following the death of his own mother one counsellor's supervisor had discussed personal grief and ways to manage that in relation to counselling practice.

- *Our supervisor, about a year before my mother died, he'd lost his mother and we talked about a process and what we would do and that was very useful and informative* *T-B4*

- *I had more supervision, peer group supervision and when I went to supervision in (IMR) we actually spent a lot of time talking about bereavement and my process and how I was coping and I found that immensely helpful. I also read a couple of books my supervisor recommended to me which I also found very helpful.* *T-B3*

- *She was very supportive and hands off and kept saying things like "it's only you that can make the decision and you will know when you are ready" and things like that. She certainly didn't try to stop me from practising or push me back in to it too quickly.* *T-D14*

- *He was very supportive and I did go and see him and talk to him about it well…um so that was really useful, very useful.* *T-E3*

- *Talking through with him how I was feeling and he just said "you sound really grounded." He said "I think you're fine to practise" and if he'd said anything different I wouldn't have. T-G3*

Counsellors C and F had clinical and managerial supervisors.

- *It would have been me saying "well, actually this is what I need to do, this is what I want to do" and because of their knowledge of me as well in reference to my mother's death had helped. T-C6*

- *They had an understanding that this wasn't me being…I'm trying to think what the right word is …um…in denial or irrational or something like that. They had actually seen it before…um… when I had been able to continue working while other stuff was going on for me. T-C6*

- *I found it really useful because she would approach things in just a different way to me, to make me explore that bit deeper that bit further than I could manage on my own. T-F16*

- *I also took it to my managerial supervisor in the agency … just to check out with her what she thought (---) talked through my reasons and the process that I had gone through myself .... of asking myself the questions and doing that exploration of being with my supervisor. T-F18*

When encountering difficulties with client work during grief counsellors found it

helpful to take these to supervision.

- *Lots of supervision and you know I would talk about being able to unpick mine and theirs and just being able to voice the fact of that's what I felt like saying or doing was very, very helpful...um…and of course not allowing that to be what I would do. T-C8*

- *I saw somebody new last week who was a recovering addict and that in itself would not have stopped me seeing (IMR), but the way the first session went, I felt quite uncomfortable about myself and I took it to supervision (---) and I asked my colleague if he has space and I'm going to pass (IMR) over. T-A8*

Sub-category 3.4

The Framework did not play a major part in the assessment and monitoring of FtP when grieving.

- *The Ethical Framework did not give me any indication as to how I would know I was fit to work. T-C6*

- *I was very aware of it and aware that it was my responsibility that if anything went wrong, that if a client complained, or if I suddenly burst into tears in the middle of a counselling session it would be my neck on the block and …um …that was about it really. I certainly didn't lose sleep over the Ethical Framework.* *T-D5*

- *I'm not sure that I … really took that (The Ethical Framework) into account. I think it was talking to my supervisor and thinking about what was right for me.* *T-E3*

- *To be honest I don't think I thought about it. (The Ethical Framework).* *T-G3*

Sub-Category 3.5

Continuing to practise when grieving was helpful to some counsellors.

Counselling during both pre and post death grief can be helpful and this in most cases was related to philosophical approaches to life. Two counsellors thought work had helped them prior to the actual loss.

- *It was almost as if counselling took me out of my life and gave me some respite from it and then when (IMR) died the anxiety just went…and it was pure grief, pure sadness.* *T-A9*

- *Being in work really, really helped me during my anticipatory grief.* *T-F9*

A was employed and referring to herself and husband said

- *We actually needed a structure in our lives; it's pretty aimless without that. So I actually went back to work after a month but I didn't counsel for eight months.* *T-A4/5*

- *I did find working could be quite helpful to me because if I'm focussing totally on my client it gives me a breather from my grief.* *T-B3*

- *It felt the right thing to do because my mind set was in the … you've just got to get on … to just move forward … got to keep moving forward.* *T-C5*

- *One of my main ways of coping is to get on with work.* *T-D3*

- *It was that let's get back to routine, get back to routine as quick as I can and I'll be Ok… that will be my safe place.* *T-F10*

Sub-category 3.6

Counsellors varied regarding seeing clients on anniversaries of their loss.

Participants spoke about how they managed the occasion in their personal lives and this has been omitted (Please see page 27). For some not counselling on anniversaries was part of their self-care.

- *The first anniversary I went home (---)* *T-B5*

- *I will always know the date she died and I will always know the day she was buried and I think if I had someone who was working with a bereavement issue, I wouldn't see them on that day … even now*
  ***R:** It sounds as if the first year you took time out.*
  ***B:** I did, I took a week out that, I thought that was quite important.* *T-B5*

- *On the first anniversary I made sure that I wasn't working anyway and I had time for me and it was very much about looking after myself.* *T-E6*

- *I have looked and watched those anniversaries ahead of them to see what day they fell on, to see what I was doing that day. So I have checked it out and I do know thinking about it, I do know that I would not have counselled on an anniversary day because it is something I just needed to be with me. T-F22*

- *I didn't work on the actual anniversary.* *T-G5*

- *I haven't felt that I've needed to take time out of my practice.* *T-C10*

- *It doesn't come into work life at all.* *T-D3*

THEME 4: Counsellors had conflicts or dilemmas when a loved one died.

Sub category 4.1

All the grieving counsellors were concerned for their clients.

One counsellor had a contingency plan.

- *I had set up with my colleague, in fact from the time I went into private practice, that if there was an emergency we would help each other out and we would, if either of our clients needed a session we would look after them.T-B4*

- *When my mother died, I phoned my colleague and I said "look can you help me out here?" and she said "yes". I gave her my diary, she had all the numbers and she contacted all my clients and said I would contact them in about three weeks' time.* *T-B3*

When it was obvious that her mother's death was imminent G said

- *I had been able to say I might have to cancel at short notice. I think that is quite important. . T-G3*

- *Having to cancel clients at very short notice when my mum actually died and then I guess just knowing what to say to clients, really how long I was not going to be available. T-G4*

- *The needs of my clients and what I am able to offer them, how I might behave with them is just so important to me. T-C10*

- *I was concerned that my clients had someone else to see or that they had a choice of what they wanted to do. . T-E4*

- *They were given the option of waiting to see me or seeing another counsellor. T-A5*

- *We were a long way down the road with her therapy and I didn't want to let her down. T-F16*

Sub-category 4.2

Counsellors' opinions were divided regarding disclosing their bereavement to clients.

- *The agency rang them and explained the situation so everybody knew I had a bereavement. T-A5*

- *I was happy for them to know what had happened. I felt it was important especially for the people who were going to return. T-E4*

- *A client came recently who had lost her father on the same date as my father died, many difference in years, and in similar circumstances, but I chose to share that at the end of our sessions, not in the first session because I thought that was very much about her. T-E5*

- ***R:*** *Did you give any indication as to why you weren't available?*
  G: *Yes, Yes,*
  R: *So personal disclosure was not a problem?*
  G: *No T-G4*

Some counsellors thought personal disclosure was a boundary issue.

- *My colleague just said there was a family issue so we didn't say the word bereavement, so I didn't share that with my clients. T-B4*

- *Most of my clients said "did you get it sorted?" and I just said "yes" and I left it at that and so I don't think that my clients knew that I had a bereavement in my family because I thought that was crossing a boundary. T-B4*

- *I've never overstepped that line (IMR) no I've never disclosed. T-C7*

F was working with a bereaved client at the time of her mother's death and for her disclosure was a dilemma.

- *Congruence is really important to me and I wouldn't lie to her and at the same time I recognise it wouldn't have been helpful to her, it could have blocked her or it could have stopped her sharing what she needed to share, (---) I think I kinda trusted that she wouldn't ask. T-F19*

Sub-category 4.3

Some counsellors had concerns about breaking down in sessions.

- *I had to be 99% sure that's as good as it can be, so I was 99% that I'd be OK and that I wouldn't break down. T-F19*

- *If I suddenly burst into tears in the middle of a counselling session it would be my neck on the block. T-D5*

but when did happen it appeared helpful for clients.

- *I can recall two occasions when clients have been very tearful and I have felt tearful with them … It's very difficult to say whether that is I'm crying for my mother or whether I'm empathising so much with the client that I have tears as well …um … and the clients haven't minded at all. I think that they have appreciated the fact that their upset is so real that I can show that I'm upset as well. T-D5*

E had been able to be congruent

- *I have felt a lump in my throat and I have been able to share what was going on for me. T-E5*

Though not related to bereavement, Counsellor E said

- *Recently with a client … um … I did break down in a session … um … it wasn't around bereavement, it was about (---) I chose not to hide those tears and actually that was hugely powerful with this particular client. T-E5*

Sub-category 4.4

Counsellor's financial situation may be a dilemma.

Only one counsellor had financial concerns but others were aware of the potential for this to be a dilemma.

- *I do have a mortgage to pay and really just have to get on with it. T-D4*
- *Fortunately finance wasn't an issue. So I didn't think oh gosh I've got to get back to work because I need the money. T-E8*
- *If somebody is in private practice and really reliant on that income I suppose there might be like a pressure to get back to work. T-G6*

Sub-category 4.5

Some grieving counsellors had specific dilemmas relating to their personal circumstances.

- *An on-going dilemma and a dilemma I had before (IMR) died really because our (gender X) children have been vulnerable all their lives (---) I've always had a temerity about working with young gender X clients and I've explained that here to (agency). Now I do watch, it's not a dilemma it's a professional decision that I've made … not to work with vulnerable gender X clients. T-A7/8*
- *It's the addiction and that comes up an awful lot. You know, I'm OK with it again at an intellectual level and staying in the client's frame of reference. It's just you don't know when it is going to come in (---) and I hope that I'm OK in the moment … but then I go away and I have to deal with it. T-A9*
- *I had a particular client who was a widow who was in a new relationship (---) I was always very conscious of my desire to just say to her 'just get on with it'* T-C7
- *Would people think that I was being disrespectful to (IMR) for going back to work … um …or would people think badly of me for going back, would people be going WHOOOSH behind my back because I wanted to continue working. T-C7*
- *One thing that came up … um … which was very challenging … um was because I think I was within a few months, I met a new man and I've now remarried and … so there was that going on as well. T-C7*

THEME 5; The experience of grieving enhanced counsellors' personal and professional development.

- *The other issue is around addiction and again because I knew so much about it before (IMR) (---) I think that has helped in the empathy stakes.* *T-A8*

- *It has made me a better therapist having gone through that experience and I might self-disclose now to someone going through bereavement (---) it would be just a little snapshot of I've experienced grief too, but very measured and only in an appropriate place.* *T-B5*

- *Each of these (bereavements) has been very, very different (---) … um … and so everybody else's and I don't think that there is a right way to do grieving.* *T-C6*

- *In my practice now as well to know there is no one way … there is no right way and that everyone is different, everyone has a different time scale to how they manage that as well.* *T-E1*

- *I think people's spiritual beliefs are really so important, you know, what they believe happens after death I think is really important. Because my mother had a firm spiritual belief I knew she was O.K.* *T-G7*

D's mother died five years ago and said

- *I know that I'm a better therapist in the last five years.* *T-D4*

- *The other thing about losing somebody that you are very close to is that it makes you a more finished person, a more rounded person and that's helpful not only to me but to clients.* *T-D7*

- *It does make you think about your own death (---) now I have somebody who if anything happens to me can go in and knows exactly where the clients files are, knows how to get in touch with my employers so it's done that for me on a very practical level.* *T-D7*

THEME 6: Counsellors were sceptical about the value of a tool to assess FtP.

Participants found it difficult to comment on something abstract, though some were interested in the concept, they thought it would be difficult to design a tool appropriate for everybody.

- *If the tool was a good tool then of course it would be helpful … um … and I don't really know what that tool might be …um … but yes it would have the potential to help. I'm not saying I would have used it myself…because I would have to know about it and I'm not sure that I would know where to look for it or*

be bothered to look for it at that time because I think there was enough going on for me. (---) May be it's a thing for supervision but left to myself I wouldn't have sort out something like that. *T-B6*

- *I'm sure that had there been one I would have wanted to use that…you know…but I would be interested to know what sort of tool there might be because the only thing that I could think of when I read this question was the … um scales in that … the Core measure (---) so I couldn't … sort of … I didn't know what the tool might be (---) I suppose how helpful it would have been is a different matter isn't it. What would it have told me……..I suppose that comes back to what is fitness to practise.* *T-E7*

- *I would've filled it in because I'm quite a compulsive form filler in (---) but I'm not saying I would have been influenced by it.* *T-D5*

- *I don't know what they are but the fact that I'm person-centred and I don't carry a tool bag around with me, my instinct would be to say I wouldn't have found it helpful.* *T-A1*

- *If the tool was something which was if you tick yes to three of these you are not allowed to practise or you know whatever the thing might be…um…I would find that very rigid and would not have been very helpful for me, you know I just can't imagine in what way you could devise a tool which would be appropriate for everybody.* *T-C10*

F counselled throughout her mother's terminal illness, was working with a bereaved client when her mother died and returned two weeks later to continue with that client said

- *A standard test would have said definitely not (FtP). I'm almost certain of that but then I'm also still very certain that the process I went through was valid and it was personal to me and I didn't suffer any adverse effects from it and I don't think my client suffered either.* *T-F23*

CHAPTER 5
DISCUSSION

The format used to present the themes and outcome statements in the previous chapter is used to structure this discussion.

Previous grief experience shaped counsellors' philosophical approach to life and loss

All participants had experienced the loss of a loved one prior to counsellor training. Expected deaths in old age were thought of as part of life and regarded as normal (Raphael, 1994). However a child predeceasing a parent "tips all the rules out of the window because this is out of the order of things so those other losses, I can't compare them" (T-A2). Some participants said each grief experience had been different (T-A1, T-C6, T-E1) and there was no right way to grieve. This finding is congruent with the contextual factors of grief (Lendrum & Symes, 2004; Parkes, 1996; Worden, 2009). This awareness may have arisen because grief is an emotional response that includes the recognition of past, present and future losses (Rando, 2000a). However, bereavement training may have heightened this awareness but the co-researchers made no reference to this.

Counsellors perceived their training as helpful when monitoring FtP during grief.

Self-development, monitoring FtP and self-care during training was perceived as helpful when bereavement related grief arose in practice. Three co-researchers' self-understanding increased as a result of examining their relationship with their mothers

during personal development (T-A2, T-C2, T-G1). Training encouraged reflexive practice (T-C5, T-F20) the need for awareness of personal issues (T-G2) and life events that may affect practice, the importance of acknowledging and exploring their feelings (T-E2) and that monitoring FtP was an on-going process which C expressed explicitly

> *Reflecting on my part in things and what I might be bringing into the room and all of that (---) which is obviously nothing to do with bereavement but is what one is doing in the normal course of working it is that that's useful. T-C5*

This statement reflects the importance of "fostering a sense of self, that is meaningful for the person(s) concerned" (BACP, 2010:02). Participants were aware that self-awareness, monitoring FtP and self-care are inextricably linked. Three co-researchers thought specific bereavement training helpful to some degree; one thought it helped her understanding of the cognitive process of grief. She found the unpredictability of emotions difficult but was able to control these when counselling; bereavement training helped her to recognise the need to grieve again later (T-A3, T-A9). B thought there was a duty of care to trainees to include personal bereavement and loss in training (T-B6).

Counsellors' phenomenology of grief in relation to practice was idiosyncratic.

The duration of absences from practice when grieving were influenced by the circumstances surrounding the loss, the age of the deceased and the expectedness of the death being particularly evident. This is congruent with the participants' experiences of loss prior to becoming counsellors and the contextual factors described by Lendrum and Symes (2004), Parkes, (1996) and Worden (2009). Five participants for whom the deaths of their mothers were in old age and/or expected took a month or less out of practice. This appeared to be influenced by their

philosophical approach to life and loss, personality and prior experience (T-G6, T-C3, T-C5, T-D6, T-F9).

Co-researchers made a personal exploration of their FtP. This finding suggests the participants “trusted their own process through self-evaluation” (Raffles, 2006:143). An employed co-researcher undertook client assessments for eight months and thought this a fair analysis of where she was with her grieving and how safe she would be to share clients’ experiences (T-A5). D ‘tested the water’ by returning to teaching (counselling) and when finding she was able to talk to students without breaking down knew she was ready to see clients (T-D4). Resuming practise to continue working with a client’s grief was a difficult decision for F who asked herself why she was doing this despite the fact she knew her agency would support her to do otherwise (T-F15). F concluded that counselling during her anticipatory grief had been helpful and the only difference now was that her mother had died (T-F15). All participants were aware grief could affect their FtP, explored this with their supervisors in accordance with the Ethical Framework (BACP, 2010) and valued their support as did Evans (2003), Hargrave (2003) and Lambert (2003).

One co-researcher had established a contingency plan for emergencies with similarities to the suggestions of Raffles (2010) when she commenced private practice (T-B4). Subsequently her supervisor’s mother died prior to her own loss and she said “we talked about a process and what we would do and that was useful and informative” (T-B3). Following her loss, B had more supervision during which she discussed her bereavement, how she was coping and read books recommended by her supervisor (T-B3). A supervisors’ prior knowledge of a supervisee’s coping

behaviour and its efficacy during previous life stresses was useful to both parties (T-C6).

The co-researchers thought the Ethical Framework (BACP, 2010) did not play a major part in monitoring of their FtP and it was not referred to by Evans (2003), Hargrave (2003) or Lambert (2003). This suggests these practitioners may have reached a level of unconscious competence as the values and principles of counselling were implicit in their actions and consistent with an ethical decision making process regarding FtP described by Dale (2010).

Anniversaries of the death may re-awaken painful memories (Parkes, 2010). Counsellors spoke about how they managed this in their personal lives and this has been omitted (see page 27). For some, anniversaries did not come into work life (T-D3, T-C10), for others not counselling on anniversaries was a self-care need (T-B5, T-E6, T-F22) and suggests oscillation to loss orientated coping (Stroebe & Schut, 2001).

Grief is the emotional response to an impending or actual death and encompasses coping (Rando, 2000a). Counselling prior to their losses was a coping response for A and F and provided helpful respite (T-A9, T-F9,). Returning to employment following her loss provided structure to the life for A (T-A4/5) as it did for Evans (2003) and Hargrave (2003), both of whom returned to paid employed but like A, initially did not counsel; an option not available to private practitioners. F who counselled during anticipatory grief resumed practice two weeks after her loss because that would be her safe place (T-F10). C who reduced her client contact hours said “if I’m focussing totally on my client it gives me a breather from my grief”

(T-B3,). The other counsellors who continued to practise when grieving did not comment whether this was helpful but doing so is congruent with the DPM (Stroebe & Schut, 2001).

Grieving counsellors had conflicts or dilemmas in relation to their practice.

All participants spoke of concerns regarding their unavailability to clients. However, one participant had a contingency plan in place regarding notifying her clients and for their on-going care in the event of her unavailability (T-B3/4). When it became obvious her mother's death was imminent G thought it important to advise her clients that she may have to cancel appointments at short notice and subsequently found it difficult to say how long she would be unavailable (T-G3/4). The clients of two co-researchers were offered the choice of waiting for their counsellors' availability or seeing another counsellor (T-E4. T-B5,). A long standing therapeutic relationship with a client with grief issues was a dilemma for counsellor F (F14). For counsellor C the needs of her clients and what she was able to offer them was important to her (T-C10).

Co-researchers' opinions were divided regarding disclosing their bereavement to clients. A's agency informed them on her behalf (T-A5). E was happy for them to know and felt it especially important for clients who were going to return to her (T-E4) and for G it was not a problem (T-G4). Congruence was important to F but disclosure posed a dilemma for her when she resumed counselling a client with bereavement issues (T-F19). All these counsellors practised from a person-centred perspective. Two co-researchers thought disclosing their bereavement was a boundary issue (T-B4, T-C7).

Some co-researchers were concerned about breaking down in sessions. F who did not want to disclose her bereavement felt she was 99% sure that she would not break-down (T-F19). Interestingly D thought that if she burst into tears when counselling her 'neck would be on the block' but when this happened she thought clients appreciated the fact that their upset was so real that she was able to show her upset (T-D6). E was congruent when she had felt a lump in her throat and though not related to bereavement had broken down when counselling and this had been hugely powerful for the client (T-E5).

Loss of income may have influenced D's decision to continue to practise (T-D4) when grieving (Guy, 1987) but as D believed "death is part of life, just get on with it" (T-D6), it is difficult to say whether continuing to practise was motivated solely by financial needs. Two other participants were aware that financial concerns could be a pressure to return to practice (T-E8, T-G6).

Grieving counsellors may avoid certain client issues due to a fear of re-awakening their own sorrow or limit their investment in therapy (Guy, 1987; Theriault & Gazzola, 2008). Counsellor A's gender X children had always been vulnerable and even prior to her loss she had a temerity about working with young gender X clients and has now made a professional decision not to work with vulnerable clients of that gender (T-A7/8). Her loss was related to addiction and she finds working with this issue difficult (T-A9). After feeling uncomfortable in a first session with a recovering addict and addressing this in supervision she referred the client to a colleague (T-A8).

During grief, therapists may be more directive in their way of relating (Theriault & Gazzola, 2008). C was aware of wanting to tell a widowed client in a new relationship

to “just get on with it” (T-C7). She found being able to voice in supervision what she had felt like saying to the client was helpful (T-C8). A further dilemma for this counsellor was that she may be thought disrespectful to her deceased husband by continuing to practise and by being in a new relationship within a few months of his death (T-C7).

The experience of grieving enhanced counsellors’ personal and professional development.

Participants thought their grief experiences had a positive impact on their practice. It enabled increased empathy when working with addiction issues for a counsellor whose loss was addiction related (T-A8). Two co-researchers were very aware that every bereavement is different (T-C6, T-E1). Participant B thought the experience had made her a better therapist and she might now self-disclose when working with clients’ grief. (T-B5). D thought losing a loved one has made her a more finished person, helpful to herself and clients. Because it evoked thoughts of her own death she now has plans in place in relation to her practice for that eventuality (T-D7). Counsellor G, comforted by her mother’s spiritual beliefs thinks it important to ask bereaved clients what they think happens after death. The findings of this theme suggest co-researchers’ adjustment to bereavement included personal growth (Tedeschi & Calhoun, 1995) and meaning making (Neimeyer, 1995). It is consistent with the findings of Hunt (2004), Raffles (2006) and Skovholt & Ronnestad, (1995).

Counsellors were sceptical about the value of a tool to assess FtP.

The co-researchers found it difficult to comment on something abstract and were sceptical its value. One thought tools inconsistent with a person-centred approach

(T-A11). Others thought it would be difficult to design a tool with sufficient sensitivity to be applicable to all (T-C6, T-F23), a finding similar to that Raffles (2006). Two participants would have wanted to use a tool if it had been available; however one said she would not have been influenced by the results (T-D5). Another said “it comes back to what is FtP?” (T-E7) which is only minimally defined by BACP (Raffles, 2006) One participant thought even had one been available she would have had to know of its existence because there was too much else going on at the time of her loss to have sought it out (T-B6).

CHAPTER 6
CONCLUSIONS

6.1 CONCLUSIONS

The findings of this study suggests:

- Grief experienced prior to counsellor training was formative in the development of a philosophical approach to life and the response to subsequent losses.

- Counsellor training increased self-awareness, made counsellors aware of life events that might affect FtP, the requirement to continuously monitor FtP and for self-care, all which were perceived as helpful when bereavement related grief arose in practice.

- Specific bereavement training was found to be minimally helpful to counsellors grieving during practice.

- The duration of absence from practice seemed to be influenced by past experience of loss, the philosophical approach to life and the circumstances surrounding the death. Following expected or deaths of a loved one in old age counsellors returned to practise within a month or less.

- Financial need could be a pressure to return to work.

- Participants made a personal exploration of their FtP following their loss, consulted their supervisors and valued their support.

- Practising or returning to work to undertake non-counselling duties while grieving was found to be a helpful coping mechanism that provided structure to life and respite from grief.

- The Ethical Framework (BACP, 2010) had little influence on the monitoring of co-researchers' FtP during grief.

- Following their losses counsellors were concerned that clients had access to counselling and balanced their own needs with those of their clients.

- Counsellors' opinions varied regarding disclosing their bereavement to clients. Some thought this was a boundary issue but person-centred counsellors thought disclosure could be appropriate.

- Two counsellors were concerned about breaking down in a session but when this did happen, it had a beneficial impact on the therapeutic relationship.

- Some counsellors had dilemmas pertaining to their personal circumstances.

- The grief experiences of participants during counselling practice enhanced personal and professional development.

- Participants in this research were sceptical about the value of a tool to assess FtP and thought that it would be difficult to design one which addressed the peculiarities and individual nature of every practitioner's situation.

6.2 RECOMMENDATIONS FOR FURTHER RESEARCH

- A similar small-scale study with an all male sample would be useful.

- A larger study with maximum variation, an emergent design and working to theoretical saturation conducted by a team of researchers would provide a fuller picture of the experience of grief during counselling practice. A team of researchers would minimise any bias and facilitate the use of a larger sample.

- Grief is evoked by losses other than the death of a loved one and which may also lead to the impairment of counsellors' FtP. Stroebe and Schut (2010) have been questioned about the applicability of the DPM to other stressful life events, for example divorce or chronic illness of a loved one. They suggest there are parallels across different types of loss events in both loss and restoration domains. I think counselling researchers could explore the usefulness of the DPM in relation to many losses. Some suggestions are the loss of one's home, infertility, loss of reproductive ability after hysterectomy or the menopause, loss of body parts or children leaving home. The list is probably endless and need not be confined to members of the counselling profession.

6.3 RECOMMENDATIONS FOR PRACTICE

- As it appears that working in some capacity can be healthy and adaptive, employed and volunteer grieving counsellors could approach agency managers regarding undertaking non-counselling activities within their organisation if they think their FtP is impaired.

- Counsellors could consider coping with their grief by reducing their client contact hours. This could be achieved by not accepting new clients and seeing existing clients less frequently as did Lambert (2003) and participant B in this study.

- Practising grieving counsellors could consider increasing time spent in their supervision.

6.4 CONCLUDING COMMENT

I endorse the suggestions of Raffles (2006) that an awareness based approach to disablement from FtP should be included in core counsellor and supervisory training programmes as well as in the domain of continuing professional development. The production of the BACP information sheet P14 by Raffles (2010) provides a means of facilitating this.

EPILOGUE

The topic for this research arose from my own experience of grief which occurred shortly after I had retired but before I became a counsellor. During my work as a nurse and midwife I had experienced deaths of patients and had taught grief in relation to reproductive losses as a midwife teacher, but this prior knowledge had not prepared me for the experiential learning that was to come. The intensity and duration of the emotions following my mother's expected death took me by surprise.
I had not adjusted to retirement which was also a loss and a concurrent stressor for me when grieving. The findings of this research lead me to believe that had I still been in employment this could have provided some respite and facilitated my grieving process (Stroebe & Schut, 1999, 2001).

I am aware that there any many factors that can affect FtP and the co-researchers mentioned some but none mentioned aging. I qualified as a counsellor when past what had been the mandatory retirement age. Now in my early seventies, while undertaking this study I have wondered how long I would be FTP and hope I would know when to retire from practise. I knew the time was right for me to retire from my previous occupation and welcomed the opportunity to do so early.

In a course assignment I wrote "My greatest wish is to avoid harm to clients, preserve my professional integrity and to arrive at an autonomous decision to cease practice or at least that I am able to accept with dignity my supervisor's suggestion that that is appropriate" (Johnson, 2008). Counselling provides a sense of purpose and self-worth. I am still interested in continuing to develop and derive great satisfaction from

my work. However like some other practitioners I could become resistant to suggestions that I ought to retire (Name withheld, 2011).

Sugg (2011) raises the question of an 'MOT or FtP test much as I raised the question of a tool to assess FtP with my research participants. Sugg (2011) goes on to suggest some proactive questions that counsellors might ask themselves on an annual basis. This is an important step forward as although the Ethical Framework (BACP, 2010) encourages members to monitor their FtP it offers only a minimal definition and no guidance on how to do monitor this (Raffles, 2006). I think the introduction of a formal 'MOT' for therapists would require a 'judge and jury' as Sugg (2011) suggests. This raises questions for me about regulation and autonomy.

I do not think that I will undertake supervision in the future, but the findings of this study would be helpful when supporting a colleague during grief in practice. Knowledge of the DPM (Stroebe and Schut, 2001) has already been also be useful in my practice when working with clients presenting with loss and grief issues. The findings of the study, particularly the possibility of continuing to practise if I experience a loss will be of benefit to me personally.

Word count 17,118

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LIST OF APPENDICES

APPENDIX 1

BEREAVEMENT RESEARCH

ARE YOU A COUNSELLOR WITH EXPERIENCE OF A MAJOR BEREAVEMENT DURING PRACTICE?

WOULD YOU BE INTERESTED IN TAKING PART?

As part of my M.A. degree in counselling studies at the University of Chester, I am undertaking some research into counsellors' experience of a major bereavement while in practice. My working title is:

An exploration of grieving counsellors' assessment of their fitness to practise.

I am seeking practising counsellors who have grieved the loss of a loved one at least two years ago. If you are willing to complete a short questionnaire and to participate in an interview, I would be delighted to hear from you.

'***Counsellor'*** is used as a generic term and refers to counsellors or psychotherapists.

My contact details:-

Pamela H. Johnson

Telephone no.

E-mail:

Address:

THANK YOU FOR TAKING THE TIME TO READ THIS

APPENDIX 2

Address
Telephone Number
Email address

Date

Dear

As part of my MA degree course in Counselling Studies at the University of Chester, I am undertaking a research study on counsellor's grief. My working title is:-

'An exploration of grieving counsellors' assessment of their fitness to practise.'

I would be most grateful if you could display the enclosed poster on your staff notice board.

Yours sincerely

Pamela H Johnson

APPENDIX 3

ADVERTISEMENTS PLACED IN THERAPY TODAY

JUNE 2010

Grieving counsellors 'An exploration of grieving counsellors' assessment of their fitness to practise' Participants sought for face to face interviews. Contact Pam email address

JULY 2010

Research participants invited for "An exploration of grieving counsellors' assessment of their fitness to practice" by MA student with university ethical approval. Confidentiality assured. For more details please contact phone number and email address

APPENDIX 4

AN EXPLORATION OF GRIEVING COUNSELLORS' ASSESSMENT OF THEIR FITNESS TO PRACTICE.

QUESTIONNAIRE TO SELECT MY CO-RESEARCHERS

For the purpose of this research, a major bereavement means one that has evoked grief.

Counsellor/counselling are used as generic terms for psychotherapist/psychotherapy

- Have you achieved a Diploma in Counselling or an equivalent qualification?
  Please specify:

- Have you experienced a major bereavement while in practice?
  YES/NO

- Is it at least two years since your last experience of a major bereavement?
  YES/NO

- Are you currently a member of BACP or BABCP?
  Please specify

- Are you currently in regularly supervised practice?
  YES/NO

- Are you able to access personal therapy?
  YES/NO

- Do you believe that your bereavement issues have been sufficiently worked through to allow you to participate in this study?
  YES/NO

NAME (Please print)

ADDRESS:

EMAIL: PHONE NUMBER:

SIGNATURE: DATE:-

When completed please return to me in the enclosed stamped addressed envelope

THANK YOU

APPENDIX 5

An exploration of grieving counsellors' assessment of their fitness to practise.

Information for potential co-researchers.

This information is provided to help you make a fully informed decision regarding your participation in my study.

THE RESEARCH

This research has the ethical approval of the University of Chester and is the subject of my dissertation for an MA degree in Counselling Studies.

There appears to have been little research into my chosen topic. The findings will add to the existing small body of knowledge and may be of interest to supervisors, trainers, counsellors, managers of counselling agencies and student counsellors.

THE CO-RESEARCHERS

Potential co-researchers are asked to complete the attached questionnaire to determine if they meet the inclusion criteria for my sample.

Eligible co-researchers will be invited to participate in an audiotaped semi structured interview with myself for which their fully informed, voluntarily given signed consent is required. Together we will be contributing to the limited body of knowledge available to the counselling community on this topic.

PRIOR TO THE INTERVIEW

You will receive a copy of the semi-structured interview guide and two copies of the Consent Form for Audio Recording of the Interview in advance of the agreed interview date.

A stamped addressed envelope will be provided for the return of both consent forms signed by the co-researcher, which I will sign prior to commencing the interview. We will each retain a copy

THE INTERVIEW

The venue for the interview must afford privacy, be free from extraneous noise and interruptions. If this can be achieved at your home or place of work, I am willing to travel to that location to conduct the interview. Alternatively, the interview could be conducted at my home or the counselling rooms that I use in Chester. The audio-recorded interview will last for approximately three quarters of an hour.

(continued)

FOLLOWING THE INTERVIEW

There will be approximately a further half hour for debriefing and collection of demographic details.

Co-researchers will be invited to review a transcript of the interview and may request deletions or amendments up two months following the interview.

CONFIDENTIALITY

At all times I will be the only person to know the identity of the participants in the study but the contents of the tapes will be shared with my research supervisor.

Words or phrases from the tapes may be used in my dissertation but no identifying information will be entered in it.

My completed dissertation will be available for public scrutiny at the University of Chester and may become available electronically.

In accordance with the University of Chester policy all tapes, transcripts and written notes will be retained for five years. They will be stored in a manner that protects the co-researchers identity.

CO-RESEARCHERS' WITHDRAWAL FROM THIS STUDY

Co-researchers may stop the interview and/or withdraw from the study without explanation or fear of reprisal at any time up to two months following the interview.

POTENTIAL RISKS TO CO-RESEARCHERS

Please be aware that participation in this study has the potential to evoke the re-emergence of bereavement related emotions. In the event of this occurring for ethical reasons, I am unable to enter into a therapeutic relationship with you. It is therefore important that you have access to supervision and/or personal therapy...

ABOUT ME

I trained as a Cruse Bereavement Care volunteer counsellor in 1999 and remained actively involved with the organisation until 2007. I obtained a Diploma in Counselling and a Certificate in Cognitive Behavioural Therapy in 2005. Currently I work in Primary Health Care and have a very small private practice. I am a member of BACP and BABCP

(Continued)

I am willingly to discuss any queries or concerns you may have regarding your participation in this research. However, these may be directed to my research supervisor without prior reference to me.

FINALLY:

My research supervisor is:

Dr Rita Mintz
Department of Social and Communication Studies
University of Chester
Parkgate Road
Chester
CH1 4BJ Telephone Number

THANK YOU FOR TAKING THE TIME TO READ THIS.

APPENDIX 6

Address
Telephone Number
Email Address

Date

Dear

Thank you for your interest in participating in an interview for my research the working title of which is

‘An exploration of grieving counsellors’ assessment of their fitness to practise.’

I have pleasure in forwarding you an information sheet, regarding this research and a short questionnaire to establish your eligibility to participate and a stamped addressed envelope for the return of the latter.

I will forward the interview guide and consent form when your suitability to participate in a pilot interview is established.

I look forward to hearing from you soon.

Yours sincerely,

Pamela H Johnson

APPENDIX 7

Address
Telephone number
Email address

DATE

Dear

AN EXPLORATION OF GRIEVING COUNSELLORS ASSESSMENT OF THEIR FITNESS TO PRACTISE

I look forward to meeting you on DAY DATE TIME and to your participation in an audiotaped interview for my research.

I enclose a copy of the Interview Guide and two copies of the consent form. Please sign both copies and return them to me in the enclosed stamped addressed envelope.

Your participation in this research is very much appreciated.

Yours sincerely

Pamela H Johnson

APPENDIX 8

UNIVERSITY OF CHESTER
M.A. In Counselling Studies

Consent Form
Audio Recording of Interview

I..... .hereby give consent for the details of a written transcript based on an audio-recorded interview with me and..... to be used in preparation and as part of a research dissertation for the M.A. in Counselling Studies at the University of Chester. I understand that my identity will remain anonymous and that all personally identifiable information will remain confidential and separate from the research data. I further understand that the transcript may be seen by the Counselling Tutors and the External Examiner for the purpose of assessment and moderation. I also understand that all these people are bound by the British Association for Counselling and Psychotherapy Ethical Framework for Good Practice in Counselling and Psychotherapy.

I understand that I will have access to the transcribed material should I wish to and would be able to delete or amend any part of it. I am aware that I can stop the interview at any point, or ultimately withdraw the interview up to two months after it taking place. Excerpts from the transcript and possibly the entire transcript will be included in the dissertation.

A copy of the dissertation will be held in the University of Chester and may be made available electronically. In line with the University of Chester regulations, the data obtained from the interviews will be held by me, the researcher, for a period of five years and then destroyed.

Without further consent, some of the material may be used for publication and /or presentations at conferences and seminars. Every effort will be made to ensure complete anonymity.

Finally, I believe I have been given sufficient information about the nature of this research including any possible risks, to give my informed consent to participate.

Signed (Co-researcher).....

Date.....

Signed (Researcher).....

APPENDIX 9

AN EXPLORATION OF GRIEVING COUNSELLORS' ASSESSMENT OF THEIR FITNESS TO PRACTISE

CO-RESEARCHERS' INTERVIEW GUIDE

1. Before you became a counsellor what experience of grieving did you have?

2. How helpful was this past experience (or counsellor training) at the time of your loss during your practice?

3. How would you describe your practice at the time of your most recent loss?

3. In what ways did your counsellor training prepare you to monitor your fitness to practise?

5. How did you reach a decision regarding your fitness to practise following your loss?

6. Were there any specific dilemmas or conflicts that you experienced regarding your decision, and if so how did you deal with them?

7. Following your loss how did you manage any client situations/emotions that you found difficult?

8. How did you deal with any anniversary reactions that you experienced?

9. If a tool had been available to assess your fitness to practise following your loss how helpful do you think it would have been to you?

10. Is there anything else that you would like to add?

APPENDIX 10

AN EXPLORATION OF GRIEVING COUNSELLORS' ASSESSMENT OF THEIR FITNESS TO PRACTICE

THE RESEARCHER'S INTERVIEW GUIDE

PRE-INTERVIEW PROCEDURE

- Introductions
- Thank for participation
- Background to study
- Sign consent forms
- Phones off
- Test tape recorder
- Emphasise that tape recording can be stopped at any time
- Rewind tape
- Tape on
- Check wishes to go ahead

INTERVIEW QUESTIONS

1. Before becoming a counsellor what experience of loss did you have?
2. How helpful was this past experience (or counsellor training) at the time of your loss during your practise?
3. How would you describe your practice at the time of your more recent loss?
4. In what ways did your counsellor training prepare you to monitor your fitness to practise?
5. How did you reach a decision regarding your fitness to practise following your

6. Were there any specific dilemmas or conflicts that you experienced regarding your decision, and if so how did you deal with them?

7. Following your loss how did you manage any client situations/emotions that you found difficult?

8. How did you deal with any anniversary reactions that you experienced?

9. If a tool had been available to assess your fitness to practise how helpful, do you think it would have been to you?

10. Is there anything else that you would like to say?

POST-INTERVIEW PROCEDURE

- Tape recorder off
- How would you describe your experience of being interviewed?
- Hopefully no re-stimulated emotions but if so take to supervision of personal therapy
- Collect any demographic details that have not emerged during the interview
- Check willingness to be contacted should the need for clarification arise
- Invite member checking of transcript.
- Express appreciation of participation

APPENDIX 11

UNIVERSITY OF CHESTER

M.A. in Counselling Studies Research

Consent Form

Audio Recording of a Pilot Interview

I.....hereby consent to an audio recorded pilot interview with me by ..... which will not be used as part of her research dissertation for the M. A. in counselling studies at the University of Chester.

I understand that my identity will remain anonymous and that all personally identifiable information will remain confidential.

I am aware that I can stop the interview at any point.

Finally, I believe I have been given sufficient information about the nature and purpose of this pilot interview including any possible risks, to give my informed consent to participate.

Signed (Co-researcher).....

Date.....

Signed (Researcher).....

APPENDIX 12

DISCOVERY SHEET

Dying is part of life

Grief a unique experience

Training

Self-awareness

Personal development

Anticipatory grief

Anniversaries

Monitoring FtP

Framework

Supervision

Working helpful

Personal disclosure

Informing clients

Dilemmas

Things close to home

Other losses

Better therapist

Concern for clients

Increased empathy

Deaths in old age

Money

Breaking down

Awareness of own mortality

Endings

Things in place

Tool to assess FtP

Time out of practise

Get on with it

Reflexive practice

Self-care

APPENDIX 13

ANALYSIS OF THE UNITISED AND CODED DATA

After the preparation of the data, I proceeded to analyse it following the stages suggested by Maykut and Moorehouse (1994) represented diagrammatically in Chapter Three.

Inductive Category Coding.

The discovery sheet and the focus of enquiry were pinned to a wall. Initially each idea on the discovery sheet was regarded as a provisional category. I selected one prominent idea from the discovery sheet (Appendix 12), wrote it on an index card which was taped to the wall next to the focus of enquiry. This was my first provisional category heading card. I then looked through the unitised data cards using the look/feel alike criteria (Lincoln & Guba, 1985) to find others that fit this initial category and placed them under the category heading card. As each new unit of meaning was selected for analysis I compared it those already categorised. A new category was created when I encountered a data card that did not fit category already established.

A continuous refinement of categories.

This was an on-going process during the inductive category coding when it became evident that more than one item on the discovery sheet could be subsumed into a provisional category. Some units of meaning were changed between categories, fitted into more than one category and others were designated as miscellaneous. 20 provisional categories emerged (Appendix 14).

A further examination of the 20 provisional categories suggested it was possible to amalgamate some categories while others stood alone. Writing statements (rules of inclusion) to indicate what outlined the parameters of the categories led to the development of propositional statements for 18 revised categories (Appendix 15).

Exploration of relationships and patterns across categories

I then arranged the revised categories in to themes with outcome propositions as presented in Chapter Four.

APPENDIX 14

FIRST CATEGORY CODING

1. Past experience of loss and life
2. Philosophical approach to life
3. Self-awareness and personal development
4. Training and monitoring FtP
5. Self-care
6. Specific bereavement training
7. The Ethical Framework
8. Time absent from practice
9. Supervision
10. Concern for clients
11. Assessing FtP
12. Anniversaries
13. Working during grief
14. Breaking down in sessions
15. Monetary concerns
16. Personal dilemmas
17. Disclosure
18. Things in place
19. Better therapist
20. Tool to assess FtP

APPENDIX 15

PROPOSITIONAL STATEMENTS FOR REVISED CATEGORIES

1. Previous grief experience shapes counsellors' philosophical approach to life and loss.
2. Self-awareness and personal development in training was helpful when assessing FtP.
3. Training made counsellors aware of the need to monitor FtP.
4. Training encouraged counsellors to consider their self-care.
5. Specific bereavement training was minimally helpful.
6. The majority of grieving counsellors only took a short break from practice.
7. Grieving counsellors made a personal exploration of their FtP.
8. Grieving counsellors found supervision supportive.
9. The Ethical Framework was not a conscious part of grieving counsellors' assessment of their FtP.
10. Continuing to practise when grieving can be helpful.
11. Counsellors varied regarding seeing clients on anniversaries of their loss.
12. All grieving counsellors were concerned for their clients.
13. Counsellors opinions varied regarding disclosing their bereavement clients.
14. Some grieving counsellors had concerns about breaking down in session.
15. Grieving counsellors' financial situation can be a dilemma.
16. Counsellors had some dilemmas specific to themselves.
17. Counsellors thought their grief experience enhanced on their personal and professional development.
18. Counsellors were sceptical about a tool to assess FtP and found it difficult to comment on something which did not exist

APPENDIX 16

JOURNAL EXTRACTS

26 5 10.
Disappointed with response to Flyers inviting willing participants. Will send some further a field and have decided to advertise in Therapy To-day in June and July issues.

6 6 10. Met with (IMR) for another practice with my interview following which she commented that assessing FtP was an on-going process just like personal development. Well I knew that but why had I not factored it in to my interview which only lasted 25 minutes or so.

22 7 10. Supervision with Rita Discussed interview guide and responses to advertisement in Therapy Today. Many or those who responded were too soon after bereavement. I have got 5 potential participants, just waiting for their completed pre-interview questionnaires.

20 8 10. Pilot study to-day. Wanted this with a counsellor I had not met before. Relieved it went well. It lasted 45 minutes and the interviewee thought I covered the topic. The recording was clear. Now have four complete pre-interview questionnaires. Will start to arrange interviews, but would like six participants just in case any withdraw.

10 9 10. Discussed ethical concerns re some participants with Rita to-day. Need to comment on these in my dissertation.

27 9 10. Interview with 'A' to-day. Said she wanted to help and had participated in a research study before. The interview lasted just over an hour. She looked upset at times but wished to continue. Agreed to member checking and would like to see research results.

30 9 10. Transcribing takes a long time and am finding punctuating it difficult.

4 10 10. Interview with 'B'. Interesting that she had things in place in the event of her being unavailable to clients. She found this was extremely helpful to her when her mother died. Though she reduced her practise hours following her mother's death, she found working helpful. Did not want a copy of the transcript.

9 10 10. Went to Ffynnon Forum took some Flyers inviting participants. Two counsellors were interested in participating and said they would contact me by email.

11 10 10. Heard from 'A' to-day. Says the interview transcript is fine.

18 10 10. A questionnaire received to-day from an interested counsellor at Ffynnon.

27 10 10. Interview with ‘C’. The long train journey was worth the effort. A met me at the station which was kind of her. Said she always read the research ads in Therapy To-Day to see if she could help but had never participated before. Had done a counselling research MA herself. Longish interview, several bereavements while practising. Will concentrate on the most recent. Agreed to member checking.

28 10 10. There were a few words that I couldn’t hear while transcribing interview with C. She has agreed to member checking so she may be able to fill them in for me.

3 11 10. Interview with ‘D’. Since her mother’s death she has put things in place in the event of her being unavailable to her clients. During the debriefing ‘D’ said she wanted to help, had been apprehensive about the interview but had found the interview guide a helpful preparation. Did not want a copy of her transcript, but when transcribing I found that I needed clarification on a few things, so sent her one and she did clarify these things for me.

5 11 10. Another questionnaire received to-day from the other person who expressed interest at Ffynnon. Now have a sample of six. All that anxiety regarding getting a sample is over. Even if somebody withdraws I should be OK

12 11 10. Interview with ‘E’. She was very well prepared with well thought out responses. It was kind of her to say that she was impressed with the professionalism of the paperwork received about the research. Very encouraging! After the interview we talked about the BACP leaflet on Personal Crisis by Kathy Raffles. ‘E’ was very interested and said this was something useful to discuss at group supervision. ‘E’ did not want a copy of her transcript. Have since contacted her to clarify some details re employment status.

20 11 10. Received a questionnaire sent out way back. Think I will include this counsellor as well. She has apologised for the delay.

30 11 10. Interview with ‘F’. This interview lasted one and a half hours.
‘F’ was distressed but wanted to continue, however at one stage I stopped the tape, Later ‘F’ wanted to go on. She spoke about two years of anticipatory grief following her mother’s diagnosis of a terminal cancer. Work had been helpful for her both before and after her loss. Will have to go back to my literature review regarding anticipatory grief, hand not foreseen this coming up but now I recall that others have made reference to anticipatory grief. F said she had wanted to help, had found the interview interesting and that it touch on things she had not thought. I am concerned that though ‘F’s questionnaire states that she holds a Diploma in counselling but during her mother’s illness and at the time of her death ‘F’ was doing her training placement hours. Thinking about this she must have been assessed as competent to start her placement and was thus accountable for her practice. Will discuss this with Rita

11 12 10, Interview with ‘G’. She didn’t want a copy of the transcript.

20 1 11. Supervision. Discussed my concerns about 'F' not having her Diploma at the time of her mother's death. Rita agreed that 'F' was accountable for her practice and I could include her in the study.

29 1 11. Have finished transcribing F's tape which took a long time it was the longest interview. Just got tape G to do the I want to get on and finish Chapter 2. Got to revise it to include something about anticipatory grief, and get as far as I can with Chapter 3 before I start the analysis.

10 5 11. Read transcripts and put re-occurring themes on to a discovery sheet

15 5 11. Identified units of meaning, but there is a lot of very personal material that I need to exclude, don't think this is going to affect the outcomes. Think perhaps I will exclude the genders of children to protect their and their parent's anonymity. Will talk to Rita about this.

16 5 11. Coded units of meaning, cut them from the transcripts and attached them to index cards. Put the discovery sheet and focus of enquiry on the wall.

20 6 11. This analysis is taking what seems like for ever and I seem to be moving things all over the place. Seems like there are some dilemmas common to most and some specific depending on personal circumstances. Personal development seems to be emerging quite strongly.

22 9 11. Will try and arrange the categories in to themes with outcome statements

APPENDIX 17

PROPOSITIONAL STATEMENT 16 AND RELATED UNITS OF MEANING

Some grieving counsellors had specific dilemmas relating to their personal circumstances.

- *An on-going dilemma and a dilemma I had before (IMR) died really because our (gender X) children have been vulnerable all their lives (---) I've always had a temerity about working with young gender X clients and I've explained that here to (agency). Now I do watch, it's not a dilemma it's a professional decision that I've made … not to work with vulnerable gender x clients. T-A7/8*

- *It's the addiction and that comes up an awful lot. You know, I'm OK with it again at an intellectual level and staying in the client's frame of reference. It's just you don't know when it is going to come in (---) and I hope that I'm OK in the moment … but then I go away and I have to deal with it. T-A9*

- *I had one very long standing client (---) after six months she couldn't wait any longer and she moved to another counsellor. They arranged that .....she knew I was there she knew I was working back there but she knew I wasn't counselling. As soon as she had moved to I felt ready to go back. She was … because she took so much from me of my personal reserves I knew that I hadn't got it in me to continue working with her. I didn't realise it at the time. It was only when I made that decision, it was about three weeks later I thought I feel ready I feel OK now. (to resume seeing clients) TA-5*

- *Would people think that I was being disrespectful to (IMR) for going back to work … um …or would people think badly of me for going back, would people be going WHOOOSH behind my back because I wanted to continue working.*

- *I had a particular client who was a widow who was in a new relationship (---) I was always very conscious of my desire to just say to her 'just get on with it' T-C7*

- *One thing that came up … um … which was very challenging … um was because I think I was within a few months, I met a new man and I've now remarried and … so there was that going on as well. T-C7*

- *I really asked big questions of myself, I really, really did because I knew there was an option and I knew I would be supported by my agency to say "No I'm going to take time out" but I actually recognised at the time that it was … it would help me. T-F14*

- *It couldn't just be about I need to do this to get back into my routine so that I'm alright. It had to be about both of us, we were both in that relationship and I did really try and check it out from both sides. T-F14*

- *I'm thinking of that one in particular because she was the one where there was bereavement. I've got to know I'm OK because I can't go back and start with her after two weeks and then go "Oh no, sorry actually I can't do this." T-F15*

- *Right OK (refers to self by name) you've just suffered a loss, a big loss, your closest friend, your mum and you are going to back into a room and work with a person who has suffered a loss. It was a massive dilemma for me and so one that I did not just self-explore but I did take it to supervision and I also took it to my managerial supervisor if see if she was OK with that. T-F18*

- *There was that question mark hanging in the air between me and my client … why I'd been off for two weeks and I didn't practise what I was going to say to her. I didn't know if she would ask me and I was really at a loss as to what I was going to say. T-F19*

PROPOSITIONAL STATEMENT 18 AND UNITS OF MEANING

Counsellors were sceptical about a tool to assess FtP and found it difficult to comment on something which did not exist.

- *I don't know what they are but the fact that I'm person-centred and I don't carry a tool bag around with me, my instinct would be to say I wouldn't have found it helpful.* *T-A1*

- *If the tool was a good tool then of course it would be helpful … um … and I don't really know what that tool might be …um … but yes it would have the potential to help. I'm not saying I would have used it myself…because I would have to know about it and I'm not sure that I would know where to look for it or be bothered to look for it at that time because I think there was enough going on for me. (---) May be it's a thing for supervision but left to myself I wouldn't have sort out something like that.* *T-B6*

- *I would need to have been aware of it long before the issue arose or my supervisor or one of my peers would have to have been aware of it and say here is this questionnaire or whatever it is or this tool 'Fitness to Practise' under these circumstances. See what boxes you tick or don't tick.* *T-B6*

- *I think it would also depend on which way the tool was to be used and If the tool was something which was if you tick yes to three of these you are not allowed to practise or you know whatever the thing might be…um…I would find that very rigid and would not have been very helpful for me, you know I just can't imagine in what way you could devise a tool which would be appropriate for everybody.* *T-C10*

- *I would have been annoyed if someone else tried to tell me what was right for me rather than my opinion being paramount and the opinion of my supervisor and I'm not talking about you know, my tunnel vision … um … opinionated opinion of myself but I'm talking about mature consideration of self-awareness and consultation with my supervisor in an appropriate way.* *T-C10*

- *I would've filled it in because I'm quite a compulsive form filler in (---) but I'm not saying I would have been influenced by it.* *T-D5*

- *I'm sure that had there been one I would have wanted to use that…you know…but I would be interested to know what sort of tool there might be because the only thing that I could think of when I read this question was the … um scales in that … the Core measure (---) so I couldn't … sort of … I didn't know what the tool might be (---) I suppose how helpful it would have been is a different matter isn't it. What would it have told me……..I suppose that comes back to what is fitness to practise.* *T-E7*

F counselled throughout her mother's terminal illness, was working with a bereaved client when her mother died and returned two weeks later to continue with that client said

- *A standard test would have said definitely not (FtP). I'm almost certain of that but then I'm also still very certain that the process I went through was valid and it was personal to me and I didn't suffer any adverse effects from it and I don't think my client suffered either.* *T-F23*

- *I can understand in some circumstances where the death is, the bereavement is, comes as, is unexpected and is traumatic, well yes it a tool might be helpful.* *T-G6*