"It's made me reassess what I think and believe." An Exploratory Study of Therapists' Experiences with Their Clients' Deathbed Visions, Deathbed Coincidences, and After-Death Communication

Gurm Bacchus, MSc, MEd, MA, MBACP

Leeds Beckett University

Divine Charura, DCounsPsych, CPsychol, AFBPsS, UKCP reg. Psych, SFHEA, UKCP Honorary Fellow

York St. John University

Tara Fox, MA, PGCHE, MBACP (Accred.), FHEA

Leeds Beckett University

Author Note

Gurm Bacchus, MA, MEd, MSc, MBACP, is an associate lecturer at the School of Health, Leeds Beckett University, England, UK, and also a hospice bereavement counselor in the UK. **Divine Charura,** DCounsPsych, CPsychol, AFBPsS, UKCP reg. Psych, SFHEA, UKCP Honorary Fellow, is Professor of Counselling Psychology and Programme Director for the Doctorate of Counselling Psychology at the School of Education, Language and Psychology, York St. John University, England, UK. **Tara Fox,** MA, PGCHE, MBACP (Accred), FHEA, is a senior lecturer and research supervisor of Psychological Therapies and Mental Health at Leeds Beckett University, England, UK. Correspondence regarding this article should be sent to Mr. Bacchus at email: g.bacchus@leedsbeckett.ac.uk.

ABSTRACT: Research literature has highlighted the occurrence of deathbed vision (DBV),

deathbed coincidence (DBC), and after-death communication (ADC) phenomena. To better inform the mental health profession about how psychotherapists respond to and are affected by working with these client experiences, we interviewed four therapists in private practice who reported having worked with clients who disclosed one or more of the phenomena. Using interpretative phenomenological analysis (IPA), we identified three main themes from their accounts: (a) making sense of inexplicable transpersonal experiences on a professional and personal level, (b) experiencing personal transformation, and (c) perceiving clients' therapeutic benefits from addressing DBV, DBC, and ADC experiences. We discuss these findings in the context of the existing literature along with implications for clinical practice and possible future research directions.

KEYWORDS: deathbed visions, deathbed coincidences, after-death communication, counseling, psychotherapy.

Deathbed visions (DBVs), deathbed coincidences (DBCs), and after-death communication (ADC) are well documented in the professional psychological literature (Brayne et al., 2006; Claxton-Oldfield & Richard, 2020; Fenwick et al., 2010; Kerr et al., 2014; Mazzarino-Willett, 2010). They differ from day-to-day personal experiences and may be thought of as spiritual experiences by those who have experienced them (Braud, 2012; Rominger, 2013). Fenwick et al. (2010) categorized DBVs and DBCs as transpersonal end-of-life experiences, and by natural extension of this idea, ADCs are transpersonal experiences that occur after a bereavement.

DBVs can occur to a dying person weeks, days, or hours before death and are usually indicators of impending death (Fenwick et al., 2010; Lawrence & Repede, 2013). The experience may involve the dying person seeing deceased friends or relatives, spiritual

beings, or other-worldly spiritual environments that they may report to members of their family or to healthcare staff (Callanan & Kelley, 1992; Devery et al., 2015; Ethier, 2005; Fenwick & Brayne, 2011; Osis & Haraldsson, 2012). It is estimated that 50% to 60% of people who are conscious before dying experience DBV (Mazzarino-Willett, 2010).

DBC typically happens at the time of death and can occur as a vision of the deceased person to a sleeping family member or as clocks stopping or alarms sounding at the time of death (Fenwick & Brayne, 2011). Among professional caregivers such as nurses, auxiliary staff, and chaplains, 50% have reported witnessing a DBC (Fenwick, 2013).

ADC is usually experienced as a message from or interaction with a deceased person in the form of a sense of presence, voices, odors, dreams, unusual activity of electronic equipment, or meaningful symbolic phenomena (Kwilecki, 2011; LaGrand, 2005; McCormick & Tassell-Matamua, 2016). Within one year of bereavement 75% of people report ADC, and at some point in their lives 33% report the experience (Streit-Horn, 2011).

Given how common these experiences are, during therapy a bereaved client may disclose that they were with a dying person who had a DBV or that they themselves have experienced a DBC or ADC. However, some practitioners in the fields of counseling and psychotherapy have been uncomfortable working with these types of experiences due to concerns around ethical issues of competence and scope of practice and to potential conflicts of beliefs, values, and morals between them and their clients (Brown et al., 2013). Barnett (2016) suggested that mental health professionals, in general, have shown significant resistance to and lack of respect for spirituality and its role in counseling and psychotherapy. Although therapists have a professional responsibility towards a client who is looking to understanding and integrate such phenomena (Abu-Raiya et al., 2015; Eliason et al., 2010; Young, 2009, pp. 163–174), the experience of therapists working with DBV, DBC, and ADC phenomena in clinical practice is still unclear.

In this article, we use the following terms in these ways:

- *Bereavement* is the condition of having lost a loved one to death in which the bereaved person may experience emotional pain and distress that they may or may not express to others. Individual grief and mourning responses can also vary (APA, 2020).
- *Grief* is the anguish experienced after significant loss, usually the death of a loved person It is often distinguished from bereavement and can include physiological distress, separation anxiety, confusion, yearning, obsessive dwelling on the past, and apprehension about the future (APA, 2020).
- *Spiritual experience* involves a "reverence, openness and connectedness to something of significance believed to be beyond one's full understanding and/or individual existence" (Krippner et al., 2001, p. 131).
- *Supernatural* is of, or relating to, phenomena that appear to depart from or transcend the laws of the physical universe (APA, 2020).
- *Therapists* are individuals working in the role of counselor or psychotherapist.
- *Transpersonal experience* refers to the varieties and effects of experiences that transcend the usual personal limits of space, time, identity, and/or influence (APA, 2020, Holden, 2017).
- *Traumatic grief* is a severe form of separation distress occurring after the sudden and unexpected death of a loved one and can be accompanied by a sense of futility and meaninglessness of life (APA, 2020).

Literature Review

People who have been told by a dying person of a DBV or who themselves have experienced a DBC or an ADC are often convinced that consciousness continues beyond death-and that they will eventually be reunited with their departed loved ones (Shared

Crossing Research Initiative, 2022). LaGrand (2005) suggested that clients who report ADC typically present in therapy with three questions: Where do I go from here, what will I do with my experience, and how will I use what I have learned? For a bereaved client, therefore, meaning-making that facilitates client growth through integration of the experience is an important part of the counseling process (Bianco et al., 2017; Frazier & Hansen, 2009; Golsworthy & Coyle, 2010; Steffen & Coyle, 2010). This process can have significant implications for the therapist-client relationship, as clients value therapists who help them interpret, draw upon, and integrate their experience (Gockel, 2011).

In a study of the counseling experiences of bereaved people who disclosed having experienced the presence of a deceased person, Taylor (2005) found that 80% of clients felt their therapists worked inadequately with them. They reported feeling unaccepted, misunderstood, and unable to develop a working relationship with the therapist. This type of experience with a therapist can lead to clients becoming reluctant to discuss their experience due to concerns of being judged, ridiculed, or viewed as mentally unwell (Keen et al., 2013). Roxburgh and Evenden (2016b) found clients who have had transpersonal experiences—including psychic experiences, mystical experiences, peak experiences, out-of-body experiences, hauntings, past-life experiences, synchronicity, spiritual crisis, near-death experiences, and unusual death-related experience—felt their therapist ignored or dismissed their experience, felt unable to explore their experiences further, and consequently ended counseling prematurely.

Counseling therefore needs to be a safe environment in which clients can explore these types of experiences without the experiences being devalued (Golsworthy & Coyle, 2010). Taylor (2005) concluded that “both generic and specialist counselors appeared ignorant of research into the normality of such experiences and that training is needed to address this lack of knowledge” (p. 60). Therapist training in working with such experiences

can therefore be a factor in how comfortable the therapist feels about engaging with their client on this subject. In their study of counseling students, Roxburgh and Evenden (2016a) reported that the majority felt unequipped to work with clients who reported these types of experiences due to not having discussed this subject in training or supervision.

The underlying lack of training in this subject is supported by Mayers et al. (2007) who found that few mental health professionals receive training on spiritual issues and that discussions of the effects of spiritual experiences on the outcome of therapy may not be that common. The issue of therapist competency to work with clients on spiritual experiences was also raised by Hofmann and Walach (2011) who found that 81% of therapists in their study stated that spiritual experiences were rarely covered in psychotherapy training and that two-thirds wanted these topics to be better covered in their training curriculum. Therapists may therefore feel that addressing spiritual matters is beyond the scope of their professional limits of competence and choose not to address these matters in therapy (Roxburgh & Evenden, 2016a). This view is supported by Morrison et al. (2009) who argued that therapists are at risk of violating their limits of professional competence in trying to deal with spirituality, as it should remain in the domain of clergy and theologians.

Therapists may also decide what should—and should not—belong in the therapy session based on their life experiences, spiritual background, and perceived role as a therapist (Florence et al., 2019). In their study of spirituality and religiosity in psychotherapy, Hofmann and Walach (2011) found that 72% of psychotherapists and clinicians surveyed said their religious opinions had an influence on their practice. Clinical exposure to working with these experiences may test these personal beliefs by challenging rational, religious, and spiritual understandings regarding relationships beyond death (Golsworthy & Coyle, 2010). However, unless therapists explicitly explore these factors, many interactions with their clients around these experiences may occur outside of their awareness and influence the

therapeutic process (Florence et al., 2019). The clinical challenges for therapists are, therefore, to develop a greater awareness of how commonly bereaved people have these experiences, to minimize personal biases for or against these experiences, and to recognize the experience's potential to help a client adapt to the death of a loved one and re-engage with life (LaGrand, 2005).

Our purpose in this study was to explore the experience of therapists when clients disclose a DBV, DBC, or ADC experience during therapy, including the approaches therapists use and challenges they encounter when supporting clients to make meaning of these experiences, their perception of how discussing the experience during therapy plays a part in the client adapting to the death of a loved one, and the impact of addressing such experiences on the therapist. In designing this study, we drew on the principles of the British Association for Counselling and Psychotherapy (BACP) Spirituality Division to seek to better understand the interface between spirituality and psychotherapy practice, training, and research (BACP, 2019).

Method

We obtained ethical approval for this research through Leeds Beckett University's School Ethics Committee. Adherence was given to the ethical code of the BACP (2018) and Data Protection Act (2018), thus providing a qualitative research framework that respected the autonomous rights of each participant, maintained confidentiality, avoided causing any harm, and was fair. Consideration was given to safety protocols for the interview itself including avenues of support in the event of participant distress and options for a follow up debriefing and right to withdraw.

We designed this qualitative study using interpretative phenomenological analysis (IPA), based on ideas from phenomenology, hermeneutics, and idiography. Through IPA, researchers seek to understand how participants make sense of their lived subjective

experience (Miller et al., 2018) by conducting semi-structured interviews and then analyzing the interview data by identifying recurring or seemingly important themes.

Participants

Recruitment was carried out in a number of ways to try and capture a range of therapists and their experiences. The bereavement counseling team leads at two hospices were contacted who then forwarded details of the study to a total of 12 therapists in their teams. A public post on the first author's LinkedIn profile was used to inform a network of 225 therapists about the study, as was message on a private Facebook group made up of 441 counselors and psychotherapists. Purposeful sampling was also used to email 12 therapists on the BACP website who lived in the local area and listed bereavement counseling and/or spirituality as an area of specialization or expertise. The first author also contacted two therapists by email who were in his cohort on the Postgraduate Diploma in Counselling and Psychotherapy course at Leeds Beckett University, who were working as therapists, and who had expressed an interest in spirituality. Four therapists who met the eligibility criteria responded to take part in the study: one from the LinkedIn message, one from the therapists contacted using purposeful sampling, and one from the ex-student cohort. The fourth participant was a colleague of the therapist recruited via LinkedIn.

The inclusion criteria for therapists to take part in the study were that (a) they were a member of the BACP or a similar professional body—to ensure they worked ethically and to a high degree of competence, and (b) they had worked with at least one bereaved client who has raised the subject of DBVs, DBCs, or ADC during therapy. This purposeful sampling allowed the experiences and opinions of the most appropriate therapists for this study to be addressed (Wilde & Murray, 2009).

Four female BACP registered therapists based in West Yorkshire, England, UK, met the inclusion criteria and volunteered to take part in the study. This sample size enabled us to

conduct an in-depth detailed case-by-case analysis that reflected the idiographic nature of IPA (Pietkiewicz & Smith, 2014). No demographic data, apart from the therapist's practice location, was collected.

Data Collection and Analysis

To enable participants to provide a detailed account of their experience(s), the first author used semi-structured interviews comprised of open-ended questions. This process provided a flexible framework for the interview that enabled exploration of other areas of interest as they arose (Oxley, 2016; Wertz, 2005). To improve the reliability and consistency of the interviews across participants (Smith et al., 2012; Smith & Osborn, 2008), an interview schedule adapted from Roxburgh and Evenden (2016b) was used. Due to Covid-19 restrictions, the interviews were recorded electronically using a secure online video platform and stored securely on a password protected computer.

The data analysis team consisted of the three co-authors. The approach we adopted for the IPA data analysis was an iterative six-step process we developed by combining recommendations from Smith et al. (2012) and Pietkiewicz and Smith (2014). This process consisted of extracting verbatim significant statements from the data, deriving meanings about them through interpretation by the researchers, grouping these meanings into groups of organized themes, and then expanding on the themes through a detailed written description (Saldana, 2016, pp. 199–200). We then organized the emerging themes into major (superordinate) and minor (subtheme) components (Pietkiewicz & Smith, 2014).

Regarding reflexivity, as the interpretation of the experience being studied needs to be grounded in the views of the study participants (Lazard & McAvoy, 2017), a researcher undertaking an IPA study needs to be continually reflexive so that they can reflect on and be aware of their own feelings and potential biases during their interpretive role (Oxley, 2016; Palmieri, 2018). As therapists who value reflexivity, we maintained a reflexive attitude

towards all stages of the study. This process involved us as researchers acknowledging and being aware that personal ontology and epistemology based on our individual experiences of DBVs, DBCs, and ADC had created a set of beliefs that would be present in, and guide, the analysis and interpretation of the data which was undertaken within the complexities of the double hermeneutic process (Larkin & Thompson, 2012). Whereas these personal experiences may have led to a deeper analysis of participants' experiences, it was important to be aware of personal positive biases in order to maintain an ethical boundary around conflicts of interests (Lazard & McAvoy, 2017). This awareness ensured that ethical and academic rigor was maintained during the interview and analysis stages (Saldana, 2016, p. 39). Thus, researcher reflexivity was an inherent and ongoing part of the research process as all of us kept diaries and held discussions about the data and its impact on us as individuals and as a group.

Results

Results of our analysis are summarized in Table 1.

Table 1

Superordinate Themes and Subthemes from IPA Analysis of Interview Data

Superordinate Theme	Subtheme
Making sense of inexplicable transpersonal experiences.	• Holding tension of opposites of personal beliefs/experiences and counseling epistemology. • Professional guardedness.
Experiencing personal transformation.	• Acknowledging the transformative effect of working with DBV, DBC, and ADC experiences. • Recognizing personal and

	professional identity shifts in relation to religion and spirituality.
Perceived therapeutic facilitative process of DBV, DBC, and ADC experiences.	• Self-disclosure and decisional balancing. • Experiencing intersubjective and therapeutic relationship shifts.

Although we separated these themes for the interpretative phenomenological analysis process, they are in essence interrelated. The narrative accounts below reflect this interrelationship between superordinate and subthemes, and it is therefore important to consider therapists' experiences in a holistic manner. In the following material, participants' names are pseudonyms.

Making Sense of Inexplicable Transpersonal Experiences

Holding Tension of Opposites of Personal Beliefs/Experiences and Counseling Epistemology

Although all participants held an open mind regarding their clients' DBV, DBC, or ADC experience, they also sought to reconcile the supernatural implications of these experiences with a physical basis for their origin.

> A little voice would come up and I would think ok . . . this feels like a coincidence to me. (Kathy, lines 51–53)
>
> One client was a scientist . . . very logical. Maybe gave it a bit more credibility. This area is always looking for a scientific base to find why these experiences happen. (Jessica, lines 60–62)
>
> I will be alert if the person is getting delusional and psychotic. (Yalda, lines 166–167)

With regard to acquiring further understanding and knowledge of DBV, DBC, or ADC phenomena, participants agreed that professional training in this subject was variable.

> Maybe I was quite lucky with that. (Kathy, line 187)
>
> It wasn't covered in training . . . nothing about these afterlife experiences. (Jessica, line 238)

Caitlyn (lines 142–143) commented that "I'm not sure how you could teach it as the trainer will be teaching it from their perspective," but for several reasons most of our participants felt that addressing these phenomena should be part of a therapist's training.

> Counselors need to be trained even if they don't believe in it to familiarise themselves with the language in order not to be shocked. (Yalda, lines 352–353)
>
> To have an awareness of what clients may bring. (Jessica, line 298)

In the absence of professional training on DBV, DBC, and ADC phenomena, participants indicated that they relied on personal experience of spiritual phenomena to address clients' experiences.

> I have spiritual experiences which make it easier for me to deal with. (Yalda, lines 160–161)
>
> Personal experiences and work-life experiences have helped me to be able to understand these experiences. (Caitlyn, lines 142–143)
>
> My aunt used to have a spirit guide that used to hang around the place. These things

> fascinate me as they make you think. (Jessica, lines 35–36)

Professional Guardedness

All participants felt competent to work with this group of clients but did not discuss client cases of DBV, DBC, and ADC phenomena experiences with their supervisor unless necessary. Peer support was also felt to be a more welcoming forum to discuss these cases.

> It was never something I felt I needed to discuss with my supervisor. I felt like I could just hold it and contain it. (Kathy, lines 154–155)
>
> It was not discussed with the supervisor unless I was stuck. Peer support was more helpful because it was a group of friends, and they know I'm not lying. (Yalda, lines 232–234)
>
> It wasn't discussed in supervision. (Caitlyn, line 160)
>
> I might not have mentioned them in supervision. Peer support was more helpful than supervision. (Jessica, lines 342–343)

Experiencing Personal Transformation

Acknowledging the Transformative Effect of Working With DBV, DBC, or ADC Experiences

All participants acknowledged that hearing about and working with DBV, DBC, and ADC phenomena experiences had been profoundly meaningful for them and had led to them becoming more open-minded towards these phenomena.

> Utterly grateful. I have become more open minded, but within reason. (Yalda, lines 413–414)

> It has been positive and made me not be afraid myself of death. (Caitlyn, line 60)
>
> It's made me reassess what I think and believe. (Jessica, line 491)

Working with these experiences also influenced participants' spirituality in a positive way by enabling them to prepare to deal with personal issues around grief and mortality in the future.

> It's increased my open mindedness as a psychotherapist and in personal life as well. As I get older, it's going to be something that helps me make meaning. (Kathy, lines 422–423)

Recognizing Personal and Professional Identity Shifts in Relation to Religion and Spirituality

Participants noted a distinction between religion and spirituality that reflected the clarity of their own position, and one participant felt particularly strongly that religion did not sit comfortably with DBV, DBC, ADC or similar experiences.

> I'm not a religious person, but I don't think that I'm not spiritual in any way. (Kathy, line 167)
>
> I'm kind of spiritual, I have spiritual experiences. (Yalda, line 39)
>
> I'm not religious at all, I'm a spiritual person. (Caitlyn, line 55)
>
> Religions don't like this type of thing. They don't like you seeing mediums or anything to do with clairvoyance. I can't see the harm in it really. (Jessica, lines 424–425)

Perceived Therapeutic Facilitative Process of DBV, DBC, and ADC Experiences

Self-Disclosure and Decisional Balancing

Participants were hesitant to self-disclose their own spiritual experiences to clients until they felt it appropriate or were asked directly by the client.

> I see spirits and hear them, but I don't give anything away unless it's necessary. I would never put this on my profile as it puts some people off as they don't believe it. (Yalda, lines 207–208)
>
> If they ask me about it, I may share some of my thoughts. (Jessica, line 164)

Participants also found that they were initially 'sounded out' by clients before clients discussed their experience.

> Clients wanted to sound you out first by doing a lot of disclaimers such as: I'm losing my mind. (Kathy, lines 40–41)
>
> Clients will often say: Do you have other clients who experience this? (Caitlyn, line 120)
>
> She asked me first before she told me—she wanted to make sure I wasn't going to freak out. (Jessica, lines 202–203)

In terms of starting the discussion, participants said they would wait for the client to raise the topic of their DBV, DBC, or ADC experience:

> The client initiates the discussion. They're usually ready to bring it--it's there at the surface. (Kathy, line 142)

> Oh yes, I'd always wait for them, always wait for them to raise it. (Yalda, line 178)

Experiencing Intersubjective and Therapeutic Relationship Shifts

The counseling frameworks that all participants felt made use of their existing therapy skills when working with a client's DBV, DBC, or ADC experience were the Person-Centered approach (Mearns & Thorne, 2013; Rogers, 1957) and the Integrative approach (McLeod, 2013).

> It completely sits with the client in terms of what it means for them. (Kathy, lines 352–353)
>
> It's their agenda. The Integrative approach allows me introduce things that are useful for the client. (Yalda, lines 476–477)
>
> I focus on the client. I'm always aware that I'm exploring the experience from the client's perspective. (Caitlyn, lines 140–141)
>
> Very Integrative. (Jessica, line 297)

Within this framework, all the participants expressed the need to create a safe therapeutic space in which clients felt comfortable talking about their experience.

> I want them to feel comfortable with bringing whatever they want. A place where the client can talk about it comfortably. (Kathy, lines 205–207)
>
> I provide space for them. I put the person at ease. I go into their world. (Yalda, lines 163)
>
> I create a safe therapeutic space where clients can share anything. (Caitlyn, lines 197)

Along with creating a safe therapeutic space for clients, normalizing the client's experience was part of the therapeutic process for the participants.

> Clients wants to know is this normal. It happens quite a lot. That's all the client needed—for someone to say that's normal and just validate it. (Kathy, lines 376–377)
>
> It's all about integrating the experience and making meaning of death. I try to normalize things with my clients. (Jessica, lines 473–474)

Clients' disclosure of their DBV, DBC, or ADC experience during therapy became a helpful therapeutic tool that acted as a bridge to addressing other issues of importance to the client's well-being.

> Talking about the experience had a tremendous effect on the therapeutic process and can lead on to some of those questions about the guilt they're holding on to. (Kathy, lines 332–333)
>
> When we discuss the experience further, clients open up. (Yalda, line 106)
>
> It has a positive effect with how we are working through with some of these issues—it opens up a better conversation. (Caitlyn, lines 83–84)

Discussion

The IPA analysis highlighted three main themes arising for therapists working with DBV, DBC, or ADC phenomena experiences in clinical practice: *making sense of inexplicable transpersonal experiences*; *experiencing personal transformation*; and the *perceived therapeutic facilitative process of DBV, DBC, and ADC experiences.* We will now synthesize the discussion represented in these strands by encapsulating them within their sub-

themes and the literature.

The absence of training around DBV, DBC, or ADC phenomena experienced by all the participants suggests that this subject should be embedded into professional counseling and psychotherapy training courses. Although this topic could be made mandatory during counselor training, Frazier and Hansen (2009) suggested that developing competence to work with these types of experiences is more related to personally valuing this area rather than the imposition of a formal training framework. A counterargument is that because healthcare patients and clients have reportedly felt emotionally distressed and harmed by their healthcare provider's response to their disclosure of experiences similar to DBVs, DBCs, and ADCs (Holden et al., 2014), all mental health professionals should be trained in how to avoid harm and promote help to disclosing clients, whatever the professionals' personal values are regarding such experiences. Indeed, those least likely to seek such training might be more prone to do harm in response to client disclosure.

Personally valuing this area implies understanding one's own spirituality, and any training program would need to involve teaching practices that nurture and develop this understanding (Bloemhard, 2008). This would enable therapists to be better prepared to work with a client's DBV, DBC, or ADC experience by engaging with clients at an appropriate level (Brayne et al., 2006). Within a wider context, as the subject of DBVs, DBC, and ADC crosses many different domains such as psychology, religion, spirituality, medicine, mythology, and philosophy, it raises the question of who is best qualified to deliver this type of training, and ~~also~~ how any biases for or against the subject by the trainer could be ethically managed.

Although formal training and personal research into DBVs, DBCs, or ADC can raise a therapist's awareness of these phenomena, participants felt that their own spiritual experiences enabled them to develop a deeper therapeutic relationship with clients who have

had a similar or related experience. As clients are more comfortable raising spiritual matters when they sense a similarity between their own and their counselor's beliefs or experiences (Knox et al., 2005), appropriate self-disclosure of therapists' own spiritual aspects may enhance the therapeutic alliance.

Although a shared spiritual experience can prompt therapists to self-disclose more readily due to common ground with the client, it can lead to the blurring of boundaries and place increased pressure upon the client (Magaldi & Trub, 2018). A therapeutic connection based on common experience can ~~also~~ give rise to transference and counter-transference between therapist and client (Samuels, 2006) from which the therapist ~~then~~ responds from their own personal perspective rather than a professional one (Paul & Charura, 2015).

Shafranske and Malony (1990) and Knox et al. (2005) found that working with spiritual issues in therapy was outside of the therapist's area of expertise, particularly as spiritual care is typically not regarded as part of bereavement care (Steffen & Coyle, 2010). However, this conclusion was not supported by our results as all of our participants felt comfortable and confident when working with DBV, DBC, or ADC experiences in clinical practice without feeling the need to discuss these cases with their supervisor.

The reluctance to discuss DBV, DBC, or ADC experiences with fellow professionals could be due to a perceived risk of being judged negatively, being ridiculed, or losing professional standing. This apprehension echoes the finding of Florence et al. (2019) that in matters relating to spirituality, when therapists perceived a threat to their professional standing they protected themselves by hiding their actions from professional colleagues. Gubi (2004) and McDonald et al. (2013) also found that this type of therapist non-disclosure is due to being aware of the potential for ridicule and losing professional credibility when raising such issues.

Given how common DBV, DBC and ADC experiences are, these factors may partly

explain the low response rate (0.6%) by therapists to take part in the study and may indicate that therapists at large are not addressing their clients' DBV, DBC, or ADC experience due to feeling that the subject is outside of their area of expertise, that they lack knowledge about the area, or that these experiences challenge their personal and professional views around life, death and the nature of bereavement. This may represent a missed opportunity for therapists to provide a safe environment for clients to discuss their DBV, DBC or ADC experience in the context of their bereavement. By identifying and openly discussing these issues, it may improve the ability of therapists to work with spiritual matters in practice (Frazier & Hansen, 2009).

Working with DBV, DBC, or ADC experiences was deeply meaningful for the participants in a manner that facilitated professional and personal psycho-spiritual growth. This could be viewed as a transpersonal (Caplan et al., 2003) or spiritually transformative experience (Kason, 1994) for them, as it initiated a "shift in how one perceives oneself and the world, and a change in one's values, sensitivities, and identity" (Hart, 2014, pp. 86–87).

The effect of learning about this type of spiritual experience and dealing with issues of grief and bereavement have been found in other studies. Claxton-Oldfield et al. (2020) found that working with DBV experiences influenced the beliefs of hospice palliative care volunteers with regards to what happens after death and also made them less fearful of dying. Foster and Holden (2013) found that learning about near-death experiences (NDEs) enhanced growth-oriented aspects of grief, and Tassell-Matamua et al. (2016) found that NDE education enhanced learners' overall wellbeing and facilitated positive change.

Therefore, as therapists work with clients in meaning-making and integration of a DBV, DBC, or ADC experience, they may go through a psychotherapeutic process of intra-personal meaning-making of these phenomena that results in psycho-spiritual growth for both client and therapist (Bianco et al., 2017; Tassell-Matamua et al., 2016). Consequently, the

potential for spiritual growth is available not only to the client who has had the experience but also to the therapist through learning about and working with the client's experience—an outcome expressed by our participants.

The Person-Centered approach and Integrative approach were adopted by all the participants when working with DBV, DBC, or ADC experiences. A Person-Centered approach using non-directive, relational practice (Simonsen & Cooper, 2015) enables clients to be the focus of the therapy session and to decide what to discuss, whilst an Integrative approach enables the therapist to draw on ideas and processes from different disciplines that may be useful for the client. This use of existing core counseling practice principles to work with spiritual experiences was noted by Roxburgh and Evenden (2016a) whereby therapists said they would work in the same way with these experiences as they would with any other issue.

Although recent work highlights how Rogers's mature ideas focused more on spirituality (Fall et al., 2017; Kalmthout, 2013), for therapists who adopt a Person-Centred approach and work in a context based predominantly on principles of secular rationalism and physicalism (Kelly, 2010), DBVs, DBCs and ADC may raise the Kantian transcendental philosophical question that 'X exists – how is X possible?' (Brinkmann, 2018). As a result, attempting to reconcile the client's DBV, DBC, or ADC experience with the physical may give rise to anxiety from challenges to one's worldview about the separation between life and death and, therefore, the nature of bereavement (Steffen & Coyle, 2010).

From an epistemological perspective, challenges to one's knowledge of how the world works and is made sense of can cause 'cognitive dissonance' (Steffen & Coyle, 2010, p. 275) for the therapist. Dissonance can lead to therapists holding a tension based on uncertainty and ambiguity about a client's DBV, DBC, or ADC experience, which Golsworthy and Coyle (2010) noted may reflect the rationalistic climate of contemporary

secular Western culture.

A therapist's epistemology is therefore a factor in their clinical practice when working with clients who report a DBV, DBC, or ADC experience, as they may hold physical, psychological, biological, spiritual, and supernatural beliefs about the meaning of their client's experience (Sanger, 2009). From a professional ethical perspective, all the participants in our study stressed the importance of setting aside their own beliefs and working with the experience from the client's perspective in order to focus on the therapeutic benefit of the experience for the client. This approach matches the opinion of Morrison et al. (2009) that as exploring spiritual experiences can promote client growth, therapists have an ethical obligation to treat these client experiences with the same attention as any other personal belief or experience. However, there is still the suggestion of an underlying incongruence for therapists adopting this approach if they are internally questioning the reality of the client's experience yet do not express this skepticism within therapy. For therapists who adopt a Person-Centred approach, Frankel et al. (2016) raised the question as to what constitutes an honest Person-Centered relationship if the therapist, at their discretion, is able to withhold personal feelings from their client.

Focusing on the client enables the therapist to adopt the conditions of empathy, unconditional positive regard (UPR), and congruence from the Person-Centered approach (Brown, 2015) as a framework for clinical practice when working with DBV, DBC, or ADC experiences. UPR enables the therapist to be non-judgmental toward the client's experience, thereby creating a safe environment in which clients can discuss their experience without it being devalued (Golsworthy & Coyle, 2010). This approach, with its non-pathologizing orientation, allows the therapist to avoid judging the client as mentally ill, the fear of which is one reason why clients are reluctant to disclose spiritual experiences to therapists (Roxburgh & Evenden, 2016b).

Participants found that clients were initially reluctant to disclose their DBV, DBC, or ADC phenomena experience with them until a level of trust had been established between them and the client. This 'testing of the water' approach by clients of introducing their experiences and observing the reaction of their therapist was also found by Mayers et al. (2007) who discovered that clients initiated discussions only after they found their counselor to be open and accepting. Existing research is conflicting regarding whether the client or the therapist should raise the subject. Knox et al. (2005) found that when therapists opened discussions on spirituality, clients felt uncomfortable, invaded, or imposed on. In contrast, Sanger (2009) and Daggett (2005) suggest that if the client does not bring the topic up, the therapist raising it provides an opportunity to check that the experience is not a sign of psychosis, is not affecting the client's ability to function, and ~~also~~ enables referral to more specialist service if needed.

Discussing DBV, DBC, or ADC experiences can help as a therapeutic tool by acting as a bridge to other issues of importance to the client's well-being. This bridging effect was found by McDonald et al. (2013), whereby it opened up conversations, and by Sanger (2009), whereby the experiences were used as steppingstones to work with other issues that were important to the client.

Therapists can support clients in making sense of and integrating their experience into their grieving process through normalization of the experience by reassuring clients that these experiences are a common and normal part of the grieving process (Roxburgh & Evenden, 2016b). In turn, the comfort derived from making sense of and integrating a DBV, DBC, or ADC experience may play a role in grief resolution by "soothing broken hearts instantly" (Kwilecki, 2011, p. 225; Taylor, 2005). This instantaneous effect of grief resolution may be especially important for therapists when working with feelings of futility and emptiness in life due to traumatic grief.

Limitations

This study reflects the experiences of four female therapists working in private practice from the same part of the United Kingdom. Although small sample sizes are the norm in IPA (Smith & Osborn, 2003), this factor could limit the findings of the study with regards to the wider counseling community and could reflect a female-oriented spirituality.

The Person-Centered and Integrative approaches were used by participants, and it would be valuable to research the experiences of therapists who use other psychotherapeutic approaches when working with this group of clients. Future researchers would do well to include a larger sample which would allow for greater representation of therapists and psychotherapeutic approaches used in clinical practice.

All the participants were interested in the subject of DBVs, DBCs, and ADC and it is therefore unclear how therapists who were not interested in these phenomena would have responded. Likewise, as all the participants described themselves as spiritual and not religious, it is not known how their experiences compare to those of therapists who are religiously affiliated.

Finally, because we did not assess participants' ethnicity and culture, future researchers into DBV, DBC, or ADC experiences in counseling and psychotherapy would do well to take these factors into account, as ethnicity, culture, religion, and spirituality are closely intertwined.

Conclusion and Recommendations

In this study, we explored the experiences of therapists working with their clients' DBV, DBC, or ADC experiences during bereavement counseling. Four accounts were analyzed using IPA to extract the common elements of these experiences and their relation to the therapist on a professional and personal basis. We identified three superordinate themes from this analysis.

Whereas our findings support those of previous studies in counselor training in DBV, DBC, or ADC phenomena, it contributes new information on the professional and personal challenges therapists experience when working with this group of clients, the transformative effect of working with these experiences on the therapist, on therapists' views of these experiences, and of therapy clinical practice when working with these client experiences.

We found it encouraging that therapists could make use of their existing Person-Centered and Integrative frameworks to work with clients on DBV, DBC, or ADC experiences. These approaches enabled them to remain focused on the client, even though they may, at times, have had doubts about the client's experience itself. Working with and hearing about these experiences also had a positive transformational effect on the therapists, making them more open-minded about these experiences and giving them hope for the future when they may have to deal with their own grief from bereavement.

Finally, we noted some implications and recommendations for clinical practice, Sanger (2009) identified a four-point framework for working with an ADC experience: the importance of normalizing the experience for the client, maintaining a non-judgmental stance, exploring the meaning that the experience has for the client, and using the experience as a steppingstone to work with other issues that are important to the client's wellbeing. The ways in which participants in the current study worked with their clients' DBV, DBC, or ADC experience reflects this framework, and it may therefore be the most suitable approach for therapists to adopt when working with these experiences in clinical practice. However, this is all underpinned by the therapist being able to foster an environment in which a client feels safe enough to hold such discussions.

Being able to normalize the client's experience requires awareness of what DBV, DBC, or ADC phenomena are, and we therefore suggest that training around these phenomena be part of a therapist's professional training or continuing education. Curriculum

should include the opportunity for therapists to explore and reflect on their own biases for or against DBV, DBC, or ADC experiences. Therapists also need to be aware that hearing about and working with these experiences may have a transformative effect on them professionally and personally, which may require them to make better use of supervision and peer support.

Despite the exploratory nature of this study, it has provided valuable insights into the experiences of therapists when working with DBV, DBC, or ADC experiences in clinical practice. Furthermore, it has highlighted the personal and professional challenges that arise for therapists in this setting and highlighted areas of further research. Both have the potential to influence professional training and practice in bereavement counseling.

References

Abu-Raiya, H., Pargament, K. I., & Exline, J. J. (2015). Understanding and addressing religious and spiritual struggles in health care. *Health & Social Work, 40*(4), 126–134. https://doi.org/10.1093/hsw/hlv055

American Psychological Association. (2020). Transpersonal psychology. *American Psychological Association (APA) dictionary of psychology*. Retrieved from https://dictionary.apa.org/

Barnett, J. E. (2016). Are religion and spirituality of relevance in psychotherapy? *Spirituality in Clinical Practice, 3*(1), 5–9. https://doi.org/10.1037/scp0000093

Bianco, S., Sambin, M., & Palmieri, A. (2017). Meaning making after a near-death experience: The relevance of intrapsychic and interpersonal dynamics. *Death Studies, 41*(9), 562–573. https://doi.org/10.1080/07481187.2017.1310768

Bloemhard, M. A. (2008). Practical implications of teaching spiritual care to health care professionals. *Australian Journal of Pastoral Care and Health*, *2*(2), 1–8.

Braud, W. (2012). Health and well-being benefits of exceptional human experiences. In C. Murray (Ed.), *Mental health and anomalous experience* (pp. 107–124). Nova Science.

Brayne, S., Farnham, C., & Fenwick, P. (2006). Deathbed phenomena and their effect on a palliative care team: A pilot study. *American Journal of Hospice & Palliative Medicine, 23*(1), 17–24. https://doi.org/10.1177/104990910602300104

Brinkmann, S. (2018, Jun). General psychological implications of the human capacity for grief. *Integrative Psychological and Behavioral Science*, *52*, 177–190. https://doi.org/10.1007/s12124-018-9421-2

Brown, C. (2015). *Understanding Person-Centred Counselling*. SAGE.

Brown, O., Elkonin, D., & Naicker, S. (2013). The use of religion and spirituality in psychotherapy: enablers and barriers. *Journal of Religious Health*, *52*, 1131–1146. https://doi.org/10.1007/s10943-011-9551-z

Callanan, M., & Kelley, P. (1992). *Final gifts: Understanding the special awareness, needs, and communications of the dying.* Simon & Schuster.

Caplan, M., Hartelius, G., & Rardin, M. A. (2003). Contemporary viewpoints on transpersonal psychology. *Journal of Transpersonal Psychology,*, *35*(2), 143–162.

Claxton-Oldfield, S., Gallant, M., & Claxton-Oldfield, J. (2020). The impact of unusual end-of-life phenomena on hospice palliative care volunteers and their perceived needs for training to respond to them. *OMEGA - Journal of Death and Dying, 81*(4), 577–591. https://doi.org/10.1177/0030222818788238

Claxton-Oldfield, S., & Richard, N. (2022). Nursing home staff members' experiences with and beliefs about unusual end-of-life phenomena. *OMEGA - Journal of Death and Dying, 86(2)*, 609–623. https://doi.org/10.1177/0030222820981238

Daggett, L. M. (2005). Continued encounters: The experience of after-death communication. *Journal of Holistic Nursing*, *23*(2), 191–207. https://doi.org/10.1177/0898010105275928

Devery, K., Rawlings, D., Tieman, J., & Damarell, R. (2015, Mar). Deathbed phenomena reported by patients in palliative care: clinical opportunities and responses. *International Journal of Palliative Nursing*, *21*(3), 117–125. https://doi.org/10.12968/ijpn.2015.21.3.117

Eliason, G. T., Samide, J. L., Williams, G., & Lepore, M. F. (2010). Existential theory and our search for spirituality. *Journal of Spirituality in Mental Health*, *12*(2), 86–111. https://doi.org/10.1080/19349631003730068

Ethier, A. M. (2005, Mar-Apr). Death-related sensory experiences. *Journal of Pediatric Oncology Nursing*, *22*(2), 104–111. https://doi.org/10.1177/1043454204273735

Fall, K. A., Holden, J. M., & Marquis, A. (2017). *Theoretical models of counseling and psychotherapy* (3rd ed.). Taylor & Francis.

Fenwick, P. (2013). *End of life experiences - a spiritual perspective*. Retrieved from https://youtu.be/UP9lM82F_Tc

Fenwick, P., & Brayne, S. (2011, Feb). End-of-life experiences: reaching out for compassion, communication, and connection-meaning of deathbed visions and coincidences. *American Journal of Hospice and Palliative Medicine*, *28*(1), 7–-15. https://doi.org/10.1177/1049909110374301

Fenwick, P., Lovelace, H., & Brayne, S. (2010, Sep-Oct). Comfort for the dying: five year retrospective and one year prospective studies of end of life experiences. *Archives of Gerontological Geriatrics*, *51*(2), 173–179. https://doi.org/10.1016/j.archger.2009.10.004

Florence, H. J., McKenzie-Green, B., & Tudor, K. (2019). Deciding what belongs: How psychotherapists in New Zealand attend to religion and/or spirituality in psychotherapy. *Counselling and Psychotherapy Research*. *19*(3), 329–337. https://doi.org/10.1002/capr.12220

Foster, R. D., & Holden, J. M. (2013). Eternal connection: An exploratory study of the effects of learning about near-death experiences on adult grief. *Journal of Loss and Trauma*, *19*(1), 40–55. https://doi.org/10.1080/15325024.2012.735189

Frankel, M., Johnson, M. M., & Polak, R. (2016). Congruence: the social contract between a client and therapist. *Person-Centered & Experiential Psychotherapies*, *15*(2), 156–174. https://doi.org/10.1080/14779757.2016.1182061

Frazier, R. E., & Hansen, N. D. (2009). Religious/spiritual psychotherapy behaviors: Do we do what we believe to be important? *Professional Psychology: Research and Practice*, *40*(1), 81–87. https://doi.org/10.1037/a0011671

Gockel, A. (2011). Client perspectives on spirituality in the therapeutic relationship. *The Humanistic Psychologist*, *39*(2), 154–168. https://doi.org/10.1080/08873267.2011.564959

Golsworthy, R., & Coyle, A. (2010). Practitioners' accounts of religious and spiritual dimensions in bereavement therapy. *Counselling Psychology Quarterly*, *14*(3), 183–202. https://doi.org/10.1080/09515070110037993

Gubi, P. M. (2004). Surveying the extent of, and attitudes towards, the use of prayer as a spiritual intervention among British mainstream counsellors. *British Journal of Guidance & Counselling*, *32*(4), 461–476. https://doi.org/10.1080/03069880412331303277

Hart, T. (2014). Integrating spiritual experiences: Peaks to plateaus. *Journal of Near-Death Studies*, *33*(2), 86–98. https://doi.org/10.17514/JNDS-2014-33-2-p86-98.

Hofmann, L., & Walach, H. (2011). Spirituality and religiosity in psychotherapy - a representative survey among German psychotherapists. *Psychotherapy Research, 21*(2), 179–192. https://doi.org/10.1080/10503307.2010.536595

Holden, J. M. (2017). Transpersonal experiences: Responding therapeutically. In R. D. Foster & J. M. Holden (Eds.), *Connecting soul, spirit, mind, and body: A collection of spiritual and religious practices in counseling* (pp. 145–153). Association for Spiritual Ethical, and Religious Values in Counseling. https://library.unt.edu/aquiline-books/connecting-008-3/

Holden, J. M., Kinsey, L., & Moore, T. R. (2014). Disclosing near-death experiences to professional healthcare providers and nonprofessionals. *Spirituality in Clinical Practice, 1*(4), 278–287. https://doi.org/10.1037/scp0000039

Kalmthout, M. (2013). A person-centred perspective on spirituality. In M. Cooper, M. O'Hara, P. F. Schmid, & A. C. Bohart (Eds.), *The handbook of person-centred psychotherapy and counselling* (pp. 106–112). Palgrave Macmillan.

Kason, Y. (1994). Near-death experiences and kundalini awakening: Exploring the link. *Journal of Near-Death Studies, 12*(3), 143–157. https://doi.org/10.17514/JNDS-1994-12-3-p143-157.

Keen, C., Murray, C., & Payne, S. (2013). Sensing the presence of the deceased: A narrative review. *Mental Health, Religion & Culture, 16*(4), 384–402. https://doi.org/10.1080/13674676.2012.678987

Kelly, E. F. (2010). A view from the mainstream: Contemporary cognitive neuroscience and the consciousness Debates. In E. F. Kelly, E. W. Kelly, A. Crabtree, A. Gauld, M. Grossp, & B. Greyson (Eds.), *Irreducible mind: Toward a Psychology for the 21st century* (pp. 1–46). Rowan & Littlefield.

Kerr, C. W., Donnelly, J. P., Wright, S. T., Kuszczak, S. M., Banas, A., Grant, P. C., & Luczkiewicz, D. L. (2014, Mar). End-of-life dreams and visions: a longitudinal study of hospice patients' experiences. *Journal of Palliative Medicine, 17*(3), 296–303. https://doi.org/10.1089/jpm.2013.0371

Knox, S., Catlin, L., Casper, M., & Schlosser, L. Z. (2005, Jul). Addressing religion and spirituality in psychotherapy: clients' perspectives. *Psychotherapy Research, 15*(3), 287–303. https://doi.org/10.1080/10503300500090894

Krippner, S., Jaeger, C., & Faith, L. (2001). Identifying and utilizing spiritual content in dream reports. *Dreaming, 11*(3), 127–-147. https://doi.org/10.1023/A:1016640227117

Kwilecki, S. (2011). Ghosts, meaning, and faith: after-death communications in bereavement narratives. *Death Studies, 35*(3), 219–243. https://doi.org/10.1080/07481187.2010.511424

LaGrand, L. E. (2005). The nature and therapeutic implications of the extraordinary experiences of the bereaved. *Journal of Near-Death Studies, 24*(1), 3–-19. https://doi.org/10.17514/JNDS-2005-24-1-p3-20.

Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. In A. Thompson & D. Harper (Eds.), *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners* (pp. 99–116). John Wiley & Sons.

Lawrence, M., & Repede, E. (2013). The incidence of deathbed communications and their impact on the dying process. *American Journal of Hospice and Palliative Medicine, 30*(7), 632–639. https://doi.org/10.1177/1049909112467529

Lazard, L., & McAvoy, J. (2017). Doing reflexivity in psychological research: What's the point? What's the practice? *Qualitative Research in Psychology, 17*(2), 159–177. https://doi.org/10.1080/14780887.2017.1400144

Magaldi, D., & Trub, L. (2018). (What) do you believe?: Therapist spiritual/religious/non-religious self-disclosure. *Psychotherapy Research, 28*(3), 484–498. https://doi.org/10.1080/10503307.2016.1233365

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology & Psychotherapy, 14*(4), 317–327. https://doi.org/10.1002/cpp.542

Mazzarino-Willett, A. (2010). Deathbed phenomena: its role in peaceful death and terminal restlessness. *American Journal of Hospice and Palliative Medicine, 27*(2), 127–133. https://doi.org/10.1177/1049909109347328

McCormick, B. M. E., & Tassell-Matamua, N. (2016). After-death communication: A typology of therapeutic benefits. *Journal of Near-Death Studies, 34*(3), 151–172. https://doi.org/10.17514/JNDS-2016-34-3-p1

McDonald, C., Murray, C., & Atkin, H. (2013). Palliative-care professionals' experiences of unusual spiritual phenomena at the end of life. *Mental Health, Religion & Culture, 17*(5), 479–493. https://doi.org/10.1080/13674676.2013.849668

McLeod, J. (2013). *An introduction to counselling* (5th ed.). McGraw-Hill.

Mearns, D., & Thorne, B. (2013). *Person-centred counselling in Action*. SAGE.

Miller, R. M., Chan, C. D., & Farmer, L. B. (2018). Interpretative phenomenological analysis: A contemporary qualitative approach. *Counselor Education and Supervision, 57*(4), 240–254. https://doi.org/10.1002/ceas.12114

Morrison, J. Q., Clutter, S. M., Pritchett, E. M., & Demmitt, A. (2009). Perceptions of clients and counseling professionals regarding spirituality in counseling. *Counseling and Values, 53(3),* 183–194. https://doi.org/10.1002/j.2161-007X.2009.tb00124.x

Osis, K., & Haraldsson, E. (2012). *At the hour of death*. White Crow Books.

Oxley, L. (2016). An examination of interpretative phenomenological analysis (IPA). *Educational & Child Psychology*, *33*(3), 55–-62.

Palmieri, F. (2018). Counselling psychologists' experience of the death of a terminally ill client: An interpretative phenomenological analysis. *Counselling Psychology Review*, *33*(1), 33–45.

Paul, S., & Charura, D. (2015). *An introduction to the therapeutic relationship in counselling and psychotherapy*. SAGE.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Czasopismo Psychologiczne Psychological Journal*, *20*(1), 7–14. https://doi.org/10.14691/cppj.20.1.7

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), 95–103. https://doi.org/10.1037/h0045357

Rominger, R. (2013). Integration of spiritually transformative experiences - models, methods, and research. *Journal of Near-Death Studies*, *31*(3), 135–150. https://doi.org/10.17514/JNDS-2013-31-3-p135-150.

Roxburgh, E. C., & Evenden, R. E. (2016a). 'It's about having exposure to this': investigating the training needs of therapists in relation to the issue of anomalous experiences. *British Journal of Guidance & Counselling*, *44*(5), 540–549. https://doi.org/10.1080/03069885.2016.1213375

Roxburgh, E. C., & Evenden, R. E. (2016b). 'Most people think you're a fruit loop': Clients' experiences of seeking support for anomalous experiences. *Counselling and Psychotherapy Research*, *16*(3), 211–221. https://doi.org/10.1002/capr.12077

Saldana, J. (2016). *The coding manual for qualitative researchers*. SAGE.

Samuels, A. (2006). Transference/countertransference. In R. K. Papadopoulos (Ed.), *The handbook of Jungian psychology: Theory, practice and applications* (pp. 177–195). Routledge.

Sanger, M. (2009). When clients sense the presence of loved ones who have died. *Omega - Journal of Death and Dying, 59*(1), 69–89. https://doi.org/10.2190/OM.59.1.e

Shafranske, E. P., & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy, 27*(1), 72–78. https://doi.org/10.1037/0033-3204.27.1.72

Shared Crossing Research Initiative. (2022). The Spectrum of end-of-life experiences: A tool for advancing death education. *Omega - Journal of Death and Dying, 0(0)*, 1–21. https://doi.org/10.1177/00302228211052342

Simonsen, G., & Cooper, M. (2015). Helpful aspects of bereavement counselling: An interpretative phenomenological analysis. *Counselling and Psychotherapy Research, 15*(2), 119–127. https://doi.org/10.1002/capr.12000

Smith, J. A., Flowers, P., & Larkin, M. (2012). *Interpretative phenomenological analysis*. SAGE.

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53–80). SAGE.

Steffen, E., & Coyle, A. (2010). Can “sense of presence” experiences in bereavement be conceptualised as spiritual phenomena? *Mental Health, Religion & Culture, 13*(3), 273–291. https://doi.org/10.1080/13674670903357844

Streit-Horn, J. (2011). *A systematic review of research on after-death communication.* [Unpublished doctoral dissertation]. University of North Texas. https://digital.library.unt.edu/ark:/67531/metadc84284/

Tassell-Matamua, N., Lindsay, N., Bennett, S., Valentine, H., & Pahina, J. (2016). Does learning about near-death experiences promote psycho-spiritual benefits in those who have not had a near-death experience? *Journal of Spirituality in Mental Health, 19*(2), 95–115. https://doi.org/10.1080/19349637.2016.1206844

Taylor, S. F. (2005). Between the idea and the reality: A study of the counselling experiences of bereaved people who sense the presence of the deceased. *Counselling and Psychotherapy Research, 5*(1), 53–61. https://doi.org/10.1080/14733140512331343921

Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52*(2), 167–177. https://doi.org/10.1037/0022-0167.52.2.167

Wilde, D. J., & Murray, C. D. (2009). The evolving self: finding meaning in near-death experiences using Interpretative Phenomenological Analysis. *Mental Health, Religion & Culture, 12*(3), 223–239. https://doi.org/10.1080/13674670802334910

Young, A. (2009). Working with bereavement. In L. Barnett (Ed.), *When death enters the therapeutic space: Existential perspectives in psychotherapy and counselling* (pp. 163–174). Routledge.