**Cancer, Bereavement and Work**

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**Key words:** cancer, bereavement, identity, compassion, dignity, support, contribution.

**Abstract**

This chapter is an autoethnographic account of losing my twenty-five-year-old son, John, to cancer, returning to work, getting cancer myself and returning to work again after treatment. I do not claim to represent anyone else’s cancer story. Lifesaving interventions left me with some residual physical limitations and compounded psychological impacts arising because I got better when John did not. I tend to minimise my own sickness. Work was more closely aligned to my identity before I acquired the unwanted ‘bereaved mother/cancer survivor’ tag. I consider social and personal construction of identity and sense of self after intersecting traumas. Reflecting on the role my employment plays in my life now, I consider strategies I adopt and ways my employer helps me to function and contribute effectively. Potential usefulness of The Equality Act (2010) and workplace bereavement leave policies is discussed in relation to employees directly or indirectly affected by cancer.

**Reflection Questions**

* How could you support a colleague who has lost a child, of whatever age, and how might you be personally affected by their situation?
* How could you support a colleague affected directly or indirectly by cancer?
* How could the organisation react supportively to these situations?

**Recommendations**

* We need to be aware of institutional policies and relevant legislation in relation to supporting an employee with cancer or caring for someone with cancer.
* We need to be aware of institutional policies relating to bereavement leave and support of bereaved colleagues.
* We need to recognise our own relationship with the idea of the death of a child and/or a cancer diagnosis, and support each other while trying to be supportive of a colleague who is a bereaved parent and/or has cancer.
* We need to exercise compassion.

**Introduction**

Writing this is not without personal risk. Identity is not only internal but also ‘exists in the minds of others’ (Little et al, 2002, p170). Prior to 2011, cancer did not shape my identity in my eyes or anyone else’s. It does now, but I do not want people to see me and think ‘cancer’. Socrates is associated with the expression ‘an unexamined life is not worth living’ (McElwain, 2013). The need to examine all aspects of my life came into sharp focus when cancer made an unwelcome appearance. I resolved to ensure that dignity and compassion would underpin all my actions. Tony Benn said that the most helpful role older people can play in society is to encourage those younger and less experienced (Benn, 2004). I agree. As a senior academic I am well placed to do this, and I have always subscribed to the principle of usefulness in research. While getting cancer is scary and the loss of a child to cancer is the most frightening thing of all, I felt that writing accessibly about it might help others to understand, hence this paper. My focus here is on the workplace. Colleagues threw me a lifeline and in writing this I hope to give something back.

**Background**

John died nearly seven years ago, at twenty-five. Undoubtedly my grief will last for the rest of my life, but I am functioning. Social and personal reconstruction of my identity and the feeling that my former sense of self is missing colours my engagement with life and work. Having lost a child, I feel like Sleeping Beauty’s thirteenth fairy. For the benefit of an international audience, she is the one who spoiled Beauty’s christening with a hundred-year sleeping curse.

‘Bereaved mum’ was bad enough as a label, but three years later I added a dollop of my own cancer. Although I was treated successfully, intersecting traumas have left me with a strong sense of before and after. This feeling is not uncommon post bereavement (Cheung and Delfabbro, 2016; Greenblatt and Lee, 2018; Hastings, 2000; Rosenberg et al, 2012; Scott, 1997). Foucault (1994) describes experiences which place one outside the dominant hegemony as ‘othering’. I feel ‘othered’. Most people do not get cancer and children are not expected to die before their parents, especially in parts of the minority world not plagued by extreme poverty, preventable disease and conflict.

Throughout John’s twelve months of treatment I worked. He died on the 12th of December and I returned to work on January 4th. My cancer treatment required me to take two eight-week periods of sick leave and I needed a phased return post-surgery. I got off lightly. Advice I would give to anyone else would be to try and avoid finding yourself back at your desk too soon wearing office clothes, superhero lipstick and an unconvincing smile. ‘Finding yourself’ is a deliberately chosen form of words. There was something passive about my finding myself in the office, particularly after John died. Recalling how I managed then is almost impossible. Shock seems to have wiped my memory. Colleagues were amazingly supportive, and I recall saying to myself, ‘Try harder. It’s work, not therapy’. These feelings relate more to bereavement than to cancer. My own cancer left me with survivor guilt and hidden impairments and reinforced the sense of disassociation which started when John was diagnosed.

Legislation and policies offer the workplace some pointers about what is supposed to happen when an employee is affected by cancer and bereavement.

**The Equality Act (2010) and Bereavement Leave Policies**

Underpinning the Equality Act 2010 (EA) is the contention that diversity is a positive thing (Bebbington, 2009; Martin, 2017). Although I remember feeling that John’s death negated everything I had ever done or would ever do, what happened did not actually cancel years of successful work and skills acquired along the way. Without supportive employers I would not have been able to continue working. Duties under the EA possibly provided some sort of framework, but actually it was being treated with compassion that made work possible.

Cancer is covered by the EA from the point of diagnosis, under the protected characteristic of disability, therefore the requirement for employers to make reasonable adjustments is anticipatory. People indirectly affected by disability are also protected by the EA, so reasonable adjustments around flexible working to care for a family member should be part of the plan.

As with any impairment covered by the EA, once anyone at work knows, the institution is deemed to know and therefore expected to adjust reasonably. Confidentiality is not negated by ‘deemed to know’ and sensitivity is required. Employees do not necessarily want an all-staff email to announce ‘the big C’. Human Resources and Occupational Health have specific roles around anti-discriminatory practices and practical adjustments.

Bereavement in itself is not covered by the EA. Institutions tend to vary in arrangements they make for bereavement leave. The Parental Bereavement (Leave and Pay) Act 2018 should come into force in 2020. It will entitle eligible employees to two weeks’ paid leave following the death of a child up to the age of eighteen. (Brown, 2018). This would not have done me any good as my son died in early adulthood. It fails to recognise that children become adults, but parents are still parents.

Mental health problems are identified as disability and, rather ambiguously, do not have to be ‘clinically well recognised’ according to the EA. Complicated grief is defined as a mental health concern in The Diagnostic and Statistical Manual (DSM) of Mental Disorders, updated iteration 5 (2017), as is post-traumatic stress disorder (PTSD). Both conditions are frequently associated with bereavement (White, 2013). Access to medical support or counselling is not a foregone conclusion, but involvement in these systems is likely to result in the acquisition of mental health labels and often medication.

Grief and depression often coexist. Severe depression is covered by the EA, although ordinary rather than ‘Complicated Grief’ (White, 2013) may not be. Like depression, anxiety commonly accompanies bereavement. When these conditions tip over into mental health concerns covered by the EA is a matter of degree or self or clinical identification. Bereaved parents may be diagnosed or self-identify with complicated grief more often than people who have lost an elderly relative. It is not possible to say that this is definitely so, because research which focusses specifically on people who have lost one or more of their children is sparse (Hastings, 2000; Rosenberg et al, 2012).

The EA is apparently woolly around the edges when it comes to bereavement. It really depends on whether the bereaved person has acquired a mental illness label, in which case they are covered. Cancer is less ambiguous.

Wellbeing is receiving some attention in the workplace, with many organisations advertising counselling for employees (Lomas et al, 2017; Thomson et al 2018). Usually provision is limited to six sessions and cognitive behavioural therapy (CBT). Research exploring the efficacy of CBT for bereaved parents is scant (Cohen et al, 2006; Endo et al, 2015). Often there is nothing else on the table unless the individual is able to pay. A discussion follows of relevant theory, in relation to my own experience.

**Applying Grief, loss and Bereavement Theory**

Grief and loss are not only about bereavement. Losing a job, for example, can evoke a sense of loss. Grief may follow. Cancer can result in losing one’s previous sense of identity as someone without cancer (Cheung and Delfabbro, 2016; Little et al, 2002). Feelings of loss resulting from my own cancer were never something I grasped on a conscious level because I was in the early stages of a far more profound grief. Primarily I was concerned for my family. Research with people who have had cancer suggests that anxiety, depression and stress are part of the toxic cocktail (Cheung and Delfabbro, 2016; Greenblatt and Lee, 2018; Little et al, 2002).

Symptoms of anxiety include: restlessness, a sense of dread, being on edge, difficulty concentrating, irritability, impatience, distractibility and stress. Uncontrollable stress commonly exacerbates anxiety. Indicators include: dizziness, drowsiness, pins and needles, palpitations, dry mouth, sweating, shortness of breath, stomach-ache, nausea, diarrhoea, headache, excessive thirst, frequent urinating, period problems, and insomnia (Reeves, 2013; Haig, 2016).

Anxiety has to be kept consciously under control following cancer treatment. Little niggles can stimulate fear that the monster has returned to finish what it started (Little et al, 2002). Bereaved parents can become extremely anxious about their other children, particularly if there is any genetic component to the cancer death (Rosenberg et al, 2012). Making sure my anxiety does not oppress my surviving children requires effort.

Depression and anxiety often accompany grief and loss (Greenblatt and Lee, 2018; Reeves, 2013). While celebrating remission from cancer, after-effects of treatment can be somewhat depressing (Cheung and Delfabbro, 2016). I was used to being able to keep going like a little pit pony, and it frustrates me that I tire more easily now. Differences between clinical and reactive depression merit more discussion than space allows. Reactive depression can tip into clinical depression, especially if left untreated.

Haig (2016, p.87) listed symptoms of clinical depression including: ‘fatigue, low self-esteem, slowing of movement and speech, appetite disturbance, irritability, introversion, derealisation and anhedonia (which is “the inability to experience pleasure in anything”)’. Derealisation as defined by Haig strongly resonated with my own feeling after John died of not being a real person:

feeling detached from oneself’ … I derealised. The string that holds onto that feeling of selfhood, the feeling of being me, was cut, and it floated away like a helium balloon. (p187)

Bereavement is a very tangible cause of depression and anxiety. Being depressed and anxious after successful cancer treatment, although common, is perhaps more intangible (Greenblatt and Lee, 2018). The feeling of having no right to self-indulgent emotions is expressed eloquently by Haig (2016):

If you feel the same amount of depression as someone would naturally feel in a prisoner of war camp, and are instead in a nice semidetached house in the free world, then you think ‘Crap, this is everything I ever wanted, why aren’t I happy?’ (p164)

My cancer broke a few windows in my nice home which were easy enough to fix, and John’s cancer reduced his house to ashes. Like Haig, I feel that I have no right to bang on about a lesser catastrophe. Of course, I live with survivor guilt and the sad fact that it was not in my power to swap places with my beloved son.

Low self-esteem is associated with anxiety, depression and stress (Haig, 2016, p.158). Low self-esteem tips into my work and is easily explained by my sense that I failed at the most important job I will ever have. Mothers are supposed to keep their children safe. Positive feedback is something I find difficult to own and my CV looks to me like it belongs to someone else because of the bashing my sense of self has taken.

The Jungian notion of ‘individuation’ is relevant to conditions which lead to the healthy state of ‘a true integrated self’ (Jung, 1967; Kotzé, 2014, p.16). Maslow (1998) refers to a ‘hierarchy of needs’ necessary for self-actualisation. These include physiological requirements, safety, belonging and self-esteem. Disruption of the underpinning processes for individuation or self-actualisation inhibit the achievement of one’s full potential. Cancer disrupts feelings of safety (Costanzo et al, 2007; Yaskowich et al, 2003). Disrupted progress towards self-actualisation because of cancer is discussed by Coreil et al (2012) but research in this field is limited. In 2011, before John’s diagnosis, I was flying high professionally, and John was studying at Oxford University. In extremis, it is clearly possible to slide down Maslow’s pyramid suddenly and rapidly.

Disrupted earlier attachments and lack of social support can impact on one’s ability to cope with trauma. (Reeves 2013; Bowlby 1969, 1982; Freud and Strachey, 1966). Fortunately for me, I am built on very strong attachment foundations and have extremely supportive family, friends and colleagues. Bourdieu’s (2002) notion of social capital is relevant to my situation in this respect. Some people are less lucky. Financial worries were highlighted by Rosenberg et al (2012) as a factor increasing stress on parents of children with cancer. In Bordieusian terms I also have the privilege of economic capital, which eliminates a rich seam of worry.

Having experienced extreme stress while John was undergoing treatment, followed by profound grief when it was all over, workplace stress does not trouble me. While I am committed to doing a good job and welcome the distraction, I am acutely aware that the world will keep turning whether I work or not. The idea that the world is still turning without my son felt completely unacceptable to me for the first few years. Acceptance is identified by) as a stage in grieving. Although I am moving in that direction, it is a long and winding road.

Kübler-Ross’s (1970) ‘On Death and Dying’ is an early influential work which has een updated several times (Field et al, 2005; Klass et al, 2014; Parkes, 1988; Parkes and Pigerson, 1988; Stroebe et al, 2010). Research with terminally ill patients and their families framed her staged model of grieving. The stages are: denial (and isolation), anger, bargaining, depression, and acceptance (Kübler-Ross, 1970, pp.34-138). Guilt and hope are part of the picture and progress is not necessarily linear, time-limited, or identical for everyone. Subsequent staged theorists built on Kübler-Ross’s theme. Parkes (2013) describes numbness, pining, disorganisation and reorganisation. Worden (2018) identifies ‘the tasks of grief’ as: acceptance, working through the pain, adjusting to the new situation, and emotionally relocating the deceased in the past.

‘Continuing bonds’ is a contested idea which some theorists regard as symptomatic of complicated grief (White, 2013), especially if accompanied by the sense that the loved one is not really dead (Field et al, 2005; Klass et al, 2014; Scott, 1997; Stroebe et al, 2014). Acute distress lasting over six months and accompanied by intrusive repeated mental pictures, avoidance behaviours, lack of self-care and social isolation is defined by White (2013) as ‘complicated grief’.

A systematic review of 121 studies by Rosenberg et al (2012) concluded that parents who had lost a child to cancer experienced prolonged extreme distress. Studies cited focussed on children under eighteen. Literature about loss of an adult son or daughter is too thin to be called patchy. Irritation does not quite encapsulate how I relate to the idea of complicated grief. White’s (2013) research did not treat bereaved parents as a specific category but Bernstein (1997) brings insider perspective to the table as a bereaved mother. Her study involving over fifty bereaved parents was entitled ‘When the bough breaks: forever after the death of a son or daughter’. ‘Forever’ may ring alarm bells for clinicians keen to diagnose complicated grief, but parents who have lost their children experience our ongoing grief as simple. It does not make us unemployable, and it is ever-present but there is nothing particularly complicated about a broken heart. Talking about the death of his five-year-old son, Ken Loach, said ‘It changes you, you carry a stone inside’. (Hattenstone, 2016). Grief feels exactly like that to me and to Bernstein’s (1997) participants, who described reaching some sort of accommodation over time but not the slightest expectation of ever really getting over it.

Developing healthy continued bonds which locate the child in the past tense and the love in the present tense is part of the process. My continued bonds with my son are strong and the fact that my colleagues do not cringe when I talk about my three children is a gift. Bereaved parents cannot make new memories but appreciate the opportunity to reminisce about their dead child, otherwise it would feel as if the world was denying their existence (Klass et al, 2014). Nicci French (2019) wrote in a novel ‘No one is ever like anyone else. No one can be replaced. Every death is the end of a world. And they’re gone and yet they remain. They walk with us along the secret rivers’ (p374). The fact that my memories are easier to bear over time is at least in part due to the supportive reactions of other people. PTSD symptoms were undoubtedly an everyday occurrence for the first few years but now these are fading. Other people have not been so lucky.

Post-traumatic stress disorder (PTSD) can work in tandem with complicated grief (White, 2013). In 2018 Dr Anke Ehlers gave a talk at The Royal Society in London on PTSD, entitled ‘Haunted by Memories’. She described ‘disassociation’ as a common symptom and illustrated the idea with reference to a picture by Frida Kahlo. The artist, after a near fatal bus crash, depicted herself looking at her injured body from the outside. PTSD symptomatology, according to Ehlers, includes: derealisation, depersonalisation, intrusive memories, triggers, flashbacks, the feeling that the triggering event is still happening and, in extremis, a sense of just wanting to die. My relationship with these emotions has become more distant with the passage of time. While John was ill, I remember thinking it was like living in a horror film. Surprisingly, given the prominence of the notion of denial in grief theory, Ehlers associated PTSD specifically with sudden death. Because I navigated my son’s treatment through a thick fog of denial, to me his death was sudden and shocking.

Grief theory cannot be simplistically applied to every bereavement. The loss of a parent or a lifelong soul mate must feel insurmountable, but the sense of a long life well lived may be a comfort. Premature loss of life offends the natural order of things. Charities such as The Compassionate Friends describe the death of one’s child as ‘the worse loss’ but the social scientist in me questions the evidence base for this assertion. Losing a partner at a young age must be devastating. Violent or preventable deaths raise questions which I did not have to face because I knew that everything that could be done to save my son was done. Sara Ryan’s son, Connor died a preventable death. Afterwards his family had to cope with a protracted inquest during which the wellbeing of Connor’s family apparently received scant attention. (Ryan, 2016). Our experience of losing John was the opposite. We were treated with kindness.

Circumstances surrounding the death of a loved one and subsequent coping of those left behind might be an avenue for future research. Comparisons between reactions to premature death and the death of a very old relative could well provide grief theorists with some more nuanced insights. Translating the findings of any research into ridiculous generalisations which disregard intersectionalities between various factors would probably be ultimately futile. Applying the ‘complicated grief’ label after a fixed and specific period of time is crass. Attributing PTSD specifically to the aftermath of sudden death fails to factor in the process of denial which is so familiar to grief theorists.

It is impossible not to conflate my own cancer with my bereavement because the impacts are cumulative. I appreciate that this may make the narrative confusing, but life does not really happen in isolated little boxes and traumas tend to have a cumulative impact. In the next sections I focus more specifically on assimilating past events and thinking practically about getting on with my life and work.

**Getting on With It**

My engagement with having cancer is probably atypical because my son died of cancer. Psychologically I was deeply troubled by the idea that mine was curable. John went through a year of chemotherapy which was extremely gruelling and ultimately pointless. He was originally told that his cancer was inoperable but having had ‘spectacular response to chemotherapy’ the inoperable became apparently operable. When the surgeon opened him up, they discovered that this was not the case. Longing to swap places with my son preoccupied and distressed me during my treatment. My surgery was extensive and debilitating and involved more than one operation. Recovery was gruelling, painful and left me with residual impairments which are permanent. Having cancer has frightened me. Not unusually (Yaskowich and Stam, 2003) I feel like a ticking time bomb. Because I have extensive scarring I am often in pain. When my scars hurt, I find it easy to imagine that the cancer has returned.

During my two periods of eight weeks’ sick leave I wrote during breaks between DVD box sets. My identity is tied closely to my academic writing which provides some respite from the imposed othering connotations of my situation. While not a fan of the misery memoir genre I did write about losing John. My personal cancer story was effectively a postscript to a piece I aimed at medics who treated young adults unsuccessfully for cancer. Gratifyingly the work has apparently proved useful to the intended audience.

Annoyingly people feel the need to tell me their cancer stories. Despite being empathic and supportive I do not want to have general circular conversations with third parties about other people affected by cancer. It is not my hobby. I am not an enthusiast. My very strong preference would be to go back to a time when I was a university lecturer and the mum of three adult children, close in age, including identical twins. My life is in two parts and so is my career. Before was better. Although I am a functional productive person, I feel that, like Sisyphus, I will always have to push a heavy boulder up a steep hill. Sometimes I just run out of steam.

Meeting new people is awkward. Questions like ‘how many children do you have’ are a minefield. Recently at a conference I described a project I had been involved with just before John got sick as the happiest time of my life. A stranger commented that it was sad to hear me say something so negative because no one could ever know what great things could be just around the corner. It was hard to resist the temptation to say, ‘listen Buster, you don’t have to have been Vlad the Impaler in a former life for terrible things to happen’. Once again, I was playing the role, I never would have chosen in a million years, of the thirteenth fairy hovering over the greasy canapés and cheap red wine. I took from this encounter that it is probably best not to offer unsolicited opinions without an understanding of the bigger picture. Because of my deliberate attempts to lead an examined life and conduct myself with dignity and compassion I did not explain. I tend to think before I speak.

During John’s treatment my line manager was incredibly understanding and committed to the idea that the EA extends to disability by association. The organisation had a disabled staff network and a group for carers. Counselling for employees was available and I was actively encouraged to take up the opportunity, to the extent that this was arranged for me with my permission. When John was first diagnosed, I took two weeks off then I returned to work with some flexibility built in to enable me to take time as needed. He was attending university and having treatment in Oxford and I was in London. The requirement for a longer period of leave was eleven months away. Crucially my line manager listened and facilitated what I needed rather than making assumptions and imposing unworkable arrangements.

As my cancer diagnosis occurred in August, I was able to put in place various arrangements for my role to be covered from the start of term. On hearing the news, I did what anybody would have done, I went into work and removed handbags and shoes from my filing cabinet before teaching my class. It would have been so embarrassing if I had died and left an untidy office.

Between November and December, I embarked upon a phased return following a meeting with occupational health which focussed mainly on practicalities. Counselling was not part of the package, but I was able to access a bereavement counsellor at the hospital. I was very physically weak and unable to travel during the rush hour because I could not stand, so as far as possible my hours were shifted to reduce the necessity to do so. Fortunately, my teaching timetable did not include too many 9am lectures. Automatic doors were suddenly conspicuous by their absence as I was unable to push heavy doors open. Sometimes I walked with a stick which I also needed for support if I had to stand. The fact that I did not need to use my stick all the time made me feel self-conscious and I was irritable when expected to attend events which involved standing around.

Various ‘keep in touch’ conversations took place while I was recovering from surgery. These have to be handled with great care in order to avoid unintentional pressure to return. While I was away, I felt worried about being made redundant although there was no tangible reason. Presumably these feelings were tied up with residual impacts on self-esteem related to the death of my child.

Ongoing contact with kind reassuring colleagues was hugely important each time I was away. Because cancer and the death of one’s child are both huge taboos (Lucas, 2017), particularly in the minority world, people can feel uncertain about what to say. Leaving well alone strengthens the sense of otherness and abandonment and is not the answer. Colleagues were and are an important part of the social capital on which my coping strategies are built.

**Enablers at work**

When John was ill, and after he died, the person-centred counselling my Line Manager went out of her way to arrange for me was a lifeline. The disabled staff network carers group was helpful during my son’s treatment, but I did not feel I could go back after his death. The university chaplain took care of me. Workplace support groups are generally a good thing. Bereaved parents are fortunately a rare breed but one of my colleagues was in the same boat and we looked out for each other.

Flexible working helped me while I was looking after John and when I returned to work post-cancer. Occupational health made useful recommendations, but I had to be fairly assertive about things like reminding people that I could not travel on the tube in the rush hour. An occupational health follow-up would have been useful.

Despite the support I received, almost by accident, I left my job a few months after John died and moved to a different university. I transitioned from a management role in disability and wellbeing services to an academic post in education. Derealisation, disassociation and depersonalisation played a major part in this decision, if it was indeed a decision. Trying to empathise with disabled students and support them to access services to which they were entitled became too difficult because I was feeling so raw about my loss. I felt embarrassed every time I walked into the building because of my newly acquired identity. The strategy I employed to get through the working day was acting. This involved splitting so that part of me was playing the role of Head of Disability and Wellbeing Services and part of me was drowning in grief. Lecturing felt easier because of its inherently performative nature and I spotted an opportunity to escape from a situation in which everyone knew what had happened.

At the interview for my new post I performed well and then self-sabotaged by saying I was not a firm candidate because my son had died five months before. My impressive CV felt like it belonged to someone else because I had done all those things before when I was a different person. Imposter Syndrome (Lewis, 2018) is not uncommon but in my case was working in tandem with a sense of not even feeling like a real person. It never occurred to me that I would actually get the job for which I was being interviewed. I was in no fit state to make a rational decision.

Hastings (2000) discusses motivations underpinning self-disclosure by bereaved parents. In my case I just blurted it out at interview despite knowing the risk. Examining my motivation was not high on my agenda. Effectively I made it impossible to escape my new identity but at that time I was not ready to leave my son in the past because of the strength of my continuing bonds. On my first day I felt awkward because I knew that everyone knew they were taking on the thirteenth fairy. My former colleagues had given me a lovely send off and my new colleagues made me very welcome. Rites of passage are important.

Six years into my new role I am functioning well at work somehow. I no longer require the reasonable adjustments which were necessary post-cancer treatment and I have more energy. Encouraging colleagues and students and engaging only in research which is likely to be of practical use characterise my approach. The idea of making a useful contribution is more important to me than status. I am making use of my experience to make a useful contribution and the opportunity to work in a multi-disciplinary way helps. In collaboration with health colleagues, for example, I have developed course materials for palliative nursing students, and I have written about working with terminally ill students (Martin, 2015). I can navigate the question ‘how many children have you got?’ (Three but one is no longer alive). Roulstone and Williams (2014) use the term ‘glass partitions’ (p.16) to describe the situation disabled employees often encounter in which they do not wish to change roles because they have found workable support with their current colleagues. To an extent I feel this way, but I also know that my colleagues find me supportive, so it is not a one-way street.

Leading an examined life and acting with dignity and compassion is something of a mantra. Self-care is important and I know when I am running out of steam because of post-cancer physical pain and fatigue or ongoing grief. The flexibility to take the occasional day of annual leave when necessary is helpful. In December I take a week off around John’s anniversary which is two days before the birthday he should be sharing with his twin. Nobody minds. On balance it was not a mistake to be honest at interview. Pretending to be an academic robot would ultimately have been pointless.

**Conclusion**

It is amazing to me that I am able to function and contribute in the workplace following the death of my child. Cancer treatment felt like a minor interruption in comparison. Because of what happened I view my career and my life as a before and after story punctuated by a radical and unwanted shift in my own identity. In this paper I have tried to provide a useful picture of my experience, punctuated by relevant theory around grief and bereavement. My aim is to help people to think about the dual taboos of cancer and child loss and consider what they might do to help a colleague affected by either or both of these things. The relevance of the EA and bereavement leave policies is discussed but the focus is on trying to help colleagues to understand. Writing this paper still feels risky but I am wearing the armour of my achievements in the workplace. Somehow, I am managing to contribute, and the support of my colleagues is invaluable.

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