Motherhood in the therapy room.

An Interpretative Phenomenological Analysis of the experience of mother-therapists who work with mothers who grieve for their child.

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Abstract:

The aim of this study was to gain insight into the lived experience of mother-therapists' (therapists who are also active mothers) therapeutic work with mothers whose child had died. Through this exploration an awareness of how motherhood can shape the therapeutic encounter when working with this client group was created. The study furthermore considered how the work shaped participants' personal and clinical selves.

Interpretative Phenomenological Analysis with its inductive, idiographic and interpretative stance was considered appropriate for this study. Six mother-therapists were interviewed twice on their experiences of working with mothers who grieved for their child. Due to high in-sample variation, two participants' accounts were not included in the data analysis in order to achieve greater homogeneity.

The remaining four participants were mother-therapists of different therapeutic orientations either qualified and registered with BACP/UKCP/BPS or training towards such registration. They were also mothers of live-children up to the age of 16. Analysis of their interviews led to the creation of four superordinate themes: (1) The personal in the professional; (2) Sitting with the grieving mother; (3) The double-edged sword of identification; (4) How this work has shaped me;

The findings indicate that the mother-therapists in this study considered their role as mother to be influential to their overall identity as well as their work as therapists. Being a mother shaped their work directly and practically, i.e., the hours worked; and indirectly, i.e., empathising with parent-issues through an experiential lens shaped by their own experiences as mothers.

Working with grieving mothers was found to be challenging at times, due to identification with clients and similarities between children. Nevertheless, mother-therapists in this study also felt that being a mother helped empathic attunement, aided connection and working at relational depth. Supervision and self-care were deemed important when working with bereaved mothers.

The findings of this research are intended to support other clinicians who work with child-death. It furthermore contributes to the literature on 'bereavement work' and 'the person of the therapist' as it highlights the reciprocal nature of the therapist and their work.

CONTENTS:

Chapter 1: Introduction:

This chapter highlights the aims of the study, the different areas of academia that are drawn together in this research as well as my relationship to this project.

1.1. Aims of the research:

This research aims to explore the lived experience of therapists who are also active mothers (of children up to the age of 16, and who have not experienced the death of one of their own children) who have worked therapeutically with mothers whose child has died.

With this exploration, I aim to create insight into 'motherhood in the therapy room' through the sameness of gender (women) and roles (mothers), yet a difference of experience (child-death). I argue that exploring how motherhood might shape the work and the topic of the work (the death of a mother's child) will create insight into the intricacies of therapeutic work and its reciprocal nature. I hope to further understanding about firstly, how mother-therapists experience this work; secondly, how they feel that being a mother shapes this experience/the work; and thirdly, how this experience shapes the mother-therapists' ongoing personhood (mothering/motherhood) and professional practice.

The literature review that follows shows that this particular research with this particular therapeutic dyad appears not to have been done before. This research is therefore the first of its kind. It will contribute to existing literature that explores how

our personhoods, in this case motherhood, can shape the therapeutic process and vice versa. Its findings are relevant for training and supervision to promote reflective practice (Schoen, 1983). This study will furthermore contribute to the realm of bereavement work by offering referrers some aspects to consider when deciding on how to prepare a mother-therapist before entering into a therapeutic dyad with a grieving mother. It may also give other mother-therapists some insight into how some mother-therapists negotiated between their roles of mother and therapist when working within this dyad. Due to the dyad's specific nature (gender and family role), some of the findings from this study might also be transferable for reflections on other therapeutic dyads in which client and therapist share specific attributes or experiences.

Throughout this thesis, I use the term 'mother-therapist' to describe both trainee and qualified psychotherapists/psychologists/counsellors who are also mothers. Due to drawing on literature from several fields, and my sample consisting of Counselling Psychologists, Psychotherapists and Counsellors (both qualified and in training) coming from different therapeutic orientations, I am using the terms practitioner/counsellor/therapist/analyst/clinician interchangeably.

1.2. Background to the research:

This study primarily focuses on the lived experience of the person of the therapist. It is thus based within the literature that explores 'the person of the therapist'. However, this research focuses on a specific therapist attribute (motherhood) and how this interacts in the therapy with a particular client who shares this role. It is

therefore gender and role specific and thus draws on literature that explores gender and motherhood. Since the death of one's own child, which is the client presentation, can be conceptualised as 'traumatic loss' (Green, 2000), I also consider vicarious trauma. With its focus on child-death, this research also reaches into the areas of bereavement and working with death. The literature review engages in an exploration of the relevant texts from these realms and therewith creates the space that this research project aims to fill. First, however, I want to share some personal reflections that came out of this research process and give some insight into why I chose to research this topic.

1.3. Personal relationship to the research:

Being in the midst of this research process triggered reflections, which I wanted to share with the reader as they highlight my inextricable connection with the material.

1.3.1. Reflections emerging from the research process:

I am sitting in the parish hall of my parents' village, a place where I have not been for many years, and I have found myself shedding tears for the mother in the village whose child died about 25 years ago.

Her red eyes and red nose, even years after her child had died, are clear and fresh in my mind. I remember thinking back then that since her child had died, she always looked like she had just been crying. I thought then that this might be a relic of the tears she had shed. Now, as a mother myself, I wonder whether it was not a relic but

that she was still crying. I feel I grasp her loss more fully now. I am crying tears for her and her loss, a loss you cannot 'get over'.

I wonder whether this family is so present in my mind because I am in the parish hall, where the mother and father would have met with the priest to arrange their little one's funeral and maybe would have hoped to find some solace. It feels like an embodied connection through the place. The image of them sitting a floor above me in the warm office in such great pain feels very powerful and almost takes my breath away.

I wonder whether this place in connection with working on an analysis in which one of my participants engaged in deep reflections on some unconscious processes, allowed my subconscious to bring up this memory, too. I now ponder whether there was a bit of that family within me when I embarked on this research in order to validate their experience; to make sense of it and in particular, to understand the mother's weeping eyes and red nose.

I notice the parallels between the child who died and one of my own children. I notice the fears I have always felt around accidents, which is how that child had died. Whereas my other child shares attributes with one of the children who died of a terminal illness in this study. I have noticed I worry when any signs of illness are around. The death of a person you carried and nurtured inside you and gave birth to, how can you ever process such a loss?

My tears have moved from this weeping mother to the children I have encountered whose lives were cut short. I feel I can identify with this mother and her pain but also mourn the children and am wary of anything like this to ever happen to my own children, whilst appreciating their good health and liveliness more than ever.

Several of the themes in this account mirror the experiences of my participants' stories of their work with mothers who grieve their child. It offers insight into my deep connection to this research study and unconscious reasons for conducting it. It also contains the overall argument of this study that our personal, professional and academic selves are in constant interplay and shape as well as are shaped by each other. I feel that the process of this research has not just helped my understanding of the topic under research. I sense that it has also allowed me to openly process and come to terms with a memory I have been carrying within me for many years.

1.3.2. Reasons for conducting the research:

I became a mother for the first time whilst training to be a counselling psychologist and psychotherapist. The transition to motherhood had a profound impact on my identity, my priorities and worldviews. Being a mother also shaped my clinical work in practical and emotive ways. In particular, my empathy towards parent-issues shifted. Whereas before I empathised and understood, I feel that now I 'know', because I too have children. Thus, my empathy to parent-issues seems to come from an experiential place, a shift which Saltzberg and Bryant (1998) suggest is commonly experienced in therapists when they have their first child. This experiential understanding when working on parent issues has the potential to increase the level

of identification between a parent client and me. This brings both risks and enrichment to the therapeutic process, as suggested by Stevens (1996). It can aid empathy and containment of emotions. But, there is also a risk of collusion, as I might be unable to take their experience as different from mine, or over-identify with their experience and feel it as if it was mine. In my case, I think I am more likely to identify with women and in particular mothers, due to the social roles we share.

Furthermore, I had worked with a mother whose child had died prior to being a mother myself. This work was sad. Nonetheless, my empathy for her, though genuine and real, did not come from this experiential place. Similar to my reflections above, where I had noted the changes in the mother following her child's death but did not 'understand' them fully. My empathy when I was a teenager and with the mother with whom I worked before becoming a mother myself did not come from the place that knows what it is like to be a mother who has these strong attachments at home. A place that conceptualises child-death as my worst fear, a fear I could not physically conceive of before motherhood, as there was nothing actual to lose. I therefore started wondering how I, as a mother-therapist, would be able to work with mothers whose children had died. Now that I could feel this shift in empathy towards parent-issues, and now that I, too, had children whose deaths I actively avoided contemplating. In addition to these ponderings, as I reflected above, the mother that I had carried within me might have unconsciously contributed to my desire to create this study.

The reason for placing this research in the realm of 'the person of the therapist' rather than 'bereavement work' is multifaceted. Firstly, it is the primary focus of the research, as outlined above. Secondly, I have an academic passion for the concepts of intersubjectivity, gender and motherhood. Basing the research into the area of 'the person of the therapist' therefore allows me to explore aspects that make me feel alive. Nevertheless, I also wonder whether the slight distance created by approaching the subject of child-death through the lens of motherhood might be a means of protecting myself from the enormity of the dark pain that the topic of child-death elicits in me. It might therefore be a means of preserving my energy by oscillating between the emotions of pain and excitement.

The layered meanings that this research holds for me has helped keep up my passion and perseverance. An inevitable challenge that this and the shared attributes between me and participants contained was that I might over-identify with participants and their stories, or code the data in a way that would say more about me than them. Therefore, I needed to ensure ongoing reflexivity and mindfulness of my process. Keeping a reflexive journal, supervision and peer mentoring helped me with this process.

Chapter 2: Literature Review:

The literature review offers a more extensive discussion of the relevant areas and therewith creates a space for this research. It lists the aims of the study and the research questions. Within the research, I argue that the person of the therapist with his/her individual attributes is central to the therapeutic process. This forms the backdrop to this study and is explored in more detail below.

2.1. The person of the therapist:

It is well established and accepted across the different schools of therapy that therapist features shape and are shaped in the process of working with clients (Adams, 2014; Knox, 2014; Rabu et al., 2015). This reciprocity refers to a concept first postulated by the existentialist Heidegger ([1927] 1962) in his depiction of intersubjectivity, which promotes the notion that humans are interrelated and embedded in their surroundings, era and culture. Intersubjective positioning implies that it is in the meeting of all of us with all of the other that creates a dynamic 'relational unconscious' (Gerson, 2004), which is unique to the people involved in this encounter. Honing in on the notion of 'all' of us, implies that one part of us shapes another. Thus, though all is connected and appears as a whole, it is the individual pieces that create the whole. This research hones in on the aspect/piece of motherhood.

The concept of an intersubjective relationship between client and therapist has always been prominent in existential models of therapy (Spinelli, 2007). Over recent decades, this notion has also become increasingly central in the humanistic schools

of therapy (Mearns & Cooper, 2018) and the psychoanalytic tradition (Stolorow & Atwood, 1992; Benjamin, 1990). Views on counter-transference have moved from being considered an interference to the work to an invaluable tool offering insight into both the client's and the therapist's unconscious, as outlined by Maroda (2004). Clarkson (2003) furthermore argues that both client and therapist bring their own personal fears and wishes to therapy, which can be elicited in their intersubjective relating and shape the transference/countertransference interplay. Transference is therefore considered to be a dynamic and dialectical process, in which the client's projections interact with and are influenced by aspects of the therapist, such as behaviours, age and gender (Wachtel, 2008). In this view, the therapist's person is inherently part of the transference relationship and therewith the whole therapeutic relationship. Clients may push a therapist's 'button' and highlight sensitivities that need to be attended to (Heatherington et al., 2014). Though boundaries are deemed important, holding boundaries does not mean that the personal can be fully separated from when one transitions between the private and professional spheres (Norcross & Guy, 2007; Goldberg, 1986). My opinion on boundaries between the personal and professional coheres with Norcross and Guy (2007) who sum up their understanding as follows: '*In truth, the clinical encounter reflects the combined reality of both the client and the therapist' (p.53).* As an integrative practitioner, I position myself in the field of relational therapy (DeYoung, 2003) and draw on concepts from relational psychoanalytic, existential and humanistic schools of therapy. The concepts of intersubjectivity and reciprocity in the therapy room are therefore central to my conceptualisation of the therapeutic encounter.

Research investigating this mutual impact of therapy and therapist concludes that practising psychotherapy has both positive but also challenging effects on therapists' personal lives (Rabu et al., 2015; Orlinsky & Ronnestad, 2005; Norcross & Guy, 2007). Clinical practice has been found to for instance, create openness in personal relationships and greater self-reflective capacity. Yet, it can also result in a sense of isolation and withdrawal from family and friends, due to the demanding involvement of listening to and attending to others' problems, which can lead to 'burn out' (Ray et al., 2013). Findings from these studies concur with individual reflections of therapists on how their practice has shaped their lives (for example Pachter, 1997; Geller, 2014; Butler, 2014; Freudenberger & Robbins, 1979). They mirror my own experience, too.

Besides the effects of conducting therapy on therapists' lives, therapists' personal experiences, attitudes and attributes have also been found to affect their clinical practice (Adams, 2014; Hill et al., 2015; Gerson, 1996). Adams (2014), who conducted an interpretative phenomenological analysis of this phenomenon, concluded that participants' history shaped the type of therapist they became, and that personal as well as professional experiences shaped their practice. Whilst clinical experiences also shaped the person of the therapist. Her findings are aligned with individual reflections of therapists on how personal experiences, such as childhood experiences (Stevens, 1996; Warshaw, 1996), the death of one's own child (Chasen, 1996; Mendelsohn, 1996; Gerson, 1996), a divorce (Schlachet, 1996), being a parent of a child with disabilities (Crastnopol, 2009; Geller, 1996), being a child-less woman (Leibowitz, 1996), being a parent (Basecu, 1996) and

others shape therapists' clinical work because they shape their personhoods and outlook on life.

The literature therefore highlights that the personal and professional are complexly interrelated. With this research project I aim to investigate this mutual impact further through focusing on how a particular aspect of a therapist's personhood (motherhood) shapes the professional, with a particular client (mothers who mourn their dead child) and how this in turn shapes the person of the therapist and their professional practice. I am aware that a mother-therapist's other attributes, such as past experiences, spirituality, therapeutic orientation, personal bereavements etc. will further shape her overall experience of her work with grieving mothers, and that if the same therapeutic encounter was looked at through a different lens, different meanings would occur. Thus, the findings from this study are a reflection of this sample at this time only. They are not intended to be generalizable to 'all' mother-therapists' experiences when working with this client group.

The concept of therapist and client sharing attributes or demographics, such as ethnicity and gender (Fujino et al., 1994; Wintersteen et al., 2005) or sexuality (Jones et al., 2003) has received some attention within the research community and has been largely related to positive client-outcome. Yet, such findings have not been consistently repeated, alluding to a more complex relationship between therapy outcome and the dyad's shared or mixed demographics (Chang & Berk, 2009; Cabral & Smith, 2011; Roger, 2005). In fact, Raja (2015) argues that demographic matching can raise its own ethical challenges. For therapists may assume clients'

experiences to be similar to their own. Moreover, sharing certain experiences with clients, for example a personal history of trauma, has been related to an increased risk for therapists to develop vicarious trauma (Trippany et al., 2003). Thus, these findings indicate a variable effect of sharing demographics or experiences on therapy outcome. Nevertheless, when looking at this issue through the lens of intersubjectivity, similarities between client and therapist will shape the therapy process in some forms (Stolorow & Atwood, 1992) as well as the therapist's subjective experience of the therapy. Despite research on 'large' similarities such as sexuality and gender, there is less research into how 'smaller' similarities between client and therapist, i.e., parent roles, may shape the therapeutic process. There is also a lack of research into the lived experience of therapists working with similarities, though Adams (2014) touches on this issue in her study. The literature has however produced many individual accounts that reflect on therapists' experiences of working with similarities. I will illustrate some of these individual accounts below.

For example, Hauer (1997) explores how the shared experience of 'mother-loss' triggered a parallel process of grief between her and her client. She concludes that this parallel process was intensified since both she and her client were women and thus shared the role of daughter. Whereas Schlachet (1996) describes how he struggled to empathise with a female client who was going through a divorce when going through a similar type of divorce himself, because he identified and empathised more with the to-be-divorced husband than his own client. On the other hand, Goldstein (2007) reflects on her experience of working with a client who was struggling through midlife whilst being in the same stage of life herself. She argues

that sharing similar vulnerabilities could lead to identification, which in turn could pose a risk to empathic attunement if the client's experiences seemed different to her own.

Exploring accounts such as these led me to a conclusion similar to the one put forward by Raja (2015). That sharing experiences and demographics can advance the therapy, shape the therapist's personal dealing with the shared issue, but also raise challenges. Stevens (1996) sums up this double-edged notion of identification that can occur when therapist and client hold similar attributes or experiences (in her case, having a history of sexual abuse when working with clients who suffered sexual abuse). Her outline reflects my own position on this issue.

'*Identification with another's experience can be an important source of empathy, and yet when there is too much identification, movement and creativity may cease. Differences and conflict can get submerged. If this happens, identification becomes overidentification and can be destructive.*' (p. 189)

In the above outlined account, Hauer (1997) indicates that besides the shared experience, sharing gender and family role were other reasons for identification. Since therapist and client in this study share gender and family roles, I take a brief look at the literature on the impact of gender on therapy, followed by an exploration of the literature on motherhood.

2.1.1. The impact of gender:

Kort (1997) and Barlow-Sweet (2012) discuss that gender is a therapist attribute that can shape the therapeutic encounter. For gender takes up a large part in our culture and the creation of our sense of self (Paul, 2000; Leslie & Clossick, 1996).

I align myself with social constructionist concepts of gender that view gender as largely created through cultural, social and power narratives in society (Crawford, 2000; Giammatei & Green, 2012). In addition, I embrace Hollway's (2016) and Athan and Reel's (2015) arguments that there are embodied experiences that are specific to the physicality of sexes, such as a woman's capacity to carry and give birth to another human being. Yet, it is the historical and socio-cultural contexts in which such experiences are embedded that largely shape their meanings and one's reality of them (Crawford, 2000). At this point, it is important to acknowledge that child-birth is no longer exclusive to women since transgender men can also experience pregnancy and birth (Cocozza, 2018; Obedin-Maliver & Makadon, 2016; Alvarez-Diaz, 2009; Beatie, 2008). These embodied realms of gender should not be ignored when appraising gender equality and its narratives.

I cohere with Kort (1997) and Barlow-Sweet (2012) that the way we experience, 'do' and view our gender as well as other binary and non-binary gender types shape our work with the same and other gender on the cis-trans spectrum. ['Cis' refers to people who identify with the gender they were assigned to at birth (Richards, 2018), and 'trans' refers to those who do not identify with it (Cocker et al., 2018)]. This argument thus entails that when a therapist works with a client of a different gender, this will create different dynamics and transferences compared to working with their

own gender (Diamond, 1992). This is due to one's own embodied experiences as a gendered therapist (i.e., female) as well as prejudices and attitudes towards one's own and the client's gender (i.e., male) (Felton-Logue, 2012; Wintersteen, et al., 2005).

However, this study is not an exploration or critique of gender in the therapy room. But, it is my position on the impact of gender on therapy, in particular with regards to identification, that contributed to my decision to make this study gender specific.

Parenting roles contain gender specific expectations and experiences (Gross, 1998). Over recent decades, cisgender motherhood and cisgender fatherhood have become somewhat more interchangeable. Yet, there are still many traditional differences between the two. Furthermore, the binary conception of motherhood and fatherhood has been challenged in the recent past with the rise and increased acceptance of same-sex parenting and non-binary parenting (Cocozza, 2018; Obedin-Maliver & Makadon, 2016). Yet, research into non-binary parenting is still sparse (Cocker et al., 2018). The literature that I have drawn on in this thesis holds a heteronormative bias, meaning it assumes a cisgender and heterosexual position when discussing parenting (Richards, 2018; Giammattei & Green, 2012). Whilst acknowledging the existence of non-binary parents, this research focuses on cisgender mothers and cisgender fathers. Due to the word limit, for the remainder of the thesis when referring to 'mother/motherhood' or 'father/fatherhood' I refer to literature on and the experiences of cisgender parents.

Below I explore the literature on (cisgender) motherhood and therewith give academic reasoning for my decision to focus this research on mothers.

2.1.2. Motherhood:

The feminist literature distinguishes between the concepts of 'motherhood', which refers to the role of being a mother, tends to entail a status and carries different meanings and conceptions across different cultures, and the term 'mothering', which refers to the doing of being a mother. In the West, the latter relates to nurturing and caring attributes as well as the handling and raising of children (Glenn, 1993; Letherby, 1994; Arendell, 2000). In many ways, the act of 'mothering' can be performed by non-mothers – i.e., aunt (Letherby, 1994; Jeremiah, 2006). In fact, the wider family and particularly grandparents used to be very involved in the rearing of children (Glenn, 1993) and in some families, especially in the case of teenage mothers (Sjoeberg & Bertilsdotter-Rosqvist, 2017), they often still are. Nevertheless, within British society, there is a bias and expectation that mothers (especially birth-mothers) 'mother' their children well (Glenn, 1993).

This bias creates a notion that for many women becoming a mother and bearing children (motherhood) feels like a natural progression in their personal development, influenced by both biological and cultural expectations (Nachtigall et al., 1992). Motherhood is often assumed to be women's 'ultimate role' (Letherby, 1994). Especially, if they are in their mid-twenties to mid/late thirties and in financially stable heterosexual relationships (Glenn, 1993; Letherby, 1994) as opposed to for example, teenage mothers (McDermott & Graham, 2005). In Western societies, becoming a

mother is often described as a forming experience that can change a woman's outlook on life, ambitions and fears (Smith, 1999a; Horne et al., 2005; Vejar et al., 2006). Women have recounted an enrichment to their lives through the new role they inhabit as well as a loss of self, in particular if they transition, as is common in Western societies, from an independent woman with a career to a mother (Vejar et al., 2006). With the rise of equality and an expectation of women returning to work, mothers face new challenges (Eagly et al., 2012). For despite being encouraged to work, the bulk of child-rearing responsibilities and household chores are still traditionally left to the woman (Gross, 1998; Raver, 2003; Glenn, 1993).

Current narratives of good parenting in general and mothering in particular have been deeply shaped by Bowlby's (1969) attachment theory. Women across the globe seem to have largely embraced the concept of the 'sensitive mother' (Ainsworth et al., 1978) as their own conception of good mothering, in particular amongst higher educated women (Mesman et al., 2016; Athan & Reel, 2015). Thus, women often struggle to juggle their multiple roles and expectations on the self in the fulfilment of them (Gross, 1998; Keefe et al., 2018; Raver, 2003; Lyndon, 2013). In addition, the process of moving from the role of daughter to the role of mother can activate conflicts with one's own mother as it creates a shift in perceiving life through the lived experience as a daughter to the lived experience and lens of a mother (Imber, 1990).

Motherhood, in addition to these psychological and social shifts, is, if conceived of naturally, also an embodied alteration through the physical experience of pregnancy

and giving birth, which can create an embodied attachment to the live-baby (Hollway, 2016; Athan & Reel, 2015; Klaus & Kennel, 1976). This makes mothering central to women's lived experiences and narratives (Gross, 1998; Athan & Reel, 2015). However, especially over the past century, since better medical care and greater legality of abortion and contraception, women (in the West) can choose not to become mothers. On the other hand, some women despite wanting to become mothers do not, due to fertility issues, not having a partner they want to have a child with or other reasons (Letherby, 1994; Glenn, 1993). Some women conceive but never carry a pregnancy through to a live-birth due to abortion, miscarriage or stillbirth. This raises questions about when motherhood starts and ends. With the conception of a life in one's womb or with a live-birth? Similarly, does someone's status of 'mother' end when a pregnancy does not result in a live-birth or an only child dies (Davis, 2016)? Even though this research does not focus on these questions, they frame this study as they highlight how our mainstream ideas around motherhood are created through an acceptance of historical and potentially suppressive discourses that equate motherhood largely with 'birth-mothers' and that view women in terms of their reproductive output (Letherby, 1994; Glenn, 1993). In addition, motherhood can also be obtained through being a lesbian mother who does not carry the baby, an adoptive mother or step-mother; all versions of motherhood and mothering that tend to be under-researched (Letherby, 1994).

With regards to birth-mothers however, I align myself with Hollway (2016) and Athan and Reel (2015) who argue that the physical experiences of pregnancy and giving birth can create a mother's attachment and relationship to its in-vitro and new-born baby, which due to the experience of pregnancy is different to that of (cisgender)

fathers. Though fathers are more involved throughout the pregnancy and birth process in Western societies these days, their experience is different to that of their pregnant partner. This does not mean that their attachment to the baby and children is less strong. On the other hand, for some women pregnancy and birth are traumatic or negative experiences (Beck, 2003; Spies Sorenson, 2003). Furthermore, there are women who, contrary to Hollway's argument above, do not experience their pregnancy or birth in ways that supports their attachment to their offspring, and bonding with their child may only establish later on (Glenn, 1993). In addition, Post Natal Depression can create an experience of motherhood different to the blissful one a woman might have anticipated and that is often conveyed in society (Buultjens & Liamputtong, 2007; Hannan, 2015) as do many other external stressors for instance, financial, health or social. All these different aspects ought to be taken into account when discussing the transition to motherhood, its immediate as well as lasting impact on a woman's life and her attachment to her child. I will further expand on the issues around motherhood in the Discussion chapter.

The far and deep-reaching shifts in a person as a result of transitioning to mother are also true for mother-therapists (Fenster et al., 1986; Norcross & Guy, 2007). Motherhood therefore creates a therapist attribute that can shape the therapeutic encounter, which I discuss below.

2.1.3. Motherhood in the therapy room:

Within the therapeutic literature, some writings refer to parenthood more generally. Due to my conception of motherhood being a specific aspect of parenthood, I have included these texts.

In particular the first pregnancy can deeply shape both the female as well as the male therapist (Guy et al., 1986; Norcross & Guy, 2007). Therapeutic writings reflect this, since amongst the literature on motherhood/fatherhood there is a specific focus on the impact of pregnancy on the therapeutic encounter, especially regarding the woman. This is because pregnant therapists visibly bring their private person into the room through the bump. They can no longer hide or separate their 'woman-ness' from their work (Fenster et al., 1986; Guy et al., 1986; Rivera, 1997; Stuart, 1997; Napoli, 1999; Gibb, 2004; Imber, 1990; Hurdman, 1999; Dyson & King, 2008; McCluskey, 2017). Fathers' experiences, on the other hand, are largely under-researched (Guy et al., 1986).

The literature on pregnancy in the therapist has shifted over time from largely focusing on the impact of the pregnancy on the client to a deeper exploration of the therapist's countertransferential responses and lived experiences of pregnancy (Whyte, 2004). The latter largely suggest that pregnancy in the therapist brings both challenges and opportunities for therapists, clients and their intersubjective meeting (Fenster et al., 1986; Korol, 1996; Kleinplatz, 1992; Dyson and King, 2008; Saltzberg & Bryant, 1998; Raphael-Leff, 2004). Despite this degree of consensus within the literature, empirical studies on these issues are sparse with most of the above

referenced articles being individual or shared reflections of therapists' own experiences.

Nevertheless, due to the overall agreement in the literature, individual accounts of therapists are useful to gain an insight into the intricacies of female therapists' experiences of their practice whilst pregnant. Rivera's (1997) and Imber's (1990) personal accounts of their pregnancies seem particularly relevant to this study. For both recall a shift in empathy to clients when therapy revolved around mothering and infanticide (Rivera, 1997) and traumatic labour respectively (Imber, 1990). Rivera who worked before and through pregnancy with a mother who had been convicted of infanticide, found that her initial (when not pregnant) empathy and belief in her client's plea of innocence, that the death of her nephew was an accident, turned to distrust. She furthermore felt protective over her bump and expressed discomfort with her client's identification with her as a fellow mother. On the other hand, Imber's empathy towards her client's experience of a traumatic labour shifted to feeling personally threatened when her client retold this story on finding out about her therapist's pregnancy. Thus, both highlight that their forming identity of mother was pulled upon when the therapy was around labour, children, mothering and child-death. This in turn shaped the intersubjective process between them and their clients. Though participants in this study are not pregnant, their children and motherhood may still form a major part of their identity, as suggested by Derry (1994). Being confronted with motherhood and child-death in the therapy room might pull on their motherhood.

Imber (1990) furthermore describes feeling guilt and an 'infantile' sense that her good fortune (being pregnant with a baby) was at the expense of one of her clients who felt rejected due to her pregnancy. Guilt as a countertransference reaction has been picked up in the literature and been discussed amongst others by Norcross and Guy (2007) who suggest that guilt can constitute a countertransference reaction stemming from the therapist's own unresolved personal struggles. Whilst Searles (1979) conceptualises guilt in the therapist as a defensive function. He argues that guilt keeps the client regressed and the therapist unable to recognise the hate and ambivalence the client might hold towards the therapist. In Imber's (1990) account this might have been hate due to the client's perceived abandonment by the pregnant therapist. On the other hand, Basecu (1996) suggests that marriage, pregnancy and parenthood can cause envy in clients and in turn trigger guilt in therapists. Her conception of guilt in the therapist is thus similar to the notion of 'survivor guilt', which O'Connor et al. (2000) have depicted as a feeling associated with being better off than others. Basecu's interpretation of guilt thus carries a less negative connotation than Searles' (1979), in that she considers it to be a response that highlights an awareness of one's private self in relation to the client. A moment when the therapist is aware of 'having' something, which the client wishes to have too. Thus, pregnancy and motherhood can trigger strong countertransference reactions in the therapist and highlight their personal differences between them and their clients, which will inevitably shape the therapeutic process.

Research into how the transition to motherhood can shape a therapist's identity concludes that even though the identity as a therapist seems to shift, it does not become less important. The roles of mother and therapist are both of great

significance (Derry, 1994). This implies that the roles of mother and therapist may at times be in competition with one another. Davis (1984) in her personal reflections on being 'wife, mother and therapist' discusses how she attempts to avoid this through being clear about what hours she works, what client presentations she accepts and being comfortable with child-care arrangements. Nonetheless, there may be times when such smooth negotiation between the roles is more difficult; for instance, when one's child is sick or troubled, and the therapist has to decide whether to stay home with the child and be unavailable for the client or vice versa (Basecu, 1996; Norcrosss & Guy, 2007).

On the other hand, being a mother can complement the therapy and shape mother-therapists' work in multiple ways, as discussed for example by Chasen (1996) in her autobiographical account of the impact of the death of her only child on her practice. Whereas Comstock (2008) reflects on the effects that the death of a child and being a mother of a disabled child had on a colleague's practice, and Crastnopol (2009) explores how having a disabled child shaped her own work. Furthermore, Levine (2009) reflects on how her personal analysis for issues around her disabled son shaped her work with a client, a mother who too struggled with issues around her son's disability. These accounts concur that even though separation of the parent and therapist roles may be possible and promoted in an ideal world, it does not seem achievable all of the time, similar to the general literature on boundaries that I outlined above. This issue has been well depicted by Adams (2014), in her above-mentioned research. She recounts one therapist stating that when with clients who spoke about their children who were of a similar age to her own children, her thoughts could drift to her children and what to or not to do as a mother. This could

momentarily take her away from her client. On the other hand, having children of that age herself was helpful because she had a developmental context at home to which she could relate the client's narrative. Thus, when the work focused on children, the therapist's own motherhood became foregrounded and shaped her relating with her client.

The exploration of the literature indicates that being a mother is a transformative experience in a woman's life (Smith, 1999a; Vejar et al., 2006; Horne et al., 2005) that can shape countertransference reactions and impact the therapeutic process (Guy et al., 1986; Basecu, 1996), especially when the themes of therapy are around mothering or child-rearing (Adams, 2014; Levine, 2009).

The literature that I have referred to here, largely draws on the experience of birth-mothers. This again highlights the neglect of the experiences of adoptive-, step- and other less common 'versions' of mother and mothering.

Due to the often close attachment between parent and child, the death of one's child can be experienced as a 'traumatic loss' (Green, 2000; Klass, 1996; Harding, 2015). This implies that working with a bereaved mother might resemble trauma work, which could lead to vicarious traumatisation in the therapist. I give a brief overview of the concept of vicarious trauma.

2.1.4. Vicarious Trauma:

The concept of 'vicarious trauma' (McCann & Pearlman, 1990) was created to make sense of how repeated exposure to traumatic material in the therapy room could impact a therapist's functioning, both professionally and personally. McCann and Pearlman (1990) suggest that through the repeated hearing of, attuning and relating to people who have been traumatised a therapist may become overloaded by the tragic side of life. This can lead to permanent changes in a therapist's cognitive schemas about others and the world, which can impact their emotions, personal relationships and perceptions. Because of these changes, clinicians may experience symptoms similar to that of the traumatised themselves including intrusions, avoidance, sleep disturbance, depression and anxiety (Pearlman & Saakvitne, 1995). These phenomena have also been referred to as compassion fatigue (Figley, 1995), countertrauma (Gartner, 2014), secondary traumatic stress, secondary victimization, compassion stress and others. Though containing some nuanced differences, these concepts largely overlap with vicarious trauma (Canfield, 2005). For this research, I use the terms vicarious trauma and compassion fatigue interchangeably since they are best known.

All these concepts refer to a cumulative effect of being empathically engaged with others' trauma. Whereas the concept of 'Secondary Stress Reaction' (STSR) (Harris, 1995) refers to the direct result of hearing emotionally shocking material from a client, which can be a one-off experience and is considered to be short-term. Yet if not resolved or cumulative, this STSR can develop into Secondary Stress Disorder (STSD), which is similar to the concepts of posttraumatic stress disorder and

vicarious trauma. Thus, stress and deep impact in a therapist can occur after one event and is not necessarily only related to cumulative experiences. On the other hand, Pearlman and Saakvitne (1995) argue that certain countertransference responses set the stage for the creation of vicarious trauma, such as intense affect in the therapist in response to the client's story. Their outline of this countertransference reaction to trauma material is thus similar to Harris' (1995) conception of STSR.

In turn, working (with trauma) when vicariously traumatised shapes countertransference reactions in the therapist, such as a defence to deep engagement or lack of hope, due to a less idealistic view of the world (Pearlman & Saakvitne, 1995). Thus, despite countertransference and vicarious trauma being separate concepts, they are entangled and shape each other and therewith the intersubjective process (Rasmussen, 2005). For example, Austin et al. (2009) found that patients of mental health workers, who considered themselves to suffer from compassion fatigue, reported less satisfaction with treatment, indicating that clinicians' way of relating was affected by their compassion fatigue. This reciprocal position mirrors my own.

As stated above, a personal attribute that has been linked to greater risk of developing vicarious trauma is holding a personal history of trauma (Trippany et al., 2003; Kinninger, 2008; Figley, 2001; Buchanan et al., 2006). Yet, these findings have not been consistently repeated (Schauben & Frazier, 1995). The notion that sharing a history of trauma does not necessarily lead to the development of vicarious

trauma is also indicated in the above quote by Stevens (1996), where she implies that sharing a trauma experience with her clients constituted a source of empathy. Other factors that are thought to contribute to the development of vicarious trauma are lack of professional and social support, a high caseload of trauma clients and lack of experience (Ray et al., 2013; Kinninger, 2008). For example Gartner (2004), in a personal account, contributed his experience of compassion fatigue to the extent of horrific material he was exposed to as a therapist working with sexually abused men whilst not holding such a history himself. Astin (1997) when reflecting on her personal experience of vicarious trauma found that her sharing 'womanhood' with female clients, who were victims of random rape attacks, made her feel frightened of leaving her house. Her vulnerability was not a result of sharing the experience of trauma but the repeated exposure to such stories and her identification with her clients as a fellow woman. This is similar to participants of this study who share the experience of motherhood with their clients, but not the trauma of death of one of their offspring.

Coming into contact with death in general and child-death in particular has been related to an increased risk of developing compassion fatigue (Figley, 1995). Abendroth and Flannery (2009) found greater levels of compassion fatigue amongst nurses working in palliative care than normal hospital wards. Whereas Maytum et al. (2004) found heightened occurrences of compassion fatigue amongst nurses working with children suffering from chronic conditions. Childhood deaths have furthermore been found to contribute greatly to secondary stress and the development of Posttraumatic Stress Disorder amongst emergency service personnel (Barbee et al., 2016).

Conversely to these negative impacts of working and being confronted with trauma and death, Ling et al. (2014) propose that there are several features and activities that help trauma therapists navigate these adverse impacts; such as attending to both the difficult and the rewarding features of the work, accessing suitable support networks, diversity in one's caseload and overall structure of the work. In this way, the challenging aspects of working with trauma and death can be processed and re-conceptualised as well as separated from one's own reality. Secure attachment (Brandon, 2000) and preparation for what to expect have also been considered to reduce the risks of developing vicarious trauma (Barbee et al., 2016; Canfield, 2005) and increasing resilience (Kapoulitsas & Corcoran, 2015). In fact, working with trauma clients carries the potential for posttraumatic growth, not just in clients but also practitioners (Gill, 2015; Hyatt-Burkhart, 2014). Posttraumatic growth as outlined by Tedeschi and Calhoun (1995) comprises a set of positive changes as a result of coming through trauma, whilst not eliminating the painful aspects of being exposed to the trauma.

Concluding from this literature, sharing the experience of motherhood when working with child-death may influence the work in several ways. Despite raising the potential for vicarious trauma, it is far from inevitable that mother-therapists will develop this phenomenon. I now take a look at the literature that focuses on child-death and bereavement work.

2.2. Child-death and bereavement work:

This is the other broad area that this research reaches into. As outlined above, I have based this study in the realm of 'the person of the therapist'. Yet, the context in which I am looking at 'motherhood in the therapy room' is found in this area; the death of a child, its impact on parents, in particular mothers, and working with bereavement.

2.2.1. Child-death:

With the rise of good health care across the world over the past hundred years, the occurrence of child-death has seen a steady decline, especially in Western countries (Hindmarch, 1993; Cadranell, 1994). Care during pregnancy, medical attention during labour and child-birth whether full-term or premature mean that for most couples when they fall pregnant, the expectation that their child will be born alive and outlive them is omnipresent in the West (Hindmarch, 1993). This is despite the figures suggesting that between 15-20% of pregnancies are miscarried, which means that the foetus dies before 24 weeks gestation (Hindmarch, 1993; Statistical bulletin, 2018). As this study focuses on the death of a live-child (a child/infant who was born alive), I am not going to expand further on what this optimistic narrative despite the relatively high figures of miscarriage creates for couples who miscarry. Death of a live-child, on the other hand, has seen a steady decline over the last 100 years (Hindmarch, 1993) and even over recent decades. Infant death in England and Wales (that is death of a live-child before reaching its 1st birthday) has fallen by 60.4% since 1986. Whereas the rate of deaths for children up to the age of 15 has

continually decreased. For instance in 2016 the child mortality rate from disease of the nervous system decreased by 28.6% (Statistical bulletin, 2018).

Therefore, the death of one's offspring has become something of an anomaly. This means that the narratives around child-death in our Western worlds have moved even further into the background (Hindmarch, 1993; Thomas, 1994). In the West, the death of a child is considered to go against the natural order of life (Wheeler, 2001; Dyregrov, 2003; Thomas, 1994; Valiente-Barroso & Lambrana-Ruiz, 2014; Gilmer et al., 2012). The death of one's own child has been referred to as the 'ultimate tragedy' (Schiff, 1977), the most painful event a parent may experience (Gilmer et al., 2012; Dyregrov, 2003) and as a parent's worst fears becoming reality (Cadranell, 1994). Being confronted with this ultimate tragedy in a society that generally pushes death to one side and the death of children is largely absent from our narratives, can thus leave parents and professionals alike ill-equipped to deal with this tragic loss and often continuous grief (Thomas, 1994). Hindmarch (1993) suggests that the age of the child might be significant in what one has lost – the fantasy of a child that was never born alive or a child who died before its parents. Nonetheless, the experience of grief that parents feel seems to be no different whether the child died in-vitro through stillbirth or miscarriage or as a live-child in infancy or later on through their childhoods or as adults (Schiff, 1977; Thomas, 1994; Shimshon Rubin, 1996). Moreover, not one type of death seems to be easier to deal with than another (Schiff, 1977; Kuebler-Ross, 1983). Parents, grandparents, friends and others report that the death of a child and the grief for a child, in particular if it is their own child, is different to the death of and grief for a contemporary (Schiff, 1977; Kuebler-Ross, 1983; Shimshon Rubin, 1996). It is a 'magnification of other losses' (Hindmarch, 1993).

Bereaved parents have furthermore reported a sense of survivor guilt, since they feel they should not have outlived their children (Rando, 1985).

Death in general and the death of a child in particular create narratives that we like to avoid in our societies. Bereaved families thus often find themselves becoming isolated as others either actively avoid them, or avoid bringing up the loss out of fear of saying the wrong thing. Or, they are surprised by the ongoing agony and enduring pain a parent can experience (Riches & Dawson, 2000). The latter goes against our Western attitude, in which it is assumed that once the funeral is over life should go back to normal (Hindmarch, 1993; Riches & Dawson, 2000). Yet, for bereaved families and parents, life never goes back to 'normal'. Despite Valiente-Barroso and Lombrana-Ruiz's (2014) findings that religiosity in mothers had a positive impact on their dealing with the death of one of their children, the loss of one's child seems to go so deep that one cannot 'get over it' (Arizmendi & O'Connor, 2015) or 'move on' from (Young & Dowling, 2012). A chronic sense of loss may persist (Gerrish & Bailey, 2012). The devastating grief that parents face when their child dies puts them at risk of developing 'complicated grief' (Hindmarch, 1993; Dyregrov, 2003; Stroebe & Schut, 1999).

Complicated grief refers to grief that is either 'chronic', which Stroebe and Schut (1999) depict as mourning that is focused primarily on the loss without engaging in restorative processes, or 'absent'/'avoidant', which they refer to a type of grieving, which is heavily engaged in restorative activities (such as cognitive or action-oriented) without confronting the emotions around the loss. Their 'dual process

model' of grief (Stroebe & Schut, 1999/2009) promotes a notion that healthy or normal grief involves an oscillation between engaging in loss-orientated and restorative oriented processes. An absence of this oscillation, they argue, can result in complicated grief, which implies that one mode is engaged in exclusively, thus the person becomes stuck.

In addition, the notion of successful mourning has moved over recent decades from Freud's (1917) conception that the resolving of grief is achieved through the severing of ties with the deceased person. Instead, establishing 'continuing bonds' with the deceased and an integration of the loss to one's life (Silverman & Nickman, 1996; Klass, 1996; Arizmendi & O'Connor, 2015) have been advocated as a healthy way to come to live despite the loss. This in turn can result in 'posttraumatic hope' in bereaved parents (Romond, 2010), which is similar to posttraumatic growth (Tedeschi & Calhoun, 1995). The notion of continuing bonds represents what one is thought to have lost - an attachment object, as postulated by Bowlby (1969). Individuals therefore grieve for their individual attachment/bond to the deceased, which varies from person to person. As I outlined above, attachment theory prevails in Western ideas of parenting. It promotes a strong and good quality attachment between the infant and its caregivers, in particular the mothers (Gross, 1998; Athan & Reel, 2015). A concept which mothers themselves seem to have largely internalised (Mesman et al., 2016; Vejar et al., 2006). As a result, the loss of a strong attachment (such as between the mother and her child) tends to trigger an equally strong yearning for this attachment. The death of her child can also result in the loss of identity and responsibilities in every-day life, especially if the mother was deeply

involved in the every-day care of the child, even more so if it was an only child (Rando, 1991).

Thomas (1994) as well as Young and Dowling (2012) further propose that for parents the death of one of their offspring can result in an embodied expression, as they may experience actual physical pain. In birth-mothers this mirrors Hollway's (2016) notion of the embodied experience of pregnancy, child-birth and mothering. Thus, having an embodied response to the loss of the child that constituted this embodied experience and connection in the mother seems plausible. I read one account of a bereaved mother who reported pains in her womb following the death of her terminally sick child (Thomas, 1994); as if her body was craving the child it had carried.

In addition to the notion that each person grieves their unique attachment to the deceased, there is also a body of literature on gender differences in grieving in general and in the grief for one's child in particular (Riches & Dawson, 2000; Martin & Doka, 2000; Kissane & Bloch, 2002; Stroebe & Schut, 1999/2009; Cacciatore et al., 2008). Women are generally depicted as more emotional and men more cognitively engaged in the grieving process. Women are considered to be at greater risk of staying too deep in their grief and becoming stuck (chronic grief), whereas men are more likely to suppress their grief (absent or inhibited grief). The opposite non-gender typical form of grieving also occurs, but it is less common. It has been argued that the differences in how we grieve and mourn are results of personality, temperament, age, gender and socio-cultural factors (Martin & Doka, 2000; Stroebe

& Schut, 2009). The latter two, gender and socio-cultural factors embrace the notion of a social construction of our grief.

Thus, researching mother-therapists working with grieving mothers means that culturally their attachments and nature of their relationships with their children might be similar, as well as their style of grieving and their embodied experiences of mothering. In addition, mother-therapists' own attitudes and values with regards to their own mothering and mothering in general might subconsciously shape the way they respond to a grieving mother. As Goldstein (2007) suggested above, if the client's experience of a shared set of attributes is different to the therapist's (here: the mother's attachment to her deceased child or way of grieving) this can result in a challenge to empathic attunement. For the identification with the client due to the shared feature (here: mothering, attachment to the child and personal style of grieving) might lead the therapist to expect a similar experience of it, or dealing of it as her own experience (or fantasy) of it.

The next part of the literature takes a brief look at the existing writings on working with child-death in particular and bereavement work more generally.

2.2.2. Working with child-death:

In the above section, I explored the deep and lasting impact that the death of one's child (in the West) tends to have on parents and mothers in particular. As a society, we are also more prone to despair at the death of children compared to adults

(Wilkinson, 1994). Though overall the literature is rather sparse on the impact of child-death on professionals, there is an overall consensus within both personal accounts and empirical research that the death of a child is more challenging to deal with for a professional than the death of an adult (Barbee et al., 2016; Hindmarch, 1993; Heggarty, 1994; Wilkinson, 1994).

This seems to be true amongst others for doctors, nurses, ambulance staff and the clergy (Hindmarch, 1993) as outlined above, as well as social workers and counsellors (Gilbert, 2006; Humphreys, 2012). Wilkinson (1994) points out the need not to forget that '*carers are human beings with emotions like anyone else, they will sometimes also feel the pain and sorrow of a child's death*' (p. 80). It is not a weakness. Hindmarch (1993) for example, documented an account of a family whose GP, who confirmed the death of their baby, rushed to his own home to check on his own baby who was of a similar age. Whereas Gilbert (2006) in a phenomenological exploration of the impact of the death of a child in care on social workers, concluded that one factor that seemed to increase the potential for identification with the case was parenthood. Thus, there seems to be something about the nature of child-death that has the potential, at least for some, to shake the boundaries between their own lives and that of the bereaved families they come into contact with. Professionals are encouraged to find a safe space to explore the impact that this death had on them, such as in supervision (Gilbert, 2006; Humphreys, 2012).

Despite these general explorations on how deeply child-death can impact professionals, which I also touched on in the section on vicarious trauma, the literature on how counselling grieving families and terminally sick children is experienced by counselling staff is rather small. This might be due to the myth that therapists are immune to personal pain, especially with regards to their clinical work (Dwyer et al., 2012; Adams, 2014).

As stated in the section on vicarious trauma, prolonged work with death and dying has been linked to compassion fatigue (Figley, 1996; Abendroth & Flannery, 2006). Whilst some deaths can create symptoms of trauma in the bereaved (Green, 2000; Klass, 1996; Harding, 2015). Thus, some of the literature on vicarious trauma is relevant when discussing bereavement work.

On the other hand, there is research that focuses on the impact of the death of a client on the therapist. Clark (2014), Christianson and Everall (2009) and others for instance, studied the impact of client-suicide on therapists and concluded that having this experience in their practice did not only deeply affect their participants' clinical selves but also their personhoods, and that they themselves had to come to terms with this loss. These findings are similar to those found in the accounts of individual counsellors' experiences of confronting death when working with terminally ill clients (O'Brien, 2011) and research into this phenomenon (Palmieri, 2018; Dwyer et al., 2012). In addition to an overall deep impact, Dwyer et al. (2012) for example conclude that working with terminally ill clients could trigger feelings in the therapist around their own mortality or non-resolved grief. Both, they suggest, ought to be

confronted and resolved respectively (through personal therapy, reflection or supervision) in order to be able to maintain healthy boundaries. Bonanno (2009) furthermore concluded that holding clear boundaries aided therapists' dealing with the death of a client and helped separate it from their personhoods. Conversely, Palmieri (2018) noted a deep personal affect that the death of her participants' clients had on them. It created challenges to participants, since they needed to negotiate the impact of their clients' deaths between their private and professional selves. On the other hand, this experience seemed to help reconcile difficulties with the inclusion of their personhood in their therapeutic work because it was unavoidable in this work. Palmieri thus highlights the notion of reciprocity experienced in her participants. Rather than diagnosing these experiences as compassion fatigue or similar, Palmieri stayed focused on the lived experiences of therapists and how they made sense of them.

Palmieri furthermore acknowledges that some of these experiences, in particular the challenges and impact on therapists' personhoods might be extenuated if working with the death of a child rather than an adult, as child-death might be perceived to go against the natural order of life. This suggestion is similar to Dyson and King (2008) who propose that working with bereaved parents could pose a challenge to mother-therapists. Nevertheless, the literature exploring this seems to be sparse.

Humphreys (2012/2015) and Gosney (2017) were the only pieces I managed to find that focused on the lived experiences of counsellors who came into contact with child-death. Gosney's (2017) article, however, described her own experience of

working with parents who suffered pregnancy loss rather than the loss of a live-child. Her focus was more on how she worked with them and what couples bereaved by miscarriage or stillbirth needed rather than how she experienced this work. Nevertheless, she did recount that this work was emotive, in particular when confronted with photographs of the dead babies. Humphreys (2012), on the other hand, conducted a heuristic study of the experience of counsellors in children's hospices. Her research confirmed what the above literature suggested about working with child-death in non-counselling professionals. Working with grieving families and dying children had a deep impact on her participants' personal selves, outlook on life and professional identity. She emphasised the importance of good supervision and self-care, similar to the advice given to general professionals involved with child-death (Hindmarch, 1993) and the literature that suggests techniques to prevent vicarious trauma (Ling et al., 2014).

Even though Humphreys did not focus specifically on her participants' parent-status, there was an example in a publication of her research that highlighted its impact. She recalled an experience from her own life, when buying grapes for her grandchild was suddenly perceived as too risky. She realised that this perceived risk was caused by having worked with a family whose child had died by choking on a grape (Humphreys, 2015). Thus, working with this client group had a deep and lasting impact on her that spilled over into her private part, her grand-mothering.

My research therefore adds a different, narrower focus than Humphreys (2012) general exploration of working in a children's hospice by looking at it through the lens

of motherhood. It aims to explore how motherhood shapes and is shaped by the therapy when another mother brings the topic of child-death, rather than working with the dying child itself. Moreover, how this work is experienced given that the mother-therapist has not experienced the death of one of her own children.

2.3. Synthesis of the literature, the gap this research aims to fill and aims for this study:

Drawing together the above literature, I conclude that motherhood is an experience that has the potential to shape a woman's identity and outlook on life (Smith, 1999a; Vejar et al., 2006). It therefore carries with it the characteristics of a specific and impactful personal therapist attribute that in the notion of intersubjectivity carries the potential to shape the therapeutic process, especially when the clinical work centres on child-rearing issues and/or children (Saltzberg & Bryant, 1998; Norcross & Guy, 2007; Basecu, 1996; Adams, 2014). Studies that focus on mother-therapists' lived experiences of how their motherhood shapes their clinical work are however sparse.

Furthermore, the death of one's child is an issue that has been classed as a parent's greatest fear (Cadranell, 1994). It can lead to symptoms similar to trauma (Klass, 1996) and complicated grief (Hindmarch, 1993). The yearning and mourning for one's child can take an embodied form (Young & Dowling, 2012). For mothers, due to their often great involvement in a child's everyday care, it can furthermore lead to the loss of a daily routine and identity (Riches & Dawson, 2000; Rando, 1991). Coming into contact with child-death has been found to deeply affect professionals (Barbee et al., 2016; Gilbert, 2006; Humphreys, 2012). Nonetheless, there appears

to be a lack of literature that investigates the lived experience of therapists working with child-death in general, with the exception of Humphreys (2012) and Gosney (2017), and for mother-therapists working with bereaved mothers in particular. The combination of these aspects constitute the gap in the literature that this research aims to fill.

As stated in the introduction, this research aims to create insight into 'motherhood in the therapy room' through the sameness of gender (women) and roles (mothers), yet the difference of the experience of a mother's 'ultimate tragedy' (Schiff, 1977) (child-death). Honing in on how motherhood might shape the work will create insight into the intricacies of therapeutic work and its reciprocal nature through exploring firstly, how mother-therapists experience this work; secondly, how they feel that being a mother shapes this experience/the work; and thirdly, how this experience shapes the mother-therapists' ongoing personhood (motherhood/mothering) and professional practice.

The literature review that I engaged with shows that this particular research with this particular therapeutic dyad appears not to have been done before. This is the contribution that this research makes to the existing literature. In turn I hope that this study will add to the practice of counselling psychology and psychotherapy by further noting the impact that motherhood can have on the therapeutic process, and thus add to literature used in the teaching of trainees and for supervision purposes to promote reflexive working in therapists. I hope that it will furthermore contribute to the realm of bereavement work by offering referrers some aspects to consider when

deciding on how to prepare a mother-therapist before entering the work with a grieving mother. It may also give other mother-therapists, who are in the midst of this type of work or about to embark on it, some insight into how other mother-therapists negotiated between their roles of mother and therapist. In addition to this academic and clinical contribution, I hope that I personally will gain greater understanding of how to prepare myself should I come across such a referral in the future.

2.4. The research questions:

The research questions I have created in order to achieve the above mentioned aims are as follows:

1) How do mother-therapists experience psychotherapy with grieving mothers?

2) How do mother-therapists feel that their role of mother shaped their work with these clients? And how do they feel that this work shaped their roles of mother and therapist?

Chapter 3: Methodology and Method:

Good quality research should align epistemology, methodology and method and therewith point to an internal consistency of the study (Carter & Little, 2007). In this chapter, I outline my personal epistemological stance and how this led me to choose Interpretative Phenomenological Analysis as a research method. I also discuss other methods I considered. I then move to describe the method, the design and execution of this study.

3.1. Methodology:

3.1.1. Personal philosophical perspective:

My personal epistemology is informed by existential concepts and post-modern philosophies of social constructionism (Lynch, 1996). I align myself with existential philosophers such as Heidegger ([1927]1962) and Merleau-Ponty ([1945]1962) who consider knowledge to be co-created through an interplay of language, culture, era, social context as well as our pre-established biases through which we interpret reality. I agree with Heidegger and other existentialists that there are inherent meanings in the world. However, as suggested by Heidegger ([1927]1962), I believe that we are unable to fully bracket our pre-knowledge and social embeddedness. Thus, we are unable to grasp this reality in its purest form. This means that I consider myself to hold a critical realist stance (Guba & Lincoln, 1994).

Holding this epistemological stance as an integrative psychotherapist and counselling psychologist in training means that I consider myself to be inextricably present in my work with clients, adopt a reflexive stance in terms of how I impact the process of therapy and thus take a relational position to therapy (DeYoung, 2003) as

discussed above. As a researcher, I also align myself with writers who promote a relational stance to research, such as Finlay and Evans (2009). I consider that the knowledge created from the research and interviews is co-created through the interplay of researcher and researched (Rubin & Rubin, 2012; Gergen, 2009; McLeod, 1999). This position mirrors my stance on therapy and integrates Heidegger's existential principle of intersubjectivity. It implies that I consider myself to be central to the research and active in the creation of meanings that emerge from this study. Being a mother-therapist myself, studying the experiences of other mother-therapists therefore means that I bring a great deal of pre-knowledge and bias to the phenomenon under study. Pre-knowledge, which needs to be 'bracketed' (Husserl, [1900] 1970) in order not to obscure the findings. Nevertheless, as suggested by Finlay and Evans (2009), I agree with the view that our biases cannot be fully bracketed. They will inevitably shape the research. This ought to be embraced and reflected upon. Within this dual notion, I consider it necessary, as Mantzoukas argues (2004), to neither over- nor underestimate the impact of my researcher self on the study, but to try and keep a balance of embracing the phenomena as they represent themselves and be reflexive within how they have been shaped.

3.1.2. Why qualitative:

The research questions that I outlined in the previous chapter are around wanting to explore the lived experience of mother-therapists' work with mothers whose child has died. I understand that in addition to motherhood this lived experience will be further shaped by these mother-therapists' overall experiences of themselves, their client's personhoods, the phase of their lives and the contexts of their practice. My aim

therefore is to explore a phenomenon, which will be uniquely experienced by this set of participants, and might be experienced differently by others, and potentially also by the same participants at a different time of their lives. This notion of temporality concurs with my critical realist stance. Since epistemology and research questions guide methodological choices (Carter & Little, 2007; Finlay, 2006; McLeod, 1999), I concluded that a qualitative approach to research was most appropriate to this study, due to my critical realist epistemology and wanting to learn from individuals lived experience. My research therefore stands in contrast to quantitative research, which tends to be concerned with measuring and creating general laws about the world we live in (McLeod, 1999; Lynch, 1996; Willig, 2001).

3.1.3. Why Hermeneutic Phenomenology:

Qualitative research is, as Polkinghorne (2005) calls it, 'an umbrella term', which embraces numerous language based research methods – all along the continuum between the positivist and the postmodern paradigms. In addition to the research questions, it is a researcher's ontological and epistemological stance that should be reflected in the chosen research method (McLeod, 1999).

Phenomenology is a philosophical approach to the study of human existence with a focus on the lived experience of individuals, which is what this research aims to explore. Phenomenology was developed in the early 20th century in opposition to the then dominant Cartesian approach to knowledge that argued that objectivity existed independent of human interactions and could be measured and documented as facts if the data was collected in a controlled manner (Langdridge, 2007). The founder of phenomenology, Husserl ([1900] 1970), postulated that all investigation should be

based within our 'lifeworlds' (Lebenswelt) and focus on actual lived human experience itself as a means of creating knowledge and to arrive at the deeper meanings of life. He advocated an idiographic approach to his inquiry, which means that he focused on creating deep understanding of a small group rather than establishing general rules or laws (nomothetic), as is common in positivist research (Langdridge, 2007). Despite his focus on lived experience, Husserl held a transcendental position, where he considered it possible to stand outside our 'natural attitude', which he called the biases and taken-for-granted assumptions that we attain through our experiences of being in the world, and which he felt were not taken into account in positivist research. He argued that it was possible and necessary to put aside this natural attitude through the practice of epoche/bracketing, in which one becomes fully aware of one's taken-for-granted beliefs of the world around us and steps outside them. This in turn would allow the individual to see the phenomenon in its true essence (Husserl, [1900] 1970). The description of the phenomenon as seen from this transcendental position was one of his main aims for phenomenology. He considered this to be a way of uncovering the essences that underlie the individual experiences/perceptions of objects. As I outlined above, I do not consider it possible to achieve full bracketing but instead view us to be too embedded and part of our environment to fully step outside of it and adopt a view from which we can see the phenomena in their true form. I therefore chose not to adopt a pure phenomenological approach to this research, as for instance outlined by Giorgi (1989).

Instead of the pure phenomenological philosophies, I am more aligned with Heidegger ([1927] 1962), a former student of Husserl, who diverged from Husserl's

phenomenological views on reductionism. Heidegger marked the beginnings of hermeneutic phenomenology and existentialism through his introduction of interpretation to phenomenology and emphasis on the ontological questions of existence. Heidegger ([1927] 1962) construed our existence as a dynamic 'being-in-the-world' (Dasein), which resembles a verb-like notion to living. Inherent to his views of being-in-the-world was that at the beginning of our existence we were 'thrown' into this world, a world that was already full of meanings, objects, language and people. Existing to Heidegger therefore incorporated a temporal aspect, in which our experience of ourselves in the present involves our past as well as our projection of our future. It creates a picture of humans as having freedom to choose and create themselves, as their existence is dynamic and not fixed. However, being thrown into a world that pre-dates us limits this freedom, since the world into which we are thrown ultimately shapes our experience of being-in-the-world and the choices we can or believe we can make. A concept which Heidegger called 'facticity' ([1927] 1962). Thus, being-in-the-world means a person is always in relation to something and is engaged in shaping and being shaped by their environment. They are 'intersubjective' (Smith et al., 2009). Despite this intersubjective position, Heidegger advocated bracketing our preconceptions when exploring a phenomenon so that one could focus on the thing as it appeared, and could reflect on the potential impact of one's biases. Unlike Husserl, he considered it impossible to fully transcend our natural attitude and achieve a stance outside our being-in-the-world. This social embeddedness and 'worldiness' (Heidegger, [1927] 1962) meant that all description of phenomena was interpretation as it was intrinsically shaped by the context in which it was experienced and described. Heidegger therefore introduced a hermeneutic aspect to phenomenology.

Hermeneutics itself is an ancient separate body of thought, which was originally concerned with the interpretation of biblical texts. Over time, it was taken up as a philosophical underpinning for the interpretation of a much wider range of texts (Smith et al., 2009). By introducing hermeneutics to phenomenology, Heidegger attempted to move beyond the description of experiences to finding meanings embedded in everyday occurrences. Heidegger ([1927] 1962) did so through the adoption of the 'hermeneutic circle'. The idea presented in the hermeneutic circle is that one's understanding of the whole text is created by reference to the individual parts, such as the era it was written in, the words used etc. One's understanding of the individual parts in turn is created with reference to the whole. Thus, one shapes the other. The change of an individual part will therefore modify the shape of the whole. Text should therefore always be considered within the context it was created and within which it was interpreted, since the reader brings their set of fore-conceptions to the reading of the text too.

As I outlined in the beginning chapters, I consider myself to be a relational practitioner and researcher holding the concept of intersubjectivity at the heart of the therapeutic encounter, research and life itself. Heidegger's outline of our 'worldiness' therefore resonates with me and resembles my own ontological views of existence. His views on interpretation and the importance of considering the individual features to make sense of the whole and vice versa mirror my own views on creating insight into a phenomenon.

Another existentialist that has influenced me and is relevant to this research is Merleau-Ponty ([1945] 1962). His focus on embodiment seems particularly relevant

due to the concept of the embodied experience of (birth-) motherhood that I outlined in the previous chapter (Hollway, 2016). Merleau-Ponty depicted the person as a 'body-subject', with consciousness embedded in the body. He thus argued that body and mind could not be separated. Instead, we live, experience and make sense of the experience through our body-subject. He furthermore emphasised the notion of spatiality and argued:

'*Our own body is in the world as the heart is in the organism: it keeps the visible spectacle constantly alive, it breathes life into it and sustains it inwardly, and with it forms a system.' (*Merleau-Ponty, [1945] 1962: p.203)

He therefore furthered the notion of an intrinsic connection between the body, mind and the world, and that it is always within this system that we create meanings. He argued that our perceptions of phenomena always start from our own embodied perspective, which will always be unique to us. Thus, our relations to others begin from a position of difference, for my embodied experience can never be the same as another. As a result, Merleau-Ponty like Heidegger did not believe in full bracketing. He furthermore referred to temporality, as also outlined by Heidegger, and argued that what was true in one situation might not be perceived as true in another, therefore also emphasising the impact of context. Thus, like Heidegger, Merleau-Ponty believed that interpretation was what we could achieve through the exploration of our life-worlds rather than description of its essence.

As outlined above, my own ontological stance is aligned with Heidegger's dynamic views of being-in-the-world. Furthermore, Merleau-Ponty's ([1945] 1962) concept of the body-subject that embraces the embodied nature of our existence, experience

and meaning making speaks to me, in particular in light of my stance on the embodied experience of motherhood. I therefore agree with the notion postulated by Heidegger and Merleau-Ponty that all knowledge is co-created between the individuals involved. Even though bracketing should be practiced, full epoche is not possible. Meaning should therefore be seen and read with a consideration of the context that it has been created in and the audience it has been created for.

Considering all of the above made me conclude that hermeneutic phenomenology seemed most appropriate for the purpose of this research project.

3.1.4. Why Interpretative Phenomenological Analysis (IPA):

As phenomenological psychology and existentialism gained in popularity and practice, several research methods were created that embrace the ideas of hermeneutic phenomenology and aligned philosophies (Langdridge, 2007).

IPA as outlined by Smith et al. (2009) appealed to me due to various reasons. Firstly, IPA is based on a critical realist epistemology and rejects the notion that full bracketing is possible. Instead it embraces Heidegger's ([1927] 1962) and Merleau-Ponty's ([1945] 1962) versions of phenomenological enquiry and use of but not reliance on bracketing. Secondly, it is idiographic rather than nomothetic. And thirdly, it is explicit about the impact of the researcher on the study and advocates reflexivity. IPA is transparent that it is not just participants who create meanings of their experiences in the interviews, but that this meaning-making is shaped by the presence of the researcher. It furthermore embraces that the meanings derived through the analysis will be a further interpretation of the data by the researcher – it

applies a double-hermeneutics (Smith et al., 2009). All these factors address the issues I wanted to include in my research.

My opinions on interpretation furthermore concur with Smith et al. (2009) when they draw on Schleiermacher (1998) who argued that through interpretation one was able to bring new insight about the researched to the table. This feels in line with my attitude to my clinical practice, where I do see myself to have a new set of eyes on my clients' lifeworlds, shaped as a counselling psychologist in training by psychological theory. Whilst within this research project, I consider my interpretations to bring something new to the wider understanding of the phenomenon I researched. Nonetheless, I agree with Gadamer ([1975] 1996) who limited this notion of knowing the researched better than the researched him/herself, in that this is only possible within the text or situation in front of us.

In addition, IPA promotes the in-depth investigation of a small and relatively homogenous sample. Applying this method thus allowed me to interview fewer participants, but immerse myself deeper into their lived-experience with the aim to establish greater insight into it and create meanings from the understandings of my participants' experiences for the wider population of counselling psychology and psychotherapy.

3.1.5. Alternative Methodologies:

During the preparation phase and design of the study, I considered several other research methods namely, Discourse Analysis and Narrative Analysis. I give a brief overview of them and reasons why I chose not use them.

Discourse Analysis looks at how language is used to construct experiences, power relationships, in- and outgroups (Wetherell et al., 2001). My focus in this study is on the actual experience and meaning making of participants' experiences rather than how these experiences are created with language, though reflection on language did form one stage in the coding cycles (Saldana, 2009; Finlay & Evans, 2009). Furthermore, Discourse Analysis often applies a strict post-modern paradigm, which considers that there are no inherent meanings in the world and that all experience is socially created (Lynch, 1996). This more extreme line of social constructionism goes somewhat beyond my critical realist epistemology, which might have created challenges in the analysis (Carter & Little, 2007). For I might have struggled to stick with what participants created through language and not look deeper into meanings and what this might say about my participants' lived experiences as mothers and therapists.

Narrative Analysis was the other method I considered. Narrative Analysis is interested in the full narrative of participants, and the stories that they tell. It is often used to give a voice to marginalised groups (Etherington, 2004). As I stated above, the focus of this study is on the subjective experience of working with a sensitive issue (the death of a child). Death in itself is a topic that is often unspeakable in public, the death of a child even more so (Riches & Dawson, 2000). How we as mother-therapists might be affected by working with this client group is furthermore an under-researched topic, as can be seen through the literature review. Thus, there were several aspects that drew me to Narrative Analysis. Nonetheless, Narrative Analysis tends look at the whole story, whereas IPA looks at the experience and the

content of the phenomena under study. In addition, Narrative Analysis has been linked more closely to a realist epistemology (Crossley, 2007). IPA, on the other hand, despite assuming subjectivity places it in relation to the world and context, and how this would shape an individual's subjectivity. Thus, I felt that IPA was more in line with my epistemological and ontological position and reflected best my aims for this research project.

Despite choosing IPA over these two approaches, I consider that either of them could add other interesting angles to this research and produce different, yet not less valid analyses.

3.1.6. Validity:

Over recent years, qualitative research has become more vocal about applying methods of testing validity that are different to methods that measure positivistic research, as those scales have been found largely inadequate when applied to qualitative research (McLeod, 1999; Langdridge, 2007). Validity and quality of qualitative research should be arrived at through being '*trustworthy and transparent in its process and impactful in its outcome'* (Finlay & Evans, 2009 p. 59). Furthermore, reflexivity plays a key part in assessing qualitative research in general (McLeod, 1999) and IPA in particular (Smith et al., 2009). Langdridge (2007) discusses the difficulties within qualitative research to apply one set of criteria against which to measure validity of all qualitative research due to the wide range of research methods that are clustered under the umbrella of qualitative research. Due

to this pluralist aspect of qualitative research, an application of more and varied ways of measuring validity should be applied, since different methods require different ways of being assessed and judged. Yardley (2000) considers this need for a pluralist approach a strength of qualitative research, as it embraces the notion of multiplicity in research and the creation of co-created, non-realist truths.

Within IPA Smith et al. (2009) advocate Yardley's (2000) four principles for assessing validity. Despite reading around different measures of assessing the validity of phenomenological research, such as Finlay and Evans (2009) criteria of the '4 Rs', I decided to adopt Smith et al.'s (2009) suggestion of Yardley's (2000) four criteria. They seem compatible with this research because they can be met in several ways, as they are quite broad. Yardley's criteria furthermore provide general guidelines rather than a check-list approach to validity, which fits with this type of project. Furthermore, her criteria are not specific to a theoretical orientation and therefore can be applied to a variety of research projects. This makes comparison between the validity of projects somewhat easier. The four principles proposed by Yardley are: *sensitivity to context, commitment and rigour, transparency and coherence, impact and importance.* Below I outline how my research approaches each of these principles.

Sensitivity to context:

Smith et al. (2009) state that sensitivity to context, especially when researching a 'sensitive topic' (Dickson-Swift et al., 2009), needs to start in the design of the study and the participant recruitment. From the beginning, it was clear that I needed to be mindful in my approach to reaching potential participants due to the personal

meaning that child-death may hold for some practitioners. I therefore decided against telephoning counsellors/therapists. Instead, I opted to send emails (see appendix for an example email). Whereas with bereavement services etc. I did use the phone to make initial contact. I therefore feel I paid attention to the context and topic matter of this research.

Within the interview phase, I was aware that I was interviewing participants on a potentially emotive clinical experience. I paid attention to their emotional process throughout the interview process and attuned to them in an empathic manner when recalling their experiences made them emotional (Rubin & Rubin, 2012). I furthermore embraced Haverkamp's (2005) position on power-imbalance in the research process and aimed to stay mindful of the dynamics and the power relationships between participants and myself in the interviews as well as when coding and interpreting the data. The latter I did by immersing myself into participants' narratives and their experiences. Reading the transcripts whilst listening to the recordings simultaneously helped me do this. Further along the coding process this activity also helped me to analyse our process. I showed sensitivity to context throughout my presentation of the findings by outlining the themes with considerable amounts of verbatim of each participant and thereby giving them a voice, as suggested by Smith et al. (2009). In the write up of this research, I showed sensitivity to context by outlining the different realms of the literature that this research fits into and elaborating on the literature in light of the findings in the discussion of this research.

Commitment, as outlined by Yardley (2000), comprises of attentiveness to the participants during the data collection and the careful analysis of each case. I show this through the attentiveness to participants as stated above as well as that by using IPA, I engaged in an idiographic and iterative analysis of the data, which meant that I considered each case and participant individually with regards to the research questions (Smith et al., 2009).

Rigour refers to the thoroughness of the study, which in the context of IPA Smith et al. (2009) state includes the appropriateness of the sample to the question in hand, the quality of interviews and the analysis. I used the research questions and the concept of homogeneity inherent in IPA to draw up my participant profile. When within the recruitment process it became apparent that these criteria did not match the reality of the mother-therapists I reached, I took great care in widening these criteria several times using feedback from professionals, agencies, consultations with supervisors, peers and reflective writings. The execution of this 'flexible sampling' strategy (McLeod, 1994) was thus done thoroughly and thought through. Where there was greater variation between participants, I was transparent about it and reflected on how this could impact the dynamics of individuals' experiences. I showed rigour in the interview stage by conducting in-depth interviews with my participants. Brinkman and Kvale (2015) argue that good-quality interviewing means that participants might themselves come to new insights and meanings about the phenomenon they are interviewed about, which some of my participants did. Within the analysis, Smith et al. (2009) suggest that rigour is shown if the findings strike a

balance between the descriptive – focusing on each participant's individual experience, and the interpretative – creating meaning from what the participants say that goes beyond the individual. I chose to use narrative accounts to make participants more visible, thereby creating a focus on the individual. I furthermore used themes and interpreted them in the light of the wider literature. Hence, I also struck the hermeneutic component of IPA.

Transparency and coherence:

Yardley (2000) suggests that transparency refers to the description of the individual stages that the research has taken throughout the process. Within this write-up, I have been clear and transparent about the research decisions that I have taken. I have incorporated reflexivity to enable the reader to get a sense of how I impacted the research whilst attempting to minimize this impact and focus on participants' experiences (Mantzoukas, 2004). I furthermore included the final table of themes. I added an appendix, which includes an extract of one participant's transcript with coding, a trail of emerging themes, an extract of one analysis and a collation of all the quotes used in the findings section with their location in the transcripts. The appendix also holds a copy of the recruitment poster (which contains the initial recruitment criteria), the participant information sheet (which includes the criteria post widening), a copy of the consent form, as well as the initial interview schedule.

Coherence, on the other hand, refers to the presentation of the piece, whether the argument can be followed, whether the themes hang together logically and how contradictions are accounted for and made sense of (Smith et al., 2009). Throughout

this research, I held the line that our personhoods impact our experiences in the therapy room and vice versa. I explored how this could be the case for mother-therapists who work with mothers whose child has died. The themes I created as a result of this exploration address the research questions and/or add important information about the argument – our personhood in the therapy room – which will increase readers' understanding of the phenomenon – motherhood in the therapy room.

Impact:

Yardley's (2000) last criterion of validity is impact of the study on the wider field. I align myself with Smith et al.'s (2009) argument that impact carries an individual aspect, since what might create an impact and resonate with one person may not hold much interest for another. Nonetheless, I consider this research to contribute and expand both practitioners' and academics' understanding; broadly of how our personhoods shape and are shaped by our professional encounters, especially if there are demographic or other similarities in the room. And more particular with regards to clinical practice within the area of bereavement work, how working with a bereaved mother may be experienced by and impact a therapist who is a mother herself.

3.1.7. Limitations of Interpretative Phenomenological Analysis:

In an outline of IPA, Smith and Osborne (2003) position IPA as an alternative to descriptive phenomenology. It was designed to build a connection between the cognitive and discursive psychologies. It is this alignment with cognition that has been critiqued by several phenomenologists and researchers (Willig, 2001; Langdrige, 2007; van Manen, 2018) in that they consider phenomenology to be at odds with the underlying philosophies of mind and body split, which are inherent in cognitive psychology. They argue that the attempt to bridge the two realms creates a philosophical dissonance and does not position IPA clearly in the phenomenological realm (Langdridge, 2007). In fact, van Manen (2018) argues that IPA should be called 'Interpretative Psychological Analysis', since he feels that IPA is too assumptive of individuals' inner states and therefore not clearly aligned with the phenomenological principle of exploring the inceptual meanings, insights and significances with respect to human experiences. He feels that IPA researchers often miss the dynamic, multi-dimensional, embodied and intricately connected part of phenomenological exploration. Instead, he argues, they apply a more superficial 'making sense' attitude towards experiences.

As an integrative counselling psychologist in training, holding a critical realist epistemology, I see less of a problem with these critiques. For I agree with Schleiermacher's (1998) notion that the interpretations that we make can reveal something new and deeper about the phenomenon, which the individual participant might not have been aware of, as I discussed above. Even though this is not a direct link to cognition, it does suggest that interpretation creates a different aspect to the phenomenon. An aspect that might not be 'visible' to the individual who is living the

experience. Thus, for me this 'bridge' feels less problematic. Instead, I consider it as a sign of the pluralistic aspect of reality and represents my comfort with integrating multiple paradigms. I furthermore attempted to embrace a multi-dimensional, embodied and emotive approach throughout this research process, and tried not to take a superficial 'making sense' approach as suggested by van Manen (2018).

A difficulty that I personally encountered with IPA has been the concept of homogeneity. Smith et al. (2009) argue for the recruitment of a small but 'purposive' (Polkinghorne, 2005) and relatively homogenous sample in order to create an in-depth exploration of the sample's shared experience. Smith et al. (2009) and Langdridge (2007) postulate that a common experience, such as the transition to motherhood, would call for a sample of participants that share other demographics, such as being a teenage-mother, to be homogenous. Whereas when researching a less common experience, for example, the transition from man to woman (Langdridge, 2009), the mere sharing of this experience would suffice to make it a homogenous group. Since this research seems to sit between the two notions of a common experience and a less common experience, I struggled to find the right balance between being specific enough whilst allowing for enough variation in order to recruit a meaningful sample. What I have learnt from this struggle is that the notion of homogeneity and its transition from the theoretical stage of designing the study to the reality of conducting the study needs to involve greater consideration in terms of whether what may seem an ideal level of homogeneity is also a realistic level in order to achieve the desired size of the sample. (I will reflect more on this issue under point 3.2.2.)

3.2. Method:

In this section, I outline the execution of this study. I submitted my research proposal in August, 2016 and went to the Programme Approval Panel (PAP) in October, 2016. After submitting the suggested amendments to the proposal, I submitted my ethics form. In order to follow the time-line of this study, I decided to start this section with my ethical concerns, as these were the ones I had taken into consideration in the design of the study and thus inform the following parts of this section.

3.2.1. Ethical Approval, my views on Ethics and considerations for this study:

Ethical Approval:

I submitted my ethics form at the beginning of February, 2017 and gained ethical approval from the Metanoia and Middlesex Ethics Committee on 20th February, 2017. (See Appendix for a copy of the ethics approval by Metanoia.)

My views on Ethics and considerations for this study:

In addition to attaining ethical approval for a research project, researchers have become more tuned into the ethics in the conduction of the research (Stark, 1998), such as the asymmetrical power-relations between researcher and participant throughout the research process (Haverkamp, 2005), which do not disappear once official ethical clearance has been achieved (Langdridge, 2007).

One way that qualitative researchers have attempted to create, as Haverkamp (2005) calls it, greater 'trustworthy' relationships with participants has been through adopting a stance of holding *'respect for the dignity and welfare of others'* (Stark, 1998 p. 203). Another approach to lessen power-differences between researcher

and participants is through greater involvement of participants in the research process – such as through gaining participant feedback, which has also been promoted as a means of verifying a study's validity (Finlay & Evans, 2009). Within this discussion, I align myself with, amongst others, Haverkamp (2005) and Finlay and Evans (2009) who argue that despite these attempts to reduce the power imbalance between researcher and participant it remains to some degree. Participants may feel obliged to agree with the researcher in the checking of their interpretations precisely because of these power-relationships (Langdrige, 2007). Thus, Finlay and Evans (2009) question how much focus should be paid on participant feedback in terms of validity for a study. (For a further elaboration of validity in this study, see point 3.1.7.).

In light of these arguments, ethical research requires an ongoing awareness of the power-dynamics and a mindful as well as respectful handling of the relationship between the researcher and participants, which keeps in mind the safety, welfare and dignity of participants (Haverkamp, 2005; Orlans, 2007; Langdridge, 2007; Stark, 1998). Whilst a relational stance to research can help minimize these dynamics, a reflective attitude of their impact on the research process should also be embraced (Finlay & Evans, 2009). The British Psychological Society's Code of Ethics and Conduct (2006) holds this concept of ethics as a process, rather than a list of rules, as does the BACP's Ethical Framework for Good Practice in Counselling and Psychotherapy (2010). I therefore adhere to both of them within my research.

For this research project, I was from the beginning aware that I was dealing with a 'sensitive topic' (Dickson-Swift et al., 2009), which carries the potential to impact

both the participants and the researcher. I thus needed to be sensitive in my relating with participants and treating of their stories (Dickson-Swift et al., 2009). There were occasions within the interviews where I chose not to follow up something, as I had a sense that this might open places that participants might not be prepared to go. Other times I worded questions tentatively and carefully in order not to unsettle participants. I thus embraced Haverkamp's (2005) outline of putting the well-being of participants first and manage the power-imbalance in the room. Moreover, I needed to not only protect the confidentiality of participants but also that of their clients (Haverkamp, 2005). As a result, I had to omit some data from the final analysis due to concerns over whether or not the case would be identifiable.

I used the above mentioned participant checking in so far that I sent the transcripts to my participants to check if they felt that I had misrepresented any aspect of our interviews, they wanted to edit any part or add anything to the transcripts. Due to the limits that I outlined above around further participant checking (Finlay & Evans, 2009; Langdrigde, 2007), I chose not to send my interpretations of the data to participants. My position on interpretation, which depicts my meaning-making as offering a new view to the material, as outlined by Schleiermacher (1998), implies that my interpretations might be somewhat different from the individual participant's views. This stance further encouraged my decision not to have the interpretations verified by participants.

Due to time constraints, I had to employ a professional transcriber to transcribe the second interviews. This was a difficult decision due to the issues of confidentiality as well as the sensitive nature of the topic. In order to ensure ethical and confidential

handling of the recordings, I posted the recordings on a memory stick as 'recorded and tracked delivery'. The transcriber, who was informed about the nature of the topic of the interviews before embarking on the work, encrypted the transcripts and deleted both the transcripts and the recordings once she had sent me the final documents. I thus have full confidence in the confidential and ethical handling of this process.

Dickson-Swift et al. (2009) furthermore state that the impact of 'sensitive topic' research might not just be on participants but the researcher themselves. As can be seen through my reflections in the introduction, I was deeply impacted by participants' experiences, their clients' stories and the children that had died. It evoked a personal memory of a bereaved family I had held inside. My emotions were strongest during the process of transcribing the first interviews, as well as during the coding phases, especially when reading the transcripts and listening to the tapes at the same time. In addition, the stories about bereaved families and the children that died that I read about in the literature often brought deep and dark emotions out in me. In these moments, I allowed myself to feel and release the grief for these children and families. I was aware of wanting to hold my children and feel comforted by their health. Keeping in mind why I felt this way helped me through this. There were times when I questioned why I chose such a painful topic whilst also feeling confirmed in its importance. Since because of this pain, we avoid talking about it and its effects on us, as the literature review showed.

In line with Dickson-Swift et al.'s (2009) recommendations, I aimed to stay mindful of my process through ongoing reflections, as well as through discussions with

supervisors and peers. In addition, extensive reflective writings about the impact of this research on my personhood helped me negotiate it. An awareness of the symptoms of vicarious trauma furthermore helped me respond to my needs in relation to this research. For instance, knowing that my hypervigilance to health was not necessarily a sign that my children or I were sicker. Interpreting this as a 'side effect' of conducting this research and being confronted with the reality of death instead, helped create distance to it and rationalise my fears.

3.2.2. Participant Criteria and Recruitment:

Determining the selection criteria and rationale for including participants in a qualitative study is an important initial step in conducting research' (Suzuki et al., 2007 p. 299).

My inclusion criteria, which were informed by the literature, a pilot-interview that I conducted and my research questions, were originally rather broad and included any mother-therapist who had worked with a mother whose child had died, regardless of children's ages, types of qualification, or types of death. Following my presentation of the research at the research panel, it was suggested to me that these inclusion criteria left room for a lot of in-sample variation. I was advised to be much narrower in the inclusion criteria in order to reach greater homogeneity, as it was felt that this would allow for a deeper exploration of a shared experience. This recommendation was given to me with the view that if the criteria became too narrow they could be widened.

My initial inclusion criteria thus were as follows:

Participants need to be qualified psychotherapists/counselling psychologists/clinical psychologists (of any orientation) and registered either with the BACP/UKCP/BPS. They need to be active mothers of children under the age of 5 and not have suffered a miscarriage, loss of a child themselves or are pregnant at the time of the interview. They need to have worked with mothers who were grieving a child no older than aged 7. This child should have died of reasons unforeseen during pregnancy and after being born.

I aimed to recruit 3-4 participants and interview them twice.

I used 'snowballing' (McLeod, 1994) as a recruitment method, which meant that I sent the recruitment poster to colleagues and peers, who in turn sent it to other colleagues. I contacted hospices within the West Midlands and London area, both children's hospices and adult hospices. I contacted bereavement services, some of which specialised in working with bereaved parents/families in the West Midlands and got in touch with several children's hospitals locally and the London area as well as NHS psychology departments. I furthermore advertised through the Counselling Psychology Newsletter, the website of 'Child Bereavement UK' and 'Cruse' (following gaining ethical approval from their own research committee) and emailed counsellors, therapists and psychologists of the 'Counselling Directory'.

Despite positive feedback and general interest in the study, recruitment was unsuccessful for several months. This felt like an incongruence, which left me feeling confused but also curious. How could it be an exciting, interesting research yet no one came forward to take part? Reflecting on the general positive feedback from

practitioners who themselves did not fit the inclusion criteria, I concluded that rather than the research question or topic being the issue, it might have been due to the narrow inclusion criteria and potentially other factors. I therefore decided to widen my criteria on a couple of occasions. The university agreed with me that in order to make this research come off the ground I needed to allow for more variation within my sample.

Yet, the inclusion criteria did not seem to be the only obstacle that prevented mother-therapists from coming forward. During my attempts to recruit participants, I had a lot of feedback from agencies and professionals. I think it is of value to the reader to gain some understanding of the reasons why some mother-therapists chose not to participate and my reflections on them. I think this will help create insight into this research and the topic under study. Firstly, working with child-death is an issue that some mother-therapists choose not to engage with due to its potential impact on their personhoods. Secondly, some mother-therapists, though having worked with child-death, were concerned that the interviews might bring up issues for them that were too close to home. Thirdly, a lot of grief work is done less formally in group settings through other bereaved parents (Schiff, 1977), or systemically when the therapist works with the whole family not just the mother (Kissane & Bloch, 2002), as is common in hospice settings. Fourthly, lack of time and lack of identification with the research topic might have been an additional reason. Lastly, reflecting on my recruitment posters and emails, I, as a fellow mother-therapist remained largely absent. Thus, rather than creating a transference that portrayed me as being interested in their experience as a fellow mother-therapist, it might have created a transference of me as a more distant researcher. Sharing a sensitive experience

within this pre-transference might have felt unsafe or as opening themselves up to judgement and pain. Hence, unconsciously perceived power-dynamics might have been at play when potential participants decided that this research was 'too close to home'. This final consideration comes as a result of reflecting on the participants who I did interview. All but one came through word of mouth and either had heard of me and the research through a third party known by both of us, or they knew me through previous professional involvement. Thus, a positive and safe transference might have been established before meeting me.

Considering these aspects and the voices that are therefore not represented in this research project means that the voices that are represented in this research consist of mother-therapists who firstly, felt they could take on this work, secondly, felt they had something to say about this work and thirdly, felt that they could talk about this work in a research environment. As Polkinghorne (2005) states:

'*Thus, gathering participants involves not only choosing those who fit a selection strategy but also finding people who are willing to be interviewed.*' (p. 141)

The obstacles I encountered in this recruitment process thus highlight the concept of 'inclusion bias' (Polkinghorne, 2005) in qualitative research and purposive sampling in that usually only those who feel they have something to say on the topic will be included or come forward to the study, resulting in other opinions not being taken into account (Suzuki et al., 2007).

Influenced by Polkinghorne's above statement, I applied a more open approach to sampling, which meant that I went to see who was prepared to be interviewed about their work with a bereaved mother. Doing so meant that I could include my pilot interview in this research project, who did not fit the initial inclusion criteria. I furthermore managed to recruit another five mother-therapists. I interviewed all mother-therapists twice (the participant from the pilot only once as I could include her first interview), with full consent, which included consent to the material being published.

Following these interviews, I had a further review of my sample with my supervisor and with the head of research at Metanoia. It was felt that within this sample of six mother-therapists there was a range of in-sample variation, which could be split into two separate samples. Sample 1: consisting of four mother-therapists who were either in training or fully qualified counsellors/psychotherapists/psychologists with children under the age of 16 at the time of their first interview, and who had worked with mothers whose younger child had died (0-16). Sample 2: two mother-therapists who were volunteer-counsellors and mothers of older children (+16), and who had worked with mothers whose older child had died (+18). Due to their differences in training routes, professional status and ages of the children it was felt that they should not get mixed in an IPA study. Keeping them separate meant that homogeneity of either sample would be greater and thus more desirable for an IPA study.

Since this doctorate is in the area of Counselling Psychology, we decided that the analysis would be on the interviews of sample 1 only. However, since all participants

gave consent to publication, it was suggested to me that the data of sample 2 could be used in a separate piece or be used in combination with sample 1 following the completion of this doctoral research project. Moreover, despite the mother-therapists from sample 2 not featuring in the analysis of this thesis they are present silently in the structure of the research. They were the first two interviews (after the pilot interview) that I conducted. They therefore greatly challenged some of my biases, such as my belief that this work would constitute only challenges and make mother-therapists scared that their own children would die. I learnt through these two interviews that within this work there was potential for connection, mutuality and deeper appreciation of life. Learnings, which widened my researcher lens.

Due to participants' consent suggesting that their data could be used for publication, I concluded not to inform the two mother-therapists of the decision not to include them in the data analysis for this project. For if I do publish a text that involves the data of the mother-therapists in sample 2 in the future, after telling them that their data would not be included, this might feel confusing to them. I arrived at this decision after careful reflection and consultations with a supervisor and a trusted colleague, who both questioned the ethics of informing participants about not being included. For participants gave their consent to use the data in a way that felt appropriate to the research, which in this case was not the analysis but the overall research, so they are still in the research. Furthermore, hearing that they would not feature in the analysis might make them feel that their contributions were less valuable or not good enough. It could be perceived as hurtful, which was the personal experience of my colleague who had been told that her interview would be

excluded from the analysis of a research in which she had taken part. The decision not to inform them is therefore a combination of all these reflections.

The recruitment process felt messy and created moments when I felt stuck. I felt anxiety around how to move forward and fears that this study would not happen. I had not foreseen these issues. I engaged in a lot of self-reflection and supervision in order to come to terms with these obstacles and arrive at a creative stance that enabled me to embrace and overcome them rather than to fight them. Nevertheless, this process taught me a lot about the intricacies of conducting qualitative research and the different hurdles that can emerge at various parts of the process.

3.2.3. Data Collection:

In order to collect data, I chose semi-structured interviewing as is common in IPA studies (Smith et al., 2009). Semi-structured interviewing allows the researcher to have a frame to hold on to and refer to when stuck as opposed to the unstructured interview (Rubin & Rubin, 2005).

All participants were sent the participant information sheet prior to the interview. At the beginning of the first interview, we signed the consent forms. Within the actual interviews, the interview-schedule tended to be in the background and the large part of my questions, prompts and follow-ups came from our narrative and relating at the time. This helped create a more conversational style, which has been advocated by Rubin and Rubin (2012). I sent the transcripts of the first interviews to participants between 14-7 days prior to the second interview, in order for them to have enough time to read them and comment on and to have them fresh in their minds. We

generally used the second interviews to expand and deepen aspects of the first interview and to add to our explorations. Several participants brought reflections that they had had after the first interview to explore in the second interview. All interviews were tape-recorded. With one of the participants, who I had to exclude from the analysis, the Dictaphone failed to record the second interview. Rather than repeating the interview, she preferred me to send her a detailed description/summary of the interview, which she read and approved of. Thus, in any subsequent analysis I will need to omit from using this second interview. Following this incident, I used two Dictaphones to ensure that all of the interviews would be recorded.

With regards to the interview process, I agree with the literature that conceptualises interviewing as an intersubjective experience in which participant and researcher co-create the data (Gergen, 2009; Rubin & Rubin, 2012; Suzuki et al., 2007; Smith et al., 2009; Polkinghorne, 2005; Finlay & Evans, 2009; Richards, 2009). I am aware that my questions, reflections and interpretations in the room shaped my participants' narratives. Furthermore, the interviews had a strong focus on motherhood. My first questions in the first interview were about their experiences of themselves as mothers and mother-therapists. They were intended to ease us into the experience and for us to establish rapport, as suggested by Rubin and Rubin (2012). Nevertheless, this also made us put on our 'matrocentric' (Athan & Reel, 2015) lens through which we conducted the rest of the interviews. This strong focus on being a mother will have shaped our reflections. Had we talked about the same experiences from a different perspective, the narratives would have had a different feel to them (Rubin & Rubin, 2012; Richards, 2009). In addition, some of the participants knew prior to the first interview that I was a mother-therapist myself, which might have

aided not just a cognitive but also embodied connection and trust between us. Yet, this will have also shaped our narratives in that they knew that I could relate to certain experiences, having had them myself.

Overall, within the data collection I aimed to focus on the experience of the individual participant in front of me. I tried to keep in mind Smith et al.'s (2009) '*balance between closeness and separateness, to be consistent in one's probing, picking up on important cues from the participant and digging deeper,' (p. 181)* within the interview process to create data that despite being co-created was not a mere reflection of my biases (Smith et al., 2009; Barker et al., 2002).

3.2.4. Demographic Data of the final sample:

The four participants that are included in this analysis lie on the following demographic spectrum. Due to the small sample size and in order to protect confidentiality, I have not matched these demographics to individual participants, even though some may become apparent in the narrative accounts.

Two of the four participants were British, whilst two were of European origin, as I am. Participants' ages ranged between early thirties to mid-forties. All four were mothers of children between the ages of 0 to 16 at the time of their first interview. Two of the four participants stated that they belonged to a church and identified as spiritual or religious, whereas two did not consider themselves to belong to any religion nor identified with the notion of spirituality. Three of the mother-therapists were qualified psychotherapists/psychologists whilst one was a trainee. Two were integrative, whilst one was psychodynamic and one person-centred. All of them trained in the UK. All

but one practiced one-to-one with adults, one was a child-psychotherapist who also did some parent-work and offered consultations to the parents of her clients.

One of the mother-therapists (Louisa) had had a miscarriage before having her live-children. Initially, personal miscarriage was an exclusion criterion from this study. However, this mother-therapist conceptualised the experience of a miscarriage as different (the loss of a fantasy) to that of a live-child (the loss of a reality). Her experience of her miscarriage was thus something that was difficult, but she knew she had and could survive. Whereas the death of one of her live-children was something she did not know if she would come through. It was her experience and personal conceptualisation of this difference why she identified with the research topic, and subsequently why I decided to include her in the final sample.

3.2.5. Data Analysis:

I carried out the data analysis according to Smith et al.'s (2009) outline. Having conducted two interviews per participant, I analysed one participant at a time, starting with the first interview, then moving to the second and finally cross analysing the two interviews before moving to the next participant. Once I had the final themes for each participant, I cross-analysed participants' final themes and arrived at 4 superordinate themes with 4-5 subthemes each.

In order to immerse myself into my participants' accounts, I read and re-read the transcripts both with and without the recordings. I made notes on the transcripts – first reflective notes on my narrative, then descriptive notes on the participant's and my narratives, followed by linguistic and interpretative notes. The final round of

coding involved going through the transcript line by line, reading the coding comments and see what themes emerged, as suggested by Smith et al. (2009). Following the noting down of emergent themes, I clustered them into large categories before analysing them and creating narrower categories through exploring relationships and differences. Considering the research questions, I began to form themes that addressed the research questions and themes that did not but could be used either in a different way to add something to the research, or could be discarded. Once I had created these (sub-) themes, I clustered them under over-arching categories, the superordinate themes.

The cross-analysis of all the participants' final themes created an iterative process whereby I compared all superordinate themes and their subthemes, going back to the transcripts to check the verbatim and see what themes addressed the same phenomenon and could be merged. I changed several themes around, dissected themes and noticed verbatim extracts that would better go under a different theme. This iterative process is in line with Smith et al. (2009) who state that the analysis is a continuous process, which often carries on through the writing up period.

Throughout this procedure, I was aware that another person would potentially interpret the text, use of language differently and 'find' different themes depending on their individual lens, as Saldana (2009) discusses. During this process, I was in contact with a private supervisor who checked over my interpretations, themes and reflections on them, which was helpful in order to ensure that I was not overly representing my biases and my processes within them. In other words, to ensure the validity of my interpretations.

Chapter 4. Findings:

This chapter presents my findings. I created four superordinate themes (SO) with four to five subthemes each. I aimed to capture the wholeness of participants' experiences, foregrounding the overarching argument that our personhoods shape our practice and vice versa. I thus focused on mother-therapists' experience of motherhood and its impact on their life and practice (SO 1). This in turn shaped their experience and handling of the clinical encounter (SO 2 and SO 3). Successively, these experiences shaped their personal and professional views and identities (SO 4). Several of the themes, especially the subthemes, overlap and some verbatim extracts could have gone into more than one theme. As I stated above, motherhood is only one of the aspects that will have shaped participants' experiences. Other personal attributes such as personality, past experiences etc. will have contributed to their overall experience, too. All mother-therapists were interviewed retrospectively. Only one mother-therapist was still working with the grieving mother when I interviewed her for the first time. Thus, the appraisals of their experiences represented in the findings were shaped by the experience. The themes are not a true reflection of how participants experienced this therapeutic encounter, but a reflection of how they remembered this experience and viewed the interrelationship between their personal and professional selves. This highlights a difficulty, which is inherent in research that reflects on lived experience. As Sartre (1957) states, in the moment of the experience the 'I' is absent. It only becomes objectified when reflecting on the experience retrospectively. Inherent to this position is that the reflection is already shaped by the experience. Thus, as Heidegger ([1927]1962) proposed, all descriptions of events are already interpretations. The findings and their subsequent discussion should be seen as such.

In order to make the mother-therapists more central to the findings, I have created narrative accounts for them. All names have been changed. I have furthermore withheld or changed several identifiers to protect confidentiality.

4.1. The mother-therapists:

All four mother-therapists expressed that being a mother formed an important part of their identity, which shaped their practice. Three of the participants transitioned to motherhood whilst training to be a therapist; hence, both identities were created around the same time.

None of the mother-therapists considered themselves to be bereavement counsellors. They identified as general counsellors/therapists, despite some of the work taking place in bereavement services. Working with bereaved mothers/child-death was thus not something that formed part of their every-day practice. The experience of working with this client group might be different for mother-therapists who work in a bereavement service that specialises in working with bereaved families, perinatal death or in a hospice.

Tessa: Tessa is a mother of two and feels that her children are at the centre of all her decision-making. Having worked with adult bereavement before, she thought that she would be comfortable with this client group. She was surprised by how difficult she found this work. Tessa found it more taxing than normally to maintain her

boundaries between work and home with these clients. Because of this, she decided not to work with this client group again.

Tessa showed curiosity in exploring how her motherhood shaped her work and I experienced her as easy to engage with. The interviews focused on the presence of the deceased children in the therapy room, which was what was particularly challenging to her. This presence came as a 'surprise' to her and me too. We reflected on how there seemed to be a third person (the dead child) in these therapeutic encounters. There were times when Tessa mixed up working with children and working with adults bereaved of children in her narrative, which I felt was poignant. Reflecting this back to her helped us understand just how touching the children's presence was. Tessa recalled moments when she needed to block out her children from the therapy room. In our relating, I had a sense that there were some 'doors' she did not want to open either. I interpreted this as her way of protecting herself in the interviews as she did in her work. I respected this and did not push certain interpretations and explorations.

In the interviews, Tessa referred to her experiences of working with a bereaved mother and a bereaved grandmother, who in Tessa's eyes was '*more like a mother to the child*' because of their close attachment and the amount of involvement this grandmother had in the every-day care of the child. This created a narrative by the grandmother that was similar to that of a mother. Due to this reason, I included her accounts that referred to this grandmother in the analysis.

Louisa: Louisa has two children. She spoke passionately about her transition to motherhood during her counselling training. She remembered the shift from daughter

to mother, and how that made her understand certain client issues differently. In her interviews with me, she mainly referred to a mother whose initial reason for therapy was to work through childhood trauma (trauma1). The death of her first-born child only came out once the therapy had been underway and the client trusted Louisa enough to share this experience with her. This bereavement formed a substantial part of the therapy thereafter. Louisa stated that she felt that she and her client connected deeply in the shared experience of motherhood.

Louisa enquired about my confidential handling of her client-material. This communicated to me not just her care for her client but that there might have been an unconscious concern about sharing her client's story with me, similar to what I conceptualised an obstacle in the recruitment process. I reassured her of confidentiality and outlined the process of data analysis. This seemed to help us find our rhythm. In response to her concerns, I took great care to not describe trauma1 and focus on abstracts from her discourse in the thesis that referred to the death of her client's child.

When Louisa shared her miscarriage with me during the interviews, I felt quite taken aback. Though not verbally communicating this impact, I wonder whether she picked up on it on a 'felt' level. For she shared her construction of miscarriage as a loss of a fantasy (which I outlined under point 3.2.4.) without being prompted. This felt like a reassurance to me and a justification for her taking part in the research. It rescued me from falling too deeply into concerns over whether I could include her in the study. Instead, it helped me park this thought for further reflection, re-enter the interview process and focus on her story. I wonder whether this interaction somehow shook up the power-imbalance in the room, as I suddenly might have become

'small'. In the end, this 'rescue' might have helped Louisa feel more equal to me and thus actually aided our relating.

Olivia: Olivia has two children. She had her first child when training to be a child-psychotherapist. As part of her role, Olivia offers parent-work and consultations for parents of her clients. The cases that Olivia referred to in her interviews with me came from both. Olivia spoke particularly emotively about one mother whom she identified with strongly due to similarities in their stories (they both had longed to have a baby-boy).

There were many aspects where Olivia and I seemed to identify as fellow mothers, too. Her emotive descriptions of how accounts of child-death constituted horror stories to her resembled my own feelings. I did not confirm this overtly, but I think both my utterances and body language might have communicated this agreement. This, I think, allowed Olivia to feel attuned to and safe to go deeper. Out of all the participants, I think that it was within my interviews with Olivia that we focused most deeply on the intersubjective nature of the therapeutic process and took the reflections from her subjective experience of the work more into how this shaped the process between her and the mothers/families she worked with. The reflections I shared in the introduction that were around the mother whose child had died when I was growing up, were triggered when I analysed Olivia's transcripts.

Some of Olivia's data had to be excluded from the cross analysis out of concerns around confidentiality for the family as well as some of the dynamics being too multi-faceted (between her and the whole family) for this research. The data and quotes included in this write-up contain clear dynamics between her and the mothers.

Nonetheless, I am aware that the overall dynamics in the room would have been somewhat different to my other participants who worked one-to-one.

Marion: Marion had her first child less than two years ago whilst training. She spoke about the joys of motherhood as well as a sense of having lost part of herself through it. She had only recently gone back to client work and found that her experiences as a new mother, both the joyful and difficult ones had shaped her clinical work. Overall, she found that she managed to negotiate well between her mother-self and her counsellor-self. Yet, with the one mother that she referred to in the interview, she did not. Marion had worked with two bereaved mothers before she was a mother herself and recalled that she experienced these cases as less emotionally pulling.

Marion was keen to share her experiences as a mother and mother-therapist. Due to her baby still being young, we spent more time than I did with other participants exploring the area of motherhood's impact on her overall personhood before moving onto her practice and then her client. I could relate to Marion's joys and struggles of motherhood, since I had a similar experience. This in turn helped us attune to one another. I think it also strengthened her trust in me as a non-judgemental interviewer, subsequently allowing her to go to places of deep reflection. Marion was the last participant I interviewed. I could feel when with her how my expectations and lens had shifted throughout the interviews. For instance, I was no longer 'surprised' about the positives and her increased resilience that had come out of her work with this mother.

4.2. Themes:

4.2.1. Table of final themes:

SO1: The personal in the professional	SO2: Sitting with the grieving mother	SO3: The double-edged sword of identification	SO4: How this work has shaped me
1 Being a mother has shaped my world - Tessa - Louisa - Olivia - Marion	1 Two mothers connected in the enormity of the loss - Tessa - Louisa - Olivia	1 Being a mother helps with empathy - Tessa - Louisa - Olivia - Marion	1 'The client bubble stayed' – the challenges on the self whilst working with the mother - Tessa - Louisa - Marion
2 Being a mother-therapist - Tessa - Louisa - Olivia - Marion	2 Sitting with the pain you cannot fix - Tessa - Louisa - Marion	2 The struggle 'to keep myself out' – staying safe, separate and present - Tessa - Louisa - Olivia - Marion	2 How this work has shaped my mothering and views of the world - Tessa - Louisa - Olivia - Marion
3 Other client issues that pull on mothering - Tessa - Louisa - Olivia - Marion	3 'I would write it in gold' – validating the child's life - Tessa - Louisa - Olivia - Marion	3 The power of imagery – the child's death becomes real - Tessa - Louisa - Olivia - Marion	3 How this work has shaped my clinical practice – clinical decisions and insights - Tessa - Olivia - Marion
4 A parent's greatest fear – death and harm to your child - Tessa - Louisa - Olivia - Marion	4 'I have the child you lost' – feelings around our difference - Tessa - Louisa - Olivia - Marion	4 'The parallels were killing me' – the risks of identification and how to disentangle in the moment - Tessa - Louisa - Olivia - Marion	4 'I want to put her in a glass bauble and put her on the top of the tree' – multiple lasting feelings about the work - Tessa - Louisa - Olivia - Marion
		5 What has supported me through this work - Tessa - Louisa - Olivia - Marion	

4.2.2. Themes outlined:

In presenting these findings, I have used the following annotations:

Participant quotes in *'italics'*

When an interviewer's comment is inserted this is done in 'bold' font, 'italics' and in '[]' - '***[I: I see]'***

Short pauses are indicated with '/' longer pauses are indicated in '()' - '(3secs)'

Prosodic comments in '[]' and 'italics' - '*[laughs]*'

Substitutions and/or additions to text to aid comprehension in '{}'– *'{my therapist}'* instead of *'she'*

When the quote starts or ends mid-sentence or to clarify where a section of text has been excluded as irrelevant – '…'

In the quotes presented, I changed several details such as names and ages in order to protect participants' as well as their clients' anonymity.

Superordinate theme 1: The personal in the professional:

I experienced the interviews as deep and engaging, with participants being keen to share their stories. All interviews involved a focus on the reciprocal nature of the therapeutic encounter. In line with the focus of this research, we honed in on the aspect of motherhood.

Subtheme 1: Being a mother has shaped my world:

This subtheme shows how participants conceptualised that the transition to motherhood and the ongoing experience of being a mother shaped their worlds.

All four mother-therapists spoke about their deep love and care for their children, which was passionately expressed by Louisa: *'…when I had my baby, I just couldn't get over how beautiful it was. I couldn't take my eyes of it.'* This deep love and perceived enrichment to their lives also brought some emotional shifts, which Marion reported: '*I feel my emotions are very on the surface since I had my baby. So, if I hear something about babies in the news … Everything triggered. Everything about babies, small babies. The cruelty what the parents did or,… It's so painful, it hurts!*' Marion reported that since being a mother seeing pain inflicted upon others, especially upon babies '*hurts*' her more than before. *'hurt'* indicating a visceral response.

Olivia, on the other hand, showed how the reality she encountered through her work as a child-psychotherapist shaped her mothering: '…*but in terms of my practice, I*

feel it's made me sometimes oversensitive. Because you end up comparing your children to the child that you've got in front of you. Or you start seeing the world in a different way…. You become more scared of, of what your kids are heading to into the world.' In line with Marion, there is something about the vulnerability and pain inflicted on children and the dangers children might face in the world. A reality that Olivia felt her work brought into her mothering, which in turn created maternal anxieties in her.

In addition to a greater sensitivity towards cruelty, Marion also spoke about an increased empathy towards the parents that she used to work with in a previous career: '*I am more (1secs) empathic with them … I always thought when I was little. And then my mum would come home from work how, how happy I was when my mum came … and then how the parents feel leaving their child behind. But now, it's, it's really different. Now, I'm aehm, really empathising with everything that I, I saw before, but not felt.'* Here, Marion described a shift from seeing the world through a daughter's eyes to seeing them through the eyes of a parent, which meant that parents' experiences resonated with her differently.

All mother-therapists reported a great shift in their identities as they became mothers and their children became their priority. Tessa whose children were teenagers at the time of the interviews also articulated this sense of putting herself back and the children first: '*… I want to be a at home. Even if they're annoying me, even if the kids are annoying me, and, which they do. Aehm, I know I'm there. And I think, that is part of the foundations in which I can work.'* Tessa communicated a sense that being

at home with her children could be hard work *'even if the kids are annoying me,'* she would still rather be with them. She further stated that this was '*the foundations in which I can work,'* hinting at how being a mother shaped her work.

Subtheme 2: Being a mother-therapist:

The impact of the above shift in mother-therapists' identity such as Marion's increased sensitivity towards child-pain and empathy towards parents were aspects mother-therapists felt that being a mother had added to their identity as a practitioner, especially the three who became mothers whilst practicing. Louisa said: *'I think my sensitivity to people's needs changed. To their relationships. My sensitivity there. Whereas previously, where I was just a daughter, I'd always been very independent. And I quite hadn't understood, well, I had understood it, but not really felt it. Aehm, and now I was feeling it.'* Louisa's statement here resembles Marion's statement on empathy in the previous subtheme. Olivia described this shift by emphasising that since being a mother her empathy came from this experiential place: '...*and this is what therapists say and that therapists are empathetic... but there is that bit that comes from really being empathetic because you've been there. And you can identify with a mother who has lost a baby even though you haven't lost one. But, you can imagine yourself. The pain of losing your child.'* Olivia brought into the room how because she shared the lived experience and could identify with other mothers' mothering, she felt she could also '*imagine'* what it would feel like to lose '*your child'.* She thus referred to her personal reality as a mother to show that she could relate to bereaved mothers.

This identification was also present in the opposite direction when Louisa stated that motherhood could pose a challenge when working with mothers whose attachments to their infants was different to her own: *'…I find it harder when you have someone who doesn't attach. Aehm, because that is sort of the opposite of how I am… I just think, 'What's going on there?'* Louisa's quote here shows how her motherhood shaped her expectations of mothers' attachment to their babies.

Despite stating that motherhood shaped their clinical work, participants also felt that it was important to have boundaries between work and home-life. This was particularly strong for Tessa: *'… my care of my kids is pivotal to the work that I do. Because if, if, if I'm not happy with … my availability to them and what I give to them, I think the whole, the whole thing goes belly up.'* Tessa stated that her availability to her children was always at the centre of her work, and that work that could damage this *'availability to them'* would be no good for her.

Marion described the concepts of boundaries and multiple roles using the image of juggling separate bubbles: *'But, that all my baby, that's my my bubble. But it seems there is a little bubble with my counselling world. Aehm. And there is this big bubble where I have my baby… it's two different…'* Marion conceptualised that despite both bubbles containing aspects of each other overall they were separate. Generally, she was pleased with how well she managed to keep her baby outside the consulting room. But, this was different with the mother whose baby had died: *'…when I'm with my clients… I'm with them. So, aehm, my baby didn't come in because I did, really pay attention to be present. Aehm, except for this client.'* Marion therefore recognised that

though overall it was possible to separate one's identity as mother from one's identity as therapist, sometimes keeping the 'bubbles' apart seemed less easy.

Subtheme 3: Other client issues that pull on mothering:

Exploring the phenomenon under study, mother-therapists reflected also on other client issues that pulled on their mothering. It seems important to point out that it was not just the death of a child that could shake participants' boundaries.

Tessa spoke about several client issues that were challenging for her as a mother-therapist: '*And yet with postnatal depression, I've always found that very kind of painful as well. Kind of knowing that there is a child in there who can't access their mother.*' Here, Tessa referred to an adult issue, which has a child at its centre. Tessa thus experienced empathy for the child that was caught up in its mother's difficulties. This was *'painful'* to her. Louisa, too, felt that any form of childhood trauma was difficult to work with. She referred to the client who she used for this interview to outline this in terms of the other trauma that she had come to work on: '*…it's really difficult listening to sort of, recounting the horrible, horrible trauma as / teenager, when I had my own kids at home of that age. Looking at my kids, thinking, "I can't even imagine what she went through." And having to be very careful with that separation.*' Louisa outlined how trauma1 that her client went through as a teenager pulled in thoughts about her own children. She furthermore brought in the notion of separation that the previous subtheme touched on when she said *'having to be very careful with that separation'*, which was due to the similarity of age between her children and her client then.

Olivia who worked with children referred to how her work with certain client issues could impact her mothering: *'If I had a really, really traumatic day at work and I especially around looked after children and I think there is such a horrible fate to be a child without parents that … it broke my heart. So I would come and [she uses her body/arms to show her tight hugging] … hold them tight.'* Olivia showed how the *'fate'* of looked after children would pull on her mothering and make her want to keep her children safe and close.

Tessa reflected on why these issues pulled on her as a mother: *'I think it's something to do with the innocence of children.'* This statement mirrors Marion's quote in the first subtheme, where she recalled an increased vulnerability to the pain and cruelty towards children. This argument is further amplified by Marion who had worked with two mothers whose children had died before becoming a mother herself, which she experienced quite differently: *'… the other mum was at home and her, her 12-year-old child had an accident and died when abroad with other family…. So, I felt her pain, her suffering. But, I didn't feel as strongly as if it was my own. Because, I, I guess, it's because I did not have that baby. So that, that's really big, big difference.'* Marion reflected that before becoming a mother working with mothers whose children had died, even if as sudden and traumatic as the one she described here, felt less painful than it did after becoming a mother, a difference that was *'really big'*.

Marion furthermore emphasised the notion that it was the issue that the mother brought to therapy that pulled on mothering rather than the mere working with a mother. She outlined this difference when referring to another client who was a mother

with whom she worked on a bereavement, but the deceased was not a child. Marion stated that her motherhood was not pulled upon with this mother since children were not at the centre of the work: '*She has a story. She has a full on story… I did not get that effect / as I had with this Mum.*'

These quotes create a notion that the pull on mothering for these mother-therapists occurred when a child and/or mothering were at the centre of the work; either in the form of childhood trauma talked about by an adult, or adult issues that centred around parenting and children, such as in the case of Post Natal Depression, or issues brought by children themselves. It seemed to be the violation of children's innocence that resulted in pain, empathy and thoughts about their own children.

Subtheme 4: A parent's greatest fear – death and harm to your child:

All participants reflected on what child death meant to them as mothers.

Louisa who had experienced a miscarriage in the past and knew she could 'survive' a miscarriage felt differently about the death a live-child: '*…. the loss of a child / that is always / I suppose the biggest fear I think that most parents would have. Umm you don't know if you would survive it, you don't know if you would be swept away, you don't know so / umm / hopefully I'll never be in that position to find out.*' She described the death of a child as '*the biggest fear … most parents would have*' and wondered if she would '*survive*' it. Louisa constructed the death of one of her offspring as a potential threat to her own survival.

In contrast to Louisa, Olivia did not conceptualise the death of an in-vitro child as different to the death of a live-child. Olivia's fear of the death of her children was equally great when pregnant: *'… whenever I was pregnant, I would tell people please do not tell me any horror stories about / I really, really don't want to know…'* Olivia thus actively tried not to be confronted with in-vitro and infant death when pregnant in order to protect her reality from this possibility. Marion, on the other hand, said that there were times when she imagined what it would be like if her baby died: *'…sometimes I imagine what if I lose my baby, umm, somehow, baby dies. And umm like how / how would I feel. Would I have any energy or, or purpose to live.'* Marion, similar to Louisa above, questioned whether her life would contain any purpose. Tessa was the only one who did not directly state how she felt about child-death. She summed up her opinion when reflecting on the natural order of life: *'But the loss of a child is, is just the wrong way round… it isn't okay.'* Thus, for Tessa, too, the death of a child was '*not okay*'.

Participants expressed fear and avoidance around the reality of child death, questioning if they would survive such an experience. These attitudes would have been indirectly in the room with participants when sitting with their grieving clients.

Superordinate theme 2: Sitting with the grieving mother:

This theme is designed to capture the more intersubjective aspect of participants' experience of sitting with and working with the mothers whose child had died.

Subtheme 1: Two mothers connected in the enormity of the loss:

All participants recalled deep connections with their grieving clients. Louisa, Tessa and Olivia directly reflected on these connections. The mothers that Tessa and Louisa referred to here, both knew that they were mother-therapists, whereas Olivia's did not know. Nonetheless, all three felt that the connection was mutual and aided by their shared motherhood.

For Louisa's client knowing that she was working with a mother-therapist seemed to be particularly important: *'But she had asked {whether I was a mother}, aehm, before I knew about the baby. And, then I said, 'Yes.' … because it is part of who I am… And I think that was significant for her. That I wouldn't, I guess that I'd understand or that she thought I would maybe a bit better.'* Louisa related her client's wish to know whether or not she was a mother with establishing whether she had a therapist who would *'understand'* her story about the baby she had lost, which at that point Louisa had no knowledge of. Her being a mother might therefore have been an important factor in her client's decision to share the baby and trust that her therapist would understand its significance. Louisa herself felt that their shared experience of motherhood was an important point of connection: *'I couldn't share her experiences with other things, could I? … And that was somewhere that / I guess she felt that we had something in common as well.'* By her stating *'I guess she felt that we had*

something in common as well,' Louisa indicated that she thought her client felt this connection, too.

Olivia felt that the mother she referred to (who did not know Olivia was a mother) could sense and '*get*' interventions because it came from her mother-place: '*…I think she appreciated that because / she really did get it because it was coming from a place of complete understanding and empathy.*' Even though their connection and its reciprocal impact were not overt as they were in Louisa's case, there still seemed to be a connection and something within their relating as mothers that Olivia felt this mother had picked up.

Tessa, on the other hand, who became emotional when confronted with a photograph of her client's baby who later died, described how this difficult experience also felt like a connection between the two: '*…when I got upset with the baby session there was kind of like a, aehm, … like a synergy. Do you know what I mean? Kind of like a, a mutual grief and understanding of the enormous loss.*' Tessa described her sense in that moment as '*a synergy*', whereby she felt deeply connected and they both fully understood the enormity of this mother's loss, which implies that there was a strong dynamic between the two. Olivia felt a strong dynamic in her work with this one mother during a consultation in which the father was present, too: '*It was very intense between her and me like we were having this discussion. The Dad was on the side and he was just looking on.*' Olivia pointed to her sense of an intensity between her and the mother. She described a connection to which the father was not privy. '*The Dad … was just looking on.*' Olivia stating

above that this mother '*did get'* her because her empathy and interventions came from her mother-place, implies that she felt this intense dynamic between the two also stemmed from their shared experiences as mothers.

Thus, being a mother was perceived as beneficial to the mothers that they worked with regardless of whether or not they knew about their mother-status. They further reflected on a deep connection, which they felt shaped their intersubjective relating.

Subtheme 2: Sitting with the pain you cannot fix:

This relating came into focus in their sense of being confronted with the mothers' pain and loss that could not be fixed. Tessa, Louisa and Marion directly addressed this issue in their interviews.

Tessa spoke that when a child had died the worst had happened: '*…because I can't see, how it could get any worse than that. So, and and bereavement, there is no solution… Because that baby wasn't gonna come back.'* She reflected on the finality of death and the lack of solution. Tessa further distinguished between a general lack of solution to '*stuff*' and the lack of solution to her client's feelings about the loss: '*I don't have a problem with there not being any resolution to stuff … and I suppose when the therapy moved to that. That's much more comfortable f, for me. That, coz it's almost more pr, kind of, practical issues. Aehm, and, and, and, aeh, rather than working and dwelling and sitting with the loss.'* Tessa therefore created a direct link with the

difficulty being about the '*loss*' that had no *'solution'* rather than the general concept of '*no solution'*.

Marion also noticed this lack of solution in her client's loss and reiterated Tessa's statement that this was challenging. Marion: *'Umm but still I, I, I found that it's, it's awful, it's a lot of pain, it's so big, it's so heavy, it's like [sighs].'* Her sigh here indicates a physical heaviness that this enormity of the loss put on her. Louisa also referred to this lack of solution: '*But you know, the worst had happened, hadn't it? Whatever, whatever I did, I couldn't improve the situation. I couldn't help … The feelings. I could just be there to witness it and to talk about it. And to normalise it and to treasure her baby.*' Louisa, like Tessa, referred to this bereavement as '*the worst that had happened*'. She furthermore stated what she could not do, '*… improve the situation*'. But, she brought in what she could do, and therewith conveyed the positive in the concept of 'sitting with'; that it is useful to '*witness*' clients' feelings and '*talk about it*'. She also brought in the notion of '*treasuring*' the deceased child, which is what the next subtheme outlines further.

Subtheme 3: 'I would write it in gold' – validating the child's life:

All participants spoke about a need to talk about and validate the deceased child in therapy.

Tessa expressed this in terms of what is needed for the client: *'I think it's to be able to, to be very present… to be actively kind of talk about the child… So that presence*

of, of the, of the child that's died, aehm, seems to be very important to kind of acknowledge it and to, and to keep on acknowledging… because a lot of people don't talk about it… To keep the kind of the memory alive.' Besides communicating what she felt was clinically important, Tessa also related an awareness that people generally do not want to talk about it.

Thus, finding a safe space where they could talk about the child seemed to be important to these mothers, which was something all mother-therapists noticed. Louisa saw this desire to talk about the baby in her client who on other topics was quite shut off from her emotions: '…*that was the bit she was actually more, that was keen on sharing.'* This concept was further stressed by Olivia. Once the death and existence of the baby came out in the consultation with her, the meeting focused on the mother and the death of her baby. Olivia: '*But she will speak as if it was yesterday. Like the ways she described the whole scene, it was like it was the day before. And it was horrendous. Aehm, and, the grief. I was, I was just thinking, 'Gosh, she really hasn't grieved.' She really is, it's been fifteen years.'* Olivia, here, recounted how deeply affected this mother still was by the unexpected death of her baby and the clear memory of the death that the mother had. She furthermore described a need in this mother to tell her story. Olivia also communicated her reaction to this mother's story, when she said '*and it was horrendous,'* which indicates the impact she felt when listening to the unfolding of the baby's death.

Besides noting a need in the mothers to talk about their deceased child, there was also a sense of wanting to celebrate those short lives. As Louisa said: '*But I sort of*

wanted to celebrate that she'd had some love.' Thus, Louisa herself felt it important to celebrate and validate the child and the special bond that her client had had with it. Marion, too, experienced this when writing a final report about her work with this mother; a report that was for the record of her agency and that the mother herself would never get to read. Thus, Marion's desire to validate this baby was not a clinical intervention, but came from within her: ' *… when uhh I wrote aeh, the final evaluation report, umm, I felt that to give a great / the best gift that the little one can have is respect so I wrote its name … because the Mum told me, so it's, it's / she was particular about that the baby was a person, it was a little young person, so the baby existed and I felt that I need to respect, give this final gift…'* For Marion there was something important about having this baby documented by name and thus its life recognised.

How strongly she felt about this is best summarised in this quote. Marion: '*I was just / just feeling sensing like whatever is happening inside and why I am just writing these two pages. And uhh it was very very important to me, these, these letters. And it's like, if it would be, I would write it with gold.'* She communicated this significance when stating that it was not the overall report or words that were important but the '*letters*', implying that each little part was precious. She further stressed this when saying *'I would write it with gold'*. '*Gold'* being the greatest, most special '*gift'*.

The need to validate and celebrate the children who died was not just a clinical observation but also felt by some of the mother-therapists, communicating an understanding of what it was these mothers had lost. At times this understanding,

however, made the difference between their clients' losses and their non-losses poignant.

Subtheme 4: 'I have the child you lost' – Feelings around our difference:

All participants had worked with one client whose deceased child was the same age and/or gender as their own. For Tessa this happened when working with the grandmother. Tessa's awareness of having what the grandmother had lost was similar to that of the other mother-therapists who worked with mothers. Tessa: '*I was very aware that my child was doing the same sort of thing. And I was, I had got my child and she no longer had her's*.' Tessa, though reflecting this awareness, did not describe how it made her feel. Whereas in the other three participants, this awareness raised strong feelings and fantasies.

Louisa almost exclusively spoke about the one mother who had initially come to therapy to work on trauma1. However, on a couple of occasions she recalled her work with another mother who had had a stillbirth. As stated above, Louisa conceptualised the event of a stillbirth as qualitatively different to that of a live-birth. Yet, when working with this mother whose stillbirth was in the same hospital within the same month that she had given birth to a healthy live-baby, Louisa remembered feeling deeply impacted: *'I actually felt slightly guilty. Strangely guilty. That I had taken my baby home and she had lost her's.'* Louisa's feeling of guilt in response to taking her '*baby home'* seems interesting, since the death of her client's baby had nothing to do with Louisa or the fact that her baby lived.

Yet, guilt was what Olivia and Marion experienced, too. Marion: *'I had a, aehm, I had guilt and worry that if she asks, if I'm a mum. And how would she feel, if I say my baby is healthy and alive? So, I felt fear actually that she that she would ask. And reagiert that my baby is alright and her's is not*.' Marion not only expressed feeling guilty but also a sense of fear that her client could enquire whether she had a child herself. In addition, Marion and Olivia had a fantasy of the mothers hating them and feeling jealous if they found out that they had the longed-for child. Olivia: '*And, I was, gosh. If that woman … knew that I had an alive baby boy, I'm not sure if she, she would have hated me.'* I wonder whether the shared mother-aspect was poignant in the room and represented in the strength of their fantasies and the sense of guilt, because Marion, Louisa and Olivia literally could mother what the other mother could no longer mother.

This subtheme has thus moved to focus on the internal process of the mother-therapists because of their identification with aspects of the mothers' losses, something that the next superordinate theme focuses on in more detail.

Superordinate theme 3: The double-edged sword of identification:

Identification was present to varying degrees throughout participants' experiences with their bereaved clients. This superordinate theme looks at this aspect more specifically.

Subtheme 1: Being a mother helps with empathy:

All participants communicated deep empathy for their clients, which they related back to their own mother-status.

Louisa: '*It sort of made sense, because it was the one thing {the baby} she had that was hers. Aehm, obviously I felt very strongly attached to my children. So I could, I could make sense of that.*' Louisa made sense of her client's continuous grief by reflecting on what having this baby had meant to her, which she could infer from her attachment to her own children.

Marion also drew a link to mothering when she described her empathy: '*Sadness of everything that the baby could, I mean I could, I mean, my baby is full of joy, I mean. Even at night when it every two hours my baby wakes up… and I see its little head over the cot, standing and waiting and moving, it's aeh, it's; heart-breaking and heart-warming at the same time. And, so, yeah. Feeling that heartbroken … hmm The sadness. Deep, deep, deep sadness.*' Having the image of her own live-baby in her head deepened Marion's sadness for this mother. She could literally see what the mother had lost and was thus not just sad but '*heartbroken*' for her client.

For Olivia there was also something about the embodied experience of pregnancy, which helped her empathise with the mothers she spoke about. Olivia furthermore stated that this embodied experience created a difference between mothering and fathering during pregnancy. The latter suggests why Olivia might have sensed a stronger connection/dynamic with the mother than the father in the room (as outlined in the subtheme 'Two mothers connected in the enormity of the loss'). Oliva: '*You know, when you're pregnant you know, exactly, you know the personality of your baby, I knew mine, both of them, like my first used to kick so much. And had this pattern and my second was terribly, terribly quiet. So you know like they have their own little personalities. So she would have known her baby very well / and he didn't.'* Olivia reflected on the intimate relationship that many mothers have with their in-vitro babies by remembering her own pregnancies. The fathers would have had not a lesser but a different type of relationship to their in-vitro baby, which Olivia hinted on when stating '*and he didn't'*. Olivia referred to this shared physical experience between her and this mother to explain why she could understand this mother's intense grief so well.

Olivia furthermore outlined her empathy for this mother by reflecting on similarities between their stories. This mother had longed to have a baby-boy just like Olivia. Yet, this mother's baby-boy died shortly after birth. Following this bereavement, the mother gave birth to healthy girls. Olivia showed how she used identification to understand the mother's process and continuing grief: '*And I, again that's me in identification with her, thinking, 'Yeah, what would it have been like for me. I really wanted a boy… I can understand why her grief continued.'* The similarities in their stories furthermore helped Olivia understand and empathise with the disappointment she picked up from the mother for never getting her baby-boy, which she thought would have unconsciously

limited the mother's emotional availability and attachment to her live-girls: '*What I sensed with her was the disappointment of every time giving birth to a girl that wasn't a boy. How much that would have impacted, unconsciously.*'

Louisa's client, on the other hand, spoke more directly about not allowing herself to get too attached to the children she had after the death of her baby: '*Because the pain was so bad….she had these other children; she cared for them on a functional level. But she didn't love them. And we did discuss that. That she couldn't go there again. She couldn't put herself in that much risk again. And that was really hard to hear.*' Louisa referred to her client's lack of emotional attachment as a way of protecting herself from potential loss, which she felt was '*hard to hear*'. Despite seeing the impact of this on these mothers' offspring, who in Olivia's case was her actual client, both mother-therapists communicated understanding and empathy for these mothers due to knowing how severe and terrifying the loss of their babies would have been for them. They were therefore both keen to communicate to me that despite this lack of emotional attachment it was not that the live-children were neglected, or that they were bad mothers. Olivia: '*Within her capacity she loves and cares. And you could see a glimpse of how loving, loving she could have been. Had she been, had things worked out differently. So, it's not that - a horrible mother.*' Olivia and Louisa thus communicated empathy rather than criticism on witnessing the impact of the bereavement on the mothers' ongoing relationships, which would have shaped their relating.

Tessa summed up the sense that being a mother helped with empathy succinctly: *'I should imagine its, aehm, helped with, aehm, the empathy.'* Thus, all mother-therapists communicated positives that their mother-status and, at times, identification with their clients could bring to the work.

Subtheme 2: The struggle 'to keep myself out' – staying safe, separate and present:

Nevertheless, being a mother also brought with it some challenges. The very boundaries and presence that mother-therapists stated were so important to them in SO1 took more care and energy to maintain.

For Tessa actively working to keep her own stuff out of the room formed a substantial part of maintaining her presence for her clients: *'Umm what was I keeping out of, I suppose my own reality, really, and again, that kind of having to say, this doesn't happen to every child. Not every child gets a terminal illness. Not every child has a genetic disorder and dies a month after birth. So that's the energy that has to get spent to keep me on the straight and narrow. To not delve into my own stuff. To keep me present for the client.'* Tessa thus had to rationalise child-death in order to keep her work reality separate to her mother reality and not to mix the two. This in turn protected her own reality as safe from child-death. Yet, doing this was tiring *'that's the energy that has to get spent'*.

Marion, who struggled to stay in her counsellor role during the first session, described how in the following session she was more grounded, which helped her presence and furthered the work: *'So I was able to umm umm examine the relations about this. With*

her. Because of I was more present, more aware and less into this deep sadness.' Olivia also picked up the importance of presence and cautioned against over-identification: '…*so not getting to the terror because otherwise when your get into a complete terrifying hopeless position. And a very good chance of freaking out / and not wanting to hear it. Actually this is not my job but this is / her pain.'* Olivia used the word *'terror'* to refer to the sense that was in the room. The terror of losing a child. She emphasised the risk that getting into this '*terror*' could bring when saying that it might make one '*freak out and not wanting to hear it'*, thereby describing how when in this position one would switch off from being open and attentive to the client. By reminding herself that this was the mother's '*pain*', she separated her reality from the mother's and protected herself to stay present for the client.

The need to stay separate and protect the self when working with a bereaved mother was amplified by Louisa: '*And (2sec) you know you don't put yourself exactly in the client's shoes do you. It's that one foot in the river and one foot on the bank. But when something is like the worst possible fear that could happen / there is, it's a strange umm conflict isn't it. Of not being too drawn in but still / there enough for them. But perhaps you don't put the guard up quite the same'.* Here, Louisa brought in the concept that this work made her confront '*the worst possible fear'*, which she felt had the potential to shake these boundaries and might mean that she did not '*put the guard up quite the same'* implying this need to hold back in order to protect the self.

The sense of not going places in order to protect the self was best expressed by Tessa: *'I'm wondering if there are interventions I wouldn't have made, because I'd be struggling to / aehm, you know. What if there were other things that were said that I might struggle to contain. Yeah. So maybe, it might have, aehm, hindered my interventions.'* Tessa reflected whether being a mother might have made her avoid interventions in order to protect herself. Protecting the self was thus considered to be of personal and clinical value, as being too open was deemed to have the potential to shake the boundaries and lose presence for the client. Despite participants' hard work to maintain these boundaries, there were aspects of the work that could shake them. One of them is picked up in the next subtheme.

Subtheme 3: The power of imagery – the child becomes real:

Imagery, either in the form of photographs or through the recounting of stories by their clients, came up in all narratives. It was what seemed to make the children who had died 'real' to participants.

Louisa felt that seeing a photograph of her client's baby communicated to her how much her client had loved this baby. It made this part of her client's story real to her, which helped Louisa empathise and celebrate the child: *'And aehm, obviously she showed me her little pictures of her little baby and that sort of stuff. And she dressed the baby beautifully… in proper fancy and frilly clothes, all matching. The baby looked absolutely beautiful. And she was clearly really, really proud that it was hers and she really loved this baby…'* Seeing this photo enabled her to see the pride and

love her client felt for this baby, which sparkled up when she showed her the photograph. Thus, Louisa experienced this 'reality' of her client's child as largely positive and helpful to the work.

For the other three participants however, being faced with certain images or photographs shook their boundaries. For Tessa, the reality of the deceased grandchild came into the room through her client's narrative: *'…but it's like she was making that child, that child's reality, that child's life very real to me. … So it wasn't just a child, but this child then had preferences for colours and TV programmes … what's happening then is this child is forming in, you know, in my imagination, and in the room becoming more and more present.'* Tessa's focus here was less on the adult, but the child. Feeling this presence of the child also meant that she felt empathy and grief for this child: *'…the child maybe would have known that it wasn't well. Or maybe had days where the child was feeling better than not… And I think that pains me really that maybe the child might have had some awareness of its own mortality I suppose.'* The '*pain*' for the child that Tessa referred to picks up what she spoke about in a previous subtheme, 'Other client issues that pull on mothering', when she communicated her struggles with client issues that had a child at its centre.

Olivia, too, recalled a strong image of the baby that died shortly after birth, which she still remembered vividly: *'I, and I, even I didn't see this baby. I still, if I close my eyes, I've got this image of this baby gasping for breath.'* Olivia emphasised the strength of this image when she said '*I didn't see this baby*' yet *'if I close my eyes, I've got this*

image…' In other words, it was the narrative of the mother that made this image and the scene real to her.

In Marion's case, there was one particular image where the mother held her dead baby and her breasts filled with milk that felt powerful and unsettling: *'Umm / because in, in those moments, I literally imagined a small tiny new born baby, and she's holding in that cold room, death, closed eyes, little body, just holding and the milk comes Aeh, that was the, that was my / when it really hit me.'* Marion recalled this image that she *'saw'* when the mother talked about her story, and how it was this image that *'really hit'* her, implying that this felt sudden and painful. At this stage Marion was still breastfeeding herself, thus her identification with this image might have also taken an embodied form. Tessa, too, experienced a sudden pull when the mother she worked with showed her a photograph of her baby that had died: *'…I suppose in a way, when she showed me that picture, she broke through into that kind of private part of me really. That I'm trying to keep out of the therapy room. But it got, it got, it, i, i, it got thrown in, or dragged in instantaneously with that picture'* Here, Tessa described how the photograph created a strong sensation in her and *'broke through into that … private part…that I'm trying to keep out*.' Despite stating earlier how hard she worked to maintain these boundaries, this photograph demolished them *'instantaneously'*. Using the words *'instantaneously'* and *'it got thrown or dragged in'* implies that she had no choice or control over her process in that moment, which resembles Marion's expression of *'it really hit me'.*

All mother-therapists described these images and photographs with quite some detail, which seemed to be what made them so real to them. In our relating, these details made them real to me, too.

Subtheme 4: 'The parallels were killing me' – the risks of identification and how to disentangle in the moment:

In the above subtheme, Tessa referred to a sense of being '*dragged*' into the room and that the boundaries between her personal and private self had been demolished. This subtheme focuses on this aspect in more detail.

Having her personhood dragged in led Tessa to be unable to hold back her emotions. She cried: '*… the client with the photo cried, I cried, umm, with / for her loss.'* Despite Tessa's distress, this situation also seemed to create a connection, as I outlined in the subtheme 'Two mothers connected in the enormity of the loss'. Tessa felt that her client did not feel put off by her tears because: '*Aehm, I think I was alright about it because she got a really genuine, authentic part of me. [giggles] You know. I didn't fake it. I was in it, kind of with her really / she, she wasn't put out by it. I think I brought shock, horror, aeh, loss, grief, disap, all of it. She had it. She had it from me. And I suppose we, hm, it kind of reflected everything she was kind of experiencing, really. In a very genuine way. Coz it, it really hit me like a tonne of bricks. And I wasn't afraid to, I, I didn't try and stifle the tears.'* Tessa outlined that even though her tears came from her private part and were the result of her boundaries being broken down, there seemed to be something within her reaction that mirrored her client's experience, '*I brought shock, horror…reflected everything she was experiencing*'. In turn, her client

was not '*put out by it*' but potentially felt reassured that her deep feelings around her child's death were appropriate since her therapist shared them.

Marion also said that the image outlined in the previous subtheme had '*really hit*' her. It brought her to tears, too. Marion made sense of this by reflecting that as a mother she could really 'get' this mother and put herself into her shoes (too much): '*Umm I think, again, that I have my own baby. So I can absolutely 1000% feel with the Mum.*' Marion directly referred to her own mother-status as a reason for her strong identification with the mother. The notion that her identification is too much is created when she said that she could feel '*1000% with the mum*'. It is not one foot on the shore one in the river, not even 100% but 1000%, thus creating the notion of too much. Similar to Tessa, Marion experienced this as distressing. Her client, like Tessa's, did not seem put out by seeing her therapist's tears. Thus, her tears, too, seemed to be interpreted by the client as a sign of being met and understood. Yet, different to Tessa, Marion did not feel that this experience brought her closer to her client. Instead, she became overwhelmed by her own process and had to concentrate on '*surviving*' the session.

Marion described some of her internal dialogue of that time: '*I mean, "you can't carry on crying. So let's see what we can do." So again I tried grounding. Which works. I try, I started thinking of aeh, something positive. That my supervisor said, I can always go back to my light. So I started talking, talking in my mind, I just imagined something nice. So I, I switched off a little bit from my client to bring myself back.*' Being pulled in like this furthermore made Marion feel that she lost her counsellor-self during this

session: '*Well, in the first session, I was really, I, I lost myself. Like, I, aehm, all knowledge, everything that a counsellor knew me. Me as a counsellor knew disappeared. So I was struggling and focusing on surviving myself. Surviving the session…*' Identifying with the mother '*1000%*' in that moment thus threw Marion, which resulted in a loss of her counsellor identity. She had to focus on her own process in order to '*surviving*' the session. Marion stated that this did not feel beneficial to the therapy since she had to '*switch off a little*' from her client in order to ground herself. Having an internal supervisor in this moment helped her do so.

The sense of having to work to separate the self mirrors Louisa's experience when her client's story suddenly featured aspects that triggered memories of her own children: '*But I do know, what it's like to be in a children's ward…. when my baby was a baby! Aehm, that really was quite hard. And there'd be times where I'd sort of swallow that one down [takes a deep breath]'.* In Louisa's case, it was the moments when the parallels between her and her client were heightened that her boundaries were pulled upon. She recalled one point where she had to physically pull herself back out of her own memories: '*… I pinched my thigh, so I didn't go too much into. To separate my stuff [giggles] from hers.*' Louisa outlined how strong this pull was and giggled about the realisation of this strength, when saying that she had to '*pinch*', in other words hurt herself in order to push her stuff out of the room.

The notion that the parallels made the work challenging and the differences helped the separation was present in all participants, as Tessa pointed out: '*… it was the parallels that were killing me.*' and '*Almost if it had been ah, the other*

sex / would it have been?' The greater the differences between the mother and the client the easier was the separation. The same was the case when the differences between stages of mothering or the children was greater, which Louisa reflected: *'My children are older than that, they are older umm / it helps that separation.'*

Olivia summed up the process of being pulled in, then noticing the differences between herself and the mother, feeling the guilt and then coming to a place of using her identification: *'Because the first thought is oh my God, the terror, and then oh my God, I am so glad my child is safe and then the guilt and then you process all that and then, then actually the pain and what it must be like for this woman.'* Olivia hereby put together a 'timeline' of how several of the above subthemes played out for her in the moment.

Subtheme 5: What has supported me through this work:

All participants spoke about a need to process their experiences of working with these cases, to re-establish their boundaries and disentangle.

Marion found talking about her experience of the first session most important: '*I keep talking about her with others, with; I have my therapy and my other supervisor. So, I'm, I'm really getting lots of help. That's why I feel aeh, more resilient. More, safer to. And more prepared...'* Marion felt she needed to restore her balance in order to continue working with this mother, be present and thus '*safer'* for her.

In addition to supervision, Louisa spoke about self-care, which helped her process the experience: '…*but also giving myself some space and some time to do something in a different head space to allow me to separate from that. Like, running or reading or going to choir …'* Tessa talked about needing space to express her grief for the children: *'But it was more in supervision that aehm, I think my, the, the, the, grief and the loss. I could express more in supervision.'* Whereas Olivia used supervision to disentangle: *'…because it really stuck with me. This experience. So, I have a very good supervisors that I speak to weekly. So, I spoke quite a lot about that experience. And trying to disentangle myself from, from that story. Because it did get entangled.'*

All mother-therapists felt the impact of this experience on their personhood and found it important for their personal well-being and their safety as practitioners to process it.

Superordinate theme 4: How this work has shaped me:

This superordinate theme moves along the notion of reciprocity and highlights how participants felt that these clinical experiences shaped their personhoods and practice.

Subtheme 1: 'The client bubble stayed' – the challenges on the self whilst working with the mother:

Tessa, Louisa and Marion reflected on how at times the work entered, or they feared it could enter their home-worlds.

Louisa reflected that whilst overall she was good at separating from her work, there were times when the transition between her work-identity and mother-identity was less smooth: '*…so, sometimes I would find this a really hard contradiction. There would be a bit of me mourning her baby, there would be a bit of me thinking about the trauma1, and then mine would be having a scrap on the floor and demanding tea [giggles]* **[I giggles].**' Louisa recalled being preoccupied with her client at times when at home, which she felt affected her ability to respond to the immediacy and different pace required by her mother role.

On the other hand, Tessa stated that working with mothers whose child had died made her have to face up to children's mortality: '*… what would have happened is that I would have been very consciously aware that children die when you're dealing with clients whose children have died. / And then going home to my two children*.' Tessa recalled a sense that this reality was something that she carried with her.

Though generally rationalising it out of her own reality, as shown in the subtheme 'The struggle "to keep myself out" – staying safe, separate and present', she was concerned that over time she might not be able to keep up this separation. Tessa: *'I think it just would start to impact my home life.'* Thus, Tessa envisaged that over time this work could have an adverse impact on her personal life. Her concerns thus take the potential impact of this work beyond the slight preoccupation that Louisa pointed out. Tessa's fantasy points to a vision that resembles symptoms of vicarious trauma, when the work life starts to adversely and continuously '*impact*' the *'home life'*.

Marion, too, reflected on how the first session with this mother affected her, not just in the therapy room, but also afterwards. Despite resembling some symptoms of vicarious trauma, she did not relate her experience to it. I did not consider it appropriate to put a label on her lived experience either. Marion: *'I still was in my client's bubble. For pretty much for all that week. First of, definitely on that day. In the morning, I saw my client. Came home. And in the evening I had my supervision. Luckily. So, I, I continued processing. In the next day I still cried. And in the day after. On the Friday, that was Monday. And on Friday I had my therapy. So that's when I cried again. So, it like, it took five, so actually, I haven't even landed in my bubble. Because I was always, espec, every time I cuddled my baby. Especially when I came, I started crying. Just again thinking of the mum. Aeh, holding her baby who is not alive and beautiful like mine. [clears her throat] So, I was pretty much, yeah, my client stayed with me for a long. So I never landed on that day. On that first day. So, I cried. I just sat here, baby on my lap and I cried.'* Marion described the profound impact that the first session with this mother had on her. Earlier Marion had referred to juggling her baby bubble and work bubble, which felt quite separate. Yet here, her

'client bubble' entered her home life '*I haven't even landed in my bubble'*. Moreover, it was holding her own healthy baby that seemed to trigger the image of her client holding her dead baby, '*who is not alive and beautiful like mine'*, which she found upsetting. The parallels for Marion were present in her home and the identification with this mother and her loss seemed to continue beyond the therapy room. Yet, Marion also talked about an awareness of what she needed during this week, '*supervision…processing… crying … therapy*…' similar to what all mother-therapists said carried them through their experience of working with these mothers.

Subtheme 2: How this work has shaped my mothering and views of the world:

Participants spoke about how being confronted with the reality of child-death in the therapy room made them more grateful for what they had in their personal lives. Olivia: '*When I have an experience like this I hug my children a bit too tight. They walk in and when you hear the kids and you feel so grateful that they are still here.'* This sense of gratitude expressed by Olivia was omnipresent.

Nonetheless, Marion also spoke about an increased awareness of the fragility of life: '*And never know when it ends. … Fragility and, and treasure the moment.'* Thus, this experience made her aware of her own and her baby's mortality, which encouraged her to treasure life now.

In addition, Tessa and Louisa both communicated that the reality that children die carried the potential to make them more protective of their children. Something that

they actively tried to avoid as Tessa described: *'And I think that I very consciously don't then limit my children's activity because I remind myself that it's a small percentage.'* Louisa furthermore spoke how rather than limiting her children's activities, she tried to keep good communication with them: '… *reflecting on things to the children, getting their responses and talking to them, watching them grow.'* Louisa conveyed this notion of sitting back and '*watching them grow'*, again implying a conscious effort to put a step back, be reflective of her process and appreciative of the now.

All participants felt that this work shaped their mothering and attitude towards life positively. There was also an awareness that it could make them more protective over and concerned about their children.

Subtheme 3: How this work has shaped my clinical practice – clinical decisions and insights:

As well as shaping their personhoods, this work also shaped participants' practice.

Out of all the participants, Tessa took the most drastic action as a result of this work. She made a conscious decision not to take on referrals that were about child-death in the future. Tessa explained this decision as a means to maintain her strong boundaries between her personal and professional life: '…*this isn't a client group I don't want to work with while my kids are this age, or whatever age…'* She drew a direct link between being a mother and choosing not to work with child-death again.

She did not however limit this to grieving mothers, but child-death in general. Since Tessa had reflected extensively on the presence of the deceased children, it makes sense that it was not merely about the client who brought child-death, but the deceased child itself that made this work so difficult.

Tessa furthermore reflected on the impact of the photograph that the mother had shown her, and how this continued to make her somewhat cautious when clients wanted to show her photographs: '…*actually, even when clients pull out pictures now, 'Shall I show you a picture?' People will say. And I will say, 'Yeah, I'm not good with pictures though. I'm just putting it out there'. And I will make a bit of a joke about it. Because there's something about the stark reality of seeing a picture of, aeh, aeh, a, a dead person or baby that I, I struggle with. And I know I struggle with it now. I'm probably traumatised by it. [P laughs] [I giggles]*' The impact of her encounter with the grieving mother, therefore, crossed over into her general practice when clients wanted to show her a photograph. Tessa ended this quote with '*I'm probably traumatised by it,*' and then laughed, which I joined in. She constructed *'I'm probably traumatised'* as '*a bit of a joke*' like she said she did when telling her clients that she is '*not good with pictures*'. I wonder whether this is to de-tract from the reality of the impact that the photograph had had on her, and that potentially the word '*traumatised*' is not as much of an exaggeration as she tried to convey.

Marion, on the other hand, felt that she had learnt and developed as a practitioner through this work: '*… what I can take away from this client is, is the, my learning. So,*

all these that, all this that coping mechanism that I, could aehm, support myself with all the other clients (1sec) Aehm. And even if I, even if I fall in that intense, deep, aehm / experience. I can still come, stay. And I can come back out. I mean, I can, at, at least I can stay until the end of the session. At least I can stay. So it's not as scary as. I; Well, it is scary, but it's not, aehm, aehm / It's not the end or it's not fatal.' Marion expressed that she now knew that if she fell into this '*intense, deep experience'* again, she could '*come back out'*. It, therefore, would not make the experience nicer, it was still '*scary*' but she knew that it was '*not the end or fatal'*. Bringing this knowledge into her continuing practice, thus helped Marion trust herself and monitor her empathy better: *'I feel stronger, more grounded, and especially with my empathy … it taught me that I can uhh stay with the client / and I can also get out and stay still, stay in but out.'*

For Olivia, this experience echoed the notion that knowing something was different to experiencing something: *'…I knew their stories. I read their files. But reading the file is nothing like seeing the person in front of you. And hearing their, hearing their story. And experiencing their story.*'

What participants took from this work is shown to be very individual. It ranged from general reflections on the work, increased resilience and growth as a practitioner and the decision not to work with this client group again. The variety and depth of impact on their clinical practice shows that this work stood out in some ways, which is what the next and final subtheme reflects.

<u>Subtheme 4: 'I want to put her in a glass bauble and put her on the top of the tree'</u> –
<u>multiple lasting feelings about the work:</u>

Working with these mothers brought up strong feelings in participants ranging from deep sadness to horror and a sense of preciousness.

The sense of horror or working with your greatest fear when you are a mother-therapist working with child-death was a concept that Tessa and Marion, like myself during the recruitment process, came across when talking to colleagues about their work. Tessa: *'…what I said before, you know, to other therapists that I work with … parents whose children've died, you sort of can see the horror in people's faces. Because it's the one thing they didn't want to do…'* She noted this expression of *'horror'* when talking about this work, which she had initially conceptualised as 'just' bereavement work. Tessa's own experience of this work resembled what she had encountered in her colleagues, and she reflected on this in the interview: *'Yeah. It's hard, isn't it? Because the child, the baby; my kids weren't babies but it was the baby that impacted me. And, aehm, I suppose the older child, my child was that age too at the time. So, maybe I was quite naïve kind of going into it, thinking that it wasn't going to; it was, it was about the adult's grief a, and adults grief I can kind of deal with. But, I suppose it's probably kind of about the circle of life, isn't it? If they've lost their parents or a contemporary, aehm, that feels for me much safer ground?'* Tessa's reflections centred again on the presence of the children in the room. She also noted a kind of innocence of not realising that as a mother having children at the centre of a therapeutic encounter could come with challenges and reflections on her own parenting and children. Thus,

it might be the concept of 'working with your greatest fear' that made this type of bereavement work different to 'normal' bereavement work.

Furthermore, in all narratives there was a great sense of sadness. Louisa summed up her experience of sitting with her client as such: '*It was all very sad.*' Next to all this horror and sadness, there was however also something special in these therapeutic encounters. Marion outlined these two polarities: '*I loved, I loved and I love what I do. Even if it was this painful and I'm really, now, I, I'm grateful for; not mentioning that I cried for a whole week because of this client. And even now, I just had some tears. So, it's really, she really stayed with me.*' Marion's quote contains the whole spectrum of this work. It was '*painful*', she '*cried for a whole week*' and yet she '*loves*' what she is doing and is '*grateful*'. She furthermore hinted at the ongoing impact that this mother and her baby had on her, when she stated that speaking to me in the interview brought some tears to her eyes, which told her that this client '*really stayed with*' her.

Olivia also told me that the mother whose baby died shortly after birth had imprinted herself on her personhood: '*… because in a way I've, in a way, I've been carrying her like she carried her dead baby. Umm / it stayed quite vividly in my mind and it still is because I do feel the pain and I do think very likely is connected to the fact that I'm a mother / and the thought of losing a child is the worst thing I can think of, it's my worst nightmare.*' Olivia referred to a mirror process between her and this mother whom she felt she had '*been carrying … like she carried her dead baby*'. Despite being confronted with her '*worst nightmare*', she held this mother in a special place in her heart, which she related back to her mother-status '*connected to the fact that I'm a mother*'.

The uniqueness of this work and its special place was most poignant for Marion, who perceived this grieving mother to be somewhat of her stand-out client: *'I feel that, with her, I put her in a glass … bubble [bauble] or / Christmas ornament. A beautiful glass one, up on the top, while the rest of my work with my other clients is just down, down here, on the / but yes I see that's the precious one. So in a way I just feel it's precious.'* Despite all the sadness and pain that Marion spoke about, she felt that her work with this client was '*precious*'. Outlining that she wanted to put this experience in a '*glass'* Christmas *'bauble'*, infers that she sensed the fragility/preciousness of this work as well as its uniqueness. She wanted to protect it and show it off at the same time. She wanted to put it '*up on the top'* to shine, for everyone to see, and set apart from her '*other clients'* who were just *'down here'*.

I feel that Marion's final quote sums up well the overall sense participants communicated to me about their experiences with these grieving mothers and the grandmother. It was deep on multiple layers and full of strong feelings on opposite polarities. This was often expressed using emotive language, metaphors and amplifiers (i.e., 'very, very, very…'). At times, there was a deep sense of connection between the mother-therapists and their mother clients as well as identification between the two. There were also times when the identification was less about the mothers; but the presence of the children took over. All participants felt that being a mother shaped their work with these clients in various ways. They felt that this work shaped their identities as mothers and practitioners, and that the clients and the children that we talked about in the interviews had stayed with them.

4.3. The impact of my personhood on the research process – Reflexivity:

This section outlines some reflections on how participants, the data and I co-created the findings.

The interviews had a conversational feel to them, allowing me to be engaged in the process rather than having to focus too much on the interview schedule. There were points during the interviews when my responses to participants' narratives felt quite poignant to me. Below I outline some examples.

Initially, I felt taken aback when participants communicated that they had taken away positives from this work. For instance, when Tessa said that her gratitude for her children's well-being outweighed her fears for them. I use a little extract from Tessa's transcript to outline this point. (I: stands for Interviewer, P: for participant) (Interview:1 page:11-12 Lines:258-262):

I: So, it sounds that you, you noticed in the session that these were your feelings about your child and your fears and those feelings weren't rela; not directly (P: yeah) related to the, to the child who died.

P: I mean, I don't know if it was so much kind of fears (I: okay). But kind of like a relief that my child hasn't got a terminal illness. (I: yeah).

This little bit of verbatim shows how I thought, due to my bias, that I had picked up a sense of fear in her discourse when talking about the similarities between her child and the one who had died. Tessa negated this. I feel that it was good that I used the

word *'fears'* to communicate my interpretation of what she had said, since this gave her the chance to correct me. In this way, I could not unconsciously hold on to my bias and later on interpret the data accordingly.

Nonetheless, when Tessa said that it was relief rather than fear that she felt, I noticed feeling surprise and suspicion, a slight tension rising in my body, almost feeling disappointed. Could she really not feel more fear? My interjected '*okay'* though not sounding like a full question does seem to hold a sense of surprise when listening to it. My internal response made me realise just how much I had expected to be confronted with vicarious trauma in the interviews. During this and similar moments, I attempted to bracket this bias by reminding myself that my bias was just that, and that the purpose of the research was not to confirm a hypothesis but to explore a phenomenon, which allowed for multiple experiences. In this way, I did not let my 'suspicion' coerce me to go looking for vicarious trauma. Thoughts like these also helped to ground and reassure myself, which in turn helped me to sit up straight again and step back into my researcher role. My utterance of *'yeah'* shows that rather than challenging what she said, I communicated that I was following and accepting her narrative. The below lines from a little later on in this interaction further illustrate this attempt. Tessa had explained how she kept her own child out of the therapy room, and her own reality separate from the client's. (Interview:1 page.12 Lines:280-282):

I: Yeah, I hear. (P: yeah) Yeah, yeah. Mhm. So, you, you could. So rather than colluding with the client (P: yeah), you sort of m, made a really conscious decision to block it off. (P: y, yeah, yeah) So you could keep yourself separate.'

Here, I tried to communicate to Tessa that *'I hear'* what she had said. My utterances indicate that I was thinking about what she had said before paraphrasing it back to her in order to check out my understanding. Her utterances of *'yeah'* communicate that we were looking at it the same way. I used a lot of paraphrasing during interviews in order to make sure I 'got' what participants communicated and not put my bias on their narratives too much.

Over time, I could feel how the positives I encountered became integrated into my lens and became my 'new' bias. As stated above, when meeting Marion, I was no longer surprised that her gratitude for her child outweighed her fears.

There were also times when our shared motherhood became foregrounded in the interviews. This was especially so when Olivia and I spoke about the mother's grief for and relationship to the death of her baby being different to the father's. At this point, I asked, somewhat uncomfortably, whether she thought this had anything to do with the gender difference. I felt uncomfortable because I asked a direct question, showing my assumption and something that I felt rather than something that she had expressed through her narrative, as this bit of verbatim shows.

(Interview2 page:15 Lines:288-290):

I: Hmm, yes, and do you / I mean I know that it's a very direct question, do you think this might have had anything to do with her being the mother and carrying the baby and him being the father and sort of /"

My utterances and long lead into the question show that I was unsure how to best phrase this question, since I brought the aspect of gender directly into the room. Her quick response indicated to me a sense of relief for being asked and verbalising this.

(Interview:2 page:15 Lines:291-292):

P: 'Oh absolutely. I do think that. And I know it sounds really unfair to say it, kind of out loud, because of course he's part of a process.'

Olivia's response relaxed me again. I had not been too assumptive of what I had picked up in the room and said '*out loud*'. This interaction was followed by Olivia's conceptualisation of pregnancy and early attachment to one's baby and later the '*intense*' dynamic happening between her and the mother (parts of these narratives can be seen in the subthemes 'Being a mother helps with empathy' and 'Two mothers connected in the enormity of the loss'). During these interactions, there was a sense of three women connected and one man *'looking on'*. This felt somewhat uncomfortable as if we were judging him, which Olivia's narrative above shows. Olivia thus communicated to me that she did not consider the father to be a lesser parent, but that he had had a different relationship to this baby. Her narrative here concurred with my conceptualisation, which made us elaborate on this issue but not critically examine our biases or how this might have shaped her relating to the couple or our relating in the interview further. Had I felt differently about it, this would have potentially encouraged me to explore her conception, similar to what Goldstein (2007) argued could happen when a client's experience or attitude to a shared issue is different to that of the therapist.

Other times when the shared mother aspect was foregrounded was when we spoke about the mothers' grief, and participants shared how they could identify and empathise with it, which I as a fellow mother could do, too. The sense of motherhood thus felt magnified through three mothers connecting in the sorrow over a child's death. My identification with Tessa for instance, was particularly great when she spoke about the grandchild being the same age and gender as one of her children, liking the same TV programmes and colours as her own. At this point, one of my children was of that gender and age, too, liking the same TV programmes and colours as Tessa's and the deceased child. Thus, I could identify with Tessa's identification with her client's situation. I identified with her client/the child, too. I did not communicate these identifications or connections verbally. Yet, my utterances, tone of voice, non-verbal reactions and acceptance of narratives communicated my empathy and understanding, therewith creating a deep connection in our relational unconscious.

During the interviews, I encouraged reflections on how participants' motherhood had shaped their experience and relating with their clients. There were times when I attempted to push these explorations further into how this might have shaped their relational dance with these clients. Reflecting on the interviews, I noticed that we considered the positive ways that for instance, their deep and experiential empathy seemed to be received by their clients. However, we explored their intersubjective process less when considering challenging affects participants experienced, such as their guilt. With those reflections we stayed more with the mother-therapists' process.

Potentially, there might have been an unconscious defence against reflecting on the intersubjective impact of these challenging countertransference responses from both sides. Firstly, I was aware that this was somewhat beyond the main focus of the research questions, which were centred on how motherhood shaped their experience and work, and how the experience shaped them. Rather than how all of this shaped the intersubjective process. Secondly, I was aware that if such reflections brought up something challenging, such as putting the client off, sharing this in an interview might feel shaming to participants. The fear of evoking shame constituted an ethical challenge to me and made me not push such explorations. Thirdly, participants might have felt defensive about exploring these impacts due to their fear of being shamed. My fear of their fear might have furthermore shut down rather than encouraged such explorations in both of us. Thus, in our relational unconscious there might have been a fear of containment for such explorations, which were therefore kept to a minimum.

With regards to the data analysis, I reflected extensively on my decisions for creating themes and choosing quotes in order not to super-impose my process on the findings, as suggested by Mantzouka (2004). This seemed particularly important due to my shared motherhood. For instance, I kept asking myself whether I acknowledged aspects that disconfirmed my biases as well as those that affirmed them. Nevertheless, it is impossible to fully transcend one's lens when reading and interpreting a text (Finlay & Evans, 2009). My experiences as mother and mother-therapist partly influenced my decision to create a theme that outlines to the reader the personal in the professional (SO1). Yet, this theme also adds value to the study. For these aspects shaped the mother-therapists' experiences of working with the

bereaved mothers in the room. Several quotes that are under the first superordinate theme reflect my own experiences of motherhood and practice. I wonder whether I firstly, noticed these quotes due to my matrocentric lens, but also whether this is a reflection of the inclusion bias. For mother-therapists who did not feel that their motherhood shaped their practice might not have identified with the research question.

The second and third superordinate themes focus on the actual lived experience of working with the grieving mothers and the fourth on how they felt that this work had shaped them. Several parts of my participants' narratives resembled my fantasies about this type of work, especially the challenges of identification and the need to process this work. However, as stated above, there were also many surprises. Thus, even though my motherhood is present, the themes were largely created out of what I found rather than what I thought I would find initially. Therefore, I feel that these findings, though not objective, are my interpretations of my participants' key experiences with this client group that address the research questions, as is advocated by Smith et al. (2009).

During the analysis there were moments when I noticed wanting to find the 'true' meaning and interpretations of participants' discourses. This communicated to me just how difficult it was for me to 'practice' a critical realist epistemology and to be confident that my interpretations, though not the truth, are valid and add something to the field. Whilst accepting the notion put forward by Saldana (2000) that suggests

that another person looking at these interviews would create somewhat different interpretations and findings.

Chapter 5. Discussion:

The purpose of this study was to investigate the lived experience of mother-therapists, who had not lost a child, and who had worked therapeutically with mothers who grieved for their (one of their) child(-ren). The research questions asked:

1) How do mother-therapists experience psychotherapy with grieving mothers?

2) How do mother-therapists feel that their role of mother shaped their work with these clients? And how do they feel that this work shaped their roles of mother and therapist?

I give a brief recap of the overall findings of the individual superordinate themes (SO) and how they address the above stated research questions (RQ1 and RQ2). I then discuss the findings with regards to the wider literature and explore what they tell us about 'motherhood in the therapy room'.

The findings outlined in chapter 4 indicate that for participants of this study being a mother-therapist who has not lost a child and working therapeutically with a mother who has lost a child about her grief for this child constituted an experience of 'polarities' – of working at relational depth versus working with their greatest fear (RQ1).

Participants firstly recognised that their role of mother and experiences of mothering as well as their close attachments to their children shaped their experience of themselves as therapists in several ways (SO1).

These attitudes and general experiences of the self thus shaped their experience of sitting with another mother whose child had died (SO2 – SO3). They found that due to their own close attachments to their children, they could infer what their clients had lost, and thus found it easy to empathise with them. At times they seemed to mirror the mothers' losses and felt deep grief for the mothers and their dead children (RQ2).

Working with this client group meant that participants sat with a fellow mother who had experienced a parent's 'ultimate tragedy' (Schiff, 1977). An experience that constituted participants own greatest fear. This was experienced as a challenge (RQ1). It led to wonderings whether this made them avoid certain interventions/explorations. In addition, there were moments when participants reported an increased awareness of themselves, their mother role and/or children in relation to their clients. There were moments when their worlds collided, and moments when they could relate to the mothers' pain so much that it 'threw' them professionally. All participants in this study handled such instances with great care and thus the well-being of their clients or the progression of the therapies were not negatively impacted by them. In fact, in some instances their personal emotions relating to their clients' ordeal may have enhanced relational depth. For participants

had given themselves space to process and understand their experiences in supervision, therapy, through self-reflection and self-care activities (RQ1 and RQ2).

All participants reported that despite the challenges experienced in this work, it was precious to them. They furthermore felt that they had grown through it professionally, personally and as mothers. (RQ2/SO4).

I now examine these findings in more depth and with reference to the literature. At first I discuss SO1 and how it contextualises the remaining three SOs. I then move to SO2 and SO3 and explore them with regards to the polarities that came out of the findings namely, 'working at relational depth', 'sitting with the grief and validating the child' and 'working with your greatest fear'. Within the latter section I reflect on mother-therapists' increased awareness of the self as well as on boundaries. I emphasise the importance of supervision and self-care before moving to a discussion of SO4. Within the discussion of SO4 I reflect on working with issues that are 'close to home' and vicarious trauma, as well as 'working with adult grief but child death'. I end this chapter by reflecting back on how this relates to 'motherhood in the therapy room'.

5.1. SO1: 'The personal in the professional':

As discussed in the literature review, the feminist literature depicts motherhood and mothering as different concepts. 'Motherhood' refers to the status that being a mother entails, whilst 'mothering' refers to the act of raising one's children and is usually (in the West) concerned with nurturing and caring activities and characteristics (Glenn, 1993; Arendell, 2000; Jeremiah, 2006). Mothering as an activity does therefore not necessarily have to be done by mothers, though the English word 'mothering' implies this (Glenn, 1993). Other cultures have different discourses around 'mothering'. For example, in some African and Asian cultures it is the whole community, extended family etc. that share raising a child. Their set-up is thus somewhat different to our dominant nuclear family (Glenn, 1993).

In Western cultures, Ainsworth's conception of the 'good mother' (1978) is usually prominent and, as discussed in the literature review, has been introjected as the ideal for mothers by many women across the globe, especially higher educated women (Mesman et al., 2016). Inherent to Ainsworth's concept of the 'good mother' is that the mother ought to be a child's first and main attachment figure. In addition, references to motherhood/mother tend to carry a bias towards the birth-mother. Thus inferring a biological determinism between womanhood, motherhood and mothering (Glenn, 1993; Letherby, 1994). Despite work by feminists over the previous century challenging these deterministic views and enabling women to somewhat separate from the ideal of a woman as a full-time mum, many women in 21st century Europe still consider themselves to have the main responsibility over their children either out of choice or circumstance (Glenn, 1993; Hannan, 2015). However, in addition to

being the good mother, women these days no longer want to be constricted to the household. They strive to have additional roles and careers (Gross, 1998; Glenn, 1993).

The sample represented in this study consisted of such women. I, too, am a 21st century career-mother trying to combine two very important roles in my life, that of a mother and a therapist. As Derry (1994) concluded in her study on new mother-therapists, becoming a new mother did not mean that being a therapist was no longer or less important than before being a mother. Its importance moved sideways not downwards.

Participants and I thus seem to see ourselves as such women, like Tessa said *'…even if the kids are annoying me … I know I'm there … part of the foundations in which I can work'* (SO1 subtheme1). Her quote seemed to be representative of all participants and indicates the central position that participants' own children's welfare took. Mother-therapists who feel differently are therefore not represented in this study.

As stated above, when referring to 'mother' there is an implicit bias towards 'birth-mothers' neglecting the experiences of adoptive mothers, step-mothers, lesbian non-carrying mothers and other versions of mother (Glenn, 1993; Letherby, 1994). All mother-therapists who I interviewed were birth-mothers (as am I). Despite 'birth-mother' not being one of the requirements for taking part in this research, no other 'types' of mother came forward. This might have been partly due to the fact that the

largest percentage of mothers are birth-mothers. However, it also raises the question whether non-birth-mothers might have not identified with the single term 'mother' and its description in the recruitment profile, or whether they felt they had less 'right' to take part. This again mirrors the lack of representation of such mothers' experiences in the literature, particularly when concerning the death of a child.

The findings of this research are therefore situated in and represent the current 'trend' of mothering amongst Western educated women. Participants in this study described the joys and strong attachments they felt to their children – as Louisa said '*…when I had my baby, I just couldn't get over how beautiful it was'* (SO1 subtheme1), which therefore created their lens on how they viewed mothers and mothering as well as parenting in general and their responses to it in their practice. Olivia described this, '*…but there is that bit that comes from really being empathetic because you've been there'* (SO1 subtheme2). This represents the experiential notion of empathy that is illustrated in the literature (Guy et al., 1986; Saltzberg & Bryant, 1998; Adams, 2014) and seems to carry a similar bias.

On the other hand, these experiences also seemed to create preconceptions and expectations of other mothers, which Louisa described '*I find it harder when you have someone who doesn't attach… because that is sort of the opposite of how I am,'* (SO1 subtheme2). This statement therefore shows how much the personal, one's own experiences and attitudes can shape a therapist's conception of a client, which Goldstein (2007) discussed when reflecting on her experience of being in and working with midlife.

SO1 thus locates participants' experiences of conducting therapy with mothers whose children have died. There was an expectation inherent in participants' narratives that children should outlive their parents, as Tessa said, '*But the loss of a child is, is just the wrong way round'* (SO1 subtheme4). This attitude mirrors mine, the researcher's position. Whereas in some cultures, and also in the West only one hundred or so years ago, the death of a child was not so unexpected (Hindmarch, 1993; Davis, 2016). However, for participants the idea that their child could die constituted *'horror stories,'* as Olivia called it (SO1 subtheme4). Therefore, when sitting with a mother whose child had died, they were engaged therapeutically with a client whose 'issue' presented their own '*greatest fear',* as Louisa said (SO1 subtheme4).

The strong pull that the centrality of children in client issues seemed to have on participants was not only to do with their own experiences of mothering but also the notion of, as Tessa said, *'…the innocence of children'* (SO1 subtheme3). The position that childhood is a valid phase in its own right, a period of '*innocence*' that requires protection and care is, in Western history, a relatively recent concept that came to rise over the past few centuries (Glenn, 1993). For participants of this study (and myself) however, this is a deeply rooted reality. It seemed to shape their experiences and expectations of themselves as mothers and their experiences of children, issues around children and their experiences of working with this client group. A lot of the therapeutic literature also adopts this position. Participants' lens, as well as mine, are therefore deeply shaped by our historical, cultural, educational and embodied experiences and attitudes. (In section 4.3, I reflected on how my similarity to the sample impacted the research processes.) SO1 thus outlines the

context in which participants' experiences, our interviews and my interpretations of them need to be viewed. A different era, discourses around mothering and personal attitudes might have attributed to different experiences of mother-therapists working therapeutically with mothers whose child has died. Experiences, which I now move on to discuss more thoroughly.

5.2. SO2: 'Sitting with the grieving mother' and SO 3: 'The double-edged sword of identification':

SO2 and SO3 concern themselves with the lived experience of mother-therapists whilst working with their clients. This led to some overlap between the two SOs. Hence, they are discussed together. Overall, the experience of working therapeutically with a grieving mother was one of polarities. Participants seemed to appreciate the relational depth they created with their clients and found it easy to empathise with another woman – another mother - due to their own experiences of being a woman and mother. Through this deep empathy, participants were also aware that they could not fix the client's situation and had to sit with the pain. Furthermore, sitting with another mother who had experienced their own 'greatest fear' constituted some challenges. I discuss these concepts separately, even though they overlap at times. I then reflect on supervision and self-care.

5.2.1. Working at relational depth:

This heading largely refers to subthemes 1 from SO2 ('Two mothers connected in the enormity of the loss') and subtheme 1 from SO3 ('Being a mother helps with empathy').

In current psychotherapy and counselling psychology practice, empathy tends to be one of the core-conditions (Strawbridge & Woolfe, 2003). Relational depth, on the other hand, refers to '*a state of profound contact and engagement between two people*' (Mearns & Cooper, 2018 p. xxvii) and is thought to be more than just empathy.

Mother-therapists of this study reported finding it easy to empathise with the mothers/grandmother they worked with. They all related this ease back to having children themselves as Tessa said '*I should imagine its, aehm, helped with, aehm, the empathy,*' (SO3 subtheme1). Their own experience of mothering and their attachments to their own children, thus helped them create empathy and depth in their work, as is suggested in the literature (Norcross and Guy, 2007; Adams, 2014; Guy et al., 1986).

Tessa, described the moment of bursting into tears on seeing a photograph of her client's baby that had died as a twofold experience. Even though she felt that this moment '*broke through into that … private part,*' (SO3 subtheme3), which I discuss further in the next section, therapeutically it also resembled a 'moment of meeting' (Stern et al., 1998). A moment when the therapist bypasses technique and the dyad moves into something 'authentic', where power issues are overcome and client and therapist truly 'see each other'. Tessa experienced this moment as a *'synergy'* (SO2 subtheme1) between her and her client. Their authentic relating created relational depth (Mearns & Cooper, 2018). Moreover, Gill (2015), Herman (1997), Davies and Frawley (1994) and Dwyer et al. (2012) suggest that experiencing and sharing a

client's distress could substantiate an important component of therapy. It ought to be viewed as the deep involvement of the therapist in their client's experience rather than pathologising it as vicarious trauma or relating it to poor boundary keeping.

In addition, Olivia directly referred to her own experiences of pregnancy, and her relationship to her in-vitro babies to empathise with the mother she was sitting with through identification *'…when you're pregnant you know, exactly, you know the personality of your baby, I knew mine,'* (SO3 subtheme1). This quote here, and when she talks about the difference between mothering and fathering of an in-vitro baby and their consequential attachments to a baby who dies shortly after birth '*so she would have known her baby very well / and he didn't,*' (SO3 subtheme1) support the literature that considers pregnancy to form the bond between a birth-mother and her child (Hollway, 2015; Athan & Reel, 2105). Thus, taking a somewhat biological position to a mother's attachment to her child. Nonetheless, Olivia also stressed that this did not mean that the father had no bond, merely a different bond.

The wider literature shows that not all mothers experience such a strong bond during pregnancy, at birth or shortly after as Olivia and this mother seemed to do (Pies Sorenson, 2003). For some women, pregnancy is not such a conscious and joyful experience (Beck, 2003). On the other hand, many fathers would probably argue strongly that they, too, have a deep attachment to and knowing of their in-vitro baby. Thus, equally strongly feeling the pain when it dies, as suggested by Davis (2016). In fact, Riches and Dawson (1996b) found that even though bereaved mothers expressed their grief more emotionally than fathers – who were typically engaged in

restorative mourning activities (Stroebe & Schut, 1999) – the level of pain they reported was no less than that of mothers. Hence, rather than this father's bond, who Olivia referred to in the interview, or grief for the child being less or different, it might have been his way of dealing with the loss that was different. Generally, fathers' and non-birth-mothers' experiences of pregnancies, childrearing and the death of a child tend to be underrepresented in the literature, due to a bias on birth-mothers' experiences (Zinner, 2000; Cacciatore, 2008). In addition, the therapeutic literature does at times consider a more emotional (typically female) style of grieving as healthier than a restorative/cognitive style (typically male). Therewith undervaluing the grief that many men and some women feel and deal with in their own ways (Martin & Doka, 2000). This again shows how therapists' stances can shape their relating to clients. Nevertheless, I feel that with the rise of for instance, Stroebe and Schut's (1999) dual processing model, and the recognition that some of the symptoms for grief and/or depression in men may be different to those in women (Martin & Doka, 2000; Barlow Sweet, 2012), these biases are being challenged and therapists are encouraged to become more open to valuing, accepting and working with different styles of displaying and processing emotions and experiences. During the interview, my personal position was similar to Olivia's, hence my question about the gender difference (which I outlined and discussed in section 4.3.). It was because of our agreement on this matter, shaped by our internalised attitudes and own experiences of motherhood and mothering that did not make us challenge this issue more.

For Olivia however, it seems to have been their shared mother-role that created the '*intense*' dynamic between the two (SO2 subtheme1), where she fully got the mother

and the mother *'really did get'* her *'as it was coming from a place of complete understanding and empathy'* (SO2 subtheme1). The deep understanding and empathy derived from identification with the client as a fellow mother seemed to be received by all clients and created deep connections, healing and containment for them, regardless of whether or not they knew that the therapist they were sitting with was a mother. Thus, the embodied therapist's stance, experiences and empathy were communicated to the client and created the transferences towards the therapist and therewith the dyad's unique relational unconscious (Gerson, 2004). As Crastnopol (1997) says, clients tend to be tuned into their therapists and often read accurately into their interpretations. Sharing similar attributes with one's client can therefore aid connection and add deep understanding of the shared matter, which is often conducive to the therapeutic endeavour (Fujino et al., 1994; Stevens, 1996; Levine, 2009; Hauer, 1997).

This does however, not suggest that non-mothers, fathers or non-birth-mothers (all participants and their clients were birth-mothers) would feel less empathy with such clients, or not feel the sorrow over the death of a child. For therapists who are not mothers/parents may have other strong relationships with and attachments to children (nieces and nephews, friends' children, step-children…) (Letherby, 1994) and thus equally well relate to such a loss. In addition, some mothers' attachments to their children are not positive or as central to their lives as it was for the mothers in this study and as is promoted in the current discourses on mothering in the West (Beck, 2004). This indicates that mother-therapists' empathy might have been less due to their mother-status (motherhood) but more to do with their strong attachments to children, and the time they had invested in mothering them, as also discussed by

Glenn (1993). Therewith, challenging the above noted linear biological connection between motherhood – attachment – and mothering/nurturing.

Moreover, some research in bereavement care concludes that when bereft, especially in the case of child-death, people are often stripped of their defences and thus working at relational depth can, at times, be established more easily with this client group compared to others (Humphreys, 2012; Samuel, 2017). Hence, participants' experiences of working at relational depth may have also been 'facilitated' by their clients' availability for it.

5.2.2. Sitting with the grief and validating the child:

This section largely discusses subthemes 2 and 3 from SO2 ('Sitting with the pain you cannot fix' and "I would write it in gold" – validating the child's life') as well as subtheme 3 from SO3 ('The power of imagery – the child's death becomes real').

The deep empathy derived from mother-therapists' identification and sharing of the 'enormity of the loss' (SO2 subtheme1), also meant that they had to 'sit with the loss' they could not fix. This was experienced as difficult and '*so big … so heavy',* as Marion said (SO2 subtheme2). Moreover, personal grief for the child that died seemed to add to some therapists' desires to validate the child. In particular Marion's quote *'I would write it with gold'* (SO2 subtheme3) is indicative that she did not just empathise with her client's grief but that she, too, grieved the child and wanted to validate it.

Despite not having met the children who had died, they seemed present and real to mother-therapists (SO3 subtheme3). Images of the children, created through clients' narratives or/and photographs contributed to this sense. Godel (2007) and Cacciatore et al. (2008) discuss the use of photographs in working with families bereaved from stillbirth as a means of validating the baby and integrating its life into the family narrative. Kaslow and Friedman (1977) furthermore discuss using photographs in therapy as a means of getting clients to connect to their feelings. The use of photographs can therefore aid therapeutic work.

On the other hand, Yahalom (2013) researched the lived experience of mothers looking at memorable photographs of their children. He concluded that looking at these photographs created '*an aporia of human relationships'* (p.126). It connected them to emotions, their bonds and verified them. Conversely, it also instilled a recognition that these moments were gone forever.

Mother-therapists in this study were not confronted with a memorable photograph of their own child but of their client's child. Nevertheless, they could see the memorable-ness, connection and sense of loss in their client's eyes, which in turn might have made these photographs memorable, powerful and the children's lives and deaths real to them. Louisa experienced this as largely positive. She communicated this power, '…*she was clearly really, really proud that it was her's and she really loved this baby,'* (SO3 subtheme3). Thus, for Louisa, similar to Cacciatore et al.'s (2008) and Godel's (2007) proposition, seeing a photograph and therewith the reality of her client's baby constituted a useful and therapeutically valuable

experience. Whereas for Tessa, the loss aspect seemed to be greater; triggering intense grief, which she experienced as difficult. Nevertheless, for the client, seeing her therapist's reaction seemed to be healing.

Thus, seeing the 'realities' of these dead children, either in a photograph or through their clients' narratives, may also be what deepened participants' grief for them. Having never actually met the children, participants' profound sorrow over the children's deaths relates to the concept of disenfranchised grief (Doka, 1999), which refers to grief that goes unseen and is not recognised by society. At times, professionals feel that they should not feel like this or are not entitled to engage in rituals or support to mourn the deceased (Christianson & Everall, 2009). This can cause depression and burn out in professionals (Samuel, 2017). O'Brien (2011), Christianson and Everall (2009) and Dwyer et al. (2012) thus advocate that therapists who confront death in their practice, or work with child-death (Humphreys, 2015) ought to attend to their own feelings of grief in supervision, personal therapy and through rituals.

When a therapist's personal feelings of loss are attended to, it can provide an opportunity to incorporate the personal into the professional and make therapists comfortable with the notion that they are in constant interaction, as concluded by Palmieri (2018). The lengthy report that Marion wrote '…*why, I am just writing these two pages,*' (SO2 subtheme3) might therefore have made her feel that firstly she could do something to alleviate the perceived helplessness (Samuel, 2017) (she was using the child's name, which was something that was important to her client), but

also help her process her own grief for the child and mother. Supervision, personal therapy, peer support, self-care and being aware of the impact seemed to help participants come to terms with these deaths, as Tessa stated '*…the grief and the loss. I could express more in supervision*' (SO3 subtheme5). The findings here therefore highlight the deep impact that working with a mother whose child has died can have on mother-therapists' personhoods. This ought to be embraced and attended to by therapists as well as their supervisors and managers to help them come to terms with their personal feelings and avoid burnout.

Participants' experiences of sitting with the unfixable pain, and their desires to validate the children are representative of general bereavement work (Samuel, 2017). Figley (1995) and Rothaupt and Becker (2007) suggest that there are risks in sitting with grief over a prolonged period of time, due to the heaviness of the loss and the inability to fix the reasons for clients' pain. Even more so, if the bereaved has lost their child (Humphreys, 2015). On the other hand, celebrating the deceased's life and continuing bonds with them are current 'trends' in bereavement care (Rothaupt & Becker, 2007; Silverman & Nickman, 1996). Research shows that continuing relationships with the dead is healing to the grieving (Rothaupt & Becker, 2007) in particular when the deceased is a child (Klass, 1996; Davis, 2016). Within SO2 subtheme2 and subtheme3 participants thus demonstrate their own embeddedness in current bereavement literature. If the present therapeutic position was that successful mourning was indicative of decathecting the internal image of the deceased person, which Freud proposed only a century ago and dominated theories around grief work until the early 1980s (Rothaupt & Becker, 2007), participants' experiences of their clients and their own experiences might have been interpreted

differently by them or by me. Furthermore, the above stated notion of embracing the personal in the professional is more widely accepted in current psychology and psychotherapy practice (Gerson, 1996; Knox, 2014). Hence, coming to terms with and acknowledging their own feelings may have been viewed and experienced differently during a time when therapy was considered to be a more one-directional endeavour where therapists were thought to be doing something to clients rather than attending to the 'being-with' aspects of therapy (Strawbridge & Woolfe, 2003). Or, when countertransference was considered an interference to the work (Maroda, 2004), and/or personal feelings about clients were largely unacknowledged (Clarkson, 2003).

Furthermore, images of a person (child) who has died may make them equally real to any therapist and therewith create a sense of loss, similar to that outlined by Yahalom (2013), in the knowledge that they are no more. Thus, the grief that mother-therapists' expressed for these children, though for them related to having children themselves, may have been similarly experienced by non-mother-therapists. As therapists, we often sit with clients who have experiences that are unfamiliar to us. We refer to related experiences in our lives and use explorations to create insight into and empathy for clients' unique situations, as Adams (2014) discusses. In fact, Raja (2015) debates the risks of being demographically matched with clients. The findings show that besides the positives that came out of the dyad's shared motherhood, there were also challenges. Thus, a greater difference between therapist and client does not necessarily equate in a lesser quality of the work or less understanding of or empathy for clients. At times it might create the healthy distance to not make something 'too close to home'.

On the other hand, bereaved parents themselves often report that they experience most comfort when talking to other bereaved parents (Davis, 2016; Rothaupt & Becker, 2007; Schiff, 1977), since they have been there too, and may model 'posttraumatic hope' (Romond, 2010). Fellow bereaved parents have experienced this ultimate tragedy, whereas for non-bereaved mother-therapists this ultimate tragedy may constitute their greatest fear, which it did for this sample. Working with this greatest fear is what I discuss in the next section.

5.2.3. Working with your greatest fear:

The findings of SO1 pointed towards participants holding an internalised fear around the possibility that they could outlive their children. Hence, conducting therapy with a mother who needed to mourn her dead child constituted a situation where the therapy was directly related to therapists' own greatest fears. This section focuses largely on subtheme 4 from SO2 ("I have the child you lost" – feelings around our difference') as well as from SO3 subtheme 2 ('The struggle "to keep myself out" – staying safe, separate and present'), subtheme 3 ('The power of imagery – the child's death becomes real') and subtheme 4 ("The parallels were killing me" – the risks of identification and how to disentangle in the moment'). Within this section, I reflect on participants' increased awareness of their personhoods and boundaries.

Goldstein (1997) suggests that when clients bring our 'greatest fear' to therapy, this will shape the therapist's relating with clients on this topic. Because it is something that has personal relevance, is sensitive and thus 'close to home' for the therapist. What is comfortable to look at for the therapist's personhood in relation to what the

client brings or needs to bring and explore may be in conflict. It might, as Goldstein (1997) argues, 'shut up' a client. For it may get communicated in the transference or relational unconscious that these are issues the therapist does not want to go to. Or, the therapist might avoid certain explorations.

Tessa and Louisa wondered whether there were interventions they would have avoided or as Louisa said, *'But when something is like the worst possible fear that could happen … perhaps you don't put your guard up quite the same'* (SO3 subtheme2). In other words, working with their greatest fear posed challenges and could create limits to their interventions and presence in order to protect their private spheres. It was participants' awareness of their similarities, the identification with their clients as fellow mothers and/or with their children and the child who had died that posed a risk to their private spheres, in which they struggled with the concept of and the reality of 'child-death'.

On the other hand, identification with the client could at times raise an increased awareness of the therapist's private self in relation to the client– either consciously or unconsciously. This seemed to happen at various points during their work with these mothers, which I discuss below.

5.2.3.1. Increased awareness of the self:

As discussed above, all participants reported strong identification with their clients' pain and situation, which largely aided empathic attunement. At times however, this

identification was so strong that, as in Tessa and Marion's cases, they could not hold back their tears (SO3 subtheme4). To bereaved parents, tears by a professional often feel soothing (Davis, 2016; Gosney, 2017). For they communicate an understanding of the '*enormity of the loss'* as Tessa said (SO2 subtheme1), and therewith mirror parents' feelings (Davis, 2016; Gosney, 2017), as discussed in section 5.2.1.

For Marion, the image of the mother holding her dead baby and the milk coming into her breasts seemed to trigger not just a cognitive but an embodied identification, since Marion was still breastfeeding herself at the time. She could thus not just infer but physically relate to what the mother would have felt. Her tears and deep understanding seemed to be received positively by the client, as were Tessa's. Nevertheless, Marion's internal experience of these moments are related to Steven's (1996) outline of 'over-identification'. She felt *'me as a counsellor disappeared'.* She needed to '*survive*' the session (SO3 subtheme4). Similar to Tessa, when she recalled her tears, Marion had a strong awareness of her personal self in the therapy. Moments like this seemed to make participants feel exposed, lost and vulnerable. Goldstein (1997) argues that in addition to considering the therapeutic implications of sharing personal experiences or feelings with the client, one also needs to consider how comfortable therapists are with being personally known or seen by their clients. For Tessa and Marion this was too personal. They felt they had lost their professional footing. To use the person-centred outline of empathy, '*To sense the client's private world as if it were your own, but without ever losing the "as if" quality – this is empathy…'* (Kirschenbaum & Land Henderson, 1989 p.226). Due to Marion's and Tessa's strong identification with their clients derived from their

shared mother role, they seemed to have somewhat lost the '*as if*' quality of their empathy. Marion described this as relating '*1000% with the mum*' (SO3 subtheme4). Whilst Tessa described her process somewhat differently, *'She broke through into that kind of private part of me really. That I'm trying to keep out of the therapy room. But it got … thrown in, or dragged in instantaneously with that picture'* (SO3 subtheme3). Particularly Marion made a clear link with her *'1000% with the mum'* stemming from her own mothering experiences, since she had worked with mothers whose children had died before being a mother and *'…I didn't feel as strongly as if it was my own. Because, I, I guess, it's because I did not have that baby.'* (SO1 subtheme3).

Similarly, Louisa described a moment when she had to pinch herself to put her memory of her child's stay in hospital out of the room and refocus on the client *'I pinched my thigh, so I didn't go too much into. To separate my stuff [giggles] from hers'* (SO3 subtheme4). The parallels between her and the client in this moment therefore pulled her private mothering experiences into the room to an extent that was perceived by her as too much and as potentially interfering with the work as opposed to just informing her empathy, which tends to be considered helpful (Guy et al., 1986; Adams, 2014). Thus, there seems to be a point where identification and an awareness of one's private self and experiences move from being helpful for empathy to being unhelpful or uncomfortable (Stevens, 1996). As Tessa communicated, ''*It was the parallels that were killing me*' (SO3 subtheme4).

Subtheme 4 in SO2 is one example that highlights a particularly strong awareness of participants' reality as mothers of a healthy version of the child that their clients had lost. In fact, three participants felt guilt for having what their clients had lost, *'I actually felt slightly guilty. Strangely guilty,'* as Louisa described. This survivor guilt (O'Connor et al., 2000) seemed to come from a place where participants appreciated the depth of their clients' losses and identified with them. In addition to guilt, Olivia and Marion feared that the mothers could find out that they had the child that their clients had lost. As Marion said, *'…worry that if she asks if I'm a mum.'* Both expressed fantasies of their clients' envy and hatred for them having the child they no longer had.

Indeed, the literature suggests that for some bereaved parents feeling anger and envy when confronted with parents with live-children forms part of their grief process (Davis, 2016). As stated in section 4.3., we did not explore where their fears and fantasies had come from in the interviews. Yet, I wonder whether they arose out of their identification, and sense that this is how they would feel towards other mothers if they were in their clients' shoes. As suggested by Searles (1979), their guilt might have been a defence against the clients' hatred, which Olivia and Marion might have picked up in the relational unconscious. Being therapists, they might have also been familiar with the literature that suggests feelings of envy in bereaved parents. Thus, their countertransference might have also been shaped by what they knew about parental grief. Either way, I wonder if such countertransference reactions might have made mother-therapists' cautious in interventions or avoidant in some moments in order to evade giving rise to personal questions.

5.2.3.2. Reflections on boundaries:

As stated in the literature review, I agree with the intersubjective view of boundaries, which outlines that in the moment all of the therapist sits with all of the client (Norcross & Guy, 2007). Our personal attitudes, opinions and experiences always shape our relating with clients, as also outlined in SO1. Nonetheless, there seems to be a point where this fluidity may become too one sided – too on the personal, too about us - as Tessa said, '…*to not delve into my own stuff. To keep me present for the client,*' (SO3 subtheme2). Thus, even though we cannot leave our personal self outside the therapy room, we do want to bracket it (Norcross & Guy, 2007). The experiences of participants in this study show that when our personhoods or personal fears are activated too strongly, or the use of identification for empathy has moved to over-identification and collusion, even if not harmful to the client, this can be experienced as deeply uncomfortable to the therapist. I believe that if such an experience is not attended to or happens frequently, this could lead to burn out and potentially impact therapists' clinical work negatively. Since participants in this study demonstrated high levels of self-awareness, reflective practice and had good support, this seemed not to happen.

Moreover, the findings of this study highlight the many layers and processes that operate simultaneously in therapy at any time regarding the interactions between the personal, professional and the client, especially when the topic is 'close to home'. In my opinion, this and therewith the concept of the 'personal in the professional' is related to Bromberg's (1996a) outline of multiple self-states. He argues that in good health an individual can negotiate between their different roles. Whilst one role/self-

state tends to be foregrounded, it is not isolated/separate from our other roles/self-states. When the situation, or something in the situation changes, another role might become foregrounded either to inform the self-state or to take precedence over it. This informs my views on negotiating between our professional and private selves and is similar to what participants did in this study. When the parallels between their personal lives regarding mothering or children and their clients' stories were high, their mothering/children became more foregrounded in the room. At times, this was experienced as positive and conducive to therapy. But, when the private roles/experiences/memories took precedence over their identities as therapists, this was no longer experienced as helpful by participants, as it took them away from their clients or made them too aware of their personhoods in relation to their clients.

In my opinion therefore, maintaining boundaries during the therapeutic hour is similar to bracketing in hermeneutic phenomenology. We stay present to meet the other in their own rights. We hold back our own positions and realities on the issue (our other multiple roles) in order to accept and engage in the client's reality, whilst at the same time being aware that and reflecting on how our own positions and private roles shape our overall relating with the other (Smith et al., 2009). Since, as Heidegger ([1927] 1962) postulated, full bracketing is not possible. With regards to therapy, the use of identification, reference to our own positions and experiences can aid relational depth and empathy whilst posing its own challenges (Stevens, 1996; Hammersley, 2003), which SO3 represents in its title ('the double-edged sword of identification'). This is representative of the concept of reflective practice (Schoen, 1983), which emphasises the need to see each client's interaction with the therapist as a new and unique endeavour, embedded in a context of meanings individual to

both parties. Reflections on the process and how the therapist's realities shape it, are considered of utmost importance. Reflective practice is one of the cornerstones of counselling psychology training and practice (Hammersley, 2003).

Negotiating between and reflecting on their self-states seems to be what participants aimed to do. Nevertheless, holding this position was more taxing than with other client groups, as Tessa said, *'So that's the energy that has to get spent to keep me on the straight and narrow and not delve into my own stuff. To keep me present for the client,'* (SO3 subtheme2). Participants' awareness and reflections on this present, in my opinion, ethical examples of reflective practice. Because when holding this position was difficult in sessions, mother-therapists reported techniques, such as pinching, grounding or accessing one's internal supervisor to disentangle from their clients (SO3 subtheme4). Yet, this disentangling also seemed useful outside the therapy room at home, in personal therapy and supervision, which I discuss below.

5.2.4. Supervision and self-care:

All participants spoke about the importance of self-care, personal therapy and supervision to help them negotiate the polarities they experienced, disentangle from the work, process the mothers' and children's stories, mourn the children and maintain their availability for their clients (SO3 subtheme5). Participants described their supervision settings in ways that created the image of supervision as a holding place, a space for reflection and processing. Their supervisors came across as supportive and empathetic towards their experiences, rather than critical of their grief for the children, sharing of tears with their clients or being pulled in too deep.

I feel that these are important attributes brought forward by participants, since at times and in some clinical settings, supervision's main focus is on what interventions and techniques to apply – promoting a focus on doing to rather than being-with clients (Harris, 2017; Strawbridge & Woolfe, 2003). In addition, therapists do at times fear exposure in supervision (Ladany, 2004), or feel that they should be 'above' personal affect from their work (Dwyer et al., 2012). The findings of this study thus highlight the benefits of reflecting on and processing the deep impact clients' trauma can have on our personhoods in a supportive and holding supervision setting. The literature considers the importance of reflective supervision - supervision that focuses on being-with (Harris, 2017), ongoing personal therapy and professional networks as factors that help prevent negative impact (vicarious trauma and burnout) from clinical work (Norcross & Guy, 2007; Orlinsky & Ronnestad, 2005), in particular when working with death (Dwyer et al., 2012) and trauma (Ling et al., 2014). The findings on self-care and supervision furthermore support Humphreys (2015) conclusions on the importance of self-care when working with child-death.

5.3. SO4: 'How this work has shaped me':

Intersubjective positioning suggests that therapists are shaped by their clinical practice, their clients and stories they encounter both personally (Rabu et al., 2015; Geller, 2014) and professionally (Casement, 1985; Orlinsky & Ronnestad, 2005).

Participants in this study found that their work with bereaved mothers was at times difficult to leave at the office, or they had to rationalise child-death out of their realities on returning home in order to avoid it affecting their mothering.

This highlights again the concept of 'the personal in the professional' and that even if we are comfortable with the notion that they are reciprocal, we do want to keep our realities somewhat separate and thus safe from some of the trauma that we encounter in our work (Norcross & Guy, 2007); emphasising the above discussed issues around boundaries between the personal and professional. This seems to require particular attention when working with issues that are 'close to home'. I reflect on this and how this relates to the concept of vicarious trauma below.

5.3.1. Reflections on working with issues that are 'close to home' and vicarious trauma:

This section largely refers to subtheme 1 ("The client bubble stayed" – the challenges on the self whilst working with the mother'), subtheme 2 ('How this work has shaped my mothering and views of the world') and subtheme 3 ('How this work has shaped my clinical practice – clinical decisions and insights') from SO4.

Regarding therapeutic practice, working with an issue that is 'close to home' means that the client issue is something that has personal relevance or is about something the therapist feels sensitive about, like our greatest fear. Working with such an issue can put the therapist at an increased risk of developing vicarious trauma or struggling to keep a healthy balance between the personal and professional (as discussed above). Nonetheless, the general literature on vicarious trauma talks about a cumulative effect of hearing clients' trauma (McCann & Pearlman, 1990), something they do not necessarily need to have experienced themselves or have particular sensitivities about. On the other hand, sharing personal experiences,

especially trauma, with a client, can constitute a client-issue that is 'close to home' and can increase the risk of vicarious trauma (Kinninger, 2008). When carrying personal trauma, it is thus advised to have fully processed it before working therapeutically with this issue (Stevens, 1996). In bereavement care, there is an understanding that therapists ought to have dealt with personal bereavements before engaging in such work because otherwise the personal and professional could get mixed up (Dwyer et al., 2012; O'Brien, 2011).

Whilst agreeing with this position, being confronted with others' losses and issues may revoke memories of our own, especially if similar. They may therefore shape our work with clients - often in positive ways. As stated above, bereaved parents often report benefits from working with other bereaved parents (Davis, 2016; Schiff, 1977). Similar to my position on boundaries, we cannot 'forget' our personal experiences or leave them out of the room when sitting with a client. Thus working with similarities may often bring the personal into the foreground and requires a careful negotiation of incorporating the personal into the professional without making it too much about our own experiences.

For participants of this study, the issue of child-death was close to home. They had not experienced such a bereavement themselves (except Louisa's miscarriage, which she conceptualised as different) nor any other (consciously) unresolved bereavements. Yet, this issue was close to home because participants had children whom they felt protective of. Moreover, because the death of one's own child was their personal greatest fear. Furthermore, their shared role of mother brought

another mother's experience close to home. The pull on their mothering was therefore less about their own unprocessed past (Clarkson, 2003) or personal losses (Hayes et al., 2007), but about being confronted with a client issue that was close to home.

Marion seemed to struggle most after the first session with this client. She felt overwhelmed by the mother's ordeal and could not get the image of the mother holding her dead baby out of her head. Her identification with the mother carried over from the office into her living room, intensifying when she picked up her own child. Her child had come to represent what the client had lost. This felt distressing (SO4 subtheme1).

Parts of Marion's intense experience resemble some of McCann and Pearlman's (1990) symptoms of vicarious trauma, such as her changed view of the world. Her experience is also indicative of disenfranchised grief (Doka, 1999). There are considerable overlaps between trauma and grief (Arizmendi & O'Connor, 2015), and at times they are linked as in traumatic loss (Green, 2000). Marion's experience might have thus been a mixture of her own grief for the child that died, an expression of the mother's grief coming out of her identification with the mother as well as secondary stress reaction (Harris, 1995). Over time, this led to her raised awareness of the fragility of life (SO4 subtheme2). Despite this deep impact, Marion was aware of what was happening and worked hard to process this image by engaging in supervision and therapy, as advocated by Humphreys (2012) and Ling et al. (2014). Due to her awareness and quick response to her distress, Marion's 'symptoms' may

have remained in the classification of secondary stress reaction, rather than fully progressing into secondary stress disorder (Harris, 1995) or vicarious trauma. For the latter concepts are typically related to longer term and/or cumulative consequences of working with trauma rather than an immediate response to a one-off presentation (Canfield, 2005). Marion's intense experiences and great efforts to process them highlight again the importance of self-care, personal therapy and supervision for the maintenance of a healthy practice (as discussed above).

Marion stated that as a result of this work she was mindful that she could '*never know when it ends,*' (SO4 subtheme2), whilst Tessa described an increased awareness '*that children die*' (SO4 subtheme1). Both could potentially be seen as signs of vicarious trauma (McCann & Pearlman, 1990). Nonetheless, all participants also reported shifts in their outlook on life and attitudes to living in the opposite direction, such as treasuring life and enjoying one's children more. *'…you feel so grateful that they are still here'*, as Olivia said (SO4 subtheme2), which are indicative of posttraumatic growth (Gill, 2015; Hyatt-Burkhart, 2014). This points to the fluid nature between these processes and how something that seems negative can have a positive polarity. The reality that children die can allow mothers to appreciate their children more. A greater appreciation of one's own health and good fortune has been reported as one of the positive 'side-effects' of working with bereavement (Rothaupt & Becker, 2007).

On the other hand, Dwyer et al. (2012), O'Brien (2011) and others state that being confronted with death in therapeutic work makes therapists have to face up to their

own mortality. In addition, working with child-death meant that participants needed to face up to their children's mortality, too. Tessa spoke about this '*I would have been very consciously aware that children die when you're dealing with clients whose children have died. / And then going home to my two children*' (SO4 subtheme1). Over time, she feared that she could no longer keep the above outlined two concepts and polarities of this work side by side. She feared that the tragic side would take over, leading to vicarious trauma, '…*it just would start to impact my home life,*' (SO4 subtheme3). She thus concluded not to work with this client group again.

Similar to my position on boundaries, I view the varied ways that this work shaped participants' lives and practices as multifaceted. Despite appreciating her children more, Tessa felt she wanted to protect her reality from an ongoing exposure to child-death. Whilst Marion felt that this experience helped her negotiate between her professional and personal roles better. Hence, despite a more challenging experience overall, she did not feel she needed to back away from engaging in this type of grief work (SO4 subtheme 3). One can therefore not generalise that strong countertransference reactions to clients' trauma make therapists less able to work with such a client group in the long run, nor that posttraumatic growth equates with being better equipped or more likely to work with certain issues in the future. But, it shows that self-awareness and knowing one's limits is what creates good and healthy practice.

5.3.2. Working with adult grief but child-death:

This section discusses subtheme 4 ("I want to put her in a glass bauble and put her on the top of the tree" – multiple lasting feelings about the work') from SO4 and also refers to aspects from previous SOs.

In particular Tessa and Marion seemed to be surprised at how deeply affected they were by this work. For, as Tessa said, she had worked with bereaved adults before *'…it was about the adult's grief a, and adults' grief I can kind of deal with,'* (SO4 subtheme4) but then the deceased, too, was an adult. Hence, it was the presence of the child (as described in SO3 sutheme3) and the centrality of '*innocent*' children (SO1 subtheme3) that brought the concept of child-death to the foreground and made this work, in their eyes, different to working with the death of an adult's contemporary. This difference was particularly evident for Marion, who was working with another mother on the bereavement of a contemporary at the same time as this mother, *'I did not get that effect / as I had with this mum,'* (SO1 subtheme3). Moreover, as stated above, their deep impact was not the result of personal unresolved grief, since when working with adult death this impact was not present and none of them had been confronted personally with the death of a child.

The findings of this study thus support the literature on working with child-death that conceptualises it as more challenging to working with the death of adults (Hindmarch, 1993; Humphreys, 2012; Wilkinson, 1994; Barbee et al., 2016; Maytum et al., 2004) for any professional regardless of their parent status, but in particular for parents (Gilbert, 2006).

I feel that this is where the personal in the professional comes back full circle. For, potentially due to child-birth being more chosen by parents in the West these days, hence children being 'wished for' (Letherby, 1994), and because the death of a child is largely not expected any more, Western societies as a whole tend to feel more pain around the death of children (Hindmarch, 1993; Davis, 2016). In addition, the notion of the death of a child being a parent's greatest fear was internalised by participants of this study – potentially due to social attitudes and their own experiences as mothers and their attachments to their children. Working with the death of a child is thus not something we as a society nor participants in this study did or wanted to have as part of their reality. This seems to be one of the reason why as a society we tend to shy away from narratives of children's deaths (Davis, 2016; Thomas, 1994) and some (mother-) therapists do not take on such work as I, Tessa and Marion encountered. *'…you sort of can see the horror in people's faces. Because it's the one thing they didn't want to do,'* (Tessa: SO4 sbutheme4). These general attitudes towards child-death may have further made this work different to working with the death of a contemporary, which participants (and I) may have had more experience and knowledge of both personally and professionally.

5.4. Conclusions on motherhood in the therapy room:

Overall, all participants viewed their experiences of therapy with bereaved mothers as precious (SO4 subtheme4). The work with these mothers, the polarities of their experiences stayed with them, as did the clients and their deceased children *'I've been carrying her, like she carried her dead baby,'* as Olivia said (SO4 subtheme4). I discussed the findings with literature that argues that participants' experiences may

not have been solely down to their shared motherhood with their clients; that relational depth, identification with the loss of a strong attachment and its inherent challenges might have been experienced similarly by other non-mother-therapists and differently by other mother-therapists.

Yet, for participants of this study, their motherhood, their children and experiences of mothering were related to their experiences of working with these grieving mothers. They felt that their own mother role became foregrounded in their work with these clients, shaping their experience of their work as well as their interventions, especially when the parallels were high. In turn, they noticed how these experiences impacted them outside the therapy room and shaped them in the longer run as mothers and as therapists. Thus, 'motherhood in the therapy room' may become foregrounded when the issues of the therapy are around mothering and children and share parallels between the client and the mother-therapist.

Discussion of the findings highlighted the importance of reflective practice, embracing the personal in the professional, an intersubjective positioning on boundaries and the negotiation of our multiple roles inside the therapeutic encounter, especially when the issue of therapy has personal relevance to us and thus might foreground personal roles, attitudes or experiences (in this case motherhood, mothering and child-death). Findings furthermore support the importance of reflective and non-judgemental supervision, which appears necessary for therapists to process clients' stories and their own stories with their clients; as well as other self-care

practices and continuing personal therapy to avoid burn out and promote ethical and

individualised relational therapy.

Chapter 6: Conclusion:

In this final chapter, I reflect on the limitations of this study, propose possible future research and highlight implications for practice. I end this thesis with a conclusion, recapping the major findings of the study and the impact this research had on my personal and professional development.

6.1. Limitations of the study and possible future research:

One of the major limitations of this study is that the initially set-out level of homogeneity was not reached. The greater in-sample variation in this study thus means that there might be certain aspects, such as the foregrounding of gender in parts of Olivia's narratives, or the dynamics between Tessa and the grandmother that might have accentuated certain aspects of these findings that would have been different amongst a more homogenous sample. In addition, there might have been an unconscious impact that Louisa's miscarriage had on her work with the mothers that she referred to. Olivia being a child-psychotherapist furthermore carried with it a somewhat different dynamic to the other mother-therapists. A repetition of this study with the initial strict criteria might be of interest.

On the other end of the polarity, an inclusion bias is present in this study as only mother-therapists who felt deeply impacted by this work and felt they could share their experiences came forward and are represented (Polkinghorne, 2005). This research focuses on and represents a rather specific and small group of mother-therapists. A lot of bereavement work is done with a more systemic approach including the whole family and often also the dying child (if it dies of an illness)

(Kissane & Bloch, 2002; Hindmarch, 1993; Humphreys, 2012), or it is undertaken by fellow grieving parents (Schiff, 1977). Thus, participants' at times strong reactions might have been because they recalled their first experiences of working with this client group. It might be the case that if these mother-therapists decided to continue working with this client group, these impacts would lessen, as is indicated by Gosney (2017).

In addition, I was unaware of the presence of the deceased children in the therapy room, which was what made this work so difficult and different from normal bereavement work, especially for Marion and Tessa. It could therefore be argued that motherhood was only one of the factors that created a platform for identification whilst the children created another. The literature furthermore suggests that fathers' grief, in particular in the case of perinatal and neo-natal death, often goes unrecognised (Zinner, 2000; Cacciatore, 2008). A redesigned study, allowing for a larger and broader sample and potentially applying a different research method, such as grounded theory (i.e., Glaser & Strauss, 1967), might be a useful way to capture a wider sense of mother-, father- and non-parent therapists' attitudes to and experiences of working with bereaved mothers/fathers/families and/or just working with child-death.

All mother-therapists, myself and the mothers they worked with in this study were cisgender birth-mothers, who, as Hollway (2016) states would have not just had the cognitive transition to motherhood but also the embodied transition through the experience of pregnancy and birth. As stated in the discussion, being a birth-mother

was not an inclusion requirement but no other types of mother-therapists came forward. The experiences of adoptive mother-therapists, step-mother-therapists and others are therefore not included in this research, but might be of interest to the therapeutic community. Considering the difficulties I faced in the recruitment phase, recruitment for such a study would need to be carefully planned and thought through.

Moreover, the question raised in the literature review concerning when a mother was a mother or not – as in the cases of mothers who have no surviving children – all the clients that participants worked with had surviving children. Hence, questions as to what happens to a mother's motherhood when she is bereft of her children and its impact on a woman's identity did not come up. In addition, participants and I were of white European and similar socio-economic backgrounds. Our embodied experiences of mothering and motherhood as well as our biases towards them were embedded within this culture. I wonder how/if this type of work or the interviews would have been experienced differently and therewith shaped different data if I or participants were either not birth-mothers or of a different sexual orientation or held a non-binary gender identity. Or, if one of us was of a different ethnic, cultural or socio-economic background holding different attitudes, biases, experiences and identities regarding mothering, motherhood, womanhood and child-death.

I drew on the concept of intersubjectivity throughout this thesis, yet I only attempted to understand this phenomenon through the experience of the therapist. We only reflected limitedly on how participants' experience shaped their relational dance, as discussed above. I think a study that investigates this aspect more deeply would be

of interest to the therapeutic community. Similarly, the second part of the intersubjective puzzle – the grieving mother – was missing. Though potentially challenging, a study that incorporates not just the mother-therapists' lived experience of this therapeutic encounter but also that of their clients would be of value.

Valiente-Barroso and Lombrana-Ruiz (2014) argue that religiosity in bereaved mothers played a modulatory role against the negative effect of the death of their children. Despite asking about religious orientation and spirituality in the demographic questions, this dimension is largely neglected in this study concerning both the mothers and the mother-therapists. I wonder whether for us the spiritual aspect in the raw experience of the death of a child seemed not enough to 'make' this experience 'better'. This is certainly true for me. Thus, my bias of not perceiving religion or spirituality as helpful when thinking about this concept might have spilled over into the lack of exploration of this realm in the interviews. Participants did not bring up how their spirituality, or lack of spirituality, shaped their experiences either. In addition, despite being clear that participants had not experienced the death of one of their own children, we did not explore how other personal bereavements, especially if unresolved, might have shaped their experiences of working with these mothers, as is suggested by Hayes et al. (2008). However, other literature suggests that the death of a child is experienced as more difficult and different to the death of a contemporary (Schiff, 1977; Kuebler-Ross, 1983; Shimshon Rubin, 1996). Thus, one of the reasons why we might have overlooked prior personal losses is that participants and I did not consider that an adult loss was comparable to the loss of a child (potentially a sign of our shared mother-bias). None of the participants (except

Louisa through her miscarriage, which she conceptualised as different) seemed to have been in direct contact with child-death prior to these therapeutic experiences.

My similarity to participants as a white, middle-aged UK trained psychotherapist and counselling psychologist in training is both a limitation as well as a positive. The positive aspect of my fellow motherhood was that I could deeply empathise with participants and their experiences. On the other hand, it meant that I potentially brought more biases to the study than if I was more different to participants, such as my personal conception of child-death being a mother's greatest fear. As stated in the section on reflexivity, I aimed to bracket this as much as possible. Nonetheless, it would be of interest if a researcher less similar to the sample was to repeat this study.

Moreover, the literature review concluded that there had not been an investigation into mother-therapists' experience of working within this dyad before. This research therefore constitutes the first of this kind, which meant there were no previous studies to compare and contrast the current findings with. In order to make more sense of the current findings, a replication of this study to see what factors might create the same or different findings might be of interest.

The impact of motherhood and mothering on therapy are themselves rather under-researched areas. Yet, this study has shown that they can shape therapy in many ways with the client group under study but also others, as SO1 subtheme3 suggests. Thus, more research that focuses on mother-therapists might be of interest. I think

that research on father-therapists or research that explores how other roles and attitudes that therapists hold may shape practitioners' experiences of conducting therapy with certain client groups would be of value, too; therewith widening the literature on the person of the therapist.

6.2. Clinical implications and relevance for practice:

Even though the findings are representative of this sample at that time only and do not lend themselves to the creation of nomothetic rules about 'motherhood in the therapy room', the discussion has shown that there are issues and concepts that can inform the wider community of counselling psychology and psychotherapy. The contribution of this study and its implications are therefore on several levels namely, academic, clinical and training. I outline each below.

6.2.1. Academic contribution:

The findings and their discussion add to literature on 'motherhood in the therapy', an issue that is generally under-researched as literature often stops after a successful pregnancy of the therapist. In line with other literature (Basecu, 1996; Levine, 2009), this research has shown that being a mother can shape therapeutic work in many ways; especially, when working with another mother, when the issue of therapy is around mothering and children and when there are parallels between therapist and client.

This study furthermore adds to the literature that emphasises the reciprocity of the personal and the professional in the work of a therapist (Rabu et al., 2015; Orlinsky & Ronnestad, 2005; Adams, 2014; Gerson, 1996; Knox, 2014). It accentuates, in particular, that sharing attributes with a client, such as motherhood, can be highly positive and enhance the therapeutic encounter, but it can also create challenges around identification (Stevens, 1996; Raja, 2015; Goldstein, 1997; Goldberg, 1986).

The findings of this sample furthermore highlight that working with bereavement that involves the death of a child can be experienced differently to working with bereavement that involves adults only, especially if the therapist is a parent/mother who has not lost a child themselves. The deep impact that participants have described therefore aligns itself with existing literature that explores working with the death of a child (Abendroth & Flannery, 2006; Gilbert, 2006; Hindmarch, 1993). It also adds to it as it looks at it through the lens of a mother-therapist who herself has not lost a child, something that appears not to have been done before.

6.2.2. Clinical implications:

Due to the findings showing that for mother-therapists working with this client group can create some challenges, it is suggested that clinicians who distribute referrals ought to be aware of the deep impact that working with a mother/parent whose child has died can have on mother-therapists. This may be particular so if this mother-therapist has little or no experience of working with this client group at this point or since being a mother. In addition, supervisors who work with mother-therapists who are involved in this type of work can gain deeper insight from this study as to what

their supervisees might be experiencing. It might help them empathise and support their supervisees if they were to encounter similar challenges to the mother-therapists in this study. Rather than viewing it as a sign of poor practice or poor boundary keeping by the therapist, it might be more helpful to see it as a result of being a mother-therapist (who has not lost a child) with this client group.

I hope that other mother-therapists and parent-therapists who are about to embark on working with a bereaved mother, are in it or done it in the past may gain from this study. Either in the form of creating an awareness of how this work might be experienced or to find support when in it and struggling with it. Alternatively, to evaluate their own experience against this sample and reflect on what might have contributed to their different or same experience of this work.

The research with its focus on identification derived from similarities in private roles (woman and mother) yet differences in experience (child-death) furthermore raises points that can be applied to other therapeutic dyads where client and therapist share certain attributes, such as gender or experiences, which might raise the potential for identification and thus shape the therapist's relating with the client. In addition, as this research touched on working with one's greatest fear and issues that are 'close to home', it might be of interest to other clinicians and trainees to reflect on how these concepts might shape their relating with clients and their experiences of it.

All participants spoke about the value of self-care, supportive supervision and in some cases ongoing therapy. The findings thus promote self-care and ongoing personal therapy. They also advocate supervision settings that focus on the being-with aspects of therapy and offer practitioners a space to process clients' stories, disentangle from them and support them on their relational journeys with clients.

6.2.3. Implications for Training:

As this research highlights issues around working with similarities and how our personal roles and attitudes can shape practitioners' experiences of their practice, their interventions and in turn their personal roles and attitudes, this research might be useful for trainees to reflect on how their personhoods impact their work and vice versa. This research promotes reflective practice and can therefore constitute a useful example for students and qualified clinicians alike to stimulate thinking and working along these lines.

6.3. Conclusion:

This study fills a gap in the literature by adding an exploration of mother-therapists' lived experience of working with mothers who grieve the death of their child. An exploration, which does not seem to have been done before. It highlights how the personal and professional are linked and shape each other and therewith contribute to the relational dance of therapy. It furthermore extenuates the literature on bereavement in that it addresses the lived experience of mother-therapists' work with a mother whose child has died, a death that as a society we shy away from exploring.

In answering the research questions, participants felt that their experiences as mothers, their attachments to their children and their attitudes towards the death of children deeply impacted their work with mothers whose children had died. Their shared mother role and mothering experiences raised the potential for identification, especially when the parallels between the women or the children were high. For as mothers they could identify with the pain and deep, dark hole that the death of the child had left in their clients' lives. The findings of this study underline Stevens (1996) quote on the double-edged notion of identification, as participants recounted the healing aspects of being a mother sitting with a grieving mother/grandmother, as well as the challenging ones. The notion of sitting with your greatest fear came to light, as well as working at relational depth through the connections that these mother-therapists established with their clients (Mearns & Cooper, 2018).

All mother-therapists presented as highly reflective and engaged in self-care, supervision and personal therapy. This helped them process the challenges of this work and negotiate ethically between their personal and professional selves. Resulting in positive therapy outcomes. All mother-therapists felt that they had grown personally and professionally from this work. To them their experiences and relationships with these grieving mothers were precious.

The discussion highlighted the situatedness and social embeddedness of mother-therapists' attitudes towards their own and others' mothering as well as children and death. These social and personal contexts therefore shaped how mother-therapists' motherhood was pulled upon in the therapy room and highlights the intrinsic

connection between era, culture, the personal and the professional (Heidegger, [1927]1962). It supports the notion of intersubjectivity and highlights the importance of reflecting on, not if, but how our multiple selves are activated in the therapy room and how to negotiate between them to give the most healing experience to the client, whilst respecting our own well-being and professional boundaries.

My concluding thoughts on this research process are that despite my strong sense that this was an interesting, important and under-researched area, there were times within the recruitment process where I felt that this research was not going to come off the ground. This, in turn, emphasised the sensitive nature of child-death in our society, which some mother-therapists want to protect their realities from. Hence, they do not take on such work. On the other hand, through these processes I learnt experientially what the concept of flexible sampling entailed and how external factors, such as time constraints, can affect researcher decisions.

This learning through adversity is mirrored in my learning from my varied sample. I learnt that for mother-therapists working with a bereaved mother could be challenging regardless whether they themselves were new mothers or well established mothers. For it is about the attachment to the child, as well as our attitudes towards child-death and our embodied experiences as mother. I also learnt that shared motherhood could lead to working at relational depth. It seemed to be the degree of parallels that made separation from the work more or less difficult. I believe, I would not have reached the first and last of these insights had I achieved the initial level of homogeneity. The latter learning, in particular, is what I will take

forward and consider when/if faced with a referral for a grieving mother. To explore the degree of parallels between myself, the client and the children, and to check out my personal resilience and support network before deciding whether I am able to contain the pain this mother might bring for her as well as myself.

The research process has also helped me become more tuned into my own embeddedness in current Western discourses around mothering and child-death. I believe, I am now more open to working with mothers whose experiences, attitudes and practices around mothering may be different, whilst reflecting more deeply on how these difference might shape our relating. I thus feel that besides enlightening my research questions and helping me process a personal memory (as outlined in the introduction), this study has also made me feel more prepared with regards to working with this client group.

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<u>Appendixes:</u>

Appendix 1: Ethics approval letter:

N

METANOIA
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Kathrin Godfrey-Djundja
DCPsych programme
Metanoia Institute

20th February 2017

Ref: 13/16-17

Dear Kathrin,

*Re: Motherhood in the Therapy Room. An Interpretative Phenomenological Analysis of the
experience of mother-therapists who work with mother who grieve for their child.*

I am pleased to let you know that the above project has been granted ethical approval by
Metanoia Research Ethics Committee. If in the course of carrying out the project there are
any new developments that may have ethical implications, please inform me as research
ethics representative for the DCPsych programme.

Yours sincerely,

Prof Vanja Orlans
DCPsych Programme Leader & Faculty Head
Faculty of Applied Research and Clinical Practice

On behalf of Metanoia Research Ethics Committee
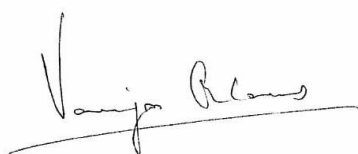
Motherhood in the therapy room.

An Interpretative Phenomenological Analysis of the experience of mother-therapists who work with mothers who grieve for their child.

- **Are you a qualified psychotherapist or Psychologist registered with the BACP/UKCP/BPS/HCPC?**
- **Are you also a mother of children aged 4 or under?**
- **Has none of your own children died nor pregnancies miscarried?**
- **Have you worked therapeutically with at least one mother whose own child aged 7 or under died?**

If yes to all these questions, would you be happy to talk with me, Kat Godfrey-Djundja Integrative Psychotherapist and Counselling Psychologist in Training, about how you experienced working with this grieving mother/mothers?

I would like to interview you on two occasions, with each interview lasting around 50-90 minutes – with a break of 2-3 months between the two interviews.

It is hoped the findings from this study will give an insight into the experience of mother-therapists' work when they are working with sensitive topics around mothering and children, in this case the death of a child; and how being a mother, who herself has not lost a child, may impact the therapeutic process and in turn may be impacted by working with this client group.

If you are interested or would like to know more please contact me on: 07779790675; or email: kathrin.godfrey-djundja@metanoia.ac.uk The research forms part of the requirements towards a Doctorate in Counselling Psychology and Psychotherapy at the Metanoia Institute, 13 Ealing Common, in conjunction with Middlesex University. The research is being supervised by Dr Saira Razzaq; email: saira.razzaq@metanoia.ac.uk

Example email to agencies:

To Whom It May Concern,

My name is Kathrin Godfrey-Djundja. I am an integrative psychotherapist and currently completing my doctoral research in Counselling Psychology.

The reason I am contacting your service is because for my doctoral research project I am looking to explore the experience of female qualified and trainee counsellors/therapists who are also mothers and who have worked therapeutically with mothers whose child has died. A colleague of mine who worked with your service for several years has recommended your service as a specialised service within bereavement counselling and as a place where I could potentially recruit participants for this study.

Participants for this study would require to be counsellors/therapists/psychologists, either trained and accredited, or in their latter stages of (bereavement) counselling/therapy training and also be active mothers of children under the age of 16. They should have worked with at least one mother whose own child, also under the age of 16, has died. Taking part in this study would involve being interviewed twice by myself, the researcher. In the interview we would explore together how participants' experienced working with bereaved mothers.

The aim of this research is to highlight how being a mother may impact the work of mother-therapists when working with grieving mothers, and how in turn their personal roles, particularly the one of being a mother, may be impacted by this work.

I have attached a copy of my recruitment poster for you to look at and circulate around your service. If there is an opportunity where I could come to your service to meet some of your counsellors in person to talk about my research, then I would love to arrange a date with you to do so.

If you have got any questions about this research, would like to arrange a date for me to meet your colleagues or if any of your counsellors are interested in taking part in my research and would like to discuss this further, please do not hesitate to contact me. You can either email me on this address: kathrin.godfrey-djundja@metanoia.ac.uk or phone me on 07779790675;

I look forward to hearing from you,

Kind regards,

Research title: Motherhood in the therapy room. An Interpretative Phenomenological Analysis of the experience of mother-therapists who work with mothers who grieve for their child.

I would like to invite you to take part in a research study. Before you decide it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part in this study.

Thank you for reading this

What is the purpose of the study?

The purpose of this study is to explore the experience of therapists/counsellors/psychologists (who are qualified or in their latter stages of training) who are also mothers of children under the age of 16 and who have worked with mothers whose child (also under the age 16) has died. I am curious how mother-therapists experience working with this client group. Furthermore, I am curious how therapists feel the theme of motherhood may emerge in the room, and how this might impact the therapist (in their role as a clinician and in their role as 'mother').

The aim of this research is to give insight into a rather specific aspect of therapeutic work. The discussion of the emerging themes will contribute to the field of intersubjectivity in the therapy room and the literature on the 'person of the therapist'.

Why have I been chosen?

You have been chosen to take part in this research study because you are a qualified counsellor/therapist/psychologist or a trainee-counsellor/-therapist/-psychologist in the latter stages of training and an active mother of children (under the age of 16), not currently pregnant and have worked therapeutically with at least one mother whose child (also under the age of 16) has died. You will be one of three to four mother-therapists who I aim to interview for this research.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form, of which I will keep one copy too. Furthermore, if you choose to take part, you can resign from this study at any point and without any explanation. You can do so either by phoning me, sending me an email or telling me face-to-face.

What will happen to me if I take part?

If you decide to take part, I will ask to interview you on two separate occasions. I plan to leave 2-3 months between our first and second interview, in order to give us time to reflect on the experience. I will arrange a place and date to conduct the

interviews with you, which will last between 50-90 minutes each. Following the interviews I will send you the transcripts, so you can look through them to see if I understood you right, and to give you the opportunity to add or edit parts of it. Your overall involvement in the interview process will be up to approximately 6 months or until after you have read and communicated back to me your reflections/additions to the transcript of the second interview.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

What do I have to do?

In order to take part in this research you need to be a qualified psychotherapist/counsellor/psychologist and registered either with the UKCP/BACP/BPS or be in the latter stages of therapy/counselling/psychology training, working towards registration with one of these professional bodies. You also need to be a mother (of one or more children, all under the age of 16, and not be currently pregnant) and have worked (or are currently working) with at least one mother who grieved the death of her child/one of her children, who at the time of death was under the age of 16; the ages of other surviving children of the client are not taken into consideration at this point. One of the main foci of your clinical work with this mother should have been around the loss of the child. Furthermore, you need to feel that you want and can talk about this experience with myself (the researcher).

If you decide to take part, I will ask to interview you on two separate occasions. I plan to leave 2-3 months between our first and second interview, in order to give us time to reflect on the experience. I will arrange a place and date to conduct the interviews with you, which will last between 50-90 minutes each. The interviews will be semi-structured, which means that I will ask you different questions and then help you explore your answers by discussing them in order to make sure that your point of view has been understood. The questions will be about your experience of being a mother-therapist who has worked with grieving mothers. In the second interview I will use themes and reflections taken from the transcript of your first interview to deepen our reflections on your experience of working with this client group, as well as of your experience of the first interview. At the end of each interview there will be time for us to debrief on your experience. You will also have the opportunity to ask me questions. Once I have transcribed each interview I will send you a copy of it, so that you can look through it and let me know if I have misrepresented anything you said, missed anything, or if you would like to ask anything. Having read through the transcript of the first interview might also help you prepare for the second interview.

What are the possible risks of taking part?

Taking part in this research could cause you some upset. If this is the case during the interview you can stop it altogether or take a break before continuing. We will also reflect on your experience of this interview when we debrief. If you feel that this experience might continue to interfere with your personal life or clinical practice, I can provide some names of therapists in your area. Furthermore, we might discuss the need to book an appointment with your supervisor, if you feel that this experience might affect your clinical work.

As the experience of this interview may cause you some upset, it is not advisable to take part if you are currently pregnant due to the stress this might cause to your unborn child. If you fell pregnant during your involvement with this research project we would need to review whether you could continue or should withdraw from this study.

What are the possible benefits of taking part?

I hope that taking part in this study will enrich your personal reflections and clinical practice. However, this cannot be guaranteed. The information that this study will produce, will contribute to the research literature of counselling psychology and psychotherapy by exploring and analysing the experience of mother-therapists. It will furthermore add to the discussion of concepts such as intersubjectivity.

Will my taking part in this study be kept confidential?

All the information you give me, including the transcripts and tapes, will be kept strictly confidential in line with the Data Protection Legislation in the UK. Any information about you which is used will have your name, address and other contact details removed so you cannot be recognised from it. Following the completion of the research your recording will be destroyed.

What will happen to the results of the research study?

The data collected and analysed in this study forms part of my doctoral research project, which will be assessed by independent verifiers. The completion of this research might also lead to publication. If this is the case, any personal information will be kept anonymous in order for you not to be recognised. If, on completion of this

research process or once published, you wish to obtain a copy of it, you can contact either myself or request it through the Metanoia Institute.

Who has reviewed the study?

This study has been reviewed by the Metanoia Institute and Middlesex University's Ethics Committee. It has satisfied the requirements of the Ethics Committee, which means this research can now be conducted.

Contact for further information:

If you would like to discuss the content of this research project further or would like to get any more information on it, please do not hesitate to contact me. If you would like to go ahead and take part in this study, please contact me to arrange a convenient time/place to conduct the interview. You can either email or phone me.

Researcher:

Kathrin Godfrey-Djundja

Email: kathrin.godfrey-djundja@metanoia.ac.uk
Mobile: 07779790675

Academic Supervisor:

Dr Saira Razzaq

Metanoia Institute
13 North Common Road
Ealing
London, W5 2QB
                    Thank you for taking the time to read this.

PARTICIPANT CONSENT FORM

Participant Identification Number:

Title of Research Project: Motherhood in the Therapy Room.

An Interpretative Phenomenological Analysis of the experience of mother-therapists who work with mothers who grieve for their child.

Researcher: Kat Godfrey-Djundja

Please initial box

1. I confirm that I have read and understand the information sheet dated ....…………………….for the above study and have had the opportunity to ask questions.	□
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided.	□
3. I understand that my interviews will be taped and subsequently transcribed	□
4. I agree to take part in the above study	□
5. I agree that this form that bears my name and signature may be seen by a designated auditor.	□

_____   _____   _____
Name of participant   Date   Signature

_____   _____   _____
Researcher   Date   Signature

1 copy for participant; 1 copy for researcher

Interview Questions:

Participant identifier:

Demographic questions:

Age:

Marital status:

Number, ages and gender of children:

Spiritual orientation – belongs to a church? Considers herself spiritual?

Professional qualification:

Years of practice and training:

Clinical orientation (psychologist/psychotherapist, integrative, CBT…):

Place(s) of work:

How many bereaved mothers have you worked with? When (before having children as well as after)? Where?

Questions:

First I will ask you a bit about motherhood and its impact and importance to you in general. I will then move to ask you about it more specifically in your therapeutic work and in particular in your practice with grieving mothers:

1) How do you feel does being a mother shape your identity? (How do you view yourself as a mother?)

   Prompts:
   Could you describe your personal attitudes to motherhood and childrearing?

   How important are you children to your overall meaning of life?
   How has having children affected your resilience and stress levels?
   How has being a mother changed your priorities, outlook on life, work-life balance?
   How has being a mother shaped your overall view of yourself?

2) How do you feel does motherhood impact your clinical work?

Prompts:

Practical – diary, holidays, availability… children's sickness, school;Clinical/therapeutically – empathy for parents, values as a therapist/parent, priorities…

How do you see yourself as a therapist? (Before children – with children?)

How do you deal with personal emotions and thoughts to do with children and other things during the therapeutic hour?

3) How did (do) you experience your clinical work with a (this) bereaved mother? Just tell me in your own words how you got the referral, thoughts before working with her, and the process of your work with this mother. In other words, tell me a bit about your story of listening to her story. I may ask you questions to clarify or deepen at points, but pretty much, I want to hear your thoughts to begin with.

Prompts:
How did you get the referral?
Thoughts before working with this clients?

What was difficult, what was easy?
Empathy?
Identification with the other mother as you are both mothers – did you? How did you experience this identification – was it a help, hindrance in your work?
How did the similarities/differences between you and your client and the children impact you? – ages of children, marital status, own age and socioeconomic background..
How was it for you that your client had experienced this great loss, and you had not?
How did you handle this 'difference'? Did you share with the client that you were a mother too? Why? How was this received by the client? Did you offer, or did the client ask? How?
How did listening to/witnessing the bereaved mother's grief affect you? In the therapeutic hours – and outside?
What thoughts can you recall you had when working with this mother? How did you deal with these thoughts in the session and outside the session?

How do you think that being a mother impacted the therapeutic process? – your interventions? – views, clinical thinking?

How – in your view – did being a mother affect your relationship with the client – positive/negative?

What questions do you think you asked because you were a mother? Which questions/areas did you not explore because of being mother? When do you think of this now, what comes up, how do you view this?

What other aspects do you feel impacted the therapeutic process? From therapist and client – personality, looks, spirituality…

How poignant to you was/is it that you were/are a mother and she is a mother and that you share(d) this role. ---- the emergent theme of motherhood.?

If the child that died was an only child – How did you view this mother? Still a mother?

4) How did/does this experience with this grieving mother(s) impact your mothering?

Prompts:

Positive/negative;

Feelings, emotions – fears, gratitude….

Attitudes, thoughts

Behaviour – do more of…, do less of…. (Patience)

Ability to switch off and enjoy when with your children.

What is the result of your changed way of being with your children/as a mum?

How long does/did it last?

Any long-term changes in you and your mothering?

Were there any special triggers in your experience with this client or your children that made these changes?

How did you negotiate between clinical work and private life?

5) How do you experience that these changes in you/your attitudes impact your therapeutic thinking/work with clients?

Prompts:

Other clients

How do you think clients reacted to this? Now and while you were going through this?

Impact on the therapeutic process?

How do you feel this experience has impacted your clinical work? Longer term/practical/in the room?

Clients that you accept – i.e., no more grieving mothers/bereavement work, or more confident in taking on these referrals.
Overall stricter/looser boundaries…

6) What do you feel helped you in your work with (this) bereaved mothers?
Prompts:
Spiritualtiy,
Supervision;
Sparetime – leisure activities,
Between clients – diary, note taking, toilet break…
Spending time with family/children
Literature
Talking to colleagues who are in a similar situation.

7) What made your work with bereaved mothers challenging?
Prompts:
What aspects of this work affected you worst?
How has the impact of this work changed over time?
How has the amount of support you need changed over time?
How has your view of the world changed as a result of working with this client/bereaved mother? How? Positive, negative?
Do you feel you developed more fears for your children? How do you manage them?
How do you feel it affected your health? – physical or/and mental health? What helped?

8) Overall – what stands out for you when reflecting on your experience of working with bereaved mothers?
Prompts:
With hindsight, is there anything you would have liked to know before you started working with this client/client group that would have made this experience easier?

9) Is there anything that you would like to add that we have not covered?

Thank you very much for taking part in this interview with me.

It might be useful to take some time to debrief on this experience with me, if this is okay with you?

How are you feeling now, that we have completed the interview?

Was the interview what you expected?

How have you experienced the interview process?

Do you feel this interview has opened up some reflective process for you? If so, does it seem helpful or unhelpful to you personally and your clinical work? Supervision. Unsettled you?

Would you like me to give you some contact details of counselling agencies in your area?

I will send you a copy of the transcript, once I have typed it up, for you to look over and tell me if you feel I have misrepresented anything, you would like to take out something or would like to add something.

I also wonder if it would be useful to schedule a date for the second interview now, as it might make the process feel more contained for both of us, rather than open ended/loose.

Thank you.

Transcript extract Interview 1 Marion p.14-15 Lines: 322-338

P: participant

I: interviewer

[] changed text for confidentiality reasons;

{} added text to give context to the reader or indicating a cough etc.

Reflective notes:

Normal font, my reflections and descriptive notes on me (right column);

Normal font, descriptive notes on P (left column)

Italic font – interpretative comments and linguistic comments on P (left column)

 CAPITAL LETTERS: EMERGING THEME (right column)

 Gaps in the columns are to give more space for the notes in another column

She states that the main image that she had got in her mid was that of the mother holding her dead baby.

She says, 'and a little… strangely … just .. her … with her dead baby'. I wonder whether her 'strangely' indicates here that she was a bit surprised that her own child and fears for her own child only came in very slightly. Maybe she unconsciously felt that I was looking for her own child to come into the room a lot, even though I never said this to her, but maybe even the title etc. might give away this idea, and I suppose it is true, it is my bias, which I however always tried hard to keep out of the room.

I28: So, what, what do you, aehm. If we think a little bit about this first session, I suppose. What, what do you feel was it that, aehm, was so difficult for you to stay in your shoe? Aehm, it sounds that she really somehow pulled you, pulled you into her grief? Or you … felt your own grief? Or what, what was it that you were feeling that was so (P: I imagined -) difficult?

P28: - I imagined (I: mhm) her baby (I: yeah) And a little, aeh, a little; st, strangely I just   simply imagined her seeing with errr, with her dead baby (I: mhm). And errr, a little bit of, 'What if i, that baby is mine?' (I: yeah) But not much of that. (I: mhm) Because I knew mine is beautiful and healthy and bigger

This question shows my bias or my main interest within this subject. It is in this what is that being pulled in about. So in a way I dismiss the techniques that she told me about or the second easier session and go back to the first challenging session and hone into that one. I was curious what it was that was impacting her. I think being clear about that, I hoped, would also prevent me from making the wrong interpretations in the analysis, which is something I have been quite conscious about.

I am also consciously using her words when I ask 'what was so difficult for you to stay in your shoe'? This was in the hope that by using her language I would ensure that we would stay on this topic and refer to the same things.

THE POWER OF THE IMAGE – THE PRESENCE OF THE CHILD

IDENTFICATION WITH THE MOTHER

THE PERSONAL/OWN CHILD GETS PULLED IN A LITTLE

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She then adds that 'a little bit of "what if that is baby is mine", but she emphasised again that there was 'not much of that'.	(I: mhm) than, that the little (I: mhm) baby. But I just, aehm, … Some people say, it's probably my hormones are still messed up (I:mhm). And it still focussing on my baby's survival rather than (I: mhm) everything. The world's about [my baby] (I: hm). So, I, I, I think it was just my emotions (I: yeah). They are just up and down. I can cry easily on any (I: mmm) situation. If I just let it (I: yeah). Aehm, so, yes. It's imagining her, it's just seeing her literally just standing there and feeling her pain. (I: mhm) But feeling it, as 100% as my own (I: mhm). Not just, as we just said (I: yeah), half. (I: yeah) As if. But I, I, head, not if but as. Hmm (I: yeah). my pain. (I: as if it was your pain) Absolutely (I: mmm).	*AWARE OF THE DIFFERENCES BETWEEN OWN CHILD AND THE ONE THAT DIED*
She goes on to say that she could keep in mind that her own child was healthy, bigger - different than that little baby. She goes on to say, what seems that people have said to her with regards to her reaction, that she was still hormonal and that her life was still focussed strongly on her baby's survival more than anything else.		*HEIGHTENED EMOTIONS DUE TO HORMONS*
Despite saying previously that the image was not that of fear that her baby could die, she then states that others have said, her hormones and the fact that she herself was still so focussed on her baby's survival were what made her so emotional about this. The former - hormones - seems something that would not be necessarily down to her changed identity as a mother, more a physical change as a result of having children. Yet the latter, because her focus is still on her baby's survival, kind of brings in her psychological stage of mothering rather than just the hormonal one, 'still focussing on my baby's survival rather than everything. The world is about him.' This seems to create a notion that there is something about babyhood and her stage of mothering that makes looking/visualising a dead baby so powerful.		*FEELING THE MOTHER'S PAIN 100% AS MY OWN NO FOOT ON THE SHORE… - OVERIDENTIFICATION WITH THE MOTHER'S PAIN*
So for her is the identification with the mother? Not the babies…? because she too is a new mum she can put herself in this mother's shoes so easily and pick up her pain… and she can feel the loss that this mother		I interject what I think I understand that she said, to communicate that I am following her narrative.

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feels… She moves back to telling me that it was this image that seemed so powerful and that it was that she felt the mother's pain as if it was her own (see above) *She says she felt the mother's pain and emphasises that it was 100% as her own pain, which emphasises the strength and creates this image of a lack of separation between the two women but her being one with the client – colluding/confluent. She reiterates this what she refers back to this notion of 50% in and 50% out – but that that for her is was 'no if but as … my pain',.* *She describes a sense of overidentification with the mother, where she felt the mother's pain as her own, in a way she was merged with the mother, they were both together in the depths of the mother's pain, - so she as the counsellor was unable to keep perspective of reflect or see out, because she was so in it. Hence she was no longer present to the client, because she was in the depth with the client. (yet since this was only short lived, for the client this did not seem to be off putting but rather reassuring).*		

Appendix 8: Emerging themes Marion interview 1:

I have noted the emerging themes from the transcript on the PC down on a piece of paper in the process of copying them onto pen and paper I have already slightly clustered them.

I have 138 emergent themes

Learning about the research

The type of the study

About the research

Experiences before being a mother and post being a mother (with bereaved mothers)

The double-edged sword of motherhood

Being a nanny vs being a mother

World revolves around the baby

The double-edged sword comes as a shock – the stuck person it's not me!

Using the experience of the double-edged sword of motherhood and share it with mothers (book)

Juggling multiple roles – lack of time to speak to supervisor about the case before meeting the client

'Marion the mother, 'Marion the counsellor, where is Marion the me?'

Vicious cycle trying to juggle motherhood and the rest of life

Co-existing identities – even if in the background – not vanished (personal in the professional)

Juggling multiple bubbles

Co-existing identities – mother and counsellor

Being mum made me lose myself

Excitement about talking about this experience – research a learning opportunity

But I am a counsellor and I can't support myself – the pressure of juggling multiple roles

How current place as mother impacts my view of myself as a counsellor and how my role as a counsellor puts pressure on my expectation on myself

Pressure on mothering skills due to previous role in child care

Learning from a changed sense of self – learning from the pain

Own difficulties helped her to stay with the client's feeling (general)

Counselling a break from motherhood

The baby brain – impact on practice (the pressure of juggling multiple roles?)

The impact of the baby brain on the rest of her life (lack of control)

Frustration about the changed self

Feeling lost despite in the middle of all this advice – challenges of the reality of motherhood

The personal in the professional – concerns about how her changed/dampened state of being impact her clinical work

Using own experience of 'sitting in it' to 'sit in it' with the client – helpful aspects of won difficulties – impact of motherhood/changed self on practice

The importance of boundaries – between work and motherhood

Keeping the personal out whilst with clients

Exception to the rule – the bereaved mother

Juggling multiple (separate) bubbles

The exception to the rule in terms of boundaries – the bereaved mother

The referral

A general tendency to over-empathise

The client/case – I want to try

Preparation for the client – reading

Importance of preparation

The need to listen to the client – I can do that

The crying therapist – my tears were running; unable to control the impact the mother's story had on her – over-identification?

From prepared and controlled therapist to losing control over emotions with the client

Too little self-awareness about how tricky this client would be/working with the parallels would be – supervisor had an awareness?

The panicked therapist – noticing the process

Attempts to disentangle

Disentangling in the moment – what helps, my empathy rope

Disentangling in the moment – working to stay present and not fall in

Having resources helps

Metaphors, visualisation and supervision – attempts to stay disentangled

The easy to work with client

The experience of the impact – wanting to leave vs needing to stay

The client's wish for privacy – no recording

Impact of the crying therapist – allowing the client to cry more 2x

Passion for counselling identity

Love for the job despite it's pain

Impact of talking about the client in the interview/tears in my eyes

Psychologically leaving the client in order to reground the self and be able to be present again – hard work to stay present? Disentangling?

Interview – a friendly child-chat in a therapeutic way

The importance of supervision – techniques to stay on the shore (visualisation and metaphors)

The impact of supervision on the second session

Supervisor points out interventions

Importance of right amount of empathy – being a mother makes empathy (too) easy?

Empathising is good – too deep in the client's stuff/over-identification not

Importance of staying separate and present – techniques help

The power of the image – the presence of the child? 3x

The personal/own child gets pulled in - a little (aware of the differences in the parallels)

Over-identification with the mother

100% as my pain

Releasing the mother's tears

Heightened emotions due to hormones

General increased sensitivity to child cruelty since being a mother

Impact when on therapist had tears (P005)

Bad News about babies everywhere

Avoiding bad news about babies

How can they? It hurts

Working bereaved mother/child death a different experience prior to motherhood

Different levels of empathy with the bereaved mother prior and post own baby

The other child that died

She couldn't even be there

Impact of that session – feeling a little tried

Changes in counsellor self impact of supervision – general

The session was hard work and busy with own process

Need to survive the session

The struggle to stay present – disentangling in the moment?

The need to keep myself alive during that session

The need to release the build up and suppressed energy after the session – impact of the work whilst with the client

Preparation helps to be more present with the client

More preparation before the work would have helped

Internal supervisor helped through the session

Feelings around having the baby 2x

A parent's worst thing – having to decide to turn off the machines

The mother's double loss

The surviving child – the mother's reason to live

Sitting with the loss – you can't fix it

The mature counsellor

The lasting impact of this client (at the time)

How this work has shaped me at the time – VT?

The importance of processing the impact of this session – peers/family, therapy, supervision (what helped me through this work)

It's better out than in – the impact

The need to cry and talk about it (home and supervision and therapy)

Positive impact of processing

Helping myself to help her

Need to process this 1st session

Ongoing impact of this client (still)

How this work has shaped me – and awareness of the fragility of life

Being pulled in prevented creativity in the therapist – could not make any interventions

Focus on survival in the session /own process prevents presence fort the client 2x

Over-identification /being pulled in stopped this session being a normal session

The intensity of over-identification – more intense than VT

The mother's anger at her own body

Identification with mother's sense of helplessness – expression of empathy?

Identity as a mother different to how she thought it – I'd be a strong mum'

With motherhood comes a shift in understanding parent-child dynamics

Motherhood leads to increased empathy for parents

Being a mother doesn't just aid empathy – it risks over-identification

The importance of keeping half-foot there – degree of empathy

How this work shaped me – increased appreciation for child and life

Increased empathy for mums

Increased appreciation – enjoy the moment

Enjoy all the minutes

The paradox of time

Being pulled away form the client (again) with worries about the self – seeing another client straight after when carrying all this suppressed impact

How this work has shaped me clinically – what I can take from this work for my future practice 2x

Learning from the client/difficult session realising the usefulness of this heavy work

The importance of staying separate in order to stay safe and present

How this work has shaped me at the time – own child reminds her of the mother's baby/client intrudes home life – parallels of the stages of mothering?

Husbands' different ways of dealing with emotions

Sadness for the mother

Motherhood helps with empathy – thinking of own healthy child makes her appreciate what the mother has lost

Crying the client's tears

Her mother's view of working with child-death

My way of dealing with emotions

Mother's need to talk about her grief

Mother's desire to talk about the baby and then not

Wanting to offer the mother the opportunity to just talk and be listened to led to over-identification – lack of control/mirror process? (internal dialogue)

<u>Superordinate theme 3: The double-edged sword of identification:</u>

<u>Subtheme 1: Being a mother helps with the empathy:</u>

p. 34	Lines: 800-801 (Sadness for the mother)
p. 24	Lines: 556-559 (identification with the mother's sense of helplessness
p. 34-35	Lines: 804-809 (thinking of own healthy child makes her appreciate what the mother (and baby) has lost

<u>Key verbatim:</u> p. 34-35 Lines: 804-809 '*Sadness of everything that the baby could, I mean I could, I mean, my baby is full of joy, I mean. Even at night when it every two hours my baby wakes up. And I'm just, 'Arrgh.' It stands up and I see its little head over the cot, standing and waiting and moving, it's aeh, it's; heart-breaking and heart-warming at the same time. And, so, yeah. Feeling that heartbroken … hmm The sadness. Deep, deep, deep sadness.*

<u>Subtheme 2: To feel the mother's pain 100% as my own – over-identification with the mother's loss:</u>

p. 25-26	Lines: 589-597 (being a mother doesn't just aid empathy – it risks over-identification)
p. 14	Lines: 327-334 (over-identification with the mother)
p. 15	Lines: 335-338 (her pain 100% as my own)
p. 35	Lines: 811 (crying the client's tears)
p. 31	Lines: 725-730 (the intensity of the over-identification – more than VT)

<u>Key verbatim:</u> p. 15 Lines: 335-338. *'It's imagining her, it's just seeing her literally just standing there and feeling her pain. But feeling it, as 100% as my own. Not just, as we just said, half. As if. But I, I, head, not if but as. Hmm. my pain. (I: as if it was your pain) Absolutely.'*

<u>Subtheme 3: Focusing on surviving the session – focus on own process:</u>

p. 12	Lines: 276-277 (noticing own process)
p. 30	Lines: 701-703 (being pulled away from client (again) with worries about managing next client when so full up)
p. 22	Lines: 513-517 (focus on own survival in the session/prevents being present with for the client)

p. 22	Lines: 506-509 (focus on own survival in the session/prevents being present with for the client – all knowledge lost)
p. 13	Lines: 290-292 (experience of the impact – wanting to leave)
p. 17	Lines: 393-396 (session was hard work and busy with own process)
p. 29	Lines: 673-674 (need to survive the session)
p. 29	Lines: 677-680 (the struggle to stay present, disentangling in the mo?)
p. 30	Lines: 704-705 (the need to keep myself alive during that session)
p. 12	Lines: 274-277 (the crying therapist – lack of control)
p. 12	Lines: 272-276 (from prepared and controlled to losing control over emotions)

Key verbatim 1: p. 29 Lines: 677-680 '*I was really struggling to stay on the shore. Struggling to stay in that moment of, 'Marion. I want to, I need to leave. Aehm, because I need to cry and I can't cry. and I'm gonna loose it, I need to leave. No, you can't leave. I mean, come on' … It's like I had my own battles*'

Key verbatim 2: p. 12 Lines: 274-277 '*And then as aeh, so, I, I noticed, as she was crying, my tears were running. Especially in my left eye, I could not stop them! So I started panicking, 'Mm-okay. A little tear is really showing empathy. But lots of tears is not okay*'

Key verbatim 3: p. 21 Lines: 506-509 '*Well, in the first session, I was really, I, I lost myself Like, I, aehm, all knowledge, everything that a counsellor knew me. Me as a counsellor knew disappeared. So I was struggling and focussing on surviving myself. Surviving the session…*'

Subtheme 4: The child gets pulled in – a little:

p. 14	Lines: 328-331

Key verbatim: p. 14 Lines: 328-331 '*…And errr, a little bit of, 'What if i, that baby is mine?' But not much of that. Because I knew mine is beautiful and healthy and bigger than, that the little baby…*'

Subtheme 5: Being pulled in hindered interventions:

p. 22	Lines: 523-525 (over-identification stopped this session being normal)
(2)p. 22	Lines: 506-509 (being pulled in prevented creativity of therapist)

Key verbatim: p. 22 Lines: 523-525 '*Yes, it stopped me, yes. Mmm. So basically that session was not like a proper, like I would normally do a counselling session. (1sec) So.*'

Subtheme 6: Attempts to disentangle:

p. 16   Lines: 372-379 (empathy rope helps to work at staying separate)

p. 12   Lines: 278-281 (attempts to disentangle)

(1)p. 13   Lines: 292-297 (metaphors, visualisation and internal supervisor)

Key verbatim: p. 12 Lines: 278-281 '*So, I tried grounding techniques, anything that came in my mind. I just drank the water, nice and cold. I change position in my sitting. The chair, 'It's nice and cold, okay.' So, tried to bring myself back. So that was okay*'

Key verbatim 2: p. 12 Lines: 292-297 '*I mean, you can't carry on crying. So let's see what we can do.' So again I tried grounding. Which works. I try, I started thinking of aeh, something positive. That my supervisor said, I can always go back to my light. So I started talking, talking in my mind, I just imagined something nice. So I, I switched off a little bit from my client to bring myself back.*'

Subtheme 7: The importance of staying safe, present and separate – staying on the shore:

p. 14   Lines: 310-316 (techniques help)

(1)p.31   Lines: 718-722 (the importance of staying separate to stay present)

(2) p. 13   Lines: 292-297 (metaphors, visualisation and internal supervisor –
                                  leaving the client to become present again)

p. 14   Lines: 318-321 (importance of right amount of empathy – being mother
                                  makes empathy too easy)

p. 32   Lines: 760-763 (empathising is good – too deep not)

p. 25-26   Lines: 596-597 (the importance of keeping half-foot there)

Key verbatim: p. 14 Lines: 318-321 '*So, I already saw, between the first and the second sessions there were changes in terms of me being able to feel empathic with just like one foot in her shoe. And the other one is, is strictly on my ground.*'

Subtheme 8: What has supported me though this work:

p. 37   Lines: 859-862 (reassurance about tears from supervisor)

p. 13-14   Lines: 306-315 (the impact of supervision and visualisation on 2nd ses)

p. 21   Lines: 510-513 (supervisor points out interventions)

p. 38   Lines: 895-897 (more specific preparation helps – would have been
                                  good before 1st session)

p. 18	Lines: 419-423 (preparation to be more present?)
p. 13	Lines: 297-305 (the importance of supervision and techniques)
p. 29-30	Lines: 687-691 (internal supervisor)
p. 36	Lines: 841-843 (it's better out than in – impact)
(1)p. 33-34	Lines: 778-797 (the need to cry and talk about it)
p. 21	Lines: 485-488 (importance of processing the session)
p. 21	Lines: 494 (helping myself to help her)
p. 32	Lines: 763-765 (the need to process this first session)

Key verbatim: p. 21 Lines: 485-488 '*I keep talking about her with others, with; I have my therapy and my other supervisor. So, I'm, I'm really getting lots of help. That's why I feel aeh, more resilient. More, safer to. And more prepared.*'

Appendix 10: PARTICIPANTS' FULL QUOTES AND LOCATIONS FROM FINDINGS:

In addition to the annotations in 'Findings', I use the following annotations:

Interview 1: I1

Interview 2: I2

Pages: p.

Superordinate theme 1: The personal in the professional:

Subtheme 1: Being a mother has shaped my world:

(Louisa I1 P.4 Lines: 85-86)

 '…when I had my baby, I just couldn't get over how beautiful it was. I couldn't take my eyes of it.'

(Marion I1 p.15 Lines: 347-357)

'*I feel my emotions are very on the surface since I had my baby. So, if I hear something about babies in the news, and every day there was something bad in the TV. / especially news. Everything triggered. Everything about babies, small babies. The cruelty what the parents did or, or the. And anyway, I am very sensitive to cruelty and aehm, aehm, aeh, what's the word ahh, injustice. So, I, I really hate; and it's so painful for me to see that peo, that one person can do this to another one. When I know; It's so painful, it hurts. It hurts a person and it hurts!*'

 (Olivia I1 p.2 Lines: 37-41)

 '…*but in terms of my practice, I feel it's made me sometimes oversensitive. Because you end up comparing your children to the child that you've got in front of you. Or you start seeing the world in a different way. Aehm / How can I put it. You become more scared of, of what your kids are heading to into the world.*'

(Marion I1 p.25 Lines: 573-580)

'I am more (1secs) empathic with them. I really understood them. I mean, I just picture the; I always thought when I was little. And then my mum would come home from work how, how happy I was when my mum came and brought me something. So, I was so excited to see when my mummy came. And my granny looked after me. So, I kind of felt that excitement and then how the parents feel leaving their child behind. But now, it's, it's really different. Now, I'm aehm, really empathising with everything that I, I saw before, but not felt.'

(Tessa I1 p.34 Lines: 793-795)

'… I want to be a at home. Even if they're annoying me, even if the kids are annoying me, and, which they do. Aehm, I know I'm there. And I think, that is part of the foundations in which I can work.'

Subtheme 2: Being a mother-therapist:

(Louisa: I1 p.6 Lines: 120-124)

'I think my sensitivity to people's needs changed. To their relationships. My sensitivity there. Whereas previously, where I was just a daughter, I'd always been very independent. And I quite hadn't understood, well, I had understood it, but not really felt it. Aehm, and now I was feeling it... '

(Olivia: I1 p.38 Lines: 892-900)

'…and this is what therapists say and that therapists are empathetic. I, they are. And I've been there. And I'm very empathetic and I am. Aehm, I can also be very strict in terms of boundaries. But I also, I think this is something very important that needs to be done Aehm, but there is that bit that comes from really being empathetic because you've been there. And you can identify with a mother who has lost a baby even though you haven't lost one. But, you can imagine yourself. The pain of losing your child.'

(Louisa: I1 p.16 Lines: 361-365)

'…I find it harder when you have someone who doesn't attach. Aehm, because that is sort of the opposite of how I am. Yeah, I have had mothers who have not attached to their baby, and they, there's just nothing there. I just think, 'What's going on there?' That's more difficult for me than somebody who feels more like I do.'

(Tessa I1 p.35 Lines: 819-822*)*

'So, really; you see. I suppose that, aehm, they are; my care of my kids is pivotal to the work that I do. Because if, if, if I'm not happy with, aehm, what I'm; my availability to them and what I give to them, I think the whole, the whole thing goes belly up.'

(Marion I1 p.10 Lines: 232-236)

'But, that all my baby, that's my my bubble. But it seems there is a little bubble with my counselling world. Aehm. And there is this big bubble where I have my baby. So, it actually, yeah. Now, I see it's two different . Small counselling bubble and then aeh.'

(Marion I1 p.10 Lines: 213-216)

'Well, the best thing I found that, when I'm with my clients; it is really true, that once I'm with them, I'm with them. So, aehm, my baby didn't come in because I did, really pay attention to be present. Aehm, except for this client.'

Subtheme 3: Other client issues that pull on mothering:

(Tessa I1 p.15 Lines: 349-351)

'And yet with postnatal depression, I've always found that very kind of painful as well. Kind of knowing that there is a child in there who can't access their mother.'

(Louisa I1 p.18 Lines: 420-424)

'…it's really difficult listening to sort of, recounting the horrible, horrible trauma as / teenager, when I had my own kids at home of that age. Looking at my kids, thinking, "I can't even imagine what she went through." And having to be very careful with that separation.'

(Olivia I1 p.26 Lines: 506-513)

'If I had a really really traumatic day at work and I especially around looked after children and I think there is such a horrible fate to be a child without parents that can't stick up for / they can't stick up for you so you are left at the mercy of organisations and social services and money and it broke my heart. So I would come and [she is using her body/arms to show how her tight hugging] **[I: And keep them tight.]** *And hold them tight.'*

(Tessa I1 p.16 Lines: 361-363)

'I think it's something to do with the innocence of children. Yeah. Yeah, it is. Because I could get upset at that.'

(Marion I1 p.15-16 Lines: 357-364)

'So, and the other child, the other mum was in at home and her, her 12-year-old child had an accident and died when abroad with other family. So she wasn't even present. Because she could not go back to see her own child before it died. So, I felt her pain, her suffering. But, I didn't feel as strongly as if it was my own. Because, I, I guess, it's because I did not have that baby. So that, that's really big, big difference. Really big, huge.'

(Marion I2 p.48-49 Lines: 959-963)

'She has a story. She has a full on story so that's another challenge. Yes, it's / yes because I do, I did not get that effect / as I had with this Mum.'

Subtheme 4: A parent's greatest fear – death and harm to your child:

(Louisa I2 p.12 Lines: 218-224)

'…. the loss of a child / that is always / I suppose the biggest fear I think that most parents would have. Umm you don't know if you would survive it, you don't know if you would be swept away, you don't know so / umm / hopefully I'll never be in that position to find out.'

(Olivia I2 p.41-42 Lines: 813-816)

'… I never like whenever I was pregnant I would tell people please do not tell me any horror stories about / I really, really don't want to know.''

(Marion I2 p.40 Lines: 786-791)

'… it was quite scary, so sometimes I imagine what if I lose my baby, umm, somehow, baby dies. And umm like how / how would I feel. Would I have any energy or, or purpose to live.'

(Tessa I1 p.33 Lines: 750-751)

'But the loss of a child is, is just the wrong way round. You know? So, aehm, how can that be okay? Because, i, it isn't okay.'

Superordinate theme 2: Sitting with the grieving mother:

Subtheme 1: Two mothers connected in the enormity of the loss:

(Louisa I1 p.36 Lines: 833-837)

'But she had asked {whether I was a mother}, aehm, before I knew about the baby. And, then I said, 'Yes.' Aehm, I'm not going to pretend or anything because it is part of who I am. I'm not going to pretend or anything. Aehm. And I think that was

significant for her. That I wouldn't, I guess that I'd understand or that she thought I would maybe a bit better.'

(Louisa I1 p.22 Lines: 426-430)

'I couldn't share her experiences with other things, could I? And I wouldn't want to do. And that was somewhere that / I guess she felt that we had something in common as well.'

(Olivia I2 p.6 Lines: 117-120)

'…I think she appreciated that because / she really did get it because it was coming from a place of complete understanding and empathy.'

(Tessa I1 p.11 Lines: 250-253)

'…when I got upset with the baby session there was kind of like a, aehm, / like a synergy. Do you know what I mean? Kind of like a, a mutual grief and understanding of the enormous loss.'

(Olivia I2 p.23 Lines: 450-452)

'It was very intense between her and me like we were having this discussion. The Dad was on the side and he was just looking on.'

Subtheme 2: Sitting with the pain you cannot fix:

(Tessa I1 p.27 Lines: 609-615)

'…because I can't see, how it could get any worse than that. So, and and bereavement, there is no solution. Whatever the person's age, because you can't bring them back. And I wanted the experience as a trainee, to see how that was. And whether I could sit with that. And I think, with the, with the, you know, with the

woman whose baby had died, there were no solutions to be found at all. Because that baby wasn't gonna come back.'

(Tessa I1 p.27 Lines: 624-630)

'I don't have a problem with there not being any resolution to stuff. That, that, that's a comfortable enough place for me to kind of sit. Aehm, / aehm, / and I suppose when the therapy moved to that. That's much more comfortable f, for me. That, coz it's almost more pr, kind of, practical issues. Aehm, and, and, and, aeh, rather than working and dwelling and sitting with the loss.'

(Marion I2 p.5 Lines: 81-82)

'Umm but still I, I, I found that it's, it's awful, it's a lot of pain, it's so big, it's so heavy, it's like [sighs]…'

(Louisa I1 p.46 Lines: 1059-1063)

'But you know, the worst had happened, hadn't it? Whatever, whatever I did, I couldn't improve the situation. I couldn't help / do anything that would help. The feelings. I could just be there to witness it and to talk about it. And to normalise it and to treasure her baby.'

Subtheme 3: 'I would write it in gold' – validating the child's life:

(Tessa I1 p.23 Lines: 521-529)

I think it's to be able to, to be very present. And, also, to, they, to be actively kind of talk about the child. That was always kind of very important. And I remember the, the mum whose child died. I must have seen her afterwards, after she, was after she had the other baby. Hm, can't think now. But she always talks about the second baby as being the second baby. Not their only child. Yeah. So that presence of, of the, of the child that's died, aehm, seems to be very important to kind of acknowledge it and to, and to keep on acknowledging Aehm, because a lot of people don't talk about it. You

know, so, aehm, aeh, I, I think that's; to be able to be very aware of that is kind of helpful when working with people whose children have died really. To keep the kind of the memory alive.'

(Louisa I1 p.10 Lines: 223-224)

'*…that was the bit she was actually more, that was keen on sharing'*

(Olivia I1 p.20 Lines: 462-466)

'*But she will speak as if it was yesterday. Like the ways she described the whole scene, it was like it was the day before. And it was horrendous. Aehm, and, the grief. I was, I was just thinking, 'Gosh, she really hasn't grieved.' She really is, it's been fifteen years.'*

(Louisa I2 p.18 Lines: 342)

'*But I sort of wanted to celebrate that she'd had some love.'*

(Marion I2 p.12 Lines: 229-234)

' *… when uhh I wrote aeh, the final evaluation report, umm, I felt that to give a great / the best gift that the little one can have is respect so I wrote its name / well we don't write the names, we write the initial, so I said the baby and I said the name of the baby because the Mum told me, so it's, it's / she was particular about that the baby was a person, it was a little young person, so the baby existed and I felt that I need to respect, give this final gift of when I was writing.'*

(Marion I2 p.36 Lines: 711-716)

'*I was just / just feeling sensing like whatever is happening inside and why I am just writing these two pages. And uhh it was very very important to me, these, these letters. And it's like, if it would be, I would write it with gold.'*

(Tessa I1 p.4 Lines: 78-80)

'*I was very aware that my child was doing the same sort of thing. And I was, I had got my child and she no longer had her's.*'

(Louisa I2 p.38 Lines: 734-738)

'*I was there / I actually felt slightly guilty. Strangely guilty. That I had taken my baby home and she had lost hers.*'

(Marion I1 p.19 Lines: 430-433)

'*I had a, aehm, I had guilt and worry that if she asks, if I'm a mum. And how would she feel, if I say my baby is healthy and alive? So, I felt fear actually that she that she would ask. And reagiert that my baby is alright and her's is not.*'

(Olivia I1 p.28 Lines: 658-660)

'*And, I was, gosh. If that woman,* the last one *knew that I had an alive baby boy, I'm not sure if she, she would have hated me.*'

Superordinate theme 3: The double-edged sword of identification:

Subtheme 1: Being a mother helps with empathy:

(Louisa I1 p.16 Lines: 358-360)

'*It sort of made sense, because it was the one thing {the baby} she had that was hers. Aehm, obviously I felt very strongly attached to my children. So I could, I could make sense of that.*'

(Marion I1 p.34-35 Lines: 804-809)

'*Sadness of everything that the baby could, I mean I could, I mean, my baby is full of joy, I mean. Even at night when it every two hours my baby wakes up. And I'm just, 'Arrgh.' It stands up and I see its little head over the cot, standing and waiting and moving, it's aeh, it's; heart-breaking and heart-warming at the same time. And, so, yeah. Feeling that heartbroken / hmm The sadness. Deep, deep, deep sadness.*'

(Oliva I2 p.17 Lines: 319-326)

'*You know, when you're pregnant you know, exactly, you know the personality of your baby, I knew mine, both of them, like my first used to kick so much. And had this pattern and my second was terribly, terribly quiet. So you know like they have their own little personalities. So she would have known her baby very well / and he didn't.*'

(Olivia I1 p.21 Lines: 476-483)

'*And I, again that's me in identification with her, thinking, 'Yeah, what would it have been like for me. I really wanted a boy.' And then. She never found out {the sex with the children afterwards} until they were born. So you kind of hold the hope until the second they are out / that it would be a boy And you find out it is a girl. So that; You lose that fantasy. One more, one more, one more times So, come to think of it. I can understand why her grief continued.*'

(Louisa I1 p.12 Lines: 268-275)

'*Really sad. Aehm, especially because she had children afterwards. But she was detached from them. She had no attachment. Because the pain was so bad. Because when she'd actually allowed herself to feel for the first time in her life, the pain was so bad when she lost her child. That she had these other children; she cared for them on a functional level. But she didn't love them. And we did discuss that. That she couldn't go there again. She couldn't put herself in that much risk again. And that was really hard to hear.*'

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(Olivia I1 p.33 Lines: 762-767):

'I *don't think she. She's not / she's not a dreadful mother. She is not somebody who maliciously does something to her kids. She is very loving and caring mother. Within her capacity she loves and cares. And you could see a glimpse of how loving, loving she could have been. Had she been, had things worked out differently. So, it's not that - a horrible mother.* '

(Tessa I1 p.19 Lines: 419)

'*I should imagine its, aehm, helped with, aehm, the empathy*'

<u>Subtheme 2: The struggle 'to keep myself out' – staying safe, separate and present:</u>

(Tessa I2 p.14 Lines: 258-267)

'*Umm what was I keeping out of, I suppose my own reality, really, and again, that kind of having to say, this doesn't happen to every child. Not every child gets a terminal illness. Not every child has a genetic disorder and dies a month after birth. So that's the energy that has to get spent to keep me on the straight and narrow. To not delve into my own stuff. To keep me present for the client.*'

(Marion I2 p.29 Lines: 564-567)

'*So I was able to umm umm examine the relations about this. With her. Because of I was more present, more aware and less in to this deep sadness.*'

(Olivia I2 p.4-5 Lines: 79-88

'*…so not getting to the terror because otherwise when your get into a complete terrifying hopeless position. And a very good chance of freaking out / and not wanting to hear it. Actually this is not my job but this is / her pain.*'

(Louisa I2 p.6-7 Lines: 110-122)

'And (2sec) you know you don't put yourself exactly in the client's shoes do you. It's that one foot in the river and one foot on the bank. But when something is like the worst possible fear that could happen / there is /it's a strange umm conflict isn't it. Of not being too drawn in but still / there enough for them. But perhaps you don't put the guard up quite the same.'

(Tessa I2 p.19 Lines: 421-426)

'I'm wondering if there are interventions I wouldn't have made, because I'd be struggling to / aehm, you know. What if there were other things that were said that I might struggle to contain. Yeah. So maybe, it might have, aehm, hindered my interventions. Perhaps. You know?'

Subtheme 3: The power of imagery – the child's becomes real:

(Louisa I1 p.13 Lines: 287-294)

'And aehm, obviously she showed me her little pictures of her little baby and that sort of stuff. And she dressed the baby beautifully. … in proper fancy and thrilly clothes, all matching. The baby looked absolutely beautiful. And she was clearly really, really proud that it was her's and she really loved this baby.'

(Tessa I2 p.26 Lines: 490-495 p. 26)

*'…but it's like she was making that child, that child's reality, that child's life very real to me. **[I: yes]** So it wasn't just a child, but this child then had preferences for colours and TV programmes / and all this sort of stuff, and umm wo what's happening then is this child is forming in, you know, in my imagination, and in the room becoming more and more present.'*

(Tessa I1 p.17 Lines: 380-384*)*

'…the child maybe would have known that it wasn't well. Or maybe had days where the child was feeling better than not. Aehm, You know, better days than, than iller days. And I think that pains me really that maybe the child might have had some awareness of its own mortality I suppose.'

(Olivia I1 p.22 Lines: 516-17)

'I, and I, even I didn't see this baby. I still, if I close my eyes, I've got this image of this baby gasping for breath.'

(Marion I2 p.25 Lines: 489-493)

'Umm / because in, in those moments, I literally imagined a small tiny new born baby, and she's holding in that cold room, death, closed eyes, little body, just holding and the milk comes Aeh, that was the, that was my / when it really hit me.'

(Tessa I1 p.28 Lines: 634-637)

'…I suppose in a way, when she showed me that picture, she broke through into that kind of private part of me really. That I'm trying to keep out of the therapy room. But it got, it got, it, i, i, it got thrown in, or dragged in instantaneously with that picture'

<u>Subtheme 4: 'The parallels were killing me' – the risks of identification and how to disentangle in the moment:</u>

(Tessa I2 p.20 Lines: 380)

'… the client with the photo cried, I cried, umm, with / for her loss.'

(Tessa I1 p.28-29 Lines: 650-658)

'*Aehm, I think I was alright about it because she got a really genuine, authentic part of me. [giggles] You know. I didn't fake it. I was in it, kind of with her really. And aehm, / and because, aeh, / she, she wasn't put out by it. I think I brought shock, horror, aeh, loss, grief, disap, all of it. She had it. She had it from me. And I suppose we, hm, it kind of reflected everything she was kind of experiencing, really. In a very genuine way. Coz it, it really hit me like a tonne of bricks. And I wasn't afraid to, I, I, I didn't try and stifle the tears.*'

(Marion I2 p.9 Lines: 169-171)

'*Umm I think, again, that I have my own baby. So I can absolutely 1000% feel with the Mum.*'

(Marion I1 p.12 Lines: 292-297)

'*I mean, you can't carry on crying. So let's see what we can do.*' So again I tried grounding. Which works. I try, I started thinking of aeh, something positive. That my supervisor said, I can always go back to my light. So I started talking, talking in my mind, I just imagined something nice. So I, I switched off a little bit from my client to bring myself back.*'

(Marion I1 p.21 Lines: 506-509)

'*Well, in the first session, I was really, I, I lost myself. Like, I, aehm, all knowledge, everything that a counsellor knew me. Me as a counsellor knew disappeared. So I was struggling and focussing on surviving myself. Surviving the session…*'

(Louisa I1 p.25-26 Lines: 583-687)

'*But I do know, what it's like to be in a children's ward. And have all the types of interventions they were having. Aehm, which was, you know, when my baby was a*

baby! Aehm, that really was quite hard. And there'd be times where I'd sort of swallow that one down [takes a deep breath]'

(Louisa I1 p.42 Lines: 978-980)

'That, 'Oh, here we go.' You know? That wasn't something that I was sort of expecting. Yeah. I pinched my thigh, so I didn't go too much into. To separate my stuff [giggles] from hers.'

(Tessa I1 p.13 Lines: 290)

'… it was the parallels that were killing me.'

(Tessa I2 p.26 Lines: 487-489)

'Almost if it had been ah the other sex / would it have been?'

(Louisa I2 p.36 Lines: 704-706)

'My children are older than that, they are older umm / it helps that separation.'

(Olivia I2 p.7-8 Lines: 137-140)

'Because the first thought is oh my God, the terror, and then oh my God, I am so glad my child is safe and then the guilt and then you process all that and then, then actually the pain and what it must be like for this woman.'

(Marion I1 p. 21 Lines: 485-488)

'*I keep talking about her with others, with; I have my therapy and my other supervisor. So, I'm, I'm really getting lots of help. That's why I feel aeh, more resilient. More, safer to. And more prepared...*'

(Louisa I2 p.40 Lines: 777-784)

'*…but also giving myself some space and some time to do something in a different head space to allow me to separate from that. Like, running or reading or going to choir …*'

(Tessa I1 p.10 Lines: 226-227)

'*But it was more in supervision that aehm, I think my, the, the, the, grief and the loss. I could express more in supervision.*'

(Olivia I1 p.41 Lines: 954-959)

'*…because it really stuck with me. This experience. So, I have a very good supervisors that I speak to weekly. So, I spoke quite a lot about that experience. And trying to disentangle myself from, from that story. Because it did get entangled.*'

Superordinate theme 4: How this work has shaped me:

Subtheme 1: 'The client bubble stayed' – the challenges on the self whilst working with the mother:

(Louisa I1 p.24 Lines: 553-556)

'*...so, sometimes I would find this a really hard contradiction. There would be a bit of me mourning her baby, there would be a bit of me thinking about the trauma1, and*

*then mine would be having a scrap on the floor and demanding tea [giggles **[I
giggles]**]'*

(Tessa I2 p.2 Lines: 30-34)

*'… what would have happened is that I would have been very consciously aware that
children die when you're dealing with clients whose children have died. / And then
going home to my two children.'*

(Tessa I1 p.31 Lines: 725)

I think it just would start to impact my home life.'

(Marion I1 p.33 Lines: 778-791)

*'I still was in my client's bubble. For pretty much for all that week. First of, definitely on
that day. In the morning I saw my client. Came home. And in the evening I had my
supervision. Luckily. So, I, I continued processing. In the next day I still cried. And in
the day after. On the Friday, that was Monday. And on Friday I had my therapy. So
that's when I cried again. So, it like, it took five, so actually, I haven't even landed in
my bubble. Because I was always, espec, every time I cuddled my baby. Especially
when I came, I started crying. Just again thinking of the mum. Aeh, holding her baby
who is not alive and beautiful like mine. [clears her throat] So, I was pretty much, yeah,
my client stayed with me for a long. So I never landed on that day. On that first day.
So, I cried. I just sat here, baby on my lap and I cried.'*

<u>Subtheme 2: How this work has shaped my mothering and views of the world:</u>

(Olivia I2 p.25 Lines: 481-483)

*'When I have an experience like this I hug my children a bit too tight. They walk in and
when you hear the kids and you feel so grateful that they are still here.'*

(Marion I1 p.28 Lines: 649-651)

'*And never know when it ends. [I: Mhm / Yeah] So, yeah. Fragility and, and treasure the moment. Yes.*'

(Tessa I2 p.4 Lines: 71-72)

'*And I think that I very consciously don't then limit my children's activity because I remind myself that it's a small percentage.*'

(Louisa I2 p.49 Lines: 964-968)

'*… reflecting on things to the children, getting their responses and talking to them, watching them grow.*'

Subtheme 3: How this work has shaped my clinical practice – clinical decisions and insights:

(Tessa I1 p.13 Lines: 302-304)

'*…this isn't a client group I don't want to work with while my kids are this age, or whatever age…*'

(Tessa I1 p.22 Lines: 495-501)

'*…actually, even when clients pull out pictures now, 'Shall I show you a picture?' People will say. And I will say, 'Yeah, I'm not good with pictures though. I'm just putting it out there'. And I will make a bit of a joke about it. Because there's something about the stark reality of seeing a picture of, aeh, aeh, a, a dead person or baby that I, I struggle with. And I know I struggle with it now. I'm probably traumatised by it. [laughs] [I giggles]*'

(Marion I1 p.31-32 Lines: 730-738)

'… what I can take away from this client is, is the, my learning. So, all these that, all this that coping mechanism that I, could aehm, support myself with all the other clients (1sec) Aehm. And even if I, even if I fall in that intense, deep, aehm / experience. I can still come, stay. And I can come back out. I mean, I can, at, at least I can stay until the end of the session. At least I can stay. So it's not as scary as. I; Well, it is scary, but it's not, aehm, aehm / It's not the end or it's not fatal.'

(Marion I2 p.19 Lines: 376-380)

'I feel stronger, more grounded, and especially with my empathy / like uhh this, this wave thing, it just / like it taught me that I can uhh stay with the client / and I can also get out and stay still, stay in but out.'

(Olivia I1 p.43 Lines: 1013-1014)

'…I knew their stories. I read their files. But reading the file is nothing like seeing the person in front of you. And hearing their, hearing their story. And experiencing their story.'

<u>Subtheme 4: 'I want to put her in a glass bauble and put her on the top of the tree' – multiple lasting feelings about the work:</u>

(Tessa I1 p.26 Lines: 603-606)

'…what I said before, you know, to other therapists that I work with adults, you know, parents whose children've died, you sort of can see the horror in people's faces. Because it's the one thing they didn't want to do.'

(Tessa I1 p.32 Lines: 743-749)

'Yeah. It's hard, isn't it? Because the child, the baby; my kids weren't babies but it was the baby that impacted me. And, aehm, I suppose the older child, my child was

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that age too at the time. So, maybe I was quite naïve kind of going into it, thinking that it wasn't going to; it was, it was about the adult's grief a, and adults grief I can kind of deal with. But I suppose it's probably kind of about the circle of life, isn't it? If they've lost their parents or a contemporary, aehm, that feels for me much safer ground?'

(Louisa I1 p.36 Lines: 842)

'*It was all very sad.'*

(Marion I1 p.21 Lines: 482-485)

'*I, I, al, I loved, I loved and I love what I do. Even if it was this painful and I'm really, now, I, I'm grateful for; not mentioning that I cried for a whole week because of this client. And even now, I just had some tears. So, it's really, she really stayed with me.'*

(Olivia I2 p.18 Lines: 350-354)

'*… is because in a way I've, in a way, I've been carrying her like she carried her dead baby. Umm / it stayed quite vividly in my mind and it still is because I do feel the pain and I do think very likely is connected to the fact that I'm a mother / and the thought of losing a child is the worst thing I can think of, it's my worst nightmare.'*

(Marion I2 p.14-15 Lines: 281-286)

'*I feel that, with her, I put her in a glass umm this umm / how you call this / bubble bubble {bauble} or / Christmas ornament. A beautiful glass one, up on the top, while the rest of my work with my other clients is just down, down here, on the / but yes I see that's the precious one. So in a way I just feel it's precious.'*