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“I’ve got this hole...”: Experiences of therapist involuntary childlessness when working with clients

Martin Stokley¹ and Val Sanders

University of Greenwich, London

Email: m.stokley@spurgeons.ac.uk; V.E.Sanders@greenwich.ac.uk

Abstract: Little has been written on how therapists experience their practice in relation to involuntary childlessness. There have been no systematic research projects exploring solely the therapist’s voice on this issue to date with only two pieces of literature specifically discussing therapist involuntary childlessness in professional practice. This research explores the lived experience of qualified therapists regarding involuntary childlessness in therapeutic practice filling the gap in the existing literature. Four female participants were recruited through an initial online survey and they completed an audio recorded semi-structured interview. One of the researchers also completed a written self-interview to add a missing male voice to the research. Interpretative Phenomenological Analysis was used to analyse all five interviews. Three main themes were identified: ‘Experience of own childlessness in work with clients’, ‘Therapist childlessness beyond client work’, and ‘Therapist childlessness and theory’. This article concentrates on explicating the main theme ‘Experience of own childlessness in work with clients’ with the further two main themes being the subject of a future article. Findings indicate that therapist involuntary childlessness cannot be separated from therapeutic practice and greater awareness of the potential proactive countertransference is needed. In addition, issues around client judgement, implicit self-disclosure, and the potential positive benefit of vicarious parenthood are considered.

Keywords: Interpretative Phenomenological Analysis, Childlessness, Qualitative research, Therapist self-disclosure, Therapeutic relationship, Counselling, Psychotherapy

Childlessness is increasing in the United Kingdom (UK) and Europe. Statistics indicate that approximately one-in-five women and one quarter of men aged 42 have never had their own children (Berrington, 2017). ‘Involuntary childlessness’ describes those who have a desire, but are unable, to have their own biological children. The term is sometimes used narrowly to refer to those who are unable to have children for biological reasons (age, infertility, or other medical conditions).

However, a wider use of the term is also recognised which encompasses what Tonkin (2019) identifies as ‘childless by circumstance’ for complex social reasons. ‘Voluntary childlessness’ (sometimes called ‘childfree’) is normally reserved for those who have actively chosen not to have children whilst remaining biologically able. Some writers (Monarch, 1993) prefer to think of an overlapping range of childlessness from exclusive involuntary to exclusive voluntary. This spectrum recognises the multifaceted and mutually

¹Corresponding author now affiliated to: Spurgeon’s College, London, SE25 6DJ.

interacting, and perhaps ambivalent, reasons for a person's childlessness.

Therapists are not immune from the experience of childlessness. My² own experience is of a growing subjective awareness of my childlessness as a white Western male in his 40s and its presence in my therapeutic practice. As I began to notice how my childlessness manifested itself with clients, I started to wonder how other therapists experienced their childlessness, both personally and professionally, in relation to their practice. The existing literature in this area was found to be minimal. This study aims to bring into focus the virtually silent and unacknowledged therapist's voice regarding their own involuntary childlessness in their counselling and/or psychotherapy practice.

Literature Review

The Psychosocial Experience of Involuntary Childlessness

The subjective experience of involuntary childlessness includes psychological elements such as: frustration and anger, stress, questions of identity, alienation, depression, envy, and cycles of hope and despair (Apfel & Keylor, 2002; Griel, 1997; Johansson & Berg, 2005; Malik & Coulson, 2013). In addition, grief and multiple loss over a lifetime (Malik & Coulson, 2013) are predominant experiences of those facing involuntary childlessness. The psychological experience varies, however. Not everyone experiences these psychological elements in the same way, if at all. Unconscious conflicts and repression of parental desires can also be part of the experience and causes (through childbearing being left too late) of childlessness (Apfel & Keylor, 2002; Kulish, 2011).

The social and cultural context of involuntary childlessness differs between societies, as does the meaning and importance of bearing children (Van Balen & Bos, 2004). Men and women have differing experiences of the social stigma of childlessness across cultures and even in the same culture (Val Balen & Gerrits, 2001). Socioeconomic, spiritual, relational instability, access to reproductive technologies, patriarchal, and pronatalist social discourse are all mediators of childlessness and indicate the socially constructed nature of the experience (Griel, McQuillan, & Slauson-Blevins, 2011; Van Balen & Bos, 2009). A significant factor is the cultural tendency for the male voice around childlessness to be missing in both social and academic discourse (Kreyenfeld & Konietzka, 2017a).

Ultimately the subjective and social aspects of childlessness intertwine, as they mutually impact each other.

Therapist Childlessness

The dearth of literature around therapist childlessness seems to mirror the hesitancy in wider society to speak about the subject. In an edited volume on fertility counselling, two chapters include brief abstract discussions about therapists' countertransference reactions, without in-depth discussion of how countertransference may be linked to the therapist's personal history of childlessness (Applegarth, 2006; Maier, Covington, & Maier, 2006). This situation is replicated in other articles on counselling and infertility. With no rich description, the childless therapist's voice is essentially silenced as accounts quickly move onto other issues. This might suggest that the therapist's inner conflicts around childlessness in relation to clinical work are too difficult to contemplate beyond an abstract recognition.

Only two pieces of research explore directly the impact of involuntary childlessness on therapists. Adams (2014) writes about therapist childlessness in the context of a research project exploring how the therapist's private life impacts on their clinical work. She describes her own childlessness and an interview with a childless therapist as part of her research. Various issues are raised around the interplay of the therapist's childlessness and their practice: self-disclosure of childlessness and the impact on the client; how countertransference around childlessness can lead to defensiveness in clinical practice; and a therapist's nurturing and parental longings being met through sublimation in work with clients thereby mitigating a sense of loss. The focus of Adams' work is predominantly around dismissing the myth that therapists are untroubled in their private lives. Although acknowledging childlessness as an issue for therapists she does not engage in an in-depth investigation into the lived experience of childless therapists and this remains a side issue in her wider study, especially as she moves on to discuss therapists who are parents.

Leibowitz (1996), in contrast, describes her own experience of childlessness in relation to her practice. Again, she highlights issues around countertransference, self-disclosure and the therapist's nurturing role. She also acknowledges other areas including: client disclosures triggering grief; the struggle with clients' perceptions, and assumptions about those who do not have children being seen to experience a lesser ability to identify with parental issues; unconscious of envy of clients who have children; and how responses to clients' questions

² Throughout this article references to the first person ('I' and my') refer to the primary researcher (Martin Stokley).

about parental status are linked to the therapist's own psychological state at that moment in time. Leibowitz discusses case material from when she was undergoing fertility treatment, and also from shortly after, when she decided not to have children through an alternative method such as adoption. She notes that when undergoing treatment, she was more defensive about discussing her childlessness with her clients. After deciding not to have children she self-disclosed to clients more openly. Leibowitz's writing focuses on her lived experience of transference and countertransference in the therapeutic relationship, yet in focusing on her own lived experience it is not clear if these insights are part of wider patterns which are applicable beyond herself. Some of her insights are also partially linked to the ongoing struggle to conceive rather than being the experience of someone who knows that parenthood or conception will never be possible. We see from this literature that there is potentially a complex interaction between clinical work and the therapist's childlessness.

Beyond these two examples, there has not been a published systematic empirical study of therapist voices regarding their lived experience of their involuntary childlessness in their practice. Crucially, neither Adams nor Leibowitz include the voice of the male childless therapist. In addition, both Adams and Leibowitz focus solely on the therapist's experience of their childlessness in relation to actual clinical sessions. Neither discusses experience in relation to wider professional practice such as supervision or in counselling/psychotherapy organisations. The aim of this study was to listen more carefully to the variety of therapists' lived experience in this area attempting to explore the potential for a broader range of responses.

Method

Design

Qualitative methodology allows for an idiographic (i.e. individual) approach which examines the uniqueness of individual experience and is therefore relevant to the phenomenon of therapist childlessness. Qualitative methodology is also a constructivist and more relativist (or critical realist) ontology (Willig, 2008) which recognises that there is no single reality regarding the experience, or state, of childlessness. The state of childlessness is an objective, biological phenomenon but it's always mediated by psychosocial variables leading to a diversity of equally valid experiences.

A hermeneutic (i.e. interpretive) approach emphasises the importance of multiple, emergent, socially created meanings.

Applied to our research, it acknowledges there is no universal experience of childlessness and therefore what is significant is both the participants' interpretation of the experience and the researcher's interpretation of their participants' interpretation. We chose to use Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) to explore therapist involuntary childlessness. IPA is a phenomenological, hermeneutical and idiographic research method which emphasises the importance of lived experience and therefore allows the therapist's voice to be heard. It highlights the importance of the 'hermeneutic circle' whereby interpretation continually oscillates between the whole and the parts. The researcher is seen to impact on, and be impacted by, the research. This allows the evolution of an interpretation of the phenomena and the development of new perspectives whilst holding the similarities and differences across participants in tension (Smith & Osborn, 2015).

Our research design was also influenced by Moustakas' (1990) heuristic research method where the researcher is explicitly present as part of the research process. I (Martin – first author) was the primary researcher. Immersing myself in the issue of therapist involuntary childlessness meant also drawing on my own subjective experience as an involuntary childless therapist through a written self-interview using the same interview schedule as my other participants. My own voice therefore became an integral part of the project. My (written) interview drew on my experiences documented in a reflexive written journal of my experience of my childlessness in my practice from the year before the research project actively began. This helped to provide some separation between myself as research participant and myself as researcher because the initial raw experiences which were not influenced by other research participants. Entwined with this in the written interview I also included aspects of the process of my own continuing illumination into the impact of my childlessness on my practice which was prompted by my ongoing role as researcher.

While IPA, as laid down by Smith et al (2009), does not explicitly emphasise the role of reflexivity (i.e. critical self-awareness), we believe our hermeneutic approach warrants making the role and impact of the researcher more transparent. Further, there are many in the qualitative field (e.g. Banister, Burman, Parker, Taylor, & Tindall, 1997; Finlay 2002, 2017) who highlight the use of reflexivity and personal accounts as both legitimate forms of data and a means to increase the transparency and trustworthiness of the research.

Participants

Purposive sampling was used to achieve as homogenous sample as possible. Selection criteria were that participants

should be: a qualified counsellor, based in the UK, works with adults, would have liked to have children but was unable to (for various reasons), and is able to give a rich description of their involuntary childlessness in relation to their practice. An online survey gathering initial data in the form of a pilot survey using the proposed interview schedule was undertaken. Sixteen respondents completed the questionnaire and were recruited via a social media groups for therapists, advertising in counselling agencies and through therapy networks. From the respondents who met the selection criteria four female participants, who were randomly chosen, agreed to take part in an audio recorded interview. The only male respondent in the online survey did not meet the above selection criteria. Reasons for lack of male recruitment are not clear but could be indicative that male therapists find it more difficult to talk about their childlessness, or that childlessness is less an issue for them. It could also be related to the smaller number of male therapists in the UK. My own voice (Martin's) therefore became the only male voice in the study. The five participants (four females, one male) were aged between 34 and 55 years old and all worked integratively as therapists. Reasons for childlessness were either infertility or other health problems, with one participant preferring not to disclose.

Ethical Considerations

Ethical approval was sought from the University of Greenwich Departmental Research Ethics Panel. As part of this approval a comprehensive risk assessment was undertaken. Controls were put in place to reduce risk to both participants and researcher. The research was also considered in the light of BACP Ethical Framework for the Counselling Professions (2016). Participant autonomy was respected with informed consent being sought for each part of the study. Potential participants were given an information sheet and consent form which detailed what the project involved and what they were consenting to. Clear withdrawal procedures were outlined. At the start of all interviews the participants were orally informed of the nature of the research project and assurances around privacy were given. Participants chose a pseudonym to ensure their anonymity.

Following to the initial informed consent, continuing consent was sought as part of the interview and data analysis process. Participants were asked to confirm permission for recording and transcription as part of the interview process. They were also reassured that they could refuse to answer any question during the interview if they wished and the researcher would not probe further. To respect participant autonomy, they were given the option to remove anything interview transcripts which they felt was too sensitive. When agreeing transcripts participants were given a reminder of their right to withdraw from the study.

The risk of significant participant distress given the sensitive and potentially emotional nature of childlessness was considered. The participants being therapists naturally exhibited a high-level of self-awareness and a committed approach to self-care which would enable them to negotiate any personal distress from the research. The main researcher used his therapeutic skills to offer a safe and empathic relational environment for the interviews, whilst asking gently probing questions. After each interview the researcher immediately checked with the participants regarding their emotional wellbeing and debriefing information was provided which indicated sources of support should the participant need it. My own potential discomfort or distress regarding my childlessness throughout the project was monitored in conjunction with the secondary researcher, each time we met this was noted and discussed if relevant. I also put in place the option of seeing a therapist should I experience increased distress around my own childlessness.

In the Findings section each participant is referred to using a pseudonym to preserve their anonymity. References to the primary researcher's own self-interview are in the first person.

Data Collection

A semi-structured interview schedule was used to allow flexibility within the predetermination of areas to be covered. The online recruitment survey enabled an initial testing of the interview schedule to take place and consequently minor adjustment to the wording of questions was made to help bring greater clarity. The schedule was designed to enable the necessary rich description (Smith, Flowers & Larkin, 2009) of the experience of therapist childlessness in their practice to be obtained. Participants were given sight of the final interview schedule beforehand to aid reflection and to help generate a richer description of experience.

Interviews explored the main areas of: i) the general experience of childlessness; ii) experiences of being aware of their childlessness in the therapy room; iii) experiences of self-disclosure of childlessness; iv) experiences of their childlessness in supervision and the wider therapy world and; v) how the experience of childless has impacted understanding counselling theory. The areas for exploration were influenced by the existing literature and my personal experience of my childlessness in my therapy practice. Apart from my own, interviews were audio recorded and transcribed. Transcripts were agreed with participants before data analysis began. My own self-interview was written (rather than spoken) in one sitting after all other interviews were completed and followed the interview schedule.

Data Analysis

Smith, Flowers and Larkin (2009) provide a systematic process for analysing qualitative data in IPA. Interviews were transcribed and this process was agreed with participants before data analysis began.

To maintain an idiographic perspective a single interview was analysed before work progressed to another one. Both interview transcript and the written self-interview were analysed in the same way. They were read and re-read to provide immersion into the data. Initial descriptive, linguistic and conceptual phenomenologically focused comments were noted. Interpretive emergent themes for a specific participant were then developed from these initial comments and the wider transcript. Connections between themes were sought by ordering and reordering the themes, and by using the processes of abstraction (drawing out overarching themes) and subsumption (individual themes being elevated overarching themes) as detailed by Smith, Flowers and Larkin (2009). This allowed superordinate and subordinate themes for the individual participant to emerge. These themes were tabulated with relevant extracts from the transcript and themes were re-checked against the transcript. The process was repeated for each participant's transcript. All transcribed interviews were analysed before the primary researcher analysed their written self-interview to mitigate as much as possible the primary researcher's experience influencing the analysis and emergent themes of the other interviews.

Before similarities and differences across participants were considered each participant was given opportunity to comment on, clarify, or query the emergent themes identified in their transcript. Patterns of themes across participants were then sought and superordinate and subordinate themes generated in the light of these patterns. A summary table of themes was tabulated with examples from each participant's transcript to ground the theme in lived experience. This table provided a summary of the varied similarities and differences of experience of the participants' childlessness in their therapy practice.

Reflexive Considerations

In this project both researchers are childless therapists who work using an integrative approach drawing on humanistic and psychodynamic ideas. The primary researcher (Martin) undertook data collection and analysis, with the secondary researcher providing consultative guidance around application of research methods and theoretical insights during the research and writing processes.

The researcher's role in the process of interpretation as an

insider necessitates a reflexive approach whereby the "ways in which the person of the researcher is implicated in the research and its findings" (Willig, 2008, p.18) are acknowledged. As primary researcher, it was necessary to be aware of, acknowledge and (where possible) mitigate that the potential skewing effect of my own involuntary childlessness on the findings of the research. A reflexive research journal aided me monitoring the potential impact of myself on the research. Answers to the interview schedule tested out in the initial online recruitment survey were read multiple times and used to highlight potential areas of difference regarding the experience of childlessness between myself and potential participants. Most significantly, this enabled identification of my tendency to assume experiences around childlessness would be negative, whilst the survey results showed other people could also identify the positive. This process also indicated areas where participants experienced their childlessness differently and helped me grow empathy for other ways of experiencing childlessness. An example of this was my own negative assumptions about my parental abilities due to childlessness being challenged by a participant who had positive assumptions about their parental abilities. It was necessary to keep this reflexive approach in mind throughout the interview and data analysis process to help me move beyond my initial assumptions. During the data analysis process multiple transcript readings (before analysis began) led to me hearing in greater depth the nuances of the participant's voice in their own terms, rather than through my own lens of childlessness.

Findings

Analysis of the interviews of the five participants using IPA produced three main themes and nine subthemes (see Figure 1). Main theme one focused on the childless therapist's experience in the room with the client, with subthemes linked to understanding and managing the therapeutic relationship, triggered subjective emotion and the therapist's sense of self being found.

The other two main themes explored the childless therapist's professional experience beyond personal contact with clients. Main theme two explores the therapist's experience of their childlessness in other professional relationships. A crucial finding highlights the issue of how open and safe childless therapists feel to discuss their experience with other therapy professionals such as supervisors or agency managers. There are some examples of good practice where difficult emotions are acknowledged but in addition there are some poorer examples where involuntary childlessness as an aspect of professional diversity is unacknowledged or even potentially stigmatised.

Main theme three highlights the mixed way in which the therapists identified how their childlessness had impacted understanding of and identification with theories of counselling and psychotherapy. There is some evidence from certain therapists that understanding child development can be more complex due to their childlessness.

The findings discussed here will focus on the main theme one of: Experiencing own childlessness in work with clients, highlighting the similar and differing ways participants experienced their childlessness in the therapy room with clients.

Generally, it is considered unethical to split research data into multiple publications as this breaches the integrity of the data as a whole and could lead to unjustified inflated publication numbers (D'Souza, D'Souza, Krishan & Menezes, 2011; Happell, 2016). However, it is recognized that splitting research into multiple articles may be justified in certain circumstances whilst maintaining the academic integrity of each article (Happell, 2016). For this research project, we considered that splitting the data between two publications was justified for the following reasons: Firstly, the voice of childless therapists has generally remained unacknowledged in the literature. This indicates an ethical obligation to respect the full contribution of the participants by offering rich and detailed discussion rather than reporting the findings at a superficial level determined limitations on publication length (Happell, 2016). The danger of requiring the full data set to be reported in one shorter article is that it would partially replicate a silencing of the childless therapist's voice.

Secondly, the data from this project can be reported with integrity as it neatly splits into two distinct and isolated categories of themes (See Figure 1) which avoid publication overlap (Happell, 2016). In this first article we concentrate on the data which explore the therapist's experience with clients and the implications for the therapeutic relationship and therapeutic practice.

In a second, future article, we will concentrate on the data which examines therapist experience beyond the therapy room in relation to other therapists, supervision, agencies and psychotherapeutic theory. Drawing on the same the research data, this second article will highlight how therapist childlessness is an often a neglected aspect of therapist diversity and difference in the professional context. It will demonstrate the need for wider consideration of therapist childlessness as a significant area of difference by the profession.

Childlessness as a Potential Source of Client Judgement

There is consensus that clients at times judged the childless therapist as less therapeutically competent compared one who was a parent. Participants assumed the client would judge them if their childless status was disclosed. Sarah and Tarka both expressed these fears and recognised how this impacted on how they responded and acted in sessions:

It comes down to judgement, you know ... that client might be making a judgement of me (Sarah)

Maybe I've got that fear that the client will then think less of me if I disclose (Tarka)

Alice and I experienced client judgement as a reality in the therapy room. I described a client (who was unaware that I have no children) questioning whether anyone who didn't have children could understand him. This led to raised anxiety around possible unconscious communication by the client and the potential effect on the therapeutic relationship should the client become aware of my parental status. Alice describes she felt irritated in response:

I got really... irritated I think ... just because I didn't have a child doesn't mean to say I've not got an idea about how, if I did have them, how I would raise them (Alice)

Alice explained the client was unable to 'hear' her interventions which led to a strong counter-transferential reaction. Her irritation was triggered by the assumption that the client was judging her as having nothing to offer in regard

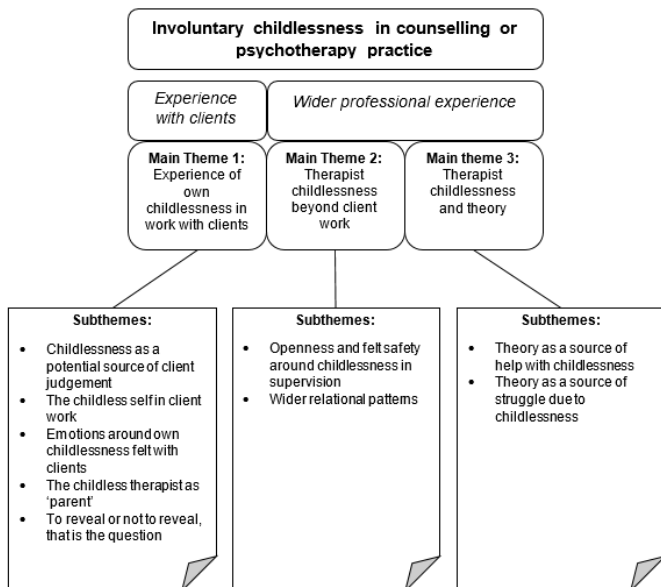


Figure 1: Main themes and subthemes

to being a parent. Significantly, Alice described fantasies about what a client might be thinking about her due to her childlessness. For Alice, it also appears as if thoughts about client judgement were not limited to the here-and-now of the session but were an experience she carried with her in between sessions (“I often wondered if she felt...”). She also reflected on how client judgement interrupted the progress of therapy:

I think it interrupted our process together ... I think she just thought ‘well who are you to tell me’ you know, you don’t even have children (Alice)

Rebecca similarly anticipated that clients may dismiss her ability to understand due to her childlessness. For her, anticipation of client judgement was stronger, potentially transforming into a rupture of the therapeutic relationship and rejection of herself as a therapist: “the client could then turn around and say you’re never going to understand me, so I’d like somebody else”. Rebecca demonstrated anxiety about the therapeutic relationship ending with no opportunity for therapist and client to work through the impact of the therapist’s childlessness together. Rebecca showed concern about being unable to repair any relationship rupture in this situation. The client’s judgement becoming an absolute judgement of the therapist as a whole person.

For all participants thoughts and experiences of client judgement were a major concern which symbolised potential and actual client rejection. The value of therapeutic interventions and processes were thus potentially hindered by therapist perceptions of client judgement or actual client judgement. Considerable therapist emotional and cognitive conflict relating to client judgement is demonstrated showing it is an important aspect of experience for childless therapists.

The Childless ‘Self’ in Client Work

Four of the participants experienced a profoundly negative impact on their sense of self in client work because of their childlessness. Whilst acknowledging the problems of defining ‘self’ (Brinich & Shelley, 2002), the word is used here to refer to the subjective sense of self rather than an objective self. Subjective feelings including a sense of lack of self-competence and esteem or self-doubt had a significant impact on the childless therapist’s sense of self. Tarka questioned her ‘self’ when asked if she has children:

Does it mean that because I haven’t got children, I can’t understand what’s going on for them or trying to help them? (Tarka)

Tarka’s focus on ‘self’ is demonstrated by the repeated use of ‘I’ and this ‘self’ focus was replicated in the transcripts of other

participants. Rebecca and I similarly experienced self-doubt around our ability to understand or work with clients who have children. I dismissed my ability to say something of worth regarding parenting with one client. When judged by a client due to her childlessness Alice experienced a powerful sense of being invalidated or discredited and she indicated the impact on her sense of self-esteem:

I have to kind of remind myself that ... it was just one person’s view and all the people that I’ve helped in the past and you know I wasn’t going to let myself sink low about that (Alice)

Alice found it necessary to bolster her self-esteem by remembering past successful work to help mitigate any negative impact on her sense of ‘self’ and self-efficacy. Sarah was the only participant who did not express the negative impact on ‘self’.

Alongside this prominent theme of self-doubt and felt lack of competence, other aspects of the subjective self in relation to childlessness are hinted at. Sarah hinted at experiencing parts of ‘self’ in relation to childlessness similar to the person-centred idea of configurations within self (Mearns & Thorne, 2000):

I am with them in being empathic of their experience... there is a niggling thing in my mind, ...I can’t quite get hold of it, but I think it’s probably something about a client moaning about their child, so there’s a part of my brain that’s like ‘you’re really lucky’ (Sarah)

This extract shows that Sarah experienced the ‘therapist’ part of herself which was seeking to be empathic (putting her childlessness aside) together with a more ‘envious’ part at the edge of her awareness that desired children. Sarah exemplifies someone who is balancing the inner dialogue of these parts of self in relation to her childless experience with clients.

Tarka explained how she tries, like flicking a switch, to ‘bracket off’ (Spinelli, 2005) her childless aspects of self to maintain focus on client:

What I have to do is I have to completely park, really park my stuff and completely switch that off so that I can be with those girls ... so I do have to really, really switch myself off for it (Tarka)

This stark image of seeking to turn off or transcend an aspect of ‘self’ to focus on the other is a form of self-denial. Yet Tarka acknowledges that this denial of subjectivity and retreat to

objectivity is not fully possible and there remains a “sensitive twinge” or a “tug on the heart strings” (Tarka).

Rebecca questioned if her parenting views were naïve indicating uncertainty about her sense of self-maturity due to her childlessness. Rebecca also experienced a very visceral response within herself to a client’s story:

It felt almost like a knife to the chest, that’s the only way I can express it ... it felt like a knife to the chest to say ‘pro column’ this and ‘con column’ that so off we go for an abortion (Rebecca)

Rebecca’s childless ‘self’ experienced emotional trauma, pain and a sense of woundedness in response to a client’s emotionally detached decision-making process around having an abortion.

For most of the participants, it seems that the subjective sense of self linked to parental status was impacted through their interactions with clients in the therapy room. Lack of self-competence, self-esteem and self-maturity, in addition to self-doubt and self-woundedness in response to client’s narratives, were all significant ‘self’ experiences for the childless therapist.

Emotions around own childlessness felt with clients

All the participants described experiencing their childlessness as a source of emotional struggle in their work with clients. These emotions were triggered by client material and three participants explicitly expressed sadness and loss. My own response offers a useful example. When unexpectedly shown photographs of a client’s child during our final session, my response was a deep sadness:

I was left with the photograph images burned on my mind for a short while after the session. I think I saw the happiness of the child and in some ways that made me happy to see a smiling child who was obviously enjoying playing with his mum. Yet, for me the experience also bought up sadness and a sense of pain. I would never experience it; I would never experience the joy of those times playing with a child (Martin)

I experienced ambivalence (happiness and sadness) which was carried after the session ended for a period, but I sought to suppress the sadness in the room with the client. Similarly, Rebecca responds to an almost idyllic picture of a parental relationship presented in photos shown by a client with grief and loss because she is missing out on this experience of parenthood. Alongside a sense of loss, Tarka described emotions of jealousy and resentment towards one client who

had children and did not care about them. The contrast between herself who wanted children, but could not, and a

client who did have children but seemingly did not want them generated powerful emotions.

Of interest is the fact that none of the participants saw the emotional activation of their childlessness as a static and stable experience. The emotional experience of childlessness with clients is dynamic and shifting. Sarah described synchronisation between her emotional experience personally and with clients:

It depends where I am emotionally so if, if I’m in a place of “well children aren’t everything I can make a fulfilling life without them” ...then it doesn’t affect me too much, but when I’m in a place of “I’ve got this hole and I don’t know how to fill it, I don’t know how to ... er ... make my family whole without children”, then ... erm ... I can find it quite upsetting (Sarah)

Time was a factor for Alice and Tarka, with both identifying emotional intensity with clients reducing over time and with distance from significant events linked to their personal journey of childlessness. I identified how the age of a client’s children could impact how I felt. Clients with younger children activated more emotion around childlessness. Alice noted that clear differences between a client’s story and hers reduced the emotional impact. Both Tarka and I indicated we play an active process in this dynamic emotional experience through the process of emotional suppression: “I push my thoughts and feelings back in ‘the box’” (Martin).

For all the participants, the general emotional experience of childlessness can be activated in the therapy room. A complex set of factors impacted the dynamic nature of the emotional experience. In addition, this is dynamic experience is clearly linked to each participant’s unique experience of childlessness.

The Childless Therapist as ‘Parent’

All of the participants, except for myself, expressed some concept of being a ‘parent’ with clients. Here the inverted commas symbolise the internal subjective phantasy of being parental whilst remaining childless. (By using the term phantasy I mean “Phantasy as representation of wish as its fulfilment” [Bell, 2017, p.98]). The idea of the childless therapist as ‘parent’ manifested itself in two ways, either by the therapist taking up a parental role in sessions or by the therapist imagining themselves as a ‘parent’ (triggered by a client’s presentation).

Rebecca, Sarah, and Tarka identified how they looked at the therapeutic relationship through a 'parental' metaphor. For Sarah and Rebecca this manifested itself in a 're-parenting' strategy:

I feel that I look after quite a lot of children because I work with the inner child of a lot of my clients, er, doing kind of the re-parenting stuff (Sarah)

Sarah then linked this strategy with a phantasy of an idealised parent (Segal, 1995) which she used as her internal model of parenting due to her lack of parenting experience. Rebecca linked her re-parenting strategy to a general 'natural parenting' ability which manifested itself in the therapy. Both saw their 're-parenting' role as being of therapeutic benefit and this could be interpreted as them providing corrective developmentally needed experiences in a new 'parental' object relationship (Clarkson, 2003). Whilst for Rebecca and Sarah use of this parental metaphor was more intentional, for Tarka her 'parental' mothering role was something she felt unconsciously drawn into and was demonstrated by her seeking to look after clients who appeared needy. Tarka was unclear as to whether she felt this was of therapeutic benefit or not. Neither Rebecca, Sarah or Tarka reflected on the paradox of being a new 'parental' object for the client as a non-parent or whether the 'parental' role of the therapist unconsciously met their desires to be a parent.

Although childless, Tarka, Rebecca and Alice were also able to imagine themselves as a potential 'parent' in various ways in relation to their client work. Rebecca could identify how she would parent differently compared to her client and could imagine how she would act as a parent. Tarka likewise was able to compare how she would parent differently but questioned her imagined parenting style due to her parental inexperience. Significantly, Tarka indicated she underwent a vicarious parenting experience through her client:

I am having that experience with them and I am really missing having that experience, if you know what I mean so I'm having it through the client (Tarka)

Whilst the childless therapist in a 'parental' role can offer the client what might be developmentally needed, it is possible that the client can also offer vicarious parenting experiences for the therapist. For Tarka, that experience triggered sadness also gave her a (vicarious) 'parenting experience' through her client she would not otherwise have had. There is a mutuality of relationship with client and therapist able to offer each other something around parenting. The therapist offers a developmentally needed 'parental' relationship and the client offers vicarious parental experiences which enriches the therapist's parental understanding and experience.

For most participants, childlessness did not preclude them the phantasy about being a parent or them thinking about their therapeutic role through the lens of parenthood. Experiences in the therapy room triggered these ideas of the participants being 'parent'. There appeared, however, to be some doubt by some therapists of whether their parental phantasies were helpful due to their lack of experience as a parent.

'To Reveal or not to Reveal?', That is the Question

A major issue identified by all participants was the impact of self-disclosure about childlessness on the therapeutic relationship and the work. Generally, this caused significant internal conflict and anxiety. I owned this anxiety every time a client asks if I have children:

I find I am floored by this simple question once again ... I don't feel sadness or any pain about my own childlessness in the moment, I just feel anxiety that my own personal life is intruding into the therapeutic relationship. (Martin)

Here this powerful boxing metaphor of being 'knocked out' describes the impact of a client's question about children. I further described a visceral experience with heart beating faster and fighting to get my breath. Rebecca links her anxiety around self-disclosure to anticipated difficulties and fear of loss of the client. Her anxiety led to the reinforcing of strict boundaries: "I don't divulge ... purely out of fear I think, purely out of fear" (Rebecca).

Therapist conflict around potential self-disclosure emerged in different ways. Rebecca linked felt conflict to the potential impact of the disclosure and whether existing trust built in the relationship would be reduced. She also used the compelling metaphor of 'holding onto a life raft' which contained her client whilst trying not to allow the currents and rough seas of self-disclosure to push them away. Avoidance of a relationship rupture was a key issue. Tarka identified the need to consider the importance of the relevancy of the self-disclosure and whether it would benefit the client. Alice likewise focused on the importance of the therapeutic benefit of the disclosure: "I wouldn't normally reveal childlessness unless it was for a therapeutic process" (Alice). Alice sometimes used self-disclosure to strengthen the therapeutic bond as well as to demonstrate she was open to discussing the client's issues around their own childlessness. My conflict alerted me to conflicts between humanistic-existential and psychodynamic responses to client questions about childlessness. I experienced an internal pressure to be authentic or congruent against a pressure to explore the client's unconscious meaning of the question. For all participants, the need to remain client-focused was a clear concern.

Interestingly Sarah focused on an aspect of self-disclosure less discussed in the literature, namely about implicit or unintentional self-disclosure.

It might come out in passing ... maybe just talking about the traffic or something like that and saying 'oh, it must be school holidays then' and if I don't know its school holidays then I probably don't have children (Sarah)

For Sarah, realization that she had implicitly self-disclosed her childlessness left her feeling exposed. Although Sarah tried to be a 'blank screen' regarding to her childlessness ("I don't make it obvious, either way") she demonstrated this is almost impossible to achieve (Lemma, 2003). Around this implicit self-disclosure Sarah experienced the same concerns highlighted above for explicit or intentional self-disclosure.

The question of whether to reveal their own childlessness varied from adhering to a clear boundary of never disclosing to an openness to disclose if it was felt therapeutically beneficial. Anxiety around the question of self-disclosure of childlessness was strong for all participants.

Discussion

The findings presented in this article focus on the therapists' experiences of their involuntary childlessness in their work with clients. They both affirm and enrich the pre-existing literature through a close study of the therapist's voice and lived experience of their childlessness. The associated five subthemes discussed indicate that all participants tended to experience their childlessness in negative ways with clients, apart from where 'reparenting' was a potentially valuable aspect of the childless therapist's role.

The findings also tap into four issues of importance concerned with: the impact of childlessness on the therapist, client assumptions, therapist self-disclosure, and about therapy as vicarious parenting.

The Impact of Childlessness on the Therapist

Considerable continuity is seen between the everyday psychosocial experience of childlessness and the therapists' experience in their therapeutic practice. Psychological experiences such as loss, envy, frustration, desire for children, negative self-judgements, and anxiety about potential of social stigma enter the therapy room as proactive countertransference with clients (Clarkson, 2003). This also impacts the therapist's sense of self leading to doubt around

their competence as a childless therapist. For childless therapists, their proactive countertransference has dynamic quality varying with time, personal experience of childlessness and the nature of the client issues brought. Further exploration of intrapsychic conflicts around childlessness and the dynamic nature of the unconscious being manifest in the shifting experience of childlessness in the therapy room is warranted.

The question of how much of the (childless) self is, and should be, available to therapeutic endeavour will be an important one for childless therapists. Although some participants attempted to bracket off their childless experience and self with clients, this was never fully achieved by any participant.

The findings of this research show the value of therapists maintaining a reflexive awareness of how their childlessness manifests in their practice together with its impact, rather than assuming that it's possible to put aside their childlessness in the therapy room. Our research highlights that triggered experiences of childlessness in a therapy session could potentially be used for the benefit of the therapeutic process (use of self) as well as how they could potentially hinder therapeutic process.

To give an example of therapeutic benefit, my own experience of sadness at being shown a client's photos of their smiling playing child provides a useful illustration. I am struck by how my sadness was triggered in response to the happy situation portrayed. Through the pictures that were chosen the client appeared to want to leave me with an almost blissful picture of being a parent. Rather than getting caught up in my own experience of childlessness and suppressing my sadness I could have more consciously used it to notice the blissful image which prompted it and reflected on how this blissful image was in direct contrast to the struggles of parenting which had been spoken about often. It would have been possible to use this insight into the client's process for their therapeutic benefit by noting the difference between the photos and the content of our sessions and exploring how she felt about being a mother as we ended therapy. Rather than trying to bracket off my experience of childlessness in the session it could have been used to therapeutic advantage.

Additional support can be sought from a supervisor or personal therapist for those personal psychological aspects of childlessness elicited by clients if they could potentially hinder the therapeutic process. A childless therapist who experiences painful emotions of loss when listening to a client share a story about their children may need to process this in supervision. A possible defence against the therapist experiencing more painful emotion could lead to the avoidance of deeper exploration into the client's story. This unconscious defensive avoidance would hinder the therapeutic process.

Client Assumptions

The findings highlight the assumption of some clients (and therapists) that childlessness could imply that the therapist is less competent to work with those who have children.

Here client judgement is not about how the therapist is actually working in the session, but who the therapist is in themselves. Therapists' anticipation of client judgement regarding competence could be due to a projection of their own unconscious self-judgement around childlessness and competency. However, Cooper (2008) in reviewing the evidence around client-therapist matching comments "the general finding here is that matched therapist-client life experiences does not make much difference to outcomes" (p. 88). It is therefore reasonable to assume that client-therapist mismatch regarding experiences of parenthood are not necessarily indicative of less favourable outcomes for childless therapists. Yet this is an open question as no research has ever been completed in this area. Regarding the current state of evidence, what seems more important is that a childless therapist needs to respond to potential client assumptions or judgement in such a way that the relational bond needed for an effective working alliance (Bordin, 1979) is strengthened rather than weakened. As client assumptions and judgements about therapist childlessness are a real possibility this indicates that potential transference-countertransference enactments around therapist childlessness may need to be acknowledged and worked through. It is important for training providers to help prepare trainee childless therapists to reflect on enactments around childlessness more deeply.

Self-disclosure

The participants all struggled with self-disclosure keenly. Generally, their concerns mirror the existing literature around whether therapist self-disclosure could be therapeutic (Maroda, 2009; Jolley, 2019). It is possible to take a rigid view of self-disclosure where childlessness is not disclosed with the justification that this is in the client's best interests. However, this could be a convenient defensive move which is more about protecting the therapist from difficult emotions regarding potential disclosure than what could be therapeutic for the client. Sarah's experience demonstrates that implicit self-disclosure may be important for the childless therapist. The potential impact on therapist and client of such implicit disclosure, although acknowledged as accidental or inadvertent, has not been extensively researched (Bloomgarden & Mennuti, 2009). Treadway (2009) suggests that reviewing the outcome of any self-disclosure is important, this is especially relevant to implicit self-disclosure. When a therapist becomes aware, they have implicitly disclosed their childlessness they should monitor the effect on the client so potential difficulties can be addressed. Implicit self-disclosure

may need to be transformed into an explicit self-disclosure of therapist childlessness so that the client's subjective response can be worked through in the therapy room.

Therapy as Vicarious Parenthood?

That a therapist is cast in a parental role within the therapeutic relationship is not surprising given the therapist-client relationship is frequently conceived of using parent-child metaphors such as 'attachment', 'holding', 'containment' or 'attunement'. In addition, the therapist role can be formulated as leading to regression to dependence and the dyadic therapist-client relationship (being equivalent to the infant-caregiver relationship) enabling a developmentally needed relational repair to proceed (Price, 2016). In these ways, therapists can meet their own psychological needs through their work with clients (Sussman, 2007). Barnett (2007) describes how childhood parental loss, separation and rejection can unconsciously motivate people to become therapists as a way of receiving the relational intimacy not previously experienced. It would not be surprising, therefore, if motivations to be a therapist was also partly and unconsciously linked to an adult sense of loss around childlessness. Childless therapists may unconsciously identify with the paternal or maternal role to mitigate this adult sense of loss, thereby experiencing sublimation of their desires for children through desiring parental-nurturing roles with their clients (Adams, 2014).

The findings of our research, however, indicate more than a simple sublimation of desire with potentially a complex developmental process for the therapist through vicarious parenthood. The idea of vicarious parenthood demonstrates the positive impact of therapeutic work on the therapist (as opposed to the client) around those aspects of life which have been missed out on due to childlessness. A client's parenting experience can be unconsciously internalized by the childless therapist. This becomes a beneficial resource to the therapist personally and in their practice. We could term this phenomenon 'internalized vicarious experience'. What this means is the therapist experiences something through the client rather than it being their own subjective experience. This is different from empathy as it proceeds via the process of identification where "the subject embodies in the self-representation attributes of the object" (Sandler & Perlow, 1987, p. 10). In other words, parental experience is unconsciously taken inside and made part of the therapist's self (Wallis & Poulton, 2001). Apart from vicarious trauma and vicarious resilience (Edelkott, Engstrom, Hernandez-Wolfe, & Gangsei, 2016) the dynamics of general vicarious experience on the therapist has been little explored in the existing literature and this suggests a new avenue of exploration.

Critical Evaluation

Reflexivity

The research methodology placed the primary researcher at the centre of the research as well as in the role of researcher. In seeking to maintain an attitude of reflexive (self-)awareness throughout the project it is important to note my impact on the research and vice versa.

My own subjective experience of childlessness and therapy undoubtedly influenced the direction and progress of the project. The semi-structured interview schedule was influenced by my own experience leading to the coverage of the specific areas chosen. The research participants quickly demonstrated that not everyone experiences their childlessness in the same way as me, and, indeed the secondary researcher's experience, though similar, was different also. In one early interview I expected the participant to describe supervision as a negative experience in relation to childlessness and it took me a while in the interview to be able hear her positive voice. Additionally, the secondary researcher and I repeatedly found myself detaching emotionally from my experience of the project. This highlights a tendency in me to avoid the emotional pain that childlessness can trigger. A consequence of this is that during transcript analysis, I became aware of how at points in the interviews I unconsciously avoided inviting participants to make deeper emotional descriptions of their lived experience and this inevitably impacted the richness of the data. It is obvious that I could not stop the project being influenced by my own subjective experience of childlessness (Willig, 2008) and therefore the data collection, analysis and interpretation are mine and other researchers may have highlighted aspects I minimised. Secondly, I cannot deny my social and cultural locatedness as a white, Western male researcher will have had an influence on the analysis and interpretation of the data. It is especially important to acknowledge my interpretation of female childless experience is through male eyes. I potentially have blind spots to aspects of female experience which may have skewed the data. Another researcher might have foregrounded aspects to do with female embodiment which is harder for me to access, for instance. Also, it is quite possible that the participants were open with me in a different way than they would have been with a female researcher. That they knew that I, too, was childless, and that I was interested in the topic, may have had an enabling effect, however.

This study listened to the voices of involuntary childless therapists and provides a rich description of five people's experiences. Finlay (2011) suggests the use of the 4 R's to evaluate research: relevance, rigour, reflexivity, and resonance. The relevance of this research is indicated through the findings that reveal some of the unique ways in which the therapeutic

relationship and the therapeutic process may be impacted. It highlights how a therapist's painful (and not painful) personal issues around childlessness can be drawn into their work with clients in varying and complex ways. This emphasises the need for therapists to adopt a reflexive approach which respects the subjective nature of therapist childlessness.

The strength of the IPA methodology used in this study is found in the way it enabled the primary researcher to attend to the uniqueness of individual participants' contributions, as well as identifying similarities across participants. It is this aspect of IPA which allowed penetration of the phenomena therapist childlessness to a deep level. In addition, my use of myself as a participant added a reflexive element which is consistent with a hermeneutic approach and, we believe, added poignancy to the findings.

Given that this was the primary researcher's first experience of IPA, application of the methodology followed closely the processes for data collection and data analysis laid out by Smith, Flowers and Larkin (2009). This provided an appropriate level of rigour and coherence to the project though some creative flair and resonance might have been lost. While the findings manage to evoke some of the pain and tensions around for therapists, in more experienced hands, a more literary presentation might have been achieved. However, the findings have been evidenced and grounded in the participants' transcripts and identified themes were validated by the individual participants before further analysis across participants was undertaken.

As the first qualitative study exploring the topic of childlessness, this study demonstrates the value of listening to therapist lived experienced around childlessness. More questions are raised which highlights the need for further research into this topic. One critique of the application of IPA methodology is the broad range of the phenomenon (in the therapy room and outside) researched by this project. Targeting a narrower aspect of the phenomenon of therapist childlessness (e.g. only on the therapeutic relationship, supervision or wider professional relationships) may have allowed further depth of insight in the identified themes to emerge.

There are, of course, limitations to the generalisability of the findings of this study. Firstly, although specifically sought during participant recruitment, this research lacks the intended gender balance due to a lack of male participants. This means that the male voice is only represented by my own and the findings are naturally biased towards the researcher's perspectives and experiences of childlessness as a therapist. Secondly this research has focused on the UK and a Western experience of childlessness. Culture is a mediator of the experience of childlessness and therefore further research is

necessary to examine how a childless therapist's experience of their practice is also mediated by their cultural background. Interestingly, all participants when asked in interview struggled to identify the impact of culture on their experience of childlessness. This corresponds with the fact that "we often fail to see ourselves as products of our cultures, of our upbringing and our locale" (Lago, 2006, p. 44) and suggests research enabling comparison of participants from different cultures would be needed to explore this further. Thirdly, both researchers and all research participants work integratively in their therapeutic practice, but there was a distinct bias towards humanistic and psychoanalytic ideas. It is unclear whether and how therapeutic orientation has an impact, for example, whether a pure cognitive therapist would experience their childlessness in their therapeutic practice in the same ways. We suspect that the issue that is more relevant is the depth of relationship that therapists have with clients, but this was not spotlighted. Finally, this research has concentrated on therapist's work with adult clients. Tarka in her interview briefly mentioned her work with children and this was disregarded in the data analysis as beyond the scope of the current project. However, indications are that further research into the experience of 'the childless child and adolescent therapist' could be valuable.

Conclusion

Previously published studies have identified important issues around childlessness, but none have systematically given involuntary childless therapists a voice. This study used a qualitative research methodology to remedy this gap in the literature; it thereby enriches the existing literature revealing some of the pain, discomfort, and tensions around the topic for childless therapists. The findings strongly suggest that the personal experience of involuntary childlessness cannot be separated from the professional practice of the therapist which demonstrates the importance of self-awareness. Proactive countertransference is a significant issue. Supervisors or training providers would do well to help childless therapists to be reflexive around parental status, countertransference, and the impact of the therapeutic work on the self. The findings also highlight how painful wider social stigmas and judgements around childlessness may potentially be played out in the therapeutic relationship. This study provides a unique insight into the participants' experiences and its force is found in the participants' depth of honesty and willingness to risk discussing an emotionally sensitive issue. Consequently, this willingness has brought into the light aspects of the phenomenon which have remained hidden until now and it provides a foundation to encourage other childless therapists to be more reflexive about their own practice.

References

- Adams, M. (2014). *The myth of the untroubled therapist: Private life, professional practice*. London: Routledge.
- Apfel, R. J., & Keylor, R. G. (2002). Psychoanalysis and infertility: Myths and realities. *International Journal of Psychoanalysis*, 83(1), 85-104. doi: 10.1516/4089-JBCW-YNT8-QTCM
- Applegarth, L. D. (2006). Individual counselling and psychotherapy. In S. L. Covington & L. H. Burns (Eds.), *Infertility counselling: A comprehensive handbook for clinicians* (2nd ed.) (pp. 129-142). New York: Cambridge University Press.
- Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1997). *Qualitative methods in psychology: A research guide*. Maidenhead, Berkshire: Open University Press.
- Barnett, M. (2007). What brings you here? An exploration of the unconscious motivations of those who choose to train and work as psychotherapists and counsellors. *Psychodynamic Practice*, 13(3), 257-274. doi: 10.1080/14753630701455796
- Bell, D. (2017). Unconscious phantasy: Some historical and conceptual dimensions. *International Journal of Psychoanalysis*, 98(3), 785-798. doi: 10.1111/1745-8315.12586
- Berrington, A. (2017). Childlessness in the UK. In M. Kreyenfeld & D. Konietzka (Eds.), *Childlessness in Europe: Contexts, causes, and consequences* (pp. 57-76). Berlin: Springer International.
- Bloomgarden, A., & Mennuti, R. B. (Eds.). *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy*. Hove, UK: Routledge.
- Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Research, Theory and Practice*, 16(3), 252-260. <http://dx.doi.org/10.1037/h0085885>
- Brinich, P., & Shelley, C. (2002). *The self and personality structure*. Buckingham, UK: Open University Press.
- British Association for Counselling & Psychotherapy (2016). *Ethical framework for the counselling professions* (6th ed.). Lutterworth, UK: Author.
- Clarkson, P. (2003). *The therapeutic relationship* (2nd ed.). London: Whurr.
- Cooper, M. (2008). *Essential research findings in counselling and psychotherapy: The facts are friendly*. London: Sage Publications.
- D'Souza, D. H., D'Souza, J. M. P., Krishan, K., & Menezes, R. G. (2011). Salami publication: A personal perspective. *Egyptian Journal of Forensic Sciences*, 1(3-4), 146-147. doi: 10.1016/j.ejfs.2011.07.004

- Edelkott, N., Engstrom, D. W., Hernandez-Wolfe, P., & Gangsei, D. (2016). Vicarious resilience: Complexities and variations. *American Journal of Orthopsychiatry*, 86(6), 713-724. doi: 10.1037/ort0000180
- Finlay, L. (2002). 'Outing' the researcher: The provenance, principles and practice of reflexivity, *Qualitative Health Research*, 12, 531-545.
- Finlay L. (2011). *Phenomenology for therapists: Researching the lived world*. Chichester, UK: Wiley-Blackwell.
- Finlay, L. (2017). Championing 'reflexivities'. Editorial. *Qualitative Psychology* (Special Issue on Reflexivity), 4(2), 120-125.
- Greil, A. (1997). Infertility and psychological distress: A critical review of the literature. *Social Science and Medicine*, 45(11), 1679-1704. doi: 10.1016/S0277-9536(97)00102-0
- Greil, A., McQuillan, J., & Slauson-Blevins, K. (2011). The social construction of infertility. *Sociology Compass*, 5(8), 736-746. doi: 10.1111/j.1751-9020.2011.00397.x
- Happell, B. (2016). Salami: By the slice or swallowed whole? *Applied Nursing Research*, 30, 29-31. doi: 10.1016/j.apnr.2015.08.011
- Johansson, M., & Berg, M. (2005). Women's experiences of childlessness 2 years after the end of in vitro fertilization treatment. *Scandinavian Journal of Caring Sciences*, 19(1), 58-63. doi: 10.1111/j.1471-6712.2005.00319.x
- Jolley, H. K. (2019). I'm human too: Person-centred counsellors' lived experiences of therapist self-disclosure. *European Journal for Qualitative Research in Psychotherapy*, 9, 12-26.
- Kreyenfeld, M., & Konietzka, D. (2017a). Analyzing childlessness. In M. Kreyenfeld & D. Konietzka (Eds.), *Childlessness in Europe: Contexts, causes, and consequences* (pp. 3-16). Berlin: Springer International.
- Kulish, N. (2011). On childlessness. *Psychoanalytic Inquiry*, 31, 350-356. doi: 10.1080/07351690.2010.516181
- Lago, C. (2006). *Race, culture and counselling: The ongoing challenge* (2nd ed.). Maidenhead, UK: Open University Press.
- Leibowitz, L. (1996). Reflections of a childless analyst. In B. Gerson, (Ed.), *The therapist as a person: Life crises, life experiences, and their effects on treatment* (pp.71-87). Hillsdale, NJ: Analytic Press.
- Lemma, A. (2003). *Introduction to the practice of psychoanalytic psychotherapy*. Chichester, UK: Wiley.
- Malik, S. H., & Coulson, N. S. (2013). Coming to terms with permanent involuntary childlessness: A phenomenological analysis of bulletin board postings. *Europe's Journal of Psychology*, 9(1), 77-92. doi: 10.5964/ejop.v9i1.534
- Maier, D. B., Covington, S. N., & Maier, L. U. (2006). Patients with medically complicating conditions. In S. L. Covington & L. H. Burns (Eds.), *Infertility counselling: A comprehensive handbook for clinicians* (2nd ed.) (pp.237-257). New York: Cambridge University Press.
- Maroda, K. J. (2009). Less is more: An argument for the judicious use of self-disclosure. In A. Bloomgarden & R. B. Mennuti (Eds.), *Psychotherapist revealed: Therapist speak about self-disclosure in psychotherapy* (pp.17-29). Hove, UK: Routledge.
- Mearns, D., & Thorne, B. (2000). *Person-centred therapy today: New frontiers in theory and practice*. London: Sage Publications.
- Monach, J. (1993). *Childless: No choice: The experience of involuntary childlessness*. London: Routledge.
- Moustakas, C. (1990). *Heuristic research: Design, methodology and applications*. London: Sage Publications.
- Price, L. (2016). *Better late than never: The reparative therapeutic relationship in regression to dependence*. London: Karnac Books.
- Sandler, J., & Perlow, M. (1987). Internalization and externalization. In J. Sandler (Ed.), *Projection, identification, projective identification* (pp.1-11). London: Karnac Books.
- Segal, J. (1995). *Phantasy in everyday life: A psychodynamic approach to understanding ourselves*. London: Karnac Books.
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage Publications.
- Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (3rd ed.) (pp.25-52). London: Sage Publications.
- Spinelli, E. (2005). *The interpreted world: An introduction to phenomenological psychology* (2nd ed.). London: Sage Publications.
- Sussman, M. (2007). *A curious calling: Unconscious motivations for practicing psychotherapy*. Plymouth, UK: Jason Aronson.
- Tonkin, L. (2019). *Motherhood missed: Stories from women who are childless by circumstance*. London: Jessica Kingsley.
- Treadway, D. C. (2009). For your client's sake: Practicing clinically constructive self-disclosure. In A. Bloomgarden & R. B. Mennuti (Eds.), *Psychotherapist revealed: Therapist speak about self-disclosure in psychotherapy* (pp.275-280). Hove, UK: Routledge.
- Van Balen, F., & Gerrits, G. (2001). Quality of infertility care in poor-resource areas and the introduction of new reproductive technologies. *Human Reproduction*, 16(2), 215-219. doi: 10.1093/humrep/16.2.215
- Van Balen, F., & Bos, H. (2004). Infertility, culture, and psychology in worldwide perspective. *Journal of Reproductive and Infant Psychology*, 22(4), 245-247. doi: 10.1080/02646830412331298299
- Van Balen, F., & Bos, H. M. W. (2009). The social and cultural consequences of being childless in poor-resource areas.

Facts, Views & Vision in ObGyn, 1(2), 106–121. Retrieved from

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4251270/>

Wallis, K. C., & Poulton, J. L. (2001). *Internalization: The origins and construction of internal reality*. Buckingham, UK: Open University Press.

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). Maidenhead, UK: Open University Press.

About the Authors

Martin Stokley is an integrative counsellor holding a Diploma in Counselling and an MSc Therapeutic Counselling from the University of Greenwich. He has several years' experience of working in both a specialist bereavement and general counselling setting. He currently works with a variety of client issues at a counselling agency in south-east London. Martin is also a part-time lecturer in practical theology and has a PhD in Physics.

Val Sanders is a Senior Lecturer at the University of Greenwich, holding an MSc in Therapeutic Counselling (University of Greenwich) and an MA in working with groups (Tavistock & Portman), who has been teaching on the BACP accredited MSc programme for 12 years. She is also a senior accredited BACP therapist and supervisor and carries a small private practice of over 25 years.