An Exploration of How Childlessness and the Decision Whether to Become a Parent is Understood by Psychoanalytic Practitioners

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ABSTRACT

Voluntary childlessness (VC) is a growing phenomenon in the 21st Century in western societies with the Office of National Statistics (ONS) in 2013 showing that one-fifth of women are childless at the age of 45. Sociological literature highlights how VC is a complex, multifaceted phenomenon and is often difficult to define. However, since its inception, psychoanalysis has made an inextricable link between femininity and motherhood thus psychoanalytic theory views motherhood as normative and it is often seen as a developmental stage. This thesis explores how psychoanalytic practitioners understand, conceptualise and respond to VC in the clinical setting. Four psychoanalytical practitioners were interviewed and three main themes arose as a result of the Interpretative Phenomenological Analysis (IPA) of the data collected. The first finding highlighted the biopsychosocial pressures that the participants felt their patients experienced. Some participants spoke of the professional pressure they experienced from within the psychoanalytic field as a result of the theory that links motherhood and femininity. The second finding highlighted the ethical dilemmas faced by some patients with regards to whether to become a mother, such as a VC choice might be the result of difficult childhoods, immaturity, or because their mental health issues precluded them from motherhood or they feared motherhood might induce mental illness. The final finding highlighted that working with childless patients was both complex and conflictual. The practitioners discussed both their personal professional responses to childlessness in general. This research is important for highlighting how psychoanalytical practitioners are influenced by the competing discourses in society surrounding motherhood. Finally, the thesis critically evaluates the research, makes suggestions for future enquiries and reflects on the clinical implications of the findings.

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CHAPTER ONE – INTRODUCTION

1.1 The starting point

The primary question of this thesis is to explore how psychoanalytic practitioners understand, conceptualise and respond to voluntary childlessness (VC) in the clinical setting. This research has been carried out from an Interpretative Phenomenological Analysis (IPA) perspective and it is the first thesis at the time of submission that focuses on how psychoanalytic practitioners make meaning of VC in the clinical setting. There are a very small number of IPA studies into VC from a psychological perspective, however there is more sociological literature to be found on this subject.

The origins of this thesis were as a result of my own life experiences as a psychotherapist and as an involuntarily childless (IVC) woman. In my clinical practice clients were presenting with difficulties in coming to terms with a diagnosis of infertility, but there were also women who had not made a conscious decision about whether or not to have children. Neither did they feel under pressure with the 'ticking of the biological clock'. The process of trying to make meaning both in my personal life and in the clinical setting set me off on this particular journey.

I was struck by the lack of literature on VC from a psychoanalytic perspective, noting that, following Sartre, 'interest in what is missing is as is important as what

is present' (Sartre, 1943/ 1956 p.42). This thesis, therefore, while concentrating mainly on psychoanalytic ideas, also draws on a variety of sociological and feminist perspectives in order to provide a broad understanding on the subject of VC. Each of these perspectives will produce a different form of knowledge based on their unique understanding of the human subject.

It is curious that there has not been more contemporary psychoanalytic research into VC, bearing in mind the following statistics. The most recent statistics on childlessness recorded by the Office of National Statistics (ONS) in 2013 showed that one-fifth of women are childless at the age of 45. The level of childlessness has also been increasing; one in 9 women born in 1940 were childless, compared with one in five women born in 1967. Additionally, completed family size is decreasing: women born in 1940 had an average of 2.36 children compared with 1.91 for women born in 1967. Various possible reasons have been put forward to explain these changes with the most obvious being the widespread availability of contraception. Additionally fewer women are choosing to get married or to have children within a marriage and are choosing a VC lifestyle. Alternatively women may have left it too late to have children owing to concentrating on their career, or they are childless due to infertility. The 2013 ONS statistics also revealed that the number of gay and lesbian couples bringing up children together had risen by 8% from the previous year. In contemporary Western societies more heterosexual individuals are choosing not to have children and those in the gay and lesbian community are choosing to have children.

For the purposes of this study, I am interested in how psychoanalytic practitioners understand VC in the clinical setting. My interest lies in two categories of VC women: those who have made a conscious decision not to have children because they want something different for themselves and those women who have not made a conscious decision either way about whether to become a parent and do not feel compelled to respond to the biological clock. There are various explanations of the different categories of childlessness that have been proposed by Ireland (1993). The distinctions she makes are between three categories of women who do not to have children – the traditional, transitional and transformative women. The traditional women are those who have not had children for biological reasons and emphasise their childlessness. The transitional women are those who pursue career opportunities and often leave it too late to have children. The transformative woman is someone who positively choose not to have children and Ireland (1993) refers to them as childfree. Ireland reflects on how this latter category of women might arrive at their decision in a number of ways from ambivalence, through to a definite decision and a rejection of motherhood. I am interested primarily in the transformative woman and the transitional women. Although I am interested in the male VC decision, the main focus of this thesis will be in female VC.

This thesis will also take into account the different aims of psychoanalytic work and how these might influence the clinical work with VC patients. At the end of discussion part of each section in Chapters four, five and six I will consider the implications of my findings in relation to the status of the VC patient in psychoanalysis or psychoanalytic psychotherapy. Although this research has focused on psychoanalytic practitioners, I would imagine that because of the

strong cultural imperative about the link between motherhood and femininity that psychotherapists from different modalities would also be affected by these societal messages.

I will briefly outline below the professional status of my participants, the differences between these titles will be discussed in appendix one. As this thesis will be drawing on research from different professionals within the mental health field I will briefly outline the differences between them in appendix two. The participants in this study include psychoanalysts and psychoanalytic psychotherapists, and are referred to with pseudonyms to protect their anonymity. Angela is a psychoanalyst registered with the British Psychoanalytic Council (BPC). Beth is a Lacanian analyst registered with the United Kingdom Council for Psychotherapy (UKCP). Cathy is a psychoanalytic psychotherapist registered with the BPC. Denise is a psychodynamic psychotherapist registered with the BPC. Further details about how these participants were recruited can be found in Chapter three, section 3.8.3

1.2 Research aims and question

This thesis has a broad primary focus, with a number of subsidiary questions narrowing the focus on specific areas that were highlighted to me during the literature review as well as through my own clinical and personal experience.

The primary research question in this thesis is to explore how psychoanalysts and psychoanalytic psychotherapists understand, conceptualise and respond to VC in the clinical setting. The first subsidiary question is whether there is binary

thinking in the consulting room with regards to parenthood/ non-parenthood and mother/non-mother, male/female. The second subsidiary question is whether contemporary psychoanalytical practitioners make an inextricable link between femininity and motherhood. Thirdly, the final subsidiary question: whether or not psychoanalytic practitioners are affected by pronatalist cultural discourse and how, if at all does this enter the consulting room. One supposes that this is inevitable, so one of my goals is to understand the nature of this influence.

One of the aims of this thesis is that it will contribute to existing knowledge by highlighting the possibility of the pathologising of VC in the clinical setting and how this might undermine the agency of female patients. This notion arises from literature I have explored during the critical literature review and in my wider reading and understanding. Another aim is to propose a biopsychosocial approach to working with VC that could be developed in further research. The third aim is to highlight the complexity of the subject by considering literature from other psychological therapists besides the psychoanalytic as well as contributions from sociologists and feminists.

I approach this thesis from a broad perspective, influenced by a number of factors, not least my own experiences both personally and as a clinician. I posit a biopsychosocial model as this fits with my perspective and goes some way to account for the complexity of the subject.

1.3 Outline of thesis

Chapter two – The Literature Review

This chapter provides an overview of the literature relating to VC from the perspectives of psychoanalysis, psychotherapy, psychology, health professionals and feminism. It considers how psychoanalytic practitioners have understood and conceptualised VC as well as descriptions of prevailing developmental theories in relation to parenthood. Consideration will also be given to a discussion of contemporary understanding of countertransference an exploration of how it might arise for practitioners when working with VC individuals. The sociological literature points to the pronatalist messages in society and this research will also explore the extent to which cultural discourse surrounding the motherhood mandate have been internalised by the practitioners in this study. Other writers such as sociologist Gillespie (2001) take a post-modernist approach that considers the changing nature of what is considered normal in terms of lifestyle choice. The work of Goffman (19630 will be drawn on to explore the possible stigmatisation of the VC woman in society. The feminist perspective presents a political stance relating to the male domination of women in society and how through a VC choice women can present a challenge to this position. This research will explore how psychoanalytic practitioners draw on psychoanalytic theory to understand VC in the clinical setting

Chapter three – Method and Methodology

This chapter sets out the rationale for my methodological approach as well as a discussion of the theoretical and philosophical underpinnings of IPA. This includes a description of my epistemological and ontological position as a

psychological researcher. Consideration will also be given to the reflexive nature of IPA research. I also compare psychoanalytic research with IPA in terms of their respective philosophies, theoretical underpinnings and research methods. There is then an in-depth discussion of my research design that includes a description of the pilot study, the recruitment and selection of participants, as well as the interview and the analytic procedures. The question of ensuring quality, validity, and rigour throughout the research process will be described as well as the ethical considerations that needed to be addressed. In IPA superordinate themes are the broad themes that can be applied to all of the participants but can present differently in each case. Within these superordinate themes are subordinate themes, which are more specific, related themes. Each findings chapter pertains to a different superordinate theme, allowing them to be discussed in depth.

Chapter four – Superordinate theme one - The biopsychosocial pressures

This chapter addresses how the participants viewed the pressures that their patients faced with regards to whether or not to become a mother. Within this superordinate theme there are two subordinate themes – one is how the participants described the pressure of the biological urge and the biological clock. This includes questioning a woman's desire for a child, the trans-generational messages with regards to motherhood and how a negative body image might affect whether a woman wants to become a mother or not. The second subordinate theme deals with the external pressures placed on women, such as: the idealisation of motherhood, pressure from family and society, as well as interestingly the implicit pressure from within psychoanalysis on the participants themselves.

The discussion section for this theme will draw on the literature review in chapter two to ascertain whether the findings are supported by the existing literature as well as discern what is novel and perhaps unexpected. Additional literature will be introduced to discuss these findings, drawn from psychoanalytic, sociological and feminist disciplines. Each section will conclude with a discussion of the implications of my findings.

Chapter five – Superordinate theme two – Ethical Dilemmas and Fitness to Parent Debate

This superordinate theme demonstrates how the participants understood and conceptualised the VC choice. This superordinate theme is further divided into four subordinate themes with the first concerned with the patients' dilemmas about whether or not to become a mother in the face of a genetic illness. This is followed by how the participants view VC as a result of the effect of early childhood relationships with primary-caregivers. The third subordinate theme presents the participants' views about whether or not their patients have sufficient maturity to become a parent. This is linked with whether or not they are able to form adult sexual relationships. The final subordinate theme discusses whether or not those with a mental illness are fit to be a parent or indeed whether becoming a parent might induce a mental illness.

As previously, the discussion section will refer back to the literature review in chapter two to see whether or not my findings support the existing literature and what is new and surprising. Additional literature will be introduced at this point to provide a discussion of these new findings, such as the findings relating to

mental illness, and thus new psychoanalytic and sociological and literature is introduced at this point. Each section will conclude with a discussion of the implications of my findings.

Chapter Six – Superordinate Theme 3 – Working with Childlessness is Complex and Conflictual

The superordinate theme describes how the participants responded to VC not only in the clinical setting but also their own personal responses. There are three subordinate themes and first one concerns how the participants see their role as attuning to their patients' unconscious in order to help them make difficult decisions with regards to whether or not to become a parent. The second subordinate theme presents the participants' personal views about VC and wider concerns about who is fit to be a parent. The third subordinate theme presents the participants' countertransferential/counter-reactive responses to their patients' dilemmas about parenthood.

The discussion section again refers to the literature review in chapter two and will highlight how the findings support this literature. There will also be a discussion of what is novel and unexpected in the findings and additional literature will be introduced at this point. The discussion highlights how the participants' responses will depend on how they understand and conceptualise VC. Psychoanalytic, psychological, sociological and feminist literature will be used to provide a broad discussion of the findings in relation to different ways of understanding VC. There is also a discussion of how a practitioner's own views and life story can have an impact on the analytic relationship. The different

theoretical approaches to how countertransference is viewed will be discussed and then applied to how it can manifest in relation to childlessness in its different forms. Each section will conclude with a discussion of the implications of my findings.

Chapter seven – Conclusion

The conclusion will revisit the research questions and aims as outlined in chapter one and will consider the extent to which these have been met. The contributions to knowledge will be explored as well as further exploration and a summary of implications for practice. There will also be a discussion of how the validity, quality and rigour issues relating to this thesis have been met. As it draws to an end I will critically evaluate my research examining both its strengths and limitations. This section will include a reflexive account of my experiences of carrying out this research project. Consideration will be given to what would be done differently if the research were to be carried out again and recommendations for clinical practice and further research will be explored.

CHAPTER TWO - CRITICAL LITERATURE REVIEW

2.1 Introduction

From the perspective of IPA, the aim of a literature review is to introduce and inform readers about the strengths and weaknesses of the key debates in the field. Smith, Flowers and Larkin (2009) suggest that often this will give a flavour of the work and if most of it is quantitative an indication of what a qualitative study can contribute. As Smith, Flowers and Larkin (2009) contend, this can often lead the researcher into unexpected territory.

There has been extensive research by the psychoanalytic community into involuntary childlessness (IVC) and this has contributed to an understanding of how to provide psychological help to infertile couples. Except for the work by Mardy Ireland (1993), there is a striking lack of research by psychoanalysts into Voluntary Childlessness (VC) whereas feminists (see section 2.7) and sociologists (see section 2.6) have given this subject extensive attention over the last 40 years.

This literature review aims to map out the variety of perspectives on VC starting first with the psychoanalytic viewpoints. This will include considering Freud's theory of psychosexual development as well as Benedek's (1959) view that parenthood is a developmental stage. There have been different psychoanalytic perspectives on how a woman's desire for a child arises as well as challenges from within the psychoanalytic community to Freud's theory of penis envy. Psychoanalysts such as Raphael-Leff (1997) and Ireland (1993) have put forward views that the womb can be considered symbolically in terms of

woman's creative potential as opposed to being only as a container for an actual baby. Some psychoanalytic writers (Williams 1986) have drawn on the research of sociologists (Veveers, 1980) to consider the stigmatisation experienced by VC women and how this can result in the use of defences as a way of managing the feelings that are evoked. Finally in the psychoanalytic section of this literature review, consideration will be given to the possible countertransference that psychoanalysts may experience when working with VC individuals. This literature review will also briefly consider the research contributions from psychotherapists, psychologists and health professionals.

In order to gain a greater understanding of VC, the second part of this literature review will draw on the work of sociologists and feminists, as there is a gap in the psychoanalytic writing on this subject. As mentioned in Chapter one statistics show that reproductive choices are undergoing changes in twenty first century Britain so it seems important to place VC in a social context and this section of the literature review will consider the influence of cultural discourse and pronatalism. One of the aims of this literature review is to consider the variety of ways that women are under pressure to conform by becoming a mother, which Russo referred to as 'the motherhood mandate' (1976). Social constructivists (Foucault, 1976; Giddens, 1990:91:92) would argue that the motherhood mandate is a product of cultural discourse, whereas feminists would state that it is to do with patriarchal systems of domination (Butler, 1990; Irigaray, 1985, 1991). The social constructionist position does not allow for a disjuncture between thoughts and feelings that might arise from unconscious internal conflict such as projections and introjections and dismiss the idea that emotions have an inner psychological depth (Du Gay, Evans and Redman, 2000). Social

Constructionism takes the view that experience is affected by the historic, cultural and linguistic influence in any given time and place thus what is perceived is not a direct reflection of any given reality. Reality is therefore constructed rather than reflected (Willig, 2008).

The sociological research provides some interesting challenges to the stereotype of VC women and portrays the choice as a transformative act. Further discussion is given to the sociological research into stigmatisation and the defences employed by VC women and how Goffman's (1963) work on stigmatised groups can help to understand how marginalised groups cope with their experiences. Consideration is also given to how VC is viewed from a post-modern perspective and some of the feminist writers propose challenges to some of the psychoanalytic literature.

This literature review will highlight how VC can be difficult to define as it is often not a 'cut and dried' decision, but a process that can be as convoluted and complex as the choice to become a parent. As mentioned in chapter one, it is also hard to define those that are VC as a distinct group as there are a number of variables – the conscious decision makers, the transitional, the circumstantial and those who have not made a decision either to be a parent or to not be a parent. There might be women who have been surrogate mothers or donated their eggs, but have chosen not to raise their own child. There could be women who are step mothers but are also VC. So from this perspective VC are a hard to define group. It is not my intention to advocate VC, but to shine a light on this phenomenon in the hope that this will inform clinical practice, not only within psychoanalysis but other psychotherapeutic traditions. My argument is that the

mandate to mother, and to some degree, to father, is so strong in society that most people do not even think to question this. This inevitably includes psychoanalysts and psychotherapists who are part of society and will be subjected to the same social influences.

2.2 Psychoanalytic Explanations of a Woman's development

Freud and subsequent psychoanalysts have been interested in putting forward a theory relating to female sexuality.

2.2.1 Psychosexual development

At a time when the prevailing view was that childhood was free of sexuality Freud (1905b) proposed his libido theory, which stresses the influence of sexuality on psychic life. Clinical studies led him to conclude that the human psyche is strongly influenced by sexual urges. Behind sexual energy was a psychic force that he called libido, which was essential for personality development. Freud considered that sexual strivings began at a much earlier age than was accepted at the time. He believed that childhood sexuality could become so conflicted and painful that they became deeply unconscious and lead to many problems in adult life. From this theoretical perspective the main aim of the psychoanalyst is to bring to consciousness the sexual contents of the patient's unconscious and to offer an interpretation. Freud named the part of the mind that contained instinctual drives the id. The id is a predominantly unconscious structure that lacks any concept of time and reality (Rycroft 1995).

In 1915 Freud further developed his libido theory and he used the word sexual to refer to sensual pleasures while libido was a force that lay behind sexual pleasure. He described certain erogenous zones such as the mouth, the anus and the genitals that bring gratification as potentially active from birth. However, he observed a maturational sequence or phase-dominance, which gave rise to his psychosexual development of oral, anal and phallic phases. The aim of the instinctual drive is gratification and Freud took the view that as these were impulsive they were the main motivators of the mind, thus all mental activity was accordingly drive driven. The Oedipus complex, according to classical theory occurs between three to five years but may occur earlier. According to Freud the Oedipus complex is a universal phenomenon. Resolution of this complex is achieved by identification with the parent of the same sex and partial renunciation of the parent of the opposite sex. The opposite sex parent is then rediscovered in adult life as her adult sex object (Rycroft (1995). The individual then achieves maximum libidinal gratification through sexual intercourse.

2.2.2 A Woman's Desire for a Penis

In 1925 Freud put forward his theories about the psychological impact of the anatomical differences between the sexes. He used maleness as the standard by which female identity and femininity are defined. In his lecture 'Femininity' Freud (1933) saw no sexual difference in children until the Oedipal stage. In the phallic stage both sexes experienced pleasures from their penis or clitoris while for the girl the vagina was yet to be discovered. However in order for the girl to become a feminine woman she needed to abandon the pleasures and importance of the clitoris instead for the vagina. The other task a girl has to achieve in 'normal'

femininity is changing her primary love object from mother to father. This path into femininity is marked by hostility towards the mother for not making her a boy and the need to repress her penis envy. Freud stated that this is hostility towards the mother is based on someone who 'sent her into the world so insufficiently equipped' (12:254). For the oedipal boy, the father continues to be a rival.

At the centre of Freud's (1933) argument was his concept of penis envy and the girl's sense of her own castration, for which she blames her mother, thus turning away from her to embrace the father, the possessor of the penis. The search for the missing penis is the crux of the female resolution of the Oedipus complex for girls and this is replaced by the wish for a baby. For boys, castration anxiety arises when a boy realises a girl lacks a penis and the equivalent for the girl is when she realises she has been castrated and enters a masculinity phase. If development proceeds normally for a girl this will give rise to femininity. Freud considered that a woman's happiness was greater if this wish for a baby became a reality and particularly if it is a boy, who brings the longed for penis with him. Therefore a woman's wish for a baby is a displaced wish for a penis.

Freud (1925) considered three ways in which penis envy this could be resolved: the girl may choose to give up on her sexuality as she is frightened by her comparison with boys and gives up all of her phallic activities and masculine strivings. The other route is that the female will cling to her assertiveness in the hope of gaining a penis, thus developing a masculinity complex. This phantasy of becoming a man and gaining a penis becomes her life's aim and may result in a homosexual object choice or alternatively she may choose a celibate life choice.

Both of these choices results in the female not desiring a child as she is still attached to the father as a love object.

The third method is when the girl chooses her father as her object choice, giving up her mother in order to achieve normal feminine development. This father object choice means that she first wishes for his phallus, then his baby, and finally, maturing towards the wish for a man who is not her father, to give her these. However the girl widens her capacity for a triadic relationship she does not reject her mother but she wishes for a different kind of relationship with her mother than she does with her father. She relies on an internalised positive maternal identity Freud (1925).

Although psychoanalysis was one of the few professions women could access at the time, in a context of fewer rights and lower socio-economic status, the profession was not keen to support 'masculine tendencies' in females. Deutsch (1930) writes: "It is the task of analysis to free these patients from difficulties of the masculinity complex and to convert penis envy into the desire for a child, thus inducing them to adopt their feminine role", as cited in Saugura (2000, p.53). Deutsch (1945) viewed female sexuality as a masochistic pleasure, and the vagina considered to be passive and receptive, while orgasm was seen as an essentially male phenomenon. Motherhood was still considered to be the main aim of a woman's life.

The concept of 'anatomy is destiny' espoused by Freud (1912) was questioned by Horney (1926). She acknowledged the existence of penis envy – but stated

that it was based more on the sexual and social freedom experienced by men. However she seemed to agree with Freud when she says ‘it is well-known that the maternal instinct receives an unconscious libidinal reinforcement from the desire for a penis‘ 1924: 46) and links penis envy to a lack of desire of pregnancy and childbirth, stating that it is a symptom of the rejection of feminine tasks and functions. However later she saw the masculinity complex not as inevitable but as the result of a male dominated culture and particular family dynamics. The fact that "a girl is exposed from birth onward to the suggestion --inevitable, whether conveyed brutally or delicately -- of her inferiority" is an experience "that constantly stimulates her masculinity complex’ (Horney, 1967, p. 69). Horney (1931) considers that a woman’s lack of maternal desire might result from severe feelings of guilt and anxiety connected to old destructive impulses towards her mother. Horney theorised that anxiety about masturbation and disappointment with her father might lead her to reject the feminine role. This masculine identity might to the complete rejection of children, but the desire for children will manifest itself physiologically through premenstrual tension. Horney (1931) states

> ‘I have found without exception and completely independent of the rest of the neurotic structure, the appearance of premenstrual tension in those cases in which one can assume with relative certainty the particularly strong desire for a child, but where there is such a strong defence against it that its realization has never been even a remote possibility.‘ (p. 104).

Horney therefore makes it clear that the desire to mother is the norm, and through successful therapy, the woman who does not wish to mother would

indeed find in herself this desire and would overcome the masculinity complex, that previously led her to feel envious of men and to discard her femininity.

Horney considered that femininity was created ‘in nature and is a biological disposition in women. She was interested in developing theories where femininity was seen as innate and primary and the mother-child relationship was considered essential to a woman’s psychological development. She did not feel that Freud had given enough importance to motherhood, seeing it as a secondary function arising from penis envy. She refused to believe that ‘one half of the human race was discontented with its sex‘ (1924:49). She along with Jones (1927) insisted that girls have an early knowledge of their own vaginas but it is often repressed. These ideas were dismissed by Freud as an ‘alien thought’. In her earliest essays on feminine psychology, Horney was committed to showing that girls and women have patterns of development and biological constitutions that need to be understood in their own terms rather than been viewed as inferior to men. Horney (1926) considered that men were actually envious of pregnancy, childbirth, motherhood, breasts and the act of suckling. A man will try to overcompensate for this envy through trying to achieve and be creative due to the small part they play in the creation of human life.

In "The Problem of Feminine Masochism" (1935), Horney challenged the idea that "masochistic trends are inherent in, or akin to, the very essence of female nature" (Horney, 1967, p. 214). Horney identified some social conditions that made women more mascochistic than men. These conditions are not universal as some societies restrict the development of women more than others.

In contrast to Freud, Horney (1939) does not preclude continued development after the age of five. Although she saw the past as always contained in the present this was expressed through a developmental process rather than Freud's view of repetition. The way in which lives "really develop," said Horney, is that "each step condition[s] the next one." Thus "interpretations which connect the present difficulties immediately with influences in childhood are scientifically only 'half truths and practically useless" (Horney, 1935, pp. 404-405).

In *The Neurotic Personality of Our Time* (1937) and *New Ways in Psychoanalysis* (1939), Horney broke with Freud as she considered disturbances in human relationships were caused by culture rather than biology. This gave rise to an interest in studies of culture from a psychoanalytic perspective. Horney's approach can be viewed as biopsychosocial which underpins the arguments in this thesis.

Some psychoanalysts such as Dujovne (1991, p. 319) argue that "many analysts are still wedded to Freud's theory and use it for the treatment of women despite its negative implications". However, a small group of analysts, including Blum (1977) and Lerner (1980), have departed from Freudian thinking and now see femaleness as the primary disposition. Blum (1977) and Lerner (1980) argue that for the emotionally healthy girl, penis envy does not become a central issue, and the Oedipus phase may well pass without major conflict if relationships are good enough within the family. Interestingly Moore (1976) states this phase is easier if male brothers do not happen to be born at this stage. No reason is given for this last point but one can surmise that this may be because the girl does not have to compete with the brother at this early stage of development. Fliegal (1963)

suggests that the concept of penis envy should be abandoned as studies show that culture outweighs biology in emerging views of female development, and that many girls are positive about their gender. Lampl-de Groot (1982, p.17) an analyst herself acknowledges that "women who do not want to have children are not suffering from a neurotic inhibition and should not be considered either inferior or superior". She defends a woman's right to make her own choices, but then adds "that a woman who decides to remain without a child deprives herself of one of the most natural experiences of satisfaction, happiness and joy available to the human species" (1982, p.17). This highlights an interesting reflection as she is stating that VC choice should not be pathologised but also suggests that without children, women will be deprived.

Psychoanalysts such as Pines (1993) argued against Freud's view that pregnancy and birth gratified every woman's basic wish to compensate for the lack of a penis. Her clinical experience did not confirm this view. She argued that there was a "marked distinction between the wish to become pregnant and the wish to bring a live child into the world and become a mother" (Pines, 1993, p.97). When a woman becomes pregnant, primitive anxieties arise due to her lifelong task of separating from her mother. Erikson (1968) also argued that the centre of the female form, which he referred to as the 'inner space' was far superior to the missing organ – the penis. He wrote that the Freudian theory upheld only a partial truth and recommended a move away from equating femininity with lack, towards a concept stressing the vital inner potential of the womb (Erikson, 1968). See section 2.2.3 As can be seen, classical psychoanalysts' tendency to emphasise penis envy contributes to a sense of 'lack' for women and the continued pathologising of VC women. Although some

of the above psychoanalytic writers reject penis envy, they still considered that motherhood was a normative stage for women.

2.2.3 Parenthood as a developmental stage

Parenthood as a developmental phase was espoused by a number of authors (Erikson, 1951; Benedek, 1959; Kestenberg, 1975 and Pines, 1993). Their views gave further credence to the notion that having children was not only a biological drive, but also essential for emotional maturity. Erikson (1951) espoused an eight-stage model of psychosocial development in which the seventh stage is referred to as generativity. This stage is concerned with guiding the next generation and is a struggle against stagnation. Benedek's (1959) theory applied both to men and women, but in this section the focus will be on her theories of feminine development. She explains how the changes at puberty set in motion the drive towards maturity, which includes the physiological readiness for procreation, and the next phase, which is parenthood. The dynamic between the mother and child leads to changes not only in the infant but also in the mother. This allows the conflicts, which were incorporated in the superego when the mother was a child, to be worked through again due to the experiences of parenthood. Benedek (1959) also outlines the opposite effect: an unsuccessful experience of being a parent might undermine the parent's self-esteem, thus enhancing the strictness of their superego and rendering it pathogenic for the parent as well as the child. Kestenberg (1956) discusses a maternal instinct and Parens argues that girl's wish for a baby is an inborn gender characteristic.

Despite his developmental model from a life cycle perspective, with regards to generativity Erikson (1951) stated that: "…although there are individuals who,

through misfortune or because of special and genuine gifts in other directions do not apply this drive to their own offspring" (Erikson, 1951:240). Erikson states that generativity can be achieved through meaningful work and creativity. Benedek (1950) combined psychology and physiology in her research on menopause, underlining the individuality of women's psychosexual history from early childhood onward and emphasising women's long-term development. Benedek considered menopause to be a developmental stage, which required a progressive adaptation to ageing. Benedek's work introduced the notion of a continuous pattern in women's development from infancy to maturity and beyond.

Since the 1970's more and more psychoanalysts (Brody, 1975; Marcus, 1975; Moore 1975; Williams, 1986; Weldon, 1988; Parker, 1995) have been questioning the premise that parenthood leads to psychological maturity. Women's roles in society have changed tremendously in the past forty years; consequently the pressing issues of many female patients of depth psychologists have also undoubtedly changed during this period. Depth Psychology was a term coined by Eugen Bleuler 1857-1939 to cover all theories of psychoanalysis that include a study of the unconscious. Brody, as cited in Parens (1975:3), considered it curious that parenthood should be considered a developmental phase, bearing in mind the history of neglected and battered children, and the parental substitutes used throughout history from wet nurses and nannies to boarding schools and external child care arrangements. She questioned whether parenthood is invariably accompanied by structural changes in the ego and superego, and argued that change does not necessarily imply advancement towards a higher level of emotional maturity. Brody carried out a 10-year longitudinal study of 131 'normal' mothers and their infants and observed that

often women appear to be unable to shift their attitudes towards the child as he or she moves through each developmental stage. In addition, Moore, as cited in Parens (1975, p.4), stated that, although the wish to have children may fulfill a biological and narcissistic need, this desire is not necessarily the greatest influence on how one may parent. The influence is more dependent on environmental, social and psychological influences in a parent's life. Moore doubted whether there is an innate drive towards parenthood or a developmental need in man to reproduce and rear children. Nevertheless, it is curious that some psychoanalysts, particularly female ones, (Benedek, 1959: Kestenberg, 1975: Pines, 1993) are still assuming that all women would be mothers. This supports the proposition that the motherhood mandate has always been pervasive, and that until relatively recently this position has been unchallenged within psychoanalysis.

2.2.4 Why do Women Choose to be Childless?

One of the few psychoanalytic studies directly addressing VC was carried out in 1977 by Kaltreider and Margolis, in which 33 women were interviewed. Half the sample had tubal ligation and the other half used contraception to prevent pregnancy. In the semi-structured interview used to elicit information, one participant described how, as the daughter of a schizophrenic mother, she did not want to repeat the same mistakes her mother made with regards to providing inadequate parenting. This might have been highlighted as an insightful, courageous act from a woman who to did not want to fulfill the poet Philip Larkin's famous statement that "man hands on misery to man" (Larkin, 1971). The researchers came to the conclusion that, "despite the culturally reinforced expectation that all women should mother, there was a distinct group who should

not mother" (Kaltrieder and Margolis, 1977, p.182). They argued that from an early age these women had identified with being an achiever so the caring role of mother did not appeal. This study did not promote VC as a transformative act, arising from a sense of agency, but rather presented it as a reactive choice.

It has been mentioned in section 2.2.2 above that psychoanalysts can explain VC as a result of a woman's 'masculinity complex'. As an alternative explanation, Ireland (1993) argues that the transformative woman is saying to the world that she is on a personal quest in which motherhood plays no part. She is making a conscious decision to explore other avenues of expression for whatever maternal feelings she has, and regardless of the external questions she may get, she will affirm herself internally as she moves in the world. This of course, can be regarded by pronatalists as an atypical female identity.

Ireland (1993) demonstrates through her interviews that VC women have chosen not to have children in order to maintain their own psychic and physical integrity. Many of Ireland's participants do not fall into the categories put forward by the Kaltreider and Margolis (1977) study which brands them as products of an unhappy childhood. Instead, they had positive female role models, which allowed them to make choices that were outside the cultural norm.

In our society there is a split representation of motherhood (typical of most western societies), according to which mothers are expected to be both childlike and mature (Parker, 1995). Parker (1995), criticises psychoanalysis for its approaches to motherhood and to femininity, arguing that they position motherhood as the developmental goal of femininity, views that are embedded in

and determined by the history of psychoanalytic theorising. Parker argued that the powerlessness that women experience in society can lead them to take this out on their child, a view supported by Welldon (1988). Acknowledging the childless woman, Parker states that psychoanalysis perpetuates the view that you are "not a real woman unless you have had a baby. Mothers who in other circumstances might prefer to be childfree feel subtly impelled into pregnancy" (2005, p.204).

2.2.5 Alternative Forms of Female Expression: the Womb as a Symbolic Space

There are several writers that consider the womb to be a symbolic space as opposed to just an organ that allows a woman to give birth to a live child. As mentioned in 2.2.2 Erikson referred to the symbolic aspect of the womb. He considered it to be "a reality superior to that of the missing organ" (1964 p 587). This inner space is relevant regardless of whether a woman is a mother or not. He states that a woman does not need to identify only with this inner space, but can forge a pathway for herself as a worker. He also states that he is "not trying to doom every woman to perpetual motherhood and to deny her the equivalence of individuality and the equality of citizenship" (Erikson, 1964:605). Erikson also stated that the womb or inner space was paradoxical as it can be the container for a healthy baby or a coffin for a dead one (Erikson, 1968). The concept that birth and death are inextricably linked is a topic that has been taken up by various authors (Gordon, 1978; Christie and Morgan, 2003; Miller, 2003). Miller (2003, p.47) for example, states "A beginning cannot be meaningful without an end. Birth and death are inextricably linked together and inform each other.

Another view is that it is possible for women to achieve gratification from creative expression without bearing children. Writing in the context of infertility and early menopause, Joan Raphael-Leff (2000 p 83-85), a psychoanalyst describes the concept of 'generative identity', which is a stage consolidated between age 18 and 36 months. This entails accepting oneself as being of one sex and half of a procreative couple, which involves interdependence rather than autonomy. If successfully realised, this would entail freeing oneself from biological determinism by utilising psychic cross-gender potentialities meaning that an individual does not have to identify with stereotypical male or female characteristics. This allows for the development of a more abstract notion of creativity in general, as opposed to the 'physical creativity' associated with having a baby. The concept is different to the views espoused by Erikson's (1951) stage of generativity which was explained in section 2.2.3 above.

Ireland (1993) states that women are reminded each month during menstruation that they have the biological potential to carry a child. Electing to be childless does not equate with rejecting the symbolic potential of the womb. For the woman who is not a mother this must include encountering her own lack of a child. This enables her to enter a transitional and potential space in order to interpret her situation, thus creating something new. By inhabiting this potential or generative space, the childless woman expands her experiences of female subjectivity. This allows a distribution of psychic energy within her as well as lets her reconnect with her own female identity and other women.

Ireland (1993) argued that opening the female womb to its symbolic potential enables a childless woman to be seen as complete. She states "...the womb is a liminal space existing at the threshold between the real and the symbolic offspring" (1993, p.139). This psychological experience can be metaphorically linked to Jung's Great Mother archetype which represents "a prototype or primordial image of the mother that is pre-existent and supraordinate to all phenomena in which the 'maternal', in the broadest sense of the term, is manifest" (Jung, 1953, para.149). As an image, the Great Mother reveals an archetypal fullness as well as a positive-negative polarity. The Great Mother is an archetype of opposites, including at one end the sympathetic, caring, solicitous mother and at the other the devouring, seductive, poisonous mother.

2.2.6 Maternal Ambivalence

Some writers (Moulton, 1979; Pines, 1993; Brinich, 1995) argue that ambivalence exists in all parent-child relationships. More importantly, it is psychologically significant for all of us as it sheds light on some fundamental aspects of human nature. Drawing on the work of Rosalind Coward, (1992) a feminist writer, Parker (1995) places the phenomenon of maternal ambivalence within the socio-cultural context, exploring how the maternal ideal manifests itself in British middle-class mothers. She argues that this ideal has its origins in increased income and leisure opportunities, allowing these women to pour endless energy into shaping their children's identities. The endless activity suggests that women are colluding with, rather than challenging societal prescriptions. Coward (1992) suggests that women need to question the psychological and educational aspects of child-care that have become the responsibility of mothers. Parker states that these activities are a manic defence

against ambivalence about the maternal role as opposed to simply trying to live up to a maternal ideal. One could argue that the chosen path of the VC woman is no more or less an expression of ambivalence than that expressed by mothers.

2.2.7 The Influence of the Mother on Voluntary Childless Women

A number of psychoanalysts (Kaltrieder and Margolis, 1977; Pines, 1993) have argued that a woman may unconsciously choose to be childless or infertile because of the influence of her own mother (as opposed the archetypal image as mentioned above in section 2.2.6). Pines (1993) observed that many of her infertile female patients had conflicted relationships with their mothers and that unconsciously they did not believe that their mothers had given them permission to bear their own child, often leading to women having difficulty in separating from their mothers. However, Chodorow (1978) states that a woman will always have difficulty in separating from her mother as the mother has a greater identification with the female baby than with the male one. Motherhood is reproduced as women become the primary care-giver because they yearn for the bond of infancy they had with their own mothers, and this is achieved by having their own child. It may be proposed that in fact the influence of the mother is no greater or lesser for the VC as for those who choose to be mothers. In fact, Kohut made a distinction between a 'healthy woman's wish for a child' and that of a woman who wants a child to repair some internal sense of damage (Kohut, 1975, p.786).

However, the main difficulty with Chodorow's (1978) theory of the Reproduction of Motherhood is that it assumes that all women will become mothers. Ireland (1993) argues that the yearning for intimacy in VC women works out in a different

way. One could argue that a woman choosing not to have a child because of a dysfunctional relationship with their mother is not only expressing agency but also making a responsible decision. The emphasis that psychoanalysis places on unconscious processes does not allow for these types of positive expressions of agency.

2.2.8 The role of the father

Men are influenced by our gender-biased society, and fathers, like mothers, are agents of social as well as biological and psychological reproduction. It can be argued that the influence of the father on VC women is very significant. In her study, Williams (1986) notes that if the girl's experience of her father is:

> predominantly nourishing, she will view herself not as robbed, barren or spoiled, but rather as a worthy person filled with potential, creativity and hope. However if her father was hostile, the girl's sadistic and destructive features are intensified (1986, p.188).

A woman whose father devalued her femininity and whose mother did not defend her, internalises a maternal object that is oppressed and powerless, and a paternal figure that is oppressive and dominating. A woman with such parents may have conflicted feelings about her creative capacities.

Benedek and Vaughn (1982) proposed a different view, arguing that there was no correlation between a woman's relationship to her father and her desire to have children. Ireland (1993) as well as Kaltreider and Margolis (1977) described how some of the women in their studies identified with their fathers' professional aspirations – their early identification was one of being achievers rather than 'little mothers'.

2.3 The stigmatisation of the voluntary childless

Some writers (Benedeck and Vaughn, 1982; Williams, 1986) discuss the social attitudes towards a VC couple. While parents are very seldom placed on the defensive with regard to their motivations for childbearing, the childless couple find themselves constantly asked by well-meaning friends and family about their 'lamentable state'. The media often portray childlessness as being the result of unfortunate circumstances as opposed to being of a voluntary nature. To cope with these circumstances, the couple must develop an adequate social defense of their decision. Many voluntary childless couples choose to say they are infertile as they might be too embarrassed to expose the truth (Benedeck and Vaughn, 1982). They argue that persons who choose to forgo parenthood might experience mental health problems because of the social stigmatisation of their choice.

It would be interesting to explore the reasons behind the tendency for VC women to remain invisible in discussions of adult identity. None of the psychological theories include this choice as an alternative in their developmental models. One could argue that the presence of VC women challenges many unconsciously accepted preconceptions of what women should be. Ireland (1993) argues that there is more resistance in society to recognising the female identity of the childless woman as she is more likely to have organised her identity around autonomy. This can often lead to even more stereotyping of these women as hard, driven and career-oriented.

Benedeck and Vaughn (1982) have drawn on the work of sociologists such as Jean Veveers (1980) to explore the defenses employed by the VC to manage the effects of stigma. Veveers did not use the term defence mechanisms in the way that psychoanalysts normally understand them. The psychoanalytic view is that defence mechanisms are a way to protect the ego from instinctual tension or the superego, and they operate on an unconscious level. Veveer's used defence mechanisms to mean the conscious mechanisms that indivduals used to avoid the feelings of being stigmatised as a group. A further discussion of how these might be employed by VC individuals will be discussed in section 2.6.5 along with Goffman's (1963) views on stigma management.

2.4 Motherhood, childlessness and Counter-transference

Freud first referred to the phenomenon of countertransference in 1910 and he considered it to be the analyst's problem and that it would only interfere with the treatment of the patient. The analyst's emotional response to a patient is known as countertransference and within the profession the term has been used to describe quite different phenomena (Cashdan, 1988). Heinmann (1950) took the view that that the analysts total emotional response to the patient was an important tool in understanding the patient's' unconscious and was not simply a hindrance as suggested by Freud. However more recently countertransference has received further exploration from within psychoanalysis as greater attention is given to the analytic relationship. The analyst's scrutiny of their countertransference can provide insights into the patients unconscious. This self-reflection is considered to be a crucial aspect of psychoanalytic training so that analysts become aware of their own conflicts. This self-awareness helps the analyst to make more sense of their countertransference and how it informs them

of the patient's unconscious. Moore and Fine (1990) refer to the unhelpful aspects of countertransference as counter-reactions. In this thesis the term. countertransference will be used to when the participant or author is using the term to indicate how this gives them information about the patient's unconscious. Counter-reaction will be used to discuss what might be considered unhelpful countertransference. See chapter 6 section 6.3.3 for a further discussion on countertransference.

It is inevitable that female psychoanalysts in contemporary British society cannot avoid internalising the negative social attitudes towards childless women because these attitudes are part of the socio-cultural and political milieu in which we all live. Unless these views are brought to consciousness these attitudes could well lead to counter-reactions in the clinical setting while working with VC patients. Alizade (2007) argues that if the analyst can accept that for many women life can be complete without children then the manner in which the patient is listened to will affect the formulations and interpretations made, and the overall course of the treatment. She along with Stuart (2012) argues that it is important for the idea that for women, life without children can be complete, needs to filter through to clinical practice. With regards to women whose childlessness is as a result of 'leaving it too late', Chodorow (2004) describes how her own strong maternal identity leads her to believe that there is no substitute for motherhood. Therefore she states that when working with a patient who is childless as a result of the biological clock it can be hard not to agree with the patient that on some level "there is something absolute and irretrievable in her situation" (2004, p.1182). Writing in the context of childlessness as a result of infertility, Apfel and Kepler (2000) and Mariotti (2012) warn that it is also

important that psychoanalysts do not give conscious or unconscious messages to their patients that successful treatment will overcome psychogenic infertility. Ruderman (2006:87) argues that female therapist's need to "deal as best they can with unresolved issues and conflicting attitudes about their femininity, as well as their attempts to balance the social, familial and professional aspects of their lives". She describes the paradox of how female therapists may consciously agree with the notion of increasing female power within society, yet they may unconsciously still have unresolved conflicts relating to their earlier experiences. Inevitably this dynamic will become part of the therapeutic relationship as the female therapist encourages her female patients to assert their needs. Ruderman (2006) was not referring to childlessness but how psychoanalysts might be affected by women's place in society. Using the definitions above, it could be argued that the writers above are referring to counter-reactions as opposed to countertransference.

2.5 Contributions from psychologists, psychotherapists and health professionals

Daniluk (1999), a counselling psychologist. points to evidence that women without children have better psychological health and wellbeing than mothers, highlighting that there has been no evidence that women's reproductive choices and mothering behaviour have either a physiological or instinctual basis. She highlights how VC women are still viewed as selfish, infantile and narcissistic by psychological theories.

Daniluk (1992) discusses the social relativity of reproductive choice. She notes that the economic and personal survival of women of certain ethnic groups and

socio-economic classes is contingent upon their ability to produce children. For these women, the decision to forgo motherhood has significant implications for their welfare and well-being, particularly if their culture is very traditional and their role options are very limited. In her study, Daniluk (1992) focuses primarily on Canadian society, but her findings are applicable to the British Asian community in the twenty first century. (See section 2.6.2 for a further discussion of this topic). Daniluk (1992) also mentions that there are no developmental theories that take into account women who do not have children. Along with Ruderman (2005), Daniluk argues for the necessity of a more positive vision of childless women in society.

Bonnici, (2010) a Counselling Psychologist, undertook research with VC women revealing that most participants did not experience a strong biological urge to make the decision to have a child. The decision not to have a child was consistent over time and they did not experience loss or regret in relation to their VC choice. The women also expressed the sense of freedom they felt in not having children whilst at the same time some of the participants stated they loved spending time with nephews and nieces. She strongly recommends that psychotherapists working with VC individuals need to be aware of the stigma associated with this choice as a way of being more empathic and understanding of the client. (See section 2.6.5 for a further discussion of stigma).

Discussing the female decision to remain childfree, Kamalamani (2009), an integrative body psychotherapist, raised a number of interesting points. She states:

> There is the inherent danger of failing to capture the diversity of individual life because on is choosing to look at it from a particular angle, when, in fact, most lives are a more complex web of interconnected events, people and phenomenon (Kamalamani, 2009, p 32).

Furthermore she states that it is often very difficult for VC women to resist the pronalitist pressure in society and there can be a "high personal cost to the resistance role" (2009 p.32). She argues that it is therefore crucial that therapists do not make assumptions about childless women as their experiences can be as varied and conflicted as those of mothers. She suggests that psychotherapists need to provide an open and supportive environment to allow the complex decision-making to unfold freely for those clients who are experiencing the growing phenomenon of VC.

Shaw, a chartered psychologist, questioned the notion of choice and women's ownership of the decision (2011)**.** She discovered that the term 'choice' itself needs unpacking, and her interviews with women revealed a complex tapestry of contributory factors on the path towards VC. The participants discussed the social pressure they experienced to become mothers as well as how their own models of mothering had discouraged them from becoming a parent. Shaw's participants also drew attention to the importance of 'owning' the decision to be childless as this reflects autonomy and empowerment.

Cooke, Mills and Lavender **(**2012**)**, all of whom are health professionals, who carried out phenomenological research into delayed childbearing. Their research highlighted how their participants experience a sense of urgency, social

pressure, and often a lack of choice with regard to timing to have a family. They argued that health professionals and the media need to be more aware of the interplay of factors for these women, and that GPs may have preconceived ideas about why women delay having children. The media often depicts delayed motherhood and VC in negative and stereotypical ways (Giles and Shaw, 2009). The choice not to have children is often complex and includes grappling with ambivalence.

2.6 Sociological perspective on Voluntary Childlessness in Women

2.6.1 Introduction

A review of the sociological literature shows that it was not until the nineteen seventies that VC was tackled as a subject in its own right as opposed to as an appendix to a woman's story. However, several books published from the middle of the twentieth century played a big role in challenging patriarchal assumptions about women. In 1963 Betty Friedan's book *The Feminine Mystique,* criticised psychoanalysis for reversing the feminine movement that took America by storm. However, Friedan, like many female psychoanalysts, did not even consider VC in her book as she was more concerned with how women could combine work with motherhood. Her position reflects social scientists' tendency to focus on those research questions which reflect their values and biases, and which are supportive of the dominant norms (see 2.6.2). Researchers such as Veveers, (1973, 1980), Morell (1993, 2000), Gillespie, (1999; 2000; 2003) and carried out qualitative research with VC women in order to gain a greater understanding of their lived experience as well as insight into the decision making process that allowed them to arrive at their choice. These are discussed in 2.6.3

2.6.2 The influence of cultural discourse and pronatalism

Pronatalism is a belief that promotes human reproduction. In her book, *The Childless Marriage*, Elaine Campbell (1984) a British writer, argues that in order to remain childless both sexes are challenging the basic assumption that family life should include children. Writers such as Mead (1962) said that all societies attempt to control reproductive activity and that which is considered 'normal' is shaped by cultural images and values. Morell (2000) carried out qualitative research with 34 VC married women in the USA and said that it was necessary to think about childlessness in new ways and to develop alternative forms of language and thought processes in order to validate the childfree choice. Her research was guided by feminism and post-structuralism and she argued that domination and influence are exercised through language as well as through external power and institutional practices. She considers personal empowerment to be important for women but it is also important to address "the conditions that limit and enforce personal choice" (2000, p.321).

Rich (1977, p.249) mentions that "there is no ready-made name for a woman who defines herself by choice", noting how the use of language reflects the secret power of the culture. Both etymology and semiotics work against the childless woman. For example, the word 'childless' implies a 'lack' whereas 'childfree' only suggests that the woman has refused motherhood, and does not indicate the political colouring of her choice. The 'free' woman is tinged with promiscuity, and the 'virgin' can be seen as pure and holy – or as frigid (Rich, 1977 p.249). She argues that "the childless woman and the mother are a false polarity which has served the institutions of motherhood and heterosexuality" (1977, p.250). These simplified categories do not embrace the numerous

conflicting variables involved in both parenthood and the choice to remain childfree. The polarisation in this kind of discourse encourages the view that mothers and non-mothers are embracing difficult qualities, which can give rise to binary thinking. This is one of my subsidiary questions as described in 1.2.

Cultural discourses are influenced by those who possess political power. Stone (1977) has argued that ideas around motherhood as being central to feminine identity are essentialist and deterministic. Gillespie (2001), a British writer, also highlights how the political right has reinforced motherhood ideology both in the United States and the UK. These include 'Back to Basics' campaigns promoting the preservation of traditional family values and restriction of the availability of abortion, as promoted by John Major in 1993 as well as similar campaigns in the US. Gillespie (2001) notes that in all countries the political right often reinforces a motherhood ideology. Conservatives and neo-liberals support what are seen to be traditional family values associated with natural kinship roles, and argue for the containment of sexual behaviour within the nuclear family (Gillespie, 2001).

Western societies still have pronatalist cultural discourses that establish a template for female behaviour and place motherhood at the cornerstone of adult femininity. Not having children is framed as a tragedy, and infertility is associated with suffering (Sandelowski, 1990; Gillespie, 2001). Many of the world's religious groups (particularly, Roman Catholics and Muslims), interpret procreation as a moral and religious obligation. According to Gillespie (2000) many women have encountered pronatalist physicians who have placed pressure on them not to have abortions or not to be sterilised. The young wives in Veveer's study (1975) reported serious social disapproval of their rejection of motherhood. There was

social pressure from parents, in-laws, siblings, work associates, friends, and doctors, yet there was no pressure from their husbands (Veveers, 1975). One would imagine that by the year 2014 that this would have changed but in a recent radio four programme entitled 'A Family Without Child' on Radio four (2014), women who were consciously VC and others who had been diagnosed with infertility discussed how they experienced isolation and stigmatisation as a result of their childlessness. The topic of stigmatisation is discussed further in 2.6.5.

The postmodern culture of reproduction seems to be sending confusing messages to women. Morell (2000) uncovers a new form of pronatalism that has a racist dimension. It attacks American middle and working class white women who remain childless or postpone childbearing, while at the same time rebuking low-income women of colour who have children as single parents. Writing in the context of American society Davis (1990) discusses the paradox of how white middle class women have gained the right to choose whether or not to reproduce, but black and Latina women are disproportionately represented in cases of nonconsensual sterilisation. In Britain, South Asian women are under particularly strong pronatalist pressure according to Culley et al, (2004). A study carried out by Brown (2005) showed how pronatalism combined with racism can be seen in the way childlessness is reported in the British press. Traditionally antinatalism has been directed towards low-income individuals, lesbians and gay men, and physically and psychologically disabled individuals. Physically disabled women also face pressure not to mother, which is discussed by Thomas (1997). In contrast to the antinatalism discourse within certain communities, there is an increasing pronatal sympathising within the lesbian community.

Heitlinger (1991) examines state policies that aim to promote equality of opportunity for women, with rights such as child-care allowances and maternity leave. However she argues that they can also be seen as pronatalist. She goes on to state how this is hard to define but can be seen as operating on several levels. This is particularly the case:

> culturally, when motherhood is seen as natural; ideologically, when it becomes a patriotic, ethnic or eugenic obligation; and psychologically, when childbearing is identified with the micro level of personal aspirations and emotions. Finally, it can also be a rational decision made by couples under the influence of population policy and the state (Heitlinger, 1991, p.345).

Despite the omnipresence of normative cultural discourses of the motherhood mandate as the pinnacle of a woman's development of an identity, Gillespie states "some women feel the need to reject the culturally-defined forms of motherhood and other hegemonic notions of femininity" (2003, p.123). In his book entitled *Power*, Steven Lukes (1974) argues that the most sinister form of power is the one that manipulates attitudes without people being aware that it is occurring. These oppressive ideologies need to be challenged so that more liberating discourses can emerge (Bordo, 1993; Gillespie, 2003).

Quoting some of the women involved in her research, Gillespie (2000) notes that even independent-thinking women tend to describe their childlessness in stereotypical ways. Her examples show how difficult it can be for individuals to break away from cultural discourses, and how engrained cultural assumptions are. There is a personal risk to those who resist normalising discourse as it can

result in social exclusion and marginalization (see section 2.6.5). Gillespie argues strongly for the need for women to resist cultural discourses relating to motherhood and childlessness so that "women's individuality, diversity subjectivity and agency may increasingly come to be more fully acknowledged, validated and accommodated." (2000, p.232). Nevertheless, suggesting that motherhood is purely enforced through ideology and systems of power, denies the agency that some women exercise in actively deciding to become mothers. Lisle (1996) a North American writer, argues that the rise of pronatalism in the 1980's was necessary to encourage women who were either ambivalent or chose to delay parenthood into parenthood sooner. A number of authors suggest that the increasing availability of Assisted Reproductive Technology (ART) intensifies a pronatalism discourse (Lisle, 1996; Gillespie, 2003).

2.6.3 Reasons for childessness from a sociological perspective

The motives for avoiding parenthood are as numerous, complex and contradictory as the reasons for having children. In her research, Veveers (1980) concludes that often individuals find it very hard to articulate the reasons for choosing to be childless. Other researchers (Movius, 1976; Veveers, 1980; Campbell, 1985; McAllister and Clarke, 1998; Morell, 2000) came to the conclusion that it is difficult to isolate a single motive for remaining childless.

Researchers have argued that the childless woman makes her VC choice because she wants 'something different' for herself. Morell (1993) concludes from her research that this 'something different' includes self-expression, independence, education, and economic self-sufficiency. These ambitions are often realised through 'confrontation, negotiation and determination' (Morell,

1993:305). Often the decision not to have children is made when the individuals are very young and their flexibility allows them to shake off the constraints of socially prescribed femininity. Many women in Morell's research made counter-cultural statements. Their interests as children included both masculine and feminine activities and hobbies (Morell, 1993:306). She argues "These self - portraits challenge the notion of the stable and monolithic feminine orientation that is consistently relational and orientated to others" (1993:311). It is interesting to note that many of these sociological writers argue for the importance of individuals being able to embrace both feminine and male qualities which links to Raphael-Leff's (1997) concept of generative identity mentioned above in section 2.2.4.

McAllister and Clarke (1998) state that few people make an early irreversible decision not to have children, and their in-depth qualitative study of 34 British VC women and some of their partners showed the complexity of the participants' decision making over time. The participants also demonstrated considerable variation in the pathways and patterns of intention they followed in reaching childlessness. Usually such decisions take place in the context of other life events, and particularly within partnerships. Highly qualified women are more likely to remain childless but whilst career identity does not emerge as central to personal identity or personal fulfillment for the majority of VC people, early retirement does prove to be a popular goal. Childless people have sometimes been represented in the media as self-centred individuals, but the absence of children does not necessarily mean the absence of other caring responsibilities. In addition, contrary to the popular view that VC is part of an 'alternative' lifestyle,

many VC people hold conventional views about partnerships and parenting but choose not to have children themselves.

McAllister and Clark's study (1998) highlights how the rejection of parenthood does not necessarily mean negation of the importance of children for society. Their research shows that most childless people are in favour of supporting children through taxes. Their findings suggest that deciding not to have children is a complex process that takes place in the context of work, life experiences, personal health and relationships. Bergum (1997) suggests that the decision to become a mother is neither entirely rational nor unequivocal. This decision cannot be fully understood until the child has been born and became a part of the mother's everyday life. It seems that both the pronatalist and anti-child choices are heavily influenced by cultural and normative narratives which attempt to determine the proper timing of motherhood for all women.

Veveer's (1980) study of VC women revealed that nine out the ten individuals interviewed reported that their parents had never been divorced or separated, and eight out of ten stated that their mothers had never been employed outside of the home. These individuals concluded that conformity did not lead to happiness. A high number of the participants were first born and only children, and many in this group had a 'little mother' syndrome. This refers to the fact that they were placed in the role of taking care of younger siblings or in some cases disabled or ill parents. Many of the participants viewed parenthood as equivalent to martyrdom and perceived their own parents in this light.

2.6.4 Characteristics of childless marriages

Veveers (1980) states that childless marriages are different from parental ones mainly because the couple can focus on the dyadic relationship. They have much in common with sterile marriages, with honeymoon couples and with those elderly parents whose children have grown and gone. Relationships with a single dyad are more intense than those encompassing a large group as the interaction between parents tends to be diluted by the existence of children. Emotional energies are less dissipated by other relationships in a childless marriage. However, this seemingly intense dyad can be a double-edged sword. A relationship typically characterised as positive, can be enhanced but a negative one may go on a downward spiral as in Edward Albee's (1962) play *Who is Afraid of Virginia Woolf* in which a woman creates a mythical child. People in positive marriages tend to receive the most hostile responses in terms of their VC choice (Veveers (1980). Their relationships are often more egalitarian and women are often encouraged by their husbands to return to education. Marriages of this kind are, in fact, equal partnerships. The androgynous (not being tied to prescribed gender roles) roles revealed in Veveers' (1980) study might suggest that the rejection of motherhood and fatherhood may be associated with the rejection of other behaviours typically thought to be a definition of feminine and masculine roles. However, as far as androgyny is concerned, we have a causality dilemma: it is still unclear according to Veveers "whether androgyny causes childlessness or whether remaining childless facilitate the expression and development of androgynous sex roles" (1980, p.105).

Campbell (1985) studied 44 childless couples in a Scottish city to gain an understanding of what it meant to them to be VC. She argues that childless

couples face the difficulty of living within a culture that, whilst it does not condone VC, it also does not condemn it. Reproduction is still a public issue and the childless still have to 'justify' their decision. Being without children can be a fluid condition and individuals may be uncertain how they will perceive their own decision later in life.

2.6.5 Managing Stigmatisation

Rainwater (1960, 1965) was one of the first researchers to draw attention to how those without children are viewed negatively compared to those with children. He interviewed 96 working class men and women and concluded that those who wanted only one child as well as those not wanting any children were condemned. The latter were viewed as 'going against nature' (Rainwater, 1960: 55).

Sociological research has highlighted how many VC women experience stigmatisation because of their childless status in society. Parks (2002) carried out a review of the literature into how VC individuals were stigmatised and examined the techniques used by women to manage their 'deviant' choice in a pronatalist society. Her work draws on the analytic framework of Goffman (1963) that discusses how information is controlled among individuals with identities that are outside the norm. Parks (2002) highlights the work of Veveers (1980) that shows that the deviance of the VC woman lies in the fact that she does *not want* children as opposed to the IVC woman who would *want* the parenting role if circumstances were different. She makes the point that deviance is perceived not only in the action or VC choice in this case, but also in terms of the personality of the individual. Goffman made the point that "we tend to impute [to sigmatised

individuals] a wide range of imperfections on the basis of the original one." (1963:5). Studies carried out by Callan (1985) Houseknecht (1987) and Mueller and Yoder (1997) have, according to Parks, highlighted how the stereotyping of VC women contributes to the 'stigma theory'. Gamong, Coleman and Mapes (1990) reviewed twenty-six documents on family structure stereotypes and concluded that parents were not viewed more positively than nonparents except when compared to VC individuals. However Veveers (1972) suggested that VC individuals are viewed as a threat to the lifestyle of parents as it makes them question whether family life is in fact bringing about personal happiness. Parks suggests that the stigmatisation of VC individuals may also arise from the view that this choice is associated with the breakdown of family life and growing individualism in society.

Goffman (1963) argues that when a stigmatised individual possesses a deviance that is not immediately visible then they must manage information about their failure to conform. By developing strategies for revealing and concealing information that depends on the audience, this will affect the individuals' attitudes towards themselves. Parks (2002) argues that VC is an invisible stigma and is often in the background throughout an individual's life-cycle until one is asked to account for one's decision. The childfree identity arises from a combination of the internal conversations about the VC choice alongside the responses from others. One of the findings of Parks' study of VC men and women found that many of the participants had not discussed their choice with family and friends which would support Goffman's (1963) view that stigma management is more a public issue than a private one. Stigmatised individuals often find it more necessary to

engage with strangers or acquaintances about their deviant status, rather than close friends or family.

As mentioned in section 2.3 Veveers used the term defences to explain how VC women manage pronatalist pressure and the consequent stigma. Veveers' research (1975) with 89 VC women concluded that, although VC couples perceive their anti-natalist sentiments as resulting in a variety of negative sanctions, they remain relatively unperturbed by the social pressure. This situation is achieved and maintained through adherence to a variant world-view which is essentially the 'obverse of the motherhood mystique' Veveers (1975, p.473). This strategy is of symbolic importance as a means of reaffirming psychological normalcy, and of avoiding the ambivalence associated with irreversible decisions. The couple may see their 'difference' as desirable and superior, whereby motherhood is defined as negative. In this world-view maternal instinct may be denied, and the experience of pregnancy and childbirth defined as unpleasant and dangerous. Pregnancy may be seen in terms of adopting the sick role and childcare is regarded as onerous and as having a negative effect on one's life chances. The childless deny the rewarding aspects of parenthood and highlight examples of abused children as a means of coping with negative social pressure. There can be negativity about mothers and stereotype them as 'breeders or just housewives' (Veveers, 1975). The results from her study would support Goffman's (1963) views that stigmatised individuals often take a superior position in relation to their deviant position. Those in Veveers' (1975) study were unaware of the existence of others in society who also rejected the motherhood mystique (1975, p.475), which means that unlike other 'deviant' groups they are not a recognised minority with a distinct point of view. As such, the women in

Veveers' study did not have an immediate group of childless friends who shared their VC decision and underlying thought processes. The childless woman's husband provided the main psychosocial support of her decision, thus allowing the couple to construct a third reality. Such couples often isolated themselves from those whose beliefs differed and even lost touch with friends who have children. Some also surrounded themselves with single people. Their circle of friends included parents who did not consider children their top priority. They were very selective about individuals they revealed their beliefs to, and sometimes inferred that they were infertile. The latter decision is logical because, as Polit (1978, p.105) states, infertility in general is viewed more favourably by society than VC. Interestingly more recent findings by Carmichael and Whittaker (2007) found that negative attributions of childless women as selfish tend to come from childless women themselves. Shaw (2011), a psychologist, wonders whether some of the 'felt stigma' is actually a fear of discrimination as opposed to 'actual stigma'.

2.7 Feminist perspective on voluntary childlessness in women

The feminist perspective holds that a woman's reproductive capacity is controlled within patriarchal systems. Rich (1977) argues that throughout recorded history the institution of motherhood "has ghettoised and degraded female potentialities" (Rich, 1977, p.13). She highlights both the power of biological potential or capacity of the mother that can bear and nourish life as well as the magical powers that are often bestowed on women by men, for example: witches, fairy godmothers, or the female gods of ancient antiquity and in Hinduism. Firestone (1972) expresses a strong view that childcare should be the responsibility of society as a whole to allow women to be freed from the restrictions of

reproduction. Campbell (1985) argues that some feminists' portrayal of motherhood as a tyranny has had two consequences: it justifies the decision to remain childless but also does not provide a sympathetic view of women who are involved with childcare (1985:18). At the time she was writing in 1985, she felt that feminists had not addressed the varieties of motherhood that were needed in a changing modern world.

Like sociologists, many feminists do not question the basic premise that all women should mother. Feminism generally tends to support the combination of marriage and motherhood with a non-familial role, and promotes the idea that women should be allowed to do both. Morell (1993) reminds us that Euro-American feminism began by emphasising the importance of women's independence and agency. Patriarchal ideology and power was blamed for making childbearing and child rearing "oppressive and as hindrances to creativity and self-expression" (Morell, 1993, p.300).

2.7.1 Feminist Criticisms of Psychoanalysis

Friedan (1963) argued that the popularisation of Freud's theories in the USA during the 1960s revived the old American prejudices that women were born to breed. She argued that the idea of the 'feminine mystique', promulgated in America in the nineteen sixties, made it more difficult for the modern woman to question the old prejudices because 'the mystique' was broadcast by the very agents of education and social sciences that were supposed to be the chief enemies of prejudice. Various authors (Friedan, 1963; Rich, 1977; Hird, 2003) criticised Freud for the universalising of human nature, arguing that he was a prisoner of his own white middle-class nineteenth-century European thinking.

Hird's (2003) review of Freud's ideas supports the contention that VC is viewed as pathological by mainstream psychoanalysis which continues to make an inextricable link between femininity and motherhood as a developmental stage.

Sandelowski (1990) argues that contemporary psychological literature continues to conflate VC and IVC. Some feminist writers equate women's desire for children with their oppression as women. Hird (2003) argues that most contemporary literature on childless women focuses on trying to explore the reasons "as though the answer is to be found in some demographic or psychosocial specificity" (2003, p.6). She goes on to argue that VC women are portrayed in stereotypical ways as white, middle class women who are striving to be like men as they develop their careers. Hird (2003) suggests that there is an ideological rift between feminists with children and childless feminists.

2.8 Childlessness and postmodernity

According to Gillespie (2001) our post-modern society is characterised by an overwhelming pace of change. This rapid change leads to "psychological fragmentation and uncertainty; increased choice that gives rise to absence of structure; and a diversity of social institutions and identities" (2000, p.146). The meaning of reproduction, and associated reproductive technology, and motherhood in particular, has taken on new meanings in our postmodern age. Gillespie (2001) has argued that there is now a 'cafeteria approach' (2001, p.146) whereby individuals can choose to have some involvement in reproduction through donating eggs or sperm but from a traditional point of view they may not consider themselves to be a parent or they may not have a child of their own and be VC. The aforementioned illustrates some of the many

configurations of what it is to be a woman in a post-modern society Furthermore Gillespie (2001) argues that motherhood is now an 'unstable category' and disproportionately available to white, middle-class heterosexual women. Postmodernity provided wider possibilities for women to build fulfilling gender identities that are separate from the hegemonic ideal of motherhood. Gillespie (2000) has argued that modern reproductive technology has also reinforced pronatalist rhetoric by emphasising the link between femininity and motherhood. A small number of male dominated groups of experts now exercise control over women's bodies and infertility is framed as 'a failed body' issue. IVC is constructed in medical terms as infertility synonymous with notions of illness and abnormality. Diagnosis leads to medicalisation and treatment in the hope of bringing about pregnancy and the birth of a child. From the medical point of view, infertile women are worthy of sympathy whereas VC women are seen as selfish and immature (Gillespie, 2000).

2.9 Conclusion

One of the aims of this thesis is to draw together the competing debates regarding VC in the hope of finding a more inclusive, biopsychosocial approach understand this complex phenomenon.

Freud's theory on psychosexual development has strongly influenced how psychoanalysis has viewed women's development and the term 'anatomy as destiny' (1912) has been linked to the view that parenthood, particularly for women as an important stage of psychological development. The concept of penis envy was reinforced by many of the early female psychoanalysts such as Deutsch, 1930). However, Horney (1926) and subsequent analysts such as

Dujovne (1991) challenged the phallocentrism of penis envy as a notion. Nevertheless most of these psychoanalysts still considered motherhood to be a natural course for all women. Moore as cited in Parens (1975) challenged this view, drawing attention to the many mothers who have neglected their children throughout history and questioned whether parenthood leads to maturity. Psychoanalysts have given their attention to why women choose to be VC and the early psychoanalysts Deutsch (1930) understood it to be related to unresolved Oedipal issues. Chodorow (1978) considered the desire to have a child as a woman's need to re-create the bond with her mother that she had in infancy. Inferring from this, one might believe that VC would result if the bond between mother and child did not exist in that woman's infancy. Williams (1986) focused on the role of the father and how he can influence the female child's wish for a child through his attitude towards her. By 1982 Benedek and Vaughn drew on the work of sociologists such as Veveers (1980) to consider that VC is complex and may not be rooted in pathology. They also used Veveers' (1980) research to highlight that many VC women experience stigmatisation as a result of their choice. Other writers such as Ruderman (2005) have suggested that if female psychoanalysts have unresolved conflicts about a woman's role in society that may cause unhelpful counter-reactions in their clinical work with female patients. Psychotherapists, psychologists and health professionals have carried out research into VC and have offered alternative views of about VC. Bonnici's (2010) and Shaw's (2011) research concluded many of their participants did not link motherhood with femininity and expressed their creativity in ways that did not involve a biological child of their own.

The sociological literature in this chapter placed VC in the context of western societies, focusing on how it has been viewed from the 1960s through to the twenty first century. Social constructivists and feminists argue that parenthood is a socially prescribed role, shaped by those dominant within society who are usually male. Cultural discourse provides conflicting representations of both the childless and parents, and cultural theorists are far from having a unified opinion on the subject of VC women. What is apparent however, is that resistance to traditional family values is a valid form of challenging the dominant social order.

Some psychoanalytic writers (Ireland 1993) and sociologists (Morell, 2000) have converged in that both argue that the rejection of motherhood in post-modern western society has become radical, and that VC women ought to be seen as 'trailblazers'. However, it could be argued that a post-industrial lifestyle has created more choices for the 'ordinary' woman, which can also be experienced as a 'tyranny of choice'. These choices and resistances come with a psychological cost to the individual and were explored by Veveers (1980) and Parks (2002) who highlighted the stigmatisation experienced, and defences used by the VC to cope with their marginalised status. Parks (2002) drew on the work of Goffman (1963) to illustrate how the VC women in her research could be considered to be a stigmatised group. As personal problems are closely related to social ills, psychoanalytic practitioners may have to engage with dominant social discourses when working to untangle a personal dilemma with clients.

2.11 Research Question and aims

It was as a result of my critical literature review that I decided to interview psychoanalysts using Interpretative Phenomenological Analysis (IPA) as my

method, as I was curious to explore how the phenomenon of VC was understood in the clinical setting in the twenty first century. The aim of this research is to make sense of how psychoanalysts make meaning of this phenomenon, bearing in mind our post-modern society with multiple choices available to individuals. This is particularly pertinent as psychoanalytic literature has historically made an inextricable link between motherhood and femininity. The findings of this research will contribute to existing knowledge as it will be the first research at the time of submission to interview psychoanalytic practitioners to explore how they understand VC in the clinical setting. I am interested in exploring how the knowledge produced from sociologists might be utilised by psychoanalysts and psychotherapists to provide a more integrative approach to understanding VC in the clinical setting. The research question for this is: How do psychoanalysts understand, conceptualise and respond to VC in the clinical setting?

Chapter Three - Methods and Methodology

3.1 Introduction

This chapter will outline the methodological approach chosen for this research and the method, which is Interpretative Phenomenological Analysis (IPA). In addition a rationale will be provided for this choice along with information regarding the methodology, i.e. the philosophical and theoretical underpinnings of the method. The epistemological and ontological basis for IPA will also be addressed. As this research is interested in the psychoanalytic view of VC, I will consider how psychoanalytic research links to IPA. As reflexivity is a crucial part of IPA, my position as a researcher will be outlined. There will be further reflections on why I have an interest in the topic in question. Reflections will be given of any pre-conceptions that I might hold that could affect the research findings and how I have addressed these so that there is transparency throughout the process. A detailed description of the research design is provided and this includes the following procedures: gaining ethical approval for my research from the Centre of Psychoanalytic Studies in Essex University, the pilot study, recruiting participants, collecting and analysing data. Consideration will also be given to how quality, validity and rigour will be ensured through the use of an audit trail. Extracts from the participants' transcripts will be provided and reference will be made to the variety of documentation that was used during the research process and these will be found in the appendices. Additionally, how ethical issues were addressed throughout the research process will also be described.

3.2 Production of knowledge

The choice of research method is driven by the epistemology of each approach or the theory of knowledge – in other words, how can the approach justify its research findings? The methods that are employed in any research will produce different kinds of knowledge. Each methodology also has its own ontology or theory of the person, which will inevitably inform the methods used to collect knowledge.

3.3 Qualitative research

Broadly speaking, these are the two identifiable 'poles' in traditional social scientific research. The quantitative pole includes positivist ideas about how cause and effect laws are to be established via the experimental control of variables designed to test existing theories. Quantitative research requires operationalised variables to be closely defined, monitored and controlled allowing for research to be replicated. The traditional positivist approach, upon which quantitative research is based, implies that through suspending our biases we can gain access to some form of 'truth' (Cresswell, 2007).

Qualitative research takes the view that the world is complex, and multi-layered and can be viewed from many perspectives. Our worlds are social, personal and relational and can be constructed through a variety of ways such as talk, action, systems of meanings as well as the institutions that have emerged in society. Each of the different qualitative methodologies that have been devised seeks to understand how the world is constructed but each adopts a different perspective (McLeod, 2007). The method used to gather data in qualitative research usually

involves semi-structured interviews of individuals or small groups in naturalistic surroundings. These methods are used in order to gather nuanced accounts relating to the research question with no intention to generalise from the sample group to the wider population. In most of these methods the researcher will acknowledge their impact on the research process, which encourages the researcher to be reflexive, and attempt to highlight power imbalances in the research situation and reduce them.

3.3.1 Overview of qualitative research in psychotherapy

In recent years qualitative research has become increasingly influential within health and education research (Mcleod, 2007). This growing popularity is understandable as qualitative research provides a set of flexible and sensitive methods for opening up areas of social life that were previously not well understood. The purpose of any research is to enhance knowledge and one of the aims of qualitative research is to create new understandings and to produce individual, personalised accounts of those who are participating in the research.

The disciplines of counselling and psychotherapy adopted qualitative studies later than those in the social sciences and other health professionals (McCleod, 2007). Psychotherapy research has expanded since the 1950s and the impetus arose from the pressure to evaluate the effectiveness of different therapeutic techniques. As a result the research methods used were dominated by those used within psychiatry and psychology, which included experimental designs, diagnostic categories and standardised instruments. There were dramatic changes over the first decade of the new millennium as the government's focus

was on funding evidence-based practice. According to Rowland and Goss (2000) this encouraged practitioners to take research far more seriously. Williams and Irving (1999) argue that still many practitioners regard research as irrelevant to the realities of their practice. McLeod (2007) highlights how many practitioners resisted qualitative research because it did not adhere to scientific rigour and the findings were not generalisable as is the case in quantitative methods. However McCleod (2007) also states that qualitative research has its own unique role to play in the creation of knowledge that can affect both policy and practice. Qualitative research can give voice to those who are often unheard in our society as well as examine institutional and social practices. This can help identify barriers and facilitators of change and the success or failure of interventions. However, choosing the method that is best suited to the line of inquiry is vital to obtaining the desired results (Starkes and Trinidad, 2007).

3.3.2 Different types of qualitative research

This section will provide a brief outline of several qualitative approaches and examine both their strengths and their limitations with specific consideration of this particular research.

3.3.2.1 Discourse Analysis

Discourse analysis evolved from linguistic studies, literary criticisms and semiotics (Starkes and Trinidad, 2007) and in some instances psychoanalysis (McLeod, 2007). It has become influential within Social Psychology in Britain and key figures have been Jonathan Potter, Margaret Wetherell, Michael Willig, Ian Parker and Derek Edwards. Discourse Analysis is not a single, unified position and is an approach or stance rather than a method (McLeod, 2007). The

philosophical view is that knowledge and meaning is produced through interaction with multiple discourses. Their aim is to understand how people use language to create their identities and actions. The data is collected either through observations of participants in their natural environment or researchers engage in dialogue with participants in order to probe for intertextual meaning. The researcher is interested in the words that the participants use, how the story is told, and in the shared meaning created through language. The researcher will also consider their own place in the discourse and how their presence might have affected the research process. The audience for this type of research has included policy makers who need to understand the discourses in use relating to the particular topic they are researching in order to develop effective messages, for example relating to improving health. Research methods using this approach highlights how different discourses shape identities, relationships and how social goods are negotiated and produced (Starks and Trinidad, 2007).

The contribution of discourse analysis to counselling and psychotherapy is reflected in the work of Madill and Barkham (1997). In their study a female client had completed eight sessions of psychodynamic therapy and the aim of the research was to gain a discourse analytic understanding of the process of therapeutic change. In the case analysis, the language between the therapist and the client was examined to identify the subject positions taken up by the client in relation to cultural messages around being a daughter. The focus of the work for this particular client was concerned with her difficult relationship with her mother and the analysis of the discourse during the eight-week psychotherapy revealed that she moved subject positions from ‘dutiful daughter’ to ‘damaged child’ in relation to a ‘bad daughter’. Madill and Barkham (1997) claim that the

value of their research is that it offers an understanding of the therapeutic process not as something that happens within the client's head but is more focused on the use of language and cultural meanings. Therapy is talk, and "in principle, understanding the discourses surrounding counselling and psychotherapy is vitally important for practitioners" (McLeod, 2007:103).

However, there are limitations to the use of discourse analysis in counselling and psychotherapy. The strict interpretation of a discourse analysis approach is in contrast to traditional therapeutic stance of being interested in the client's inner world and experiences and the gradual unfolding of the therapeutic process. Given the aims and questions in this research, there is an interest in and awareness of the way language is used to reflect cultural meanings attached to whether or not one chooses to become a mother. However as the participants in this particular research are psychoanalytic practitioners whose focus is on interpreting the unconscious conflicts experienced by their patients, discourse analysis was not considered to be an appropriate method. I did not choose this method as I was more interested in how the participants make meaning of VC in the clinical setting rather than simply the use of language. Discourse analysis on the other hand is interested in how they are constructing accounts of experience (Smith, 2011) and this is not the primary function of this particular research.

3.3.4 Grounded theory

Grounded theory originates from sociology – specifically from symbolic interactionism – which posits that meaning is negotiated and understood through interaction with others in social processes (Blumer, 1986; Dey, 1999; Jeon, 2004). Barney Glaser and Anselm Straus published the Discovery of Grounded

Theory, the seminal text, in the 1960s. The first goal of grounded theory is to develop new ways of looking at basic social processes and the second is to 'generate a 'theory' for understanding the phenomenon being investigated, Third, the theory needs to be 'grounded' in the data rather than being imposed (McCleod, 2007, p.70).

Successful grounded theory analysis requires the researcher to immerse themselves in the data, and it is best done alone, until a point of saturation is reached. This approach does not emphasise personal reflexivity like many other qualitative approaches and academic psychologists question the methodological rigour of this approach such as inter-rater reliability and convergent validity (McCleod, 2007). Those with either social constructionist or feminist epistemologies may also query an approach that downplays collaborative working.

An example of this method in psychotherapy is research by Rennie, who since the early 1980s has conducted a series of studies about aspects of the client's experience of therapy. According to McCleod (2007) these studies provide hundreds of hours dedicated effort by Rennie and represents a richness of data. However McCleod (2007) questions the emphasis that grounded theory places on the analysis of the data as opposed the data collection stage. McCleod states that Rennie is an experienced and charismatic person-centred practitioner and he gave clients a voice about their recent therapeutic experience and that "the 'findings' were constructed in the interviews rather than in the analyst's study" (p.82). Another criticism of this approach (Willig, 2008) is that it ascribes to a positivist epistemology and it does not take account of reflexivity. It assumes that

the data will speak for itself and the researcher's position is not considered to influence the theory that emerges. As I am a reflective psychotherapeutic practitioner and qualitative researcher, using IPA, I consider reflexivity to be an important aspect of the research process, therefore grounded theory was not considered an appropriate method.

3.4 Psychoanalytic Research

Midgley (2004) argues that the dialogue between psychoanalysis and qualitative research is still at an early stage because of mutual suspicion. Qualitative approaches with their strong emphasis on phenomenology, can seem naive to a psychoanalytic researcher whilst many qualitative researchers argue that there is no place in their research for psychoanalytic concepts and interpreting unconscious meaning (Morse, 2000). Busch and Milrod (2010) have argued that many psychoanalysts are resistant to research despite encouragement from eminent practitioners such as Peter Fonagy. They go on to argue that in the wider therapeutic health services, psychoanalytic treatments are not considered effective as there is little evidence with regards to its effectiveness. In their paper Busch and Milrod (2010) highlight what they consider to be trailblazing work by Lemma, Target and Fonagy (2010) and Gelman, McKay and Marks (2010) who have adapted psychoanalytically-based psychotherapeutic techniques to fit into Improving Access to Psychological Therapies (IAPT) settings. Their work includes research initiatives for assessing the outcomes of treatment for conditions such as eating disorders and those with borderline personality disorder. Scientific evaluation of psychoanalytic treatment has fallen behind those of other therapeutic approaches due to the resistance of psychoanalysts to the manualisation of treatment (Busch et al 2009). Busch and Milrod (2010)

suggest that this resistance is due to psychoanalysts believing so highly in their treatment, however, they argue that “clinical lore and observation can be highly biased, as the subjectivity of the observer can override an accurate assessment of a patient’s improvement” (2010, p.310). The intense, longer term work associated with psychoanalysis means that fewer patients are seen, than are seen in a psychotherapy practice, so therefore it is difficult to generalise about the effectiveness of the treatment for different conditions. However Dynamic Interpersonal Therapy, is a form of treatment developed by Lemma, Target and Fonagy (2010) and is coupled with research demonstrating the benefits of psychoanalytic treatments for specific disorders such as the treatment of depression.

Midgely (2006) has highlighted that psychoanalysis is rarely mentioned in textbooks on qualitative research and when it is mentioned it is often done so with a tone of suspicion. In the early days of qualitative psychological research, the new paradigm often set itself up in opposition to Freudian theory, which was considered to be conservative. Qualitative research aimed to give voice to those who were marginalised and participants were viewed as co-researchers. From this perspective psychoanalysis was considered to have a power imbalance in the research process. The psychoanalytic researcher was also seen to have access to an unconscious which was hidden from the subject. Like Heron (1981), discursive psychologists such as Edwards and Potter (1992) reject this notion that psychoanalysts have access to a deeper psychic reality, as cited in Midgley (2006, p.2).

However more recently Frosch and Emerson (2005) as cited in Midgley, (2006, p.11) have been interested in exploring what psychoanalysis might be able to offer social psychology. Kvale (2000) has suggested that psychoanalytic research is not compatible with positivist, quantitative approaches but can contribute greatly to an understanding of the "interpersonal relations of the interview when constructing knowledge", as cited in Midgley (2006 p.5). Of particular interest to Kvale (2000) is the psychoanalytic clinical interview that is a free narrative that takes place over a considerable time period allowing for a deepening of understanding. The intersubjective interaction of the psychoanalytic encounter allows for the generation of knowledge to be co-created. Social psychologists such as Hollway and Jefferson (2000) have integrated psychoanalytic understanding through the free association narrative interview technique. Transferences that are mobilised in the fieldwork encounter have implications for the questions researchers ask, the answers they hear and the materials they observe. Transferences structure the researcher's ability to develop empathic relations with the subjects who provide the essential source of data (Hunt, 1989). Therefore, a fundamental part of the context of fieldwork is the presence of images, beliefs, feelings and memories that are not directly stimulated by conscious knowledge of the current environment. The psychoanalytic exploration of fieldwork pays particular attention to the research encounter and unconscious processes that structure relations between researcher, subject and the data gathered (Hunt, 1989). Parker (2005) as a discursive psychologist is highly critical of Hollway and Jefferson's research methods as he sees it being driven by psychoanalytic theory and is pathologising

and essentialising. Paradoxically, Parker as cited in Midgley (2006, p.11) also states that psychoanalysis has informed the work of discursive psychologists alongside Marxism, feminism and post-structuralism. Frosch et al (2002) as cited in Midgley (2006, p.11) argues that Lacanian psychoanalysis has more to offer qualitative psychology due to the attention it gives to discourse. As Midgley states, neither psychoanalysis nor qualitative research are single entities but "umbrella terms for a wide range of different epistemologies and methodologies" (Midgley, 2006 p 12). Therefore one has to be specific about which particular branch of psychoanalysis or qualitative research one is referring to with regards to research approaches.

Historically, psychoanalytic theory and technique have progressed through the examination of single cases or, less commonly, through the study of case series. The knowledge gained in this way came from clinical experience rather than formal research. Freud argued that there is "an inseparable bond between cure and research." (1927, p.256). It has also been argued by Rustin (2003) that the consulting room must be considered the primary laboratory in which psychoanalytic research takes place. In 1962 the philosopher of science Karl Popper argued that psychoanalysis could not be regarded as a science as it could not provide hypotheses that had the capacity for disproof. Further criticisms of psychoanalysis were put forward by Adolf Grunbaum (1984) who thought that any evidence produced by analysts working psychoanalytically was 'contaminated'. He said "[that] patient's unconscious appears in forms which are hopelessly subject to the influence of the analyst" (1984, p.130). Rustin's belief was that it was "an alternative epistemology to that of scientific research" (2003, p.131), while Fonagy (2003) maintained that this viewpoint places

psychoanalysis in an inferior position as clinical case studies are not considered to be scientific evidence in evidence based psychological therapies. Grunbaum (1984) argued that it is the "(natural) science of the soul" as cited in Dreher (2002, p.19).

Grunbaum (1984) raised key challenges for the possibility of doing research with psychoanalytic clinical material. Anderson (2006) argues that Grunbaum is accusing psychoanalytic research of not being valid or subject to testing because it is based on the clinicians own particular paradigm. As Dreher (2000) points out, since the 1960s there are many contradictory approaches in psychoanalysis, what has formed is a conceptual pluralism, referred to as the 'near Babel of languages' by Steiner (1994), as cited in Dreher (2000, p.126). It has been argued by McDougall (1995) that these differences have arisen as a result of unresolved transferences from the analysts' training. This has resulted in the different psychoanalytic schools being more like sects and the theories being more like doctrines (McDougal, 1995). Dreher considers psychoanalytic research to be all those activities that claim to generate and integrate relevant empirical evidence for psychoanalytic theory (2000, p.13). This will include all classical case studies produced on the clinical-psychoanalytic basis; that is, those that have the analytic situation as their basis of evidence. As Dreher (2000) has suggested, concept research can investigate the historical context of a concept, as well as its current usage in clinical practice. Examples of two well known psychoanalytic case studies are Anna O (Breuer and Freud, 1895) and Wolf Man (Freud 1918) In fact, psychotherapeutic approaches such as psychoanalysis and the humanistic therapies have their roots in detailed idiographic case studies

(Rustin, 1991; Ponterotto, Suzuki and Meller, 2008). Psychoanalysts continue to use case studies as research methods today.

3.5 Similarities and differences between Psychoanalytic research and IPA

Psychoanalytic research and IPA have many similarities but also differences. Both use in-depth case studies as their research methods, which provide idiographic and rich material. Psychoanalysts have traditionally been interested in developing theory from these case studies but this is not the case for IPA researchers. Both approaches are interested in reflexivity but as they have a different ontological position with regards to the subject it is applied in contrasting ways. For instance, psychoanalytic research would be interested in the transferential and countertransferential feelings that arise in the research interaction (Hunt 1989). These are the feelings that arise from both the participant and the researcher that are part of the 'normal' reactions of being a defended, conflicted subject. This gives rise to an intersubjective space, that is co-created and it is the psychoanalytic researcher's role to interpret the participants' hidden unconscious material. There are many researchers and theorists who indicate the parallels between the intersubjective natures of both psychoanalysis and research. For example, Benjamin states that intersubjectivity is a "field of intersection between two subjectivities, the interplay between two different subjective worlds to define the analytic situation" (1990, p.29). The question of whether and how psychoanalysis is a mutual endeavour is actually very complex, for example Aron argues that patient and analyst create a unique system where there is reciprocal influence and mutual regulation (1996, p.149). IPA, like psychoanalysis, takes into account the intersubjective nature of the research process.

The IPA researcher's ontological view of the subject is that they are conscious meaning-making beings who express their experiences through words and embodiment. Like the psychoanalytic researcher, the IPA researcher is interested in the participants' experiences and will endeavor to offer interpretations but these will be grounded in the participants' own words. The primary aim of IPA is not to generate new theory, nor do researchers view themselves as having access to any hidden knowledge, however, like psychoanalytic researchers they do regard the interview process as being co-created giving rise to an intersubjective encounter. As Smith, Flowers and Larkin (2009) state, IPA and psychoanalysis have different epistemological stances, as psychoanalytic researchers will apply existing theory to the analysis and interpretation of their case studies. IPA researchers, on the other hand, in the first stage of the analysis will attempt to bracket off existing knowledge and will focus on meaning that emerges from the participants words. Researcher reflectivity is seen as being important for acknowledging that no research can be unbiased and will always be affected by the presence of the researcher.

It is therefore interesting that I have chosen to interview psychoanalytic practitioners as an IPA researcher as psychoanalysis and IPA have different ontological views of the subject. As an integrative psychotherapist I have been trained to work with unconscious material and I have been in psychoanalysis but there are two important reasons why I have chosen IPA as my research method. Firstly, I am not a psychoanalyst, even though I have knowledge of psychoanalytic theory, but more importantly I am interested in how my participants make meaning of VC in the clinical setting. Although they will be

referring to their patients' unconscious conflicts, I will ground my analysis in their words and will use my reflective journal and process supervision to consider how my unconscious material affects the research encounter. Psychoanalytic research utilises theory to conceptualise a phenomenon during case studies but IPA seeks to understand the participant's experience of the phenomenon in its own terms by using the participants' words. Theory is applied after the themes have emerged. Therefore psychoanalytic research is not appropriate to answer the research question for this project. I will now provide more detailed information about my chosen method.

3.6 Interpretative Phenomenological Analysis (IPA)

There are a number of reasons to use interpretative phenomenological analysis (IPA) for this particular research. I agree with Smith's (1996) argument that we need an approach to psychological research which would be able to capture the experiential and qualitative aspects of phenomena, but which could still communicate with mainstream psychology. The central aim in establishing IPA was to stake a claim for a qualitative approach grounded in psychology rather than importing one from different disciplines. The intention was to revive a more pluralistic psychology as envisaged by the pioneering American psychologist William James (1842-1910). The IPA approach draws on concepts and ideas that have long histories and started in health psychology, but is now used in clinical and counselling psychology as well as social and educational branches of the discipline (Smith, Flowers, and Larkin, 2009).

IPA is primarily concerned with exploring how individuals make sense of important life experiences (Smith, Flowers and Larkin, 2009). The method seeks

to obtain insight through the use of semi-structured interviews and analysis aims to understand the meaning participants make of the phenomenon. At the same time, IPA's underlying methodology takes the position that such experience is never directly accessible to the researcher. As a result, the phenomenological analysis is always an interpretation of the participant's experience (Willig, 2008 p.57) and due to this, IPA acknowledges the researcher's role and implication in the analysis. As such the researcher's reflexivity and transparency is vital in reporting findings, and this is aided by grounding data in the participants' accounts using quotations.

3.6.1 The theoretical underpinnings of IPA

3.6.2 Hermeneutics

A major theoretical underpinning of IPA comes from hermeneutics, which is the study of interpretation (Smith, Flowers and Larkin, 2009). Originally hermeneutics was used as a method of interpreting biblical texts, then subsequently historical and literary work. Hermeneutics prompts researchers to consider whether it is possible to uncover the intention or original meaning of an author. Inquiry in IPA moves back and forth between parts of the transcripts and the whole, this is known as the hermeneutic circle and is concerned with the dynamic relationship between the part and the whole at a series of levels. To understand any given part you must examine the whole and to understand the whole you must examine its parts. This oscillation has been criticised from a logical perspective because of its inherent circularity – at what point does the researcher decide when to halt the interpretative process? IPA is an iterative process as the researcher moves back and forth through a range of different ways of thinking

about the data rather than completing each step one after the other (Smith, Larkin and Flowers, 2009 p.29).

IPA involves what Smith and Osborn (2003) call a ‘double hermeneutic’ because the researcher is making sense of the participant who is making sense of the phenomenon. The researcher is like the participant in that he is a human drawing on everyday resources in order to make sense of the world. On the other hand, he is not the participant, merely an observer.

Hermeneutics may also be called a ‘dual’ process because it has two interpretative positions. According to Smith (2004) and Larkin, Watts and Clifton (2006) IPA is judged as appropriate as it long as it draws out the meaning of experience. ”The centre-ground position combines a hermeneutics of empathy with a hermeneutics of questioning” (Smith, Flowers and Larkin 2009:36). An IPA researcher seeks to adopt as close to an insider's perspective as possible (Conrad, 1987) and stand alongside the participant like a supportive but constructively critical friend. One could argue that this present research has a triple hermeneutic perspective as it is aiming to make sense of the psychoanalyst making sense of their patients attempting to make sense of their VC.

One of the issues to consider with IPA is the problem of the relativity of discourse. As Denzin (1989) writing generally about hermeneutics, points out, there is no end to interpretive process and the problem of escaping the

'hermeneutic circle' (Denzin, 1989). Everything we know about the world is mediated by language and the existing meanings available through language do not represent the world neutrally. This shift towards emphasising meaning and their interpretations is variously known as the shift from world to word, the turn to language or the hermeneutic turn that is a move to emphasise meanings and their interpretation. The term *discourse* has been used to emphasise the way in which meanings are organised around an assumed central proposition, which gives them their value and significance (Hollway and Jefferson, 2000**)**.

3.6.3 Philosophical underpinnings of IPA

Phenomenology and psychology share a number of links as both attend to interpreting human experiences (Smith, Flowers and Larkin 2009). Edmund Husserl (1859-1938), the founder of the phenomenological school of philosophy, aimed to find a method of arriving at what he termed the ultimate truth. He argued that it was necessary to examine the bedrock of everyday experience, from which our emotions, actions, perceptions of things, and relations would give an ultimately true understanding. Phenomenology strives to describe the essence of everyday experience, which places a demand on the inquirer to be involved in the process of collecting and analysing data (McLeod, 2007). The researcher needs to be immersed in the data, and strives to put aside one's own assumptions, judgments and previous knowledge in order to allow the themes to emerge.

Martin Heidegger (1896-1976) set out the beginnings of the hermeneutics and existential emphasis in phenomenal philosophy. For Heidegger, Husserl's work was too theoretical and abstract. Heidegger was interested in 'everydayness' or

a ‘natural attitude’ while Husserl sought to transcend it (McCleod, 2001, p.59). Husserl was primarily concerned with what can be broadly classified as individual psychological processes such as perception, awareness and consciousness. By contrast, Heidegger was more concerned with the ontological question of existence itself and with the practical activities and relationships in which human beings interacted, and through which the world is made meaningful. Heidegger is concerned with the conceptual basis of existence from a deliberately worldly perspective – or ‘everydayness’ (Drummond, 2007, p.17). Heidegger’s disciple, Hans-Georg Gadamer (1900-2002) tended to emphasise the importance of history and the effect of tradition on the interpretive process. Gadamer considered that understanding comes from combining historical knowledge from the perspective of how cultural constructs are embedded in language – ‘the fusion of horizons’ as cited in McLeod, (2007, p.23). The aim is to allow the new stimulus to speak in its own voice whilst acknowledging how one's preconceptions can hinder the process. One can hold a number of conceptions and these are compared, contrasted and modified as part of the sense making process. Therefore, we must interact with the material we bring to the text and what the text brings to us (Smith, Flowers and Larkin, 2009). This aspect will be demonstrated in my analysis of the data.

Another contributor to phenomenology is Maurice Merleau-Ponty (1908-1961) who emphasised the embodied nature of human relationships to the world and described how it led to the primacy of our individual situated perspective on the world. As humans, we consider ourselves as different from everything else in the world and we interact and communicate with the world in an embodied way.

Therefore the other is always experienced as different, thus we might empathise with them but never truly understand them. As an IPA researcher and integrative body psychotherapist an understanding of how we communicate and understand the world through our bodies is, for me, an essential part of the research process. It is particularly relevant given that the research inquiry is examining VC.

Phenomenology has also been influenced by existentialism and for Jean-Paul Sartre, things that are absent are as important as those that are present in defining who we are and how we see the world (Smith, Flowers and Larkin, 2009, p.20). We are better able to conceive of our experiences because of the presence and absence of others. Sartre also stresses the developmental aspect of being human. Existence comes before essence, which indicates that we are always becoming ourselves and that the self is not a pre-existing entity to be discovered but rather an on-going project to be unfurled. Sartre stresses the importance of the freedom to choose which would make us responsible for our actions (Smith, Flowers and Larkin, 2009). At the same time, complex issues need to be seen within the contexts of people's biographical lives and the social climate they exist within.

3.7 Researcher's Position

VC is complex, and this research will need to be seen in the context of the researcher's personal history, the theoretical background of both the participants (as psychoanalytic practitioners) and myself as the researcher. The knowledge produced is culturally and socially situated in a 21st century Western, affluent,

European country. The language used by the participants in my study to describe and understand their patients who are VC will depend in part upon the theoretical language used in their training organisation. It is likely participants will be influenced by prevailing cultural discourses about childless individuals. My psychotherapeutic background which is an integrative model that considers both humanistic, psychodynamic and body psychotherapy, might well have a different theoretical framework and language to understand childlessness than that of my participants who are rooted in psychoanalytic theory. This will be part of the intersubjective space between the researcher and the participants. As an integrative practitioner I am influenced by the humanistic movement, which questioned the psychoanalytic and psychiatric professions that leaned towards pathologising individuals' choices. How this enters the research field will be discussed in my reflexive diary.

My research position is biopsychosocial and as Denman (2004) points out, this was outlined by Engel in 1991 and taken up by Rossi (1994) with regards to sexuality, as cited in Denman (2004, p.2). This approach allows one to connect biological, psychological and sociological factors when taking into consideration the specific and individual nature of human sexuality. With regards to this particular study, I would see VC as being influenced by all three factors.

The reflexive approach of IPA acknowledges that no researcher can be completely objective as the researcher's past experiences will influence the choice of research problems, methods, settings and even informants in the field.

Hunt (1989) states that these echoes are less written about, although they are part of the oral tradition of fieldwork. She also argues that the researcher's inner worlds structure their choice of setting, experience in the initial stages of fieldwork and research roles they assume. These will also be considered in my reflexive diary.

It is important to examine the research relationship, but the process is not without its challenges. Finlay (2003) describes how difficult it can be to access the personal motivations that may well be unconscious and how this interplays between the researcher and the participant. Quoting Seale (1999), Finlay asks whether this in-depth understanding of the research process can only happen through intensive psychoanalysis (Finlay, 2003). However, my chosen methodology acknowledges and works with the intersubjective dynamics and will look both inward for personal meaning and outwards into shared meaning.

My life experience as an IVC woman has drawn me towards the lives of those individuals who have chosen to be childfree. Having experienced an existential crisis with regards to my IVC, I was fascinated to read about VC women who did not link their identity so closely with motherhood. As mentioned in Chapter two, there is a tendency in psychoanalytic writing to assume motherhood is normative for most women and a VC choice as pathological. This led me towards wanting to interview psychoanalytic practitioners as my participant group to see how they understood, responded to, and conceptualised VC in the clinical setting in the twenty first century. I recognise, as Romanyshyn (2007) argues, it is the topic

that chooses the researcher through his or her complexes rather than it being consciously chosen. Mogenson (1992) makes the following point: “the dark impulses which guide creative work are of a kind with the impulses that compel the work of mourning” as cited in Romanyshyn (2007, p.80).

Like Gough (2003), I am drawn to social constructionism as it seeks to explain how individuals take up the roles that are assigned to them in society. Psychoanalysis takes account of the intersubjective motivations and like social constructionism, sees the subject as defined by forces that are largely beyond their control, whether because of discourses or unconscious processes. Both humanistic and western thinking tend to promote the notion of the individual as having agency, choice and responsibility, thus the former concept is a radical challenge to this philosophy. The question is: how can an individual know which societal and unconscious processes govern their actions and, how can a researcher clearly identify the influences on the research process? (Gough, 2003). My own position with regards to this question is that it is never possible to be fully aware of all the influences that govern the research process and with the IPA approach, it is incumbent on the researcher to acknowledge to the best of their conscious awareness what they bring to the research process and how this knowledge is produced. As mentioned earlier I do not adopt the view that there is a universal truth but that there are in fact multiple realities. Using the participants’ voices, and differentiating them from the researchers’ voice allows the reader to come to understand how I have come to my conclusions. I have attempted to be transparent throughout the research process and have kept an audit trail of how the themes have emerged and have been interpreted.

My approach also follows feminist research principles and much has been written about the relationship between feminist politics, epistemology and research processes. Letherby (2002) argues that social research has focused on the inevitability of childbearing in women's lives as opposed to questioning this role. She suggests that this has helped to reinforce assumptions that a woman's identity is derived solely from the caring role, particularly through motherhood. Feminist research has scrutinised various aspects of women's lives, including their roles within the private and social sphere. Feminist researchers tend to attempt to diminish the typical power differentials between the researcher and the researched through the use of qualitative methods that acknowledge their role in the research process and aims to use the voices of the participants. As feminist researchers' intentions are to reduce the patriarchal domination in society, their research interests often aim to give voice to hitherto voiceless women by using such qualitative research to highlight the experiences of those who have been marginalised (Gillespie, 1999). It has only been since the 1950s that the voices of VC women have been represented in society or research.

Scharff (2010) has argued that feminist social research has long been concerned with questions of breaking silence and speaking out. Feminist writers who explore the significance of gender in social life highlighted the fact that social theory and research had been traditionally informed by androcentrism. Feminist writers revealed how most of the 'truths' being espoused in research expressed the views of white western males and in more recent years white middle class northern European feminists (Ryan-Flood, 2010). Feminists also challenged the notion that researcher race, gender, or social status does not matter (Ryan-

Flood, 2010). Qualitative research was initially viewed as a more egalitarian approach than quantitative research and was considered to be an inherently feminist method. It is interactive which means that it is less objectifying than quantitative research that seeks universal truths. The present research endeavoured to raise the awareness of the issues of the VC population as well as to highlight the pronatalist rhetoric and possible pathologisation of VC women by psychoanalytic practitioners. The question is – how can psychoanalysts and psychotherapists be encouraged to bring about social change and challenge the prevalent pronatalist position and encourage people to engage more with existential issues associated with VC? Of course many practitioners may well not see this as their role.

Finally, in this research I will explore how I have endeavoured to negotiate what Finlay (2003) raises about the research process. She argues that there is so much we do not know about ourselves and the research encounter and it requires a high level of self-awareness to attempt to unravel the process. This also raises a number of contentious issues, which I will attempt to negotiate. Unfortunately, this is inevitably linked to the question of class and social privilege - the ability to be reflexive is an advantage usually associated with the middle classes (Skeggs, 2004). As a post middle aged, educated, white female psychotherapist who has been in analysis, it could be argued that I have access to such privilege. However, as a child of Irish immigrants and my early life being relatively economically deprived, I have not entirely identified with a sense of privilege. It is therefore clear that power is inevitably implicated in research at every level of analysis – not just during the data collection process. The researcher has to take into consideration many subjective as well as objective

factors, and should be aware of one's own background and influences. The researcher has a position of responsibility to the represent the words of the participants in an honest, respectful and transparent manner. The researcher is the final author of the piece of research and thus has the ultimate power regarding the portrayal of their participants' voices.

3.8 Research Design

3.8.1 Ethical approval

Ethical approval was sought from the Ethics Committee at the University of Essex Centre for Psychoanalytic Studies (See appendix three). The main areas that were identified that could possibly create ethical concerns were ones around maintaining the confidentiality of the psychoanalytic practitioners and their patients. Typically, IPA studies include a fully annotated transcript as an exemplar of the analytic process. However, despite participants anonomising their patients when discussing pertinent details, this is a very specific phenomenon and I feel that in order to protect my participants and their patients that it is inappropriate for me to include the full transcripts. Excerpts aim to give an indication of participation accounts, and for the purpose of auditing, I shall keep the data in line with the data protection act for seven years. However I will not disseminate full transcripts in any publication of my thesis. On the day of the interview participants were given a consent form to sign (see appendix four) and they were informed that they could withdraw at any time as well as choose not to answer any question. This was addressed in the information sheet (appendix five) that was sent out prior to interviews where the researcher outlined how the data would be protected: my digital recorder would be kept in a locked cabinet and any computers used are password protected. In addition to this, the

participants anonymised the patients themselves as they spoke about them and I gave each patient a letter as a pseudonym to identify them when referred to in any discussion of the data collected in the interview - see appendix six for list of patients.

3.8.2 Pilot Study

At the time of my Pilot Study a thematic phenomenological approach was adopted as the method of analysis. Two interviews were conducted with participants who were psychotherapists known to me, thus were an opportunistic sample. At this stage there was difficulty in recruiting psychoanalysts, as is explained later in section 3.8.3. Both participants were integrative psychotherapists and one stated she was influenced more by humanistic theory whilst the other was drawn more towards the psychodynamic model.

I transcribed each interview and then analysed them to allow for themes to emerge, and then compared them both. The pilot study provided me with a concrete environment in which to test my research ideas. Initially I was interested in comparing the understandings of VC that were held by psychoanalysts with those of humanistic psychotherapists. Although both my participants were integrative psychotherapists they did not draw on psychoanalytic theory to any great extent and one of the participants was more interested in describing her own VC status rather than those of her clients. Therefore after the pilot study I consulted with my supervisor, as well as an expert in IPA and engaged in a consultation with a psychoanalyst to discuss my research ideas. As a result of these discussions, I decided to narrow the participant group to consist only of psychoanalytic practitioners in order to have a more closely defined homogenous

sample. At this point I decided to adopt the more structured approach of IPA as this method is now widely used in psychological research and is particularly apt for abstract concepts such as VC. I decided to enter into process supervision during my research in order to deepen my reflexive practice.

3.8.3 Procedures and participant selection

Initially I planned to focus on psychoanalysts that were registered with the British Psychoanalytic Council (BPC) as intention at this point was to have a group of participants who were broadly homogenous based on the theories they abide by in their practice and to highlight the emerging themes that arose from the interviews. Over a period of three months I contacted over 100 psychoanalysts from the BPC register (See appendix seven for the email used to make contact with the participants) and those that replied were either concerned about confidentiality or they had not worked with the patient group that this research was interested in. It was hoped that by sending out an email to numerous psychoanalysts an opportunity for snowballing would arise. This is a technique for finding research subjects who are hard to reach (Atkinson and Flint, 2001) through word of mouth. I speculated about the possible reasons why psychoanalysts were so hard to reach: it could be dues to their busy professional lives, or that they perceived themselves as an elite group; alternatively it could be as my outsider status as I was not a psychoanalyst. Harvey (1984) discussed how an elite group is hard to define but they are often regarded as numerical minorities because they frequently occupy positions at the top of employment and income pyramid. In order to gain access to such groups one needs to consider carefully the location of the interview, and develop as many social networks as possible to make contacts with these groups. This networking led

me to a professional contact whom acted as a ‘gatekeeper’ by giving me some contact details of psychoanalysts who might be interested in taking part in the research. However none of these contacts had experience of working with VC individuals in their practice. In line with the phenomenological approach it was important that the participants had the experience of the phenomenon under investigation. Therefore I decided to widen my inclusion criterion to include psychoanalytic practitioners who were registered under the Council for Psychoanalysis and Jungian Analysis (CPJA) college within the UKCP as well those registered with the College of Psychoanalysis.

At this point I decided to re-evaluate the email sent to potential participants as I wondered whether there was something in my research question that was not sparking interest. Psychoanalysts focus on unconscious meanings and therefore they might have a different understanding of the term voluntary as understood by my definition. It had been suggested to me that VC individuals would not present for psychoanalytic treatment because their childlessness would not create the same degree of conflict as IVC might. However, as Shaw (2011) suggests, I took the view that VC decision-making is complex and for many, wrought with ambivalence. Initially I sought to focus on the psychoanalyst’s understanding of VC but the attempts to recruit participants described above led me to change my research interest to include work with all those individuals who were childless for reasons other than for medical ones. Therefore I sent out an amended email in my attempt to try and attract participants (see appendix eight). As a result of these changes and my decision to widen the groups I accessed, four participants agreed to be interviewed.

3.8.4 Sample characteristics

My participants are a combination of psychoanalysts and psychoanalytic psychotherapists. The participants in this research are allocated pseudonyms in order to provide a degree of anonymity. Angela is a psychoanalyst registered with the British Psychoanalytic Council (BPC). Beth is a Lacanian analyst registered with the UKCP. Cathy is a Psychoanalytic Psychotherapist registered with the BPC. Denise is a psychodynamic psychotherapist registered with the BPC. I do not know where each of them trained and except for Beth what their particular theoretical orientation she followed. All four participants were female and aged between 50 and 70 and each had been in practice for over 10 years.

3.8.5 Preparation and design of the Interview

Before the interview I sent out an information sheet (see appendix five) and a biography (See appendix 11) to each individual and a mutually agreeable time to meet was arranged either by telephone or email.

All of the meetings took place in the participants' consulting rooms, which for each of them was in their home. Each participant was given a consent form (see appendix four) and a demographic information sheet (appendix nine). These were completed on the day, before the interview began. Each participant was asked to sign the consent form and informed that they could withdraw at any time.

In line with the IPA approach I designed a semi-structured interview (See appendix ten) that would focus on the how, why and what of the participant's experience. The interview schedule acted a guide to allow the interview to

develop organically allowing the participants to lead. An open question was asked about their experiences of working with this particular patient group to open up dialogue. Questions broadly relating to their countertransference and theoretical underpinnings were included. However, I closely followed the participants' account in order to further explore the points that were raised.

As a way of building up rapport with the participants I asked them to describe what kind of setting they worked in e.g. private or clinical. Each interview lasted approximately one hour and this data collection method is the most common form of data collection within qualitative research, and specifically IPA. The skills needed to carry out a good interview are very similar to the skills necessary for a psychotherapist, these include: sensitive listening, building rapport, encouraging people to tell their stories, and allowing the phenomena to emerge (Midgley, 2004). An audio recording device was used during the interviews.

3.8.6 Data Analysis

The following procedures were carried out after each interview. Firstly, I reflected on my thoughts, feelings and images that arose for me during the encounter with each participant and recorded these in my reflexive diary. Analysis proceeded on a case-by-case basis (Smith and Osborn, 2008). Each transcript (please note these are not included as appendices, as mentioned in section 3.8.1) was read and listened to several times to achieve generic understanding. I noted down any interesting or significant amplifications and contradictions in the narrative. I then looked for themes in each individual transcript and I carried out this process three times on each transcript, commenting on descriptive aspects of the text, the linguistics present and then my own interpretation of the data (see

appendices 11 and 12). I did not bring in any theoretical understanding at this stage but kept close to the original data. The emerging themes served to grasp the concepts and essential qualities of what was in the text. The themes were listed and clustered with other similar themes and an initial Master Table of Themes (appendix 13) was created. These were refined during the writing process and below is the final table.

3.8.7 TABLE OF MASTER THEMES

Superordinate theme 1 – Bio, Psycho, Social and Professional pressure

Subordinate theme	Angela	Beth	Cathy	Denise
a) Biological urge – most women will have to face the decision at some time	x		x	x
b) Myth of Maternity and Social and Professional expectations	x	x	x	x

Superordinate theme 2 -Ethical dilemmas and fitness to parent

Superordinate theme	Angela	Beth	Cathy	Denise
a) The terrible dilemmas of having a genetic illness	x		x	
b) Childlessness is a result of having difficult childhood experiences	x	x	x	x
c) Some individuals are too psychologically immature to become parents.	x		x	x
d) Mental health problems render some individuals unfit to parent	x	x	x	x

Superordinate theme 3 - Working with Childlessness is complex and conflictual

Subordinate themes	Angela	Beth	Cathy	Denise
a) Our role is complex and we need to attune to our patients' unconscious.	x	x	x	x
b) My personal views are different to those I have in the consulting room	x	x	x	x
c) Managing counter-reaction and understanding countertransference	x	x	x	x

3.8.8 Ensuring Quality and rigour

Smith, Flowers and Larkin (2009) recommend the guidelines designed by Yardley, (2000) for assessing the validity and quality of qualitative research. The criteria put forward in these guidelines are considered to be "pluralistic and sophisticated" (Smith, Flowers and Larkin, 2009, p.179) and can be adapted for use in different qualitative methodological approaches. As the researcher, the ontological assumptions I brought to the analysis were consistent with qualitative research: that reality is subjective with multiple versions of experience (Cresswell, 2007). Yardley (2000) argues that research involves sensitivity to context and this will include the interview process, analysis of data and presentation of findings. It is recommended that numerous extracts are provided from participant interviews in order for the reader to check the interpretations made. Literature should be presented that provides a variety of views on the research question and justifications given for the choice of method. Consideration needs to be given to the sociocultural setting and how this will impact upon the research process as well as any ethical issues that may arise. These have been dealt with in detail in section 3.8.1. This will include a reflexive account (see 3.7 and section 7.9) in which the researcher acknowledges how their presence and assumptions could impact on the research process. As described above, it is important to take into account the power imbalance in the research process, as typically the researcher is often viewed as the 'expert'. Yardley (2000), alternatively discusses how some qualitative methods, encourage the researcher, to check their findings with the participants. Riessmann (1993) as cited in Yardley (2000, p.221) encourages researchers to ask the participants' views of the findings, warns against allowing these views to compromise the interpretations and analysis of the researcher.

Yardley (2000) also states that another important aspect of qualitative research is that there should be commitment and rigour. This involves being thorough during the process of collecting and analysing data and reporting of the research findings. Commitment involves immersing oneself in the data and developing skills and knowledge in the research process. Rigour is shown by the depth and breadth of the analysis, alongside a deep engagement with the topic so as to transcend the 'taken for granted' knowledge surrounding the subject.

Yardley (2000) also considers that there is a principal of transparency and coherence, which she states relates to the clarity and cogency of the arguments presented in the research paper and descriptions provided. This involves clarity of reasoning so as to persuade the reader of the importance of the research. There will be a range of views put forward as well as samples of transcripts for the reader to come to their own interpretation of the material presented, thereby checking my interpretations. The research will also provide a clear audit trail of the research process from its initial stages through to completion. The research question should fit with the method and its philosophical underpinnings. It is important too that the research is reflexive throughout the research process.

The fourth way that Yardley (2000) suggests that qualitative research can be assessed is by considering its impact and importance. Not only should the research enrich theoretical understanding of the topic in question but it could make a practical contribution to the community in terms of policy makers and health providers. One of the intentions of this thesis is to make a contribution to

the psychoanalytic and psychotherapeutic communities about the complexities of VC, particularly as it applies in the clinical setting.

Agger (1991) argued that post-modern thinkers need to deconstruct the narrative and need to acknowledge the context within the author's life. This was echoed by Denzin (1989a) who said that all qualitative research acknowledges the impact of the writing on the researcher, on the participant and on the reader. It is important the writer is conscious of the biases, values and experiences that they bring to qualitative research. This will be addressed in section 7.4, in my critical reflections.

3.9 Conclusion

One of the aims of this qualitative research is to explore how contemporary psychoanalytic practitioners understand individuals who are childless for reasons other than medical considerations. The hope is to find a more inclusive and integrated framework with which to understand this complex phenomenon. Psychoanalytic concepts such as a masculinity complex or penis envy can be pathologising for women and these have been challenged from within the psychoanalytic communites. Erikson (1951) and Benedek (1959) extended the view of parenthood as a developmental stage to men as well as women, so this research is also interested in indirectly exploring how psychoanalytic practitioners view VC in men and what part this plays in the woman's decision. My research position is a biopsychosocial model, which embraces psychoanalytic, psychotherapeutic approaches as well as sociological, feminist and cultural approaches to understanding VC with an acknowledgement of biological processes.

In order to explore this phenomenon I chose to focus on interviewing psychoanalytic practitioners as I was particularly interested in the clinical implications of the growing trend of VC. Sociologists have written extensively about this phenomenon, so I did not feel that I could contribute more to the field by interviewing VC individuals. However, I might have chosen to explore male VC as this is under-researched. Initially I wanted to research into male and female VC but this would have made my research too broad. I was interested to discover whether psychoanalytic practitioners are influenced by pronatalist pressure in society as well as the discourse that they use to discuss their patients who fell into my research category. The emerging themes will be discussed from chapter four onwards.

Choosing to interview psychoanalytic practitioners however, was indeed a challenge as they proved to be a hard to reach population. Through my perseverance and a determination to find answers to my research question, four psychoanalytic practitioners did agree to be interviewed and these proved to be fruitful, warm and engaging experiences for the researcher and I hope, for the participants too.

My position as a psychological researcher influenced my methodological approach, which was qualitative. I have outlined how this approach acknowledges the intersubjectivity of the research process. I will incorporate the social constructivist position, alongside feminist thinking and other socio-cultural perspectives within my discussion of the data. I chose IPA as this follows the case study approach, which has been adopted by psychoanalysis since its inception. There are of course therapeutic and research approaches which dismiss this type of research as invalid as it is not generalisable or evidence

based. However, the intention of this research is to explore meaning in a comprehensive way from the perspective of a broadly homogenous sample who offer perspective on the phenomenon in question

CHAPTER FOUR - SUPERORDINATE THEME ONE - BIOPSYCHOSOCIAL AND PROFESSIONAL PRESSURE

Subordinate theme	Angela	Beth	Cathy	Denise
a) Biological urge – most women will have to face the decision at some time	x		x	x
b) Myth of Maternity and Social and Professional expectations	x	x	x	x

4.1 Introduction

This chapter will address the first superordinate theme entitled Biopsychosocial and Professional Pressure, and it has two subordinate themes. The first subordinate theme will present how the participants understand and conceptualise the biopsychosocial pressure that women in general and their patients' experience in relation to whether or not to become a mother. The participants express different views about whether the desire to procreate is an innate biological drive or whether it is mainly driven by psychological factors such as narcissism and pronatalist social pressures. The way that the participants understand the biological clock and the reasons why women delay childbearing will also be included. Some of the participants refer to the trans-generational messages that can be passed on to women and the effect it can have on women's desire to have a child. The participants discuss how these messages can influence a woman's desire for motherhood.

The second subordinate theme discusses how the participants understand and conceptualise the way that motherhood is portrayed in society. Some of the participants directly refer to the myth of motherhood and how the role is idealised in popular discourse. Each participant places a different emphasis on the kinds of social pressures experienced by women in relation to the motherhood mandate.

Three of the four participants discuss some pressure they experience, both directly and indirectly from their training organisations.

The second part of this chapter will discuss how psychoanalytic and sociological literature understands and conceptualises the biological drive, the idealisation of motherhood and the variety of pressures placed on women with regard to whether or not to become a mother. Literature relating to whether or not the need to procreate is a biological, psychological or social need has already been discussed in chapter two, as has the idealisation of motherhood. Relevant additional literature will be introduced to supplement the different perspectives given by the participants. New literature will be introduced to broaden the discussion on how psychoanalytic practitioners might experience professional pressure from the normative view of motherhood that was part of their theoretical training.

4.2 Findings – Subordinate theme 1 – The Biological Urge

Below is an example where Denise makes a general statement about how the biological clock is of more importance to women than men:

> I see more women than men on the whole, [who] want to have children. But it's less of an issue for them because they don't have the clock ticking in the same way. I think, most women at some stage think they want children, I think that's the biological urge.

Denise is suggesting that having a biological urge is natural for most women and not as pressing for men as for women. Angela echoes this perspective, emphasising that she feels the need to encourage her younger female patients not to leave it too late to have a baby:

> I think it's a way of not thinking that actually there is a biological clock, and they think, "I will look into it later, I'll think about it later". And then it's always later as if... men can do that much more, of course, but women can't - but they do. There is a paper in psychoanalysis called 'too late sub-fertility' because many women do leave it too late, and they can't afterwards. Some women even manage to grab it.

Here Angela is also comparing men and women and she is stressing how women need to be more aware of their biological clock. Her use of the term 'grab it' is an interesting one as she is painting a picture of women who experience a great sense of urgency when they realise that time is running out for them in terms of their fertility. Denise in particular implied that it was a tragedy for some women if they left it too late to have a child.

> I suppose because in my own life I've known people who have left it too late. ……Emm. And you know, the devastation of that, emm, so I, I think I can feel quite hands on about that emm,

Denise implies that she would feel the need to bring the 'biological clock' to the attention of her older female childless The way that the participants perceived their roles as psychoanalytic practitioners in these circumstances is discussed further in chapter six 6.2.1

Cathy does not refer to a 'biological urge' but does state that:

> …most women will have to face the decision at some point, and that is not an easy one, whatever you decide.

Cathy is stating that for many women deciding to have a child can be as a complex as deciding not to have a child. Her emphasis is different from Denise's view mentioned which is that most women would want a child.

Without specifically questioning the validity of the biological urge Beth questions the desire for a child.

> And there are an awful lot of women who choose to have babies, I would say, because that's what women do. It's… it's… em… and I would say, it's part of a psychical organisation.

The phrase 'this is what women do' can be interpreted in a number of ways. Beth could be suggesting that motherhood is a natural path; or that individuals are consciously or unconsciously fulfilling the roles that society is placing on them. Beth's first psychoanalytic training was Kleinian and then she re-trained as a Lacanian analyst. Discussing a female patient, who wanted two children, Beth elaborates on how Lacanian theory conceptualises the desire for a child.

> The first child was the first child and the second child was the second child. But they already had their allotted places and in relation to... unconsciously in relation to another child. As it happened she had a second child. You know a child is born... and what is said about that child – it's lucky, she's lucky, people say – 'It looks like her mum, she's got her papa's eyes', whatever or 'it looks like its grandfather or its aunt' – whoever. And the child is already identified as part of the family, and all of that has an effect on the child.

Beth highlights the Lacanian view that the unborn child will already have an identity allotted to them because of what he or she signifies to the parent at any given point in time. These parental attitudes will have an effect on the child at an unconscious level. Each human being is living with remnants from their childhood experiences, which is part of their unconscious psychic structure. It is the unconscious significance of a child that gives rise to maternal desire.

Angela discusses the trans-generational messages that might be unconsciously passed on to female children that might affect their desire to be a mother. She says:

> A trans-generational message from the mother to the infant daughter – I think that is what has a great effect. It doesn't mean that the girl and the woman don't engage with that message from the mother, they do, but it's there and its very important in shaping the image that a woman has of maternity, so I would say that that is probably one thing that I think is very important. Also, the oedipal situation which we haven't discussed very much, the way the parents related to each other, and related to the child is very important, and of course the present situation of the patient.

Angela highlights how maternal desire is not only shaped by but transmitted from mother to daughter. This is powerful message and that females do engage with it, and it influences how they view maternity. She suggests that children will also be affected by the relationship of the parental couple. Angela implies that positive trans-generational messages would result in a woman who would want a child.

In the following extract Angela speaks of a patient (F) with a 'fear of pregnancy' and a negative body image:

> .. [she] says that she is very afraid of the pregnancy – that she doesn't know what would happen to her body. That she would have to do to lose weight afterwards. She is not overweight. So it is very… something to do with the body, the shape of the body, what happens to the body during pregnancy.

Using the 'trans-generational' theory mentioned by Angela, we can suppose that the 'fearful' patient was not given a positive message about pregnancy and being a pregnant woman. Alternatively she could fear her body image changing to be plump during pregnancy when there is societal pressure for women to be slim.

The effect of this trans-generational message is echoed by Cathy who refers to the effect negative body image may have on a woman's desire to have a child. In the extract below Cathy describes patient J who was considered 'imperfect' by her parents:

> ….she feels somehow, because of her physical appearance, she is not truly the daughter that her parents wanted. She wasn't the pretty girl, the feminine child that they were expecting. And therefore, she's never been able to fulfil, or feel a proper woman herself as she always feels as if she's a kind of slightly emm... she's too big, she's too ugly... or I'm always the best friend. She's not ugly at all, actually, (*laughs*). You know she's fairly large, she's big, but she's not ugly at all, actually ... she's actually rather striking. …… that in some sense she feels a total failure in this area. But, I think, that there's a real longing.

In this extract Cathy suggests that the 'trans-generational message' had been strongly impacted by the patient's parents' view of femininity. From their perspective, the true feminine appearance was linked to the 'pretty little girl' image, while in contrast their daughter was large and athletic. Cathy's view is that this parental stereotype of the female form led the patient to reject her own body and to feel a failure as a woman. Unconsciously, she has chosen not to have a child, whilst consciously she still longs for one. Cathy refers to Kleinian theory to explain this:

> I think, the whole thing terrifies her. I really think that she's frightened about the mature female body, you know. That there is something about… something about her... now, if you are a Kleinian, you can say that there is some damage, that you have fantasies of attacking your mother.

Cathy is using powerful language to describe how these messages have literally made the patient terrified of her own female body and its capacity to bear a child. Cathy is suggesting that this patient is holding an unconscious hatred

towards her mother and this can be expressed in refusing to give the mother a grandchild. This can give rise to a woman having a damaged internal space through the mutual attacks. However, Cathy's comment that 'if you are a Kleinian' would suggest that she does not adhere strictly to Kleinian theory.

Cathy describes her patient R;

> ..someone who looked really like a little boy, when she was tiny, very thin, no hips and no breasts – very, wiry and muscly.

This description is interesting, and Cathy did state that the patient had identified with a 'mad father' (see section 5.5.2). The way Cathy describes the appearance of this client suggests that her body shape has taken on the psychological identification of male figure. Cathy does state, however, that this patient was 'obviously not gay'. This contrasts with her description of the patient who felt large and ugly, as interestingly, Cathy did not view her appearance as masculine despite describing her as 'tough and athletic'.

Denise makes a generalised statement about women who choose not to have children, and relates this to the rejection of sexuality:

> I think, it could be a denial of your sexuality/femininity if you're, not kind of… you might be scared of that part of yourself.

Denise does not elaborate on this statement, but throughout her narrative she is clear that she believes a natural, healthy course for women is to become a mother.

4.3 Myth of maternity and social and professional expectations

Angela, Beth and Cathy refer to the 'myth of' maternity in similar ways. This is term is a challenge to the idealisation of motherhood as represented in popular discourse as discussed in 2.6.2. Angela stresses that having children is not always a joyful experience, and involves self-abnegation and a lot of patience:

> The ones who are more happy childless may be much better balanced, they may get a lot from their lives without children because… let's not forget having children is not this joyful experience. There is a lot of heart-rending stuff going on: a sense of guilt, you've never done enough, you've done the wrong thing always and so on.

It is possible that Angela is commenting on both her professional experiences and her personal experience of mothering. Angela uses powerful emotive language with words such as guilt and heart-rending to express the more difficult aspects of motherhood. She is implying that the happily childless woman would be free of these particular dilemmas.

Beth focuses more on how motherhood might make a woman ill rather than idealising it.

> People get ill as a result of having children.

Like Angela, she uses powerful metaphors to describe the darker side of the mothering experience with phrases such as 'children are disturbing creatures' she is possibly speaking of her personal and professional experiences.

In the extract below Cathy is referring to woman who want to pursue a career and she states:

.

> Actually, very often you make huge sacrifices to have children, and if you care very much about your professional work, you may choose not to have children.

This is reflected in Cathy's personal story. She adds that she:

> certainly never had the feeling that she must just have children.

In the extract below Cathy speaks explicitly about the 'myth of motherhood' in relation to one of her patients:

> ....that it's a kind of legend that's been you know… had to swallow the whole myth as you like, virtually from infancy onwards if you like, that's what women do.

Cathy uses the same expression as that used above by Beth in terms of 'that is what women do'. Cathy's repetitions and hesitations suggest that she is incredulous that women succumb to this pronatalist message, particularly bearing in mind her own experience of motherhood. She refers to this experience:

> At times we're pleased about it, at other times we just can't bear it. Motherliness could be… eh… terrifying to children.

Cathy also refers to the archetypal view of motherhood, and it is clear that she does not 'swallow the legend':

> I mean, if you use the word 'motherly', you immediately think of something soft, and big breasts, and warm.

At this point in the interview, Cathy laughs, which suggests that she considers these popular images of the 'woman as mother' to be preposterous.

In her interview Cathy refers to Estella Weldon – a psychoanalyst who has written about the darker side of motherhood and has confronted the myth that all women are natural mothers:

> ... she's terrific about women because she talks about how women are, how women use their children, are so cruel to their children very often.

Cathy is implying that she approves of Weldon highlighting the negative aspects of motherhood.

However, Denise does not believe that the pull towards motherhood is just a myth, saying:

> I felt so strongly about having children.

Denise focuses on the pressure placed on women to 'have it all', both career and family, and argues that it can have a detrimental effect on both the mother and the child.

> I see women who have children who work full time and frankly I wonder why they have children, not that I don't think you can combine that, but people who don't actually see their children during the week. I think it's very hard on the children, I think they miss out on an enormous amount. I think the mothers miss out on an enormous quantity.

Denise stresses the importance of women making a choice between a high powered career and the role of a mother as she states both mother and child will miss out on important experiences. One can imagine that she is referring to the importance of the bonding that can take place between mother and child, particularly during the early years of the infant's life.

She goes on to argue that combining motherhood and a career creates role strain propels many women into therapy.

> And I think, a lot of women come with precisely that problem, juggling work and motherhood

Denise has strong personal views about the pressures placed on women in terms of work, motherhood, economic and social factors. From her perspective, society promotes a myth about how much is needed in terms of financial and material security before one is ready to have a child;

> I think there are things like money...getting a home...I think there's a lot of propaganda about how much you need in order to have a child.

Denise's use of the word 'propaganda' would suggest that this could be government messages to discourage individuals/couples from having children they cannot afford. Alternatively she could mean that the advertising industry creates desire in individuals to live up to some idealised notion of a family life.

She also blames society for making it more difficult for individuals to meet the right partner to enable them to have children:

> Whereas, I think, many women end up not having children, not necessarily out of choice, it's just they haven't been, the circumstances haven't been right. Perhaps the kind of society we live in now, makes that more difficult for the circumstances to be right.

This is an interesting reflection on contemporary society and Denise is considering the external factors that might make it difficult for women to fulfil what she considers to be their natural role. As discussed in chapter two, post-

modernism allows for a multitude of choices, and the traditional concept of family has been replaced with diversity and fluidity.

In contrast to the view that society hinders women who want children, Cathy argues that society places enormous pressure on women;

> … it's interesting to see if women are allowed to not to be mothers without feeling that they haven't fulfilled their potential.

Cathy is implying that that women can be fulfilled through other avenues other than motherhood. Cathy's use of the word 'allowed' is interesting and raises the question about who or what would need to give women this permission.

In the following quote she discusses both her own and one of her patient's experience of psychoanalysis:

> But she hardly talks about her children at all. They don't seem to be very important to her and I find...I sort of think, you know, I can't remember whether I talked about my children when I was in analysis; or I know I talked about them, but how much I talked about them growing up, the difficulties or pleasures one had.

Cathy appears to be saying that her children were not always her top priority, particularly in the self-development aspect of her professional training. She seems to take the view that it is healthy to have interests in things other than your children.

Cathy was curious about the aims of my research when she asked:

> Well I do see that there is a lot of pressure from society, and I wondered if that is what you were interested in, in turning women into mothers, you know.

This was an interesting question from Cathy as she had made an assumption that this was the underlying purpose of my research. There were several times during the interview that Cathy questioned my views on motherhood and VC and whether or not I had children. On these occasions, I sometimes gave a direct answer but other times I reiterated that I was interested in her views. See chapter 3 section 3.7 for a discussion on how the presence of a researcher can affect the research process. The implications for the research process will be explored further in chapter seven, 7.9 in my reflexive statement.

As mentioned above Cathy refers to the pressure to become a parent that individuals might experience from family members. She states that she experienced pressure from her husband to have children, and if she had been married to someone else she probably would not have had children.

> …but I think left to my own devices or had I met someone different I don't think I would have. I certainly never had the feeling that I must just have children.

The word 'just' used by Cathy suggests that she did not consider that being a full time mother would have been fulfilling for her. Cathy's comments links with the participants' descriptions of their patients' partners who had made the parenthood decision for them or because of family pressure.

Denise gives an example of patient S who chose not to have a child because of pressure from her husband's family because their son was marrying outside of his faith.

But you know the deal was if you marry out you don't have children.

However, Denise was taken aback by the reasons given for her patients' VC choice as she states;

> .And when she gave the reason for not having children was the fact that her faith, her husband was Jewish I was completely gobsmacked really.

Denise appears to find this patients conscious explanation of her VC choice as being hard to comprehend. The patient had told her that she;

> couldn't have children because he was Jewish and by marrying her he had married out and the father refused ever to see her, had seen the mother very occasionally

It is unclear whether Denise had experience of the Jewish faith but it is possible that she disapproved of this religious dictat or found it hard to believe that someone would make the VC choice on this basis.

Angela gives another example of patient H who became a father because of pressure from his partner as is illustrated below;

> They discovered that they really loved each other and the man was completely lost without her and they got married. Now then the woman said now I want to have a baby and he said "I don't want a child" but he felt that he had no choice.

The extract above is an indication of individuals who do not actively choose to have children but do so please a partner. There may also be individuals who choose not to have a child to please a partner as in the example below.

Angela gives an example of patient B who had a termination because her boyfriend did not want children.

> …[she] had a termination of pregnancy because her boyfriend wanted her to, and somehow this woman – intelligent, capable – suddenly lost any capacity to decide for herself, and went along with what her boyfriend wanted.

The repetition of the phrase 'boyfriend wanted' suggests that Angela felt that the man dominated the patient's relationship. The word 'somehow' suggests that Angela seemed perplexed that this patient did not take more responsibility for her choice. Of course this particular patient may choose at a later date to have a child.

In the following extract Cathy refers to a patient who experienced significant pressure from her family to have children:

> ..[she was] very concerned about – will she ever have a child? I think, it's also very much to do about the expectation of the family – you know that conventional idea that a fulfilled woman has to have a husband and children.

In this extract Cathy uses the expression 'fulfilled woman', a phrase that she uses frequently throughout her narrative. She often questions whether motherhood leads to this fulfilled state. Interestingly enough, Denise also uses this phrase, but the context is more pronatal: women need to have children in order to feel 'fulfilled'.

Some of the participants referred to some implicit pressure that they felt from their training organisations due to the emphasis that psychoanalytic theory places on the importance of the link between motherhood and femininity. Beth

refers to the unconscious pressure placed on psychoanalytic candidates in her original Kleinian training:

> You might disagree with me a bit…..there is a sort of unspoken pressure that – if you worked in that way and you worked with why people didn't have children – then there was a sort of unconscious pressure that really, if the therapy turned out alright then this woman would somehow have a child.

Beth's sentence contains numerous hesitations, repetitions and pauses and it is interesting that she wondered if I would disagree with her. One can wonder if she feels her views are too radical for mainstream psychoanalysis and I had the sense that her hesitations indicated uncertainty about whether she should disclose her views to me for fear of my judgement. Beth rejects what she considers was the 'judgmental' attitude of her Kleinian training and the pressure that it placed on her with regards to what is considered a successful outcome of therapy.

> It was always seen as part of ... but behind it there was... the difficulty with that position, which was good in a way... was there was an assumption behind it, but if the woman chose not to have children there was something wrong, it was, it was a negative symptom if you like, not just an ordinary symptom of everyday life. But there was some.... there was a kind of judgement that went with it. It seemed to me ... em... and that clearly ... for me couldn't be true.

Clearly, she found the Lacanian approach to be more in tune with her own personal philosophy.

> the same time I didn't really quite have the Lacanian way of thinking about it to formulate it differently .

Like Cathy, Beth also wonders whether or not I will agree with her position that VC did not need to be viewed as a normative path for women. In the

above few statements Beth is implying that she did not agree with this theory and overtly she states that her Lacanian training gave her a different theoretical framework that she felt more comfortable with.

Beth also refers to Michael Balint, a psychoanalyst, who stated that towards the end of therapy the analyst and patient:

> get a mature reciprocity, you know, how to give to the other and to… em.....to give them satisfaction, and they can reciprocate. They can do the same for you, and of course out of that comes the family.

This interesting theoretical point about reciprocity suggests that Beth experienced some pressure from the theoretical framework that the outcome of therapy should be a child. It is likely that she is referring to some kind of implicit message that can be passed unconsciously from the psychoanalyst to the patient.

Angela refers to the unconscious attitudes that her supervisees held in response to when their patients in a borderline clinic became pregnant:

> …..therapists 'lightened up' when a patient was pregnant – even if there was really nothing to be happy about.

In response to a question from me about whether her supervisees who were psychoanalytic practitioners, found it difficult to accept a patient's voluntary childlessness she states:

> Yes some difficulty, I mean covert difficult.

However, when someone chose not to have a child after realising they may not be a good mother, Angela stated:

> There was not the same positive outlook.

Presumably she means from her supervisees who were psychoanalytic practitioners. Angela does not make it clear whether she challenged the therapist's pronatalist attitudes nor whether she considers that psychoanalytic theory or popular discourse is responsible for how her supervisees responded to their patients who were pregnant. She echoes Beth's comments about the professional unconscious pressure relating to the motherhood mandate but in the above extract Angela implies that was held by the psychoanalytic practitioners whereas Beth was suggesting that the pressure was in fact coming from the training institution.

Cathy implies that the dominant cultural institutions and psychoanalytic theory links femininity and motherhood when she states:

> Well there is an enormous emphasis on the idea of the mother.

4.4 Discussion

4.4.1 The biological urge

The first part of this discussion section will include the psychoanalytic views and will be followed by sociological and feminist viewpoints. Angela, Cathy and Denise referred to a biological urge as well as a biological clock in terms of the pressure coming from within and felt in the body and the mind. This was not a new finding and has already been discussed in the literature review in Chapter two, 2.2.2. Freud's view of 'anatomy as destiny' (1912) is often quoted in support

of the link between femininity and motherhood, but it has been challenged both within and outside the psychoanalytic community. Psychoanalyst Kestenberg (1975) has highlighted how the question of whether there is an instinct to create human life continues to be debated in psychoanalytic theory. She argues that our modern life has led women to be less in touch with a primitive maternal instinct but nevertheless they cannot escape from their femininity because of menstruation. However, Hartmann, Kris and Lowenstein (1946), as cited in Kestenberg, (1975, p.27) argues that such a primitive maternal instinct applies more within the animal kingdom than to humans. Deutsch, as cited in Kestenberg (1975, p.28) was undecided about how to distinguish between the emotionally laden meaning of motherhood and a biological urge. Freud's view of instincts are that they are the "borderland between the psyche and the soma and that it is representative of demands made by the body on the mind" as cited in Parens, (1975, p.162). As referred to in my literature review, Benedek (1959) views parenthood both as a biological urge and a developmental stage. However, Williams (1986) would prefer to see a theory that views this instinct as being on a continuum as opposed to a biological determinism, arguing that psychoanalytic research includes the influence of mental processes in mediating our biology. Psychoanalyst Williams (1986) considers that a continuum would more accurately reflect the complexities of the decision making involved in the choice of whether or not to become a mother.

Psychoanalyst Stuart (2011) on the other hand, sees motherhood in evolutionary terms, which is concerned with the survival of our species. Almond (2010), psychoanalyst, states that falling in love with one's baby is a combined biological and psychological response and it is an intense involuntary reaction which can

account for why women who decide to give up their babies for adoption change their mind upon the birth of the child. Supporting the view that maternal instinct is a healthy sign for a woman, psychoanalyst De Marneffe (2004), like Denise, argues for the right of women to stay at home so they can enjoy and celebrate their strong maternal desire. She feels these positive maternal experiences have been discounted by much of the feminist literature. On the other hand, Moore as cited in Parens (1975, p.5) argues that the desire to have children also fulfils a narcissistic need and doubted that there was an innate need in man to reproduce.

Another interesting view has been put forward by psychoanalyst Chodorow (1978), who stated that the powerful urge to have a child is not because of nature or because of pronatalist language or sex role stereotyping but because it is built in developmentally into the feminine psychic structure. Using Object Relations theory she argues that the female desire for offspring is also a result of a woman's identification with her own mother. Angela in particular referred to the trans-generational messages that pass between the mother and daughter and how this shapes the woman's image of maternity.

In contrast to the some of the views above in terms of psychoanalysis linking motherhood and femininity as a biological urge or in built representation, psychoanalyst Joan Raphael-Leff (2007, p.498) argues that women are no longer a "victim of the species" as proposed by de Beauvoir (1952) because contraception allows a woman to retain her sexuality and independence. Like Cathy she sees that it is perfectly possible to combine a career and motherhood. Raphael-Leff (2007) argues that in our postmodern age femininity is not tied to

childbearing as it was in past. She argues that anatomy is no longer destiny and states that “many women choose to remain childless and that for societies reproduction is a necessity – for each woman it is a choice” (2015, p.21).

Contemporary sociobiologists and primatologists, such as Sarah Blaffer Hrdy (1999), argues that maternal instinct is a complex mix of genetic, evolutionary, social, and hormonal factors, as cited in Almond (2010, location 412. Another viewpoint put forward by Hrdy (1999), as cited in Morgan and King (2001, p.6), is that children now provide social capital rather than economic investment for old age; gaining access to communities and a quasi-religious function of providing meaning to life. Carmichael and Whittaker (2000, p.121), both sociologists, quote one of their research participants who said: “There's no pull in me. ... Not a drop of maternal instinct in me”. The participant rejects the ideology of motherhood and views her lack of interest in babies as making her unsuited to the role and points to the fact that men do not have to justify their lack of paternal interest in the same way as women.

Angela, Beth and Cathy commented that they felt many individuals chose to have children for unhealthy reasons. This particular finding was not a surprise as in Chapter two there was discussion of how some psychoanalysts (Welldon, 2006; Pines, 1993) continue to question why some individuals choose to have children (see 2.2.4). They have argued that some people have children for narcissistic reasons and sometimes people choose not to have children as an unconscious revenge against their mothers. Pines (1993) states that 50 year old women can have children now as a defence against death, a fact Cathy, Denise and Beth referred to as a defiance of their biological clock. If there are strong

narcissistic needs to becoming a mother, the baby may become a disappointment when it does not fulfil such needs.

Cathy and Denise described patients whose body image had been affected by messages from parents. The findings in section 4.4.1 highlight how body image can affect a woman's maternal desire. Orbach (2009) a psychoanalyst, points to how a growing girl's feelings about her body will have been unconsciously affected by how her mother felt about her own body. This notion is elaborated on by Welldon (2012) in her discussion of perverse mothering. McDougal (1989, p.28) argues that the "body like the mind is subject to repetition compulsion" and Welldon (2012) states that this is demonstrated by the way some women continue to have babies they are unable to care for appropriately. Welldon (2012) suggests that some women have children because unconsciously the process of pregnancy and birth keeps them in touch with their own mothers and a baby represents goodness. Perverse mothering will be discussed further in the next section 4.4.3.

In terms of the societal pressure placed on women because of body image feminist writer Malson (1997) states that the female body has been subject to conflicting popular and medical discourses. Drawing on Foucalt (1972) she argues that a post-structuralist feminist approach is useful to look at how the 'anorexic' body is related to power. Modern day discourses portray the fat female body as ugly whereas thinness is seen as beautiful. Foucault et al (1988) argued that the female body is controlled through a series of coercions, and this can lead to psychological and physical distress, and even death, in the increasing cases of anorexics. Cathy and Angela referred to patients whose childlessness had

been affected by their body image. One of Cathy's patient did not view herself as feminine because of her strong athletic body, and one of Angela's patient feared pregnancy because of what would happen to her body.

4.4.1.2 Implications

This section highlights the question whether or not the maternal desire is a biological urge for all women. The idea of biology as destiny as espoused by Freud (1912) is challenged by some psychoanalysts as well as sociologists. The need to procreate can be a healthy sign of wishing to care and nurture a child into adulthood but it can also emanate from a narcissistic desire where the child can be viewed as an extension of oneself. The wish not to have a child can be based on an unconscious, on fear of dependency, a sign of immaturity or as a fear of passing on poor parenting. Alternatively some women may not have a strong biological urge to express their creativity through the birth of their own child and make a healthy choice to find a fulfilled life in alternative ways. Some of the participants in my study as well as some of the literature (Raphael-Leff (2007) point to the need for psychoanalytic practitioners not to make assumptions that all women will need to express their femininity through motherhood. In contemporary western societies, the contraceptive pill has afforded women the choice not to have children while advanced medical technology allows gives infertile, older women, disabled, single and the LGBT individuals, opportunities to have children.

4.4.2 Myth of Maternity and social and professional expectations

Angela, Beth and Cathy made clear statements that motherhood was a very difficult task and Cathy in particular referred more specifically to the archetypal view of motherhood. All of my participants referred to the pathological mothering that many of their childless patients had experienced. Denise always referred to motherhood as being an experience that brought her great fulfilment and implied this should be case for most healthy women.

The way in which motherhood has been idealised was discussed in Chapter two 2.2.5. Jung (1953) developed the good mother archetype and Parker (1995) points out that images of the mother always have a dual side. It is one of the strongest archetypes as it is the first we experience and the quality of the mother-child dyad during these early years will determine how we relate to it and to our children. Cathy referred to an archetypal image of the mother as having 'big breasts as well as swallowing you up'.

James Hillman (1983) used archetypal psychology in his paper 'The Bad Mother' to try to understand and explain why in the mother child relationship, either the mother or child or women and children in general might be perceived or imagined as bad. He is interested in why mothering often makes women feel bad and what it is in the mother child relationship that makes it an emotional inevitability. All archetypal images have a dual side and you cannot have one without the other. The full experience of the motherhood includes the urge to destroy the child as well as to protect and love. Metaphorically speaking, the child is often seen as representing the future, dependence, joy, creativity and imagination. Hillman (1983) argues that the mother and child are are locked together in a

tandem which affects the nature of each. The tandem itself is subject to oppositional thinking, which determines not only the individual's experience but also how we perceive them. Adults are inclined to disown these childlike qualities and therefore they are carried by children instead. Mothers may resent their actual child for retaining qualities of which she is now deprived by her position in the so-called tandem, according to Hillman (1983) as cited in Parker (1995, p.211-213) Hillman (1983) suggests that therapy involves rapprochement with the patient's inner child. Angela referred to the fact that mothers often feel guilty about not having done enough for their children.

Parker (1995:208) argues that the way women describe their feelings about themselves as mothers are constructed by images of mother defined as adult in opposition to child. This is similar to Hillman's arguments above. She argues that there is a split representation of motherhood in western societies. Women are expected to be childlike and at one with their children and happily immersed in their world and reality while at the same time being very mature and adult. Parker suggests that it is simply the human condition that all of us combine an adult and child part that frequently conflict. Being a mother and being with children highlights the conflict between the woman's childlike parts and her adult self. This can leave mothers feeling inadequate and unable to reconcile these conflicting feelings. The idealisation of motherhood has allowed women to unconsciously use their babies as an extension of their bodies to fulfil their own needs. Three of the participants referred to the conflictual nature of mothering.

Welldon (2006) states that the myth of motherhood was promoted by Shirley Conrad's book 'Superwoman' that was published in the 1970s. Welldon (2006)

states that the image portrayed within this book is a facade and that many women feel frustrated and lonely and unable to share their feelings, as in the eyes of the outside world, they have a perfect life. Welldon (2006) argues that for some women the price of equality has been the single life as unconsciously they are looking for a male parental partner but such a desire clashes with their conscious choice to be independent. As stated earlier, Denise argued that it was because of the dual role of the working mother that modern women undertook that propelled them into therapy as they ended up feeling inadequate in both roles.

Writers such as Welldon (1988, 2006) and Almond (2010), mentioned above, have written extensively about the darker side of motherhood and all of my participants referred to the bad mothering that their patients had experienced. Chodorow (1978) stresses that we all have psychic imprints from our experiences of being mothered. Welldon, (1988), Parker, (1995) and Almond, (2010) have all argued that these early experiences alongside the cultural ideology of idealising mothers can lead to hating them too. Due to infantile longing, women in general can identify with the child and blame themselves as mothers or their own mothers, for not living up to an ideal image. The VC choice as a result of poor mothering in childhood is discussed in Chapter Five in 5.2.2 and 5.3.2.

Welldon (1991:85) highlights the differences in the way that men and women express their aggression:

> The reproductive functions and organs are used by both sexes to express perversion. Perverse men use their penises to attack and

> show hatred towards symbolic sources of humiliation, usually represented by part objects. If perversion in the man is focused through his penis, in the woman it will similarly be expressed through her reproductive organs and the mental representations of motherhood.

Welldon (1991) highlights the glorification of motherhood and notes that theories of motherhood are inaccurate because of an unconscious need in all of us to hold on to an image of an earth mother. She discusses the cycle of abuse as many women who abuse, have often been abused themselves by their own mothers. An important point raised by Welldon is that if women had more power in society maybe they would be less inclined to use what little they have, against their children**.** None of my participants referred explicitly to the lack of power women experience in society.

Parker (1995) discusses the fact that although most abusers are fathers, mothers can be too and she understands this as an expression of the splitting off of love and hate. It is intensified by the social and political attitudes prevailing in society towards mothers and children, which is reinforced by idealisation as mentioned above.

Almond (2010), a psychoanalyst, also supports the view that although men may struggle with whether or not to have children and whether they are good fathers, they do not hold themselves responsible for children in the same way as women do. Almond (2010, p.8) is concerned that women are "literally driving themselves and their offspring crazy" trying to live up to an ideal and it is hard on the woman's spouse as well as her children. Denise supported the view that modern

day society places undue pressure on women to have financial and material security before having a child.

Sociologist Cannold (2005) who focused her research on the circumstantially childless, argues that the good motherhood mythology contributes to what she sees as the increasing problem of women who find themselves unwilling to commit to motherhood. She highlights how the good father and good mother messages are polar opposites. While the good mother must abandon her career, fathers are compelled to concentrate on their career, thus reinforcing the message that women nurture and men provide. Cannold (2005) argues that these messages are scary for the wavering woman as many have good, rewarding careers and dread the prospect of the self-sacrifice that they see is involved in motherhood. She argues that this places pressure on women not to have children. This is a similar view put forward by Denise.

All of my participants except for Denise referred to some pressure they experienced from within psychoanalysis**.** Cathy Urwin (1985) a child psychotherapist states that developmental psychologists such as Winnicott (1896- 1971) have contributed to the modern day construction of motherhood. This has led to mother-blaming as this thinking makes the mother responsible for creating the personality of their child. A number of writers such as Parker (1995) and Kulish (2011) also state that psychoanalysis as a whole has contributed to mother blaming. A study carried out by Caplan and Hall-McCorquodale (1985) as cited in Parker (1995, p.16), reviewed 125 articles in major clinical journals where 72 treatments of psychopathology were discussed. Mothers were always mentioned in relation to the cause of the psychopathology. Monique Plasa (1982)

discussed how she experienced a split between her professional and personal self. On the one hand she had sympathy for the difficulties many modern day mothers faced, but professionally she witnessed the suffering imposed on children by their mothers. Parker (1995) argues that psychoanalytic theory should be applied constructively to support mothers and children rather than pathologising the mother in favour of the child. All of my participants made reference to the effects on the child if they had experienced poor mothering.

Psychoanalysis has confirmed the link between motherhood and femininity but Parker (1995) argues that Freud's view of women represents an attempt to address the split in the mother-child relationship, which has contradictory desires. She states that the symbols of the phallus and castration represent power and powerlessness. Parker goes on to note that it was due to psychoanalysts' attempts to understand female sexuality that motherhood and femininity became so inextricably linked. According to Parker (1995), Chodorow's (1978) theories have greatly influenced the way that motherhood is perceived. However Parker argues that a limitation of her theory is that it is based on love and does not acknowledge ambivalence. Parker (1995) says when these women write about motherhood in a professional capacity they lose the capacity to recognise the significance of maternal ambivalence. She states too that psychoanalysis reinforces the view that you are not a real woman unless you have a baby. This could subtly influence those women who want to be childfree into becoming mothers. This is discussed further in Chapter Six. Psychoanalyst Person (1986), writing in the context of working mothers argues that psychoanalysis needs to move beyond focusing exclusively on internal conflicts to also acknowledging the social situations that women find themselves in. In

different ways all of my participants acknowledged the individuals circumstances of their particular patients.

Carolyn Morell (1993, 1994, 2000) a sociologist, focuses on the feminist view of childbearing and rearing as stifling to one's creativity and reinforced by patriarchal ideology. However in recent years she says that contemporary feminist thinking has focused on the female quality of caring and relatedness and conventional views of masculinity and femininity have been promulgated. Morell (1994) argues that Object Relations' emphasis on the bond between mother and child has taken on a near sacred quality and is expected to lead to fulfilment of both mother and child. Relational and autonomous qualities are portrayed as moral polarities where former is seen as being superior and the latter inferior. However she says the meaning of motherhood changes according to prevailing economic and social conditions and that during the Great Depression, for example, forgoing motherhood was a survival strategy. Angela, Beth and Cathy referred to the idealisation of the mother/child relationship but they did not overtly challenge psychoanalytic theory on this subject.

Supporting the view that the visions of motherhood are affected by what is happening in society, Badinter (1980), a sociologist, argues that authorities became interested in the quality of mothering because of the high number of children that were abandoned in France. These children and abandoned babies became valued as a potential labour force. The value given to uncared-for children depended on the prevailing economic and social needs of society and ambivalence in mothering was either supported or condoned by religion and society. Cathy in particular referred to ambivalence about being a mother.

Cathy and Denise refer to the pressure from society that women experience in relation to whether or not to become a mother. Welldon (2006, p.67) argues there is pressure from society for women to have everything but the price is often intimate relationships and the problem of 'leaving it too late'. This was certainly a view supported by Denise. Welldon (2006) argues that they need to find out in analysis whether wanting a child is omnipotent and greedy or indeed a genuine need. Raphael-Leff (2015) draws attention to the paradox of the 'have it all society' as the needs of infants have not changed since the Stone Age, whereas women's expectations have seen enormous changes over the last 50 years. This, she argues has led to greater maternal distress as women are faced with the dilemmas of being a working mother. Denise argued that it was these pressures that propelled women into therapy.

Hewlett (2002:291) a sociologist devotes a whole chapter in her book to the 'have it all society', a theme which was emphasised by Denise. Hewlett states that 40% of corporate women are childless at the age of 40 compared to 25% men and only 14% planned to be. One of her participants asks why people think she is greedy because she wants love and work. Hewlett quotes research that shows women are happiest if they can work and have children as long as they have reduced hours. Sociologists Black and Scull (2005), say that their generation of women, unlike their parents did expect to have it all. It was hard to leave a career in one's 30s and many left it too late to have children. They argue that some women have children because work becomes too stressful whilst men are not criticised for wanting both work and a family life. Sociologists McAllister and

Clarke (1998), found childless women were no more career minded than mothers and they were often under pressure to conform from friends and family.

Psychologist Shaw's (2011), findings, of her interview of VC childless women shows how they felt pressurised to conform because of social norms. Some felt stigmatised and de-feminised because of their VC choice or were seen as rebellious and were viewed as women who have it all. None of my participants raised the issue that their patients might have experienced stigmatisation in society as an effect of their childlessness despite this being experienced as a pressure for these individuals, according to the literature. Stigmatisation can often occur as a result of pronatalist rhetoric in society alongside the idealisation of motherhood. Social psychologists Lampman and Dowling-Guyer (1995) suggest that the only cause of childlessness that is accepted in society is infertility because norms dictate that couples should want children. Childlessness is a form of non-normative behaviour and thus potentially stigmatising. They highlight research that indicates that VC couples are viewed negatively as they are seen as selfish and immature. However sociologists Carmichael and Whitaker's (2007) research shows that some stigmatisation comes from the women themselves as they have internalised the negative societal messages. See section 2.6.5 for a further discussion on stigma.

Offering a different perspective on the possible indirect discrimination of female politicians Helen Lewis (2015) draws attention to the large number of European female politicians who are childless. The New Statesman carried out research showing that 14 men in the shadow cabinet have 31 children between them and the 13 women have only 16. Seven of the women are childless, against three of

the men (Lewis, 2015 p.27). Lewis argues that the 'motherhood trap' hides one of capitalism's secrets – which is, that it relies on unpaid labour that comes mostly from women. Once women become mothers a 'maternity gap' emerges where women's wages never catch up from the time given to raising children. Michelle Budig's (2014) study found that male workers had a 'fatherhood' bonus whereas working mothers had a 'motherhood penalty', as cited in Lewis (2015, p.27). Employers viewed fathers as more stable and mothers were seen as more easily distracted whilst at work. Female politicians who are mothers have been viewed as being able to understand the lives of ordinary people, but Lewis (2015, p.28) points out that being a mother does not automatically equate with empathy. Lewis (2015) argues that parliament "reflects the structural discrimination in society" (2015, p.27). Lewis' article also reflects the competing discourses in society about the link between motherhood and femininity.

Another interesting angle is offered by Gentle (2011, p.38) a childless psychoanalyst herself, discusses how there is more awareness amongst Americans of their cultural vulnerability in the USA since September 11th and as a result more pictures appeared in magazines and newspapers of pregnant women and children. She traces the history of the way pregnancy and birth has been portrayed in America and she says now it is associated with lurking dangers such as what the mother eats, the medication she is on and her body weight during and after the birth of the baby. Symbolically, she says that the health of the mother and baby represents the future of America. She says despite the fact she is an analyst and an academic these articles s still have the power to make her feel a failure.

4.4.2.1. Implications

Recently Adam Balen, (2016) the Chairman of the British Fertility society, said pupils must be told about the best age to have a child when they are taught about contraception in sex education lessons. Professor Balen added that the number of childless middle-aged women has doubled in two generations and the lessons could spare tomorrow's women from the profound heartache of infertility. Balen's proposals would support the views of my participants as well as some psychoanalytic writers that women need to be educated about their fertility and the dangers of 'leaving it too late'. However the theme regards the myth of maternity would also suggest that children and teenagers need to be warned about the realities of motherhood in terms of for example Post-natal Depression (PND) and the challenging aspects of parenting. One could wonder if psychoanalytic practitioners give equal attention to why women want children as well as the VC choice.

4.5 Conclusion

The issue of the female biological clock is raised both by Angela and Denise. It is interesting that both of them place heavy emphasis on the need for their patients/ women to make a decision as soon as possible rather than run the risk of leaving it too late. Denise in particular, takes the view that motherhood is a biological urge, and is a natural course for most women. Cathy focuses on two of her patients who made masculine identifications that left them feeling insecure about their bodies, sexuality and gender. Gender confusion left one patient with a fear of pregnancy, while another was frightened of adult sexuality.

Meanwhile, Angela describes one of her patients as having a fear of bodily changes during pregnancy. Angela elaborates on her theory of the trans-generational maternal message, which can influence – either positively or negatively – a woman's decision to have a child. The implication is that choosing to remain childless is a direct result of negative messages about motherhood transmitted to individuals from their mother. Beth focuses on her Lacanian training, which emphases the non-developmental approach to whether or not one becomes a parent. From her perspective, individuals have children or do not have children in response to unconscious messages and reactions that they have in their psychic structure. The difficult decision concerning whether to become a parent is part of the human condition.

The myth of motherhood as a blissful state is 'turned on its head' by Angela, Beth and Cathy as they use strong metaphors to describe the darker and more troubled aspect of this role. Cathy and Denise are the only participants directly referring to their own experiences of motherhood. Cathy makes it clear that she became a mother because of pressure from her husband, while Denise consistently argues throughout her narrative that motherhood provided her with great fulfilment, and that she wants her patients to have the same experience.

Cathy and Denise also differ in their views on social pressure on women. From Denise's perspective, women are pressured into a career at the expense of family life, while Cathy feels that women are under pressure to be mothers at the expense of a career. She argues that a career can be as fulfilling as motherhood, because women make great sacrifices to have a child. Angela Beth and Cathy refer to the unconscious pressure from within the psychoanalytic community to

see the birth of a child as a successful psychotherapy outcome. Eventually, Beth trained as a Lacanian analyst because the Lacanian perspective, unlike several other schools of psychotherapy, did not use a developmental model to explain the human condition.

These different viewpoints speak of the pressure that these participants feel when working with the patients who are dealing with dilemmas surrounding motherhood. This subject is so much under the influence of dominant cultural institutions such as religion, politics, the medical profession, economics and, one could argue, the psychoanalytic training organisations, that there was a sense that the participants feel under some pressure into behaving in a certain way. At times, my sense was that my participants were 'swimming against the tide' in terms of the pressure they felt coming at them and their patients with regards to whether 'to be or not to be a – mother or parent'. Female psychoanalysts such as Parker (1995) and Welldon (2006:2012) have written about the importance of not focusing solely on the intra-psychic experiences of their patients but to also acknowledge the social and economic conditions of women. It would appear that this is an important element that needs to filter through to clinical practice.

The link between femininity and motherhood is a point of great debate that includes psychoanalysts, sociologists, feminists, and religious as well as scientific communities. There are those who argue that biology is destiny, while others stress the evolutionary instinct to survive. Freud (1957) argue that there is a strong narcissistic drive to reproduce and as has been shown by writers such as Welldon (1988) this is not always in the best interest of the child.

Others within the object relations psychoanalytical community argue that a women's wish to reproduce comes as a trans-generational imprint from their mothers. Interestingly Horney (1926) acknowledges the influence from society that reinforces the link between femininity and motherhood. In more recent times psychoanalytic writers such as Ruderman (2005), Raphael-Leff (2007) and Orbach (2007) are acknowledging the pressure to conform, placed on women by society. This often comes to light when there is a clash between career and motherhood and the woman leaves it too late and feels under pressure from her biological clock. Despite these strong views about reproduction as a biological urge there are women who argue they have felt no such urge and they have chosen to remain childless. My participants as well as the writers above have discussed the reasons for the lack of such an instinct. Some have suggested that it is because of the message given to them by their mothers, or fathers, that they do not feel like a real woman and often they have a negative body image. However some sociological research (Morell, 1993) with VC women has shown that these women still feel fully feminine and have expressed their creativity through other avenues.

As mentioned above, the influences from society come in many guises. The idealisation of motherhood comes through the Good Mother archetype as espoused by Jung (1953) as well as within the psychoanalytic community in its emphasis on the mother-child relationship. Many have argued that the emphasis on good mothering was influenced by economic and social needs with regards to the future labour force. Other power elites also promote the idealisation of motherhood and this occurs through the media, religion, and the scientific

community particularly in the way the female body is often under male control through reproductive technology.

It has been argued that this idealisation of motherhood has led to perverse mothering which is often trans-generational. Writers such as Welldon (2012) as well as sociologists such as Gillespie (1999, 2000, 2001 and 2002) and Morell (1993, 1994 and 2000) have argued that if women had more power in society there would be less need for them to abuse their power as mothers. Others have focused on the need for more support for women to be mothers, for example child-care and financial support. Parker (1995) argues that the psychoanalytic community, as well as society, do not acknowledge that maternal ambivalence is natural and omnipresent and as such this places enormous pressure on women and in the worst- case scenario can lead to perverse mothering as outlined by Welldon (1988:2012).

Other pressure comes from family and society in order to conform. Others describe the pressure on women as a result of the dual role of career and motherhood. There are different stances on this: for example some argue why shouldn't women have it all, whereas others argue that this is narcissistic and selfish and leads to a lonely and unfulfilled life. As can be seen from the above findings and discussion, women in particular experience a multitude of pressures with regards to whether or not to become a parent. These arise from biological urges, the biological clock and how in some cases the woman might 'leave it too late' to be a mother. There are conscious and unconscious psychological pressures relating to what motherhood or being childless might mean to the

woman and there are the social pressures arising from family, friends, partners and pronatalist societal messages.

CHAPTER FIVE - SUPERORDINATE THEME TWO - ETHICAL DILEMMAS AND FITNESS TO PARENT

Subordinate theme	Angela	Beth	Cathy	Denise
a) The terrible dilemmas of having a genetic illness	x		x	
b) VC and IVC is a result of having difficult childhood experiences	x	x	x	x
c) Some individuals are too psychologically immature to become parents.	x		x	x
d) Mental health problems render some individuals unfit to parent	x	x	x	x

5.1 Introduction

This chapter will address the second superordinate theme called Ethical Dilemmas and Fitness to Parent. The participants outline how they understand and conceptualise the VC choice of their patients as well as the dilemmas involving the question of who is fit to parent. There are four subordinate themes to this chapter and the findings will consider each of these in detail. The discussion section will include contributions from psychoanalytic, psychotherapeutic and health professionals as well as sociological and feminist literature to deepen the understandings of the findings.

The first subordinate theme outlines how a VC choice might arise as a result of the fear of passing on a genetic condition to an unborn child. The findings will present how the participants described their patients' dilemma and the discussion section will introduce literature to add further insight to these predicaments. The second subordinate theme addresses how the participants take the view that difficult childhood experiences might affect whether a woman chooses to be a parent. The discussion section will draw on literature that both

supports and offers different perspectives to those offered by the participants. The findings in the third subordinate theme demonstrate how the participants consider some of their patients and some individuals in general to be too immature to be a parent. Both the participants and the literature in the discussion section will consider whether parenthood is a developmental stage and whether in fact a VC choice can be a sign of maturity. The findings in the fourth subordinate theme present the views of the participants with regards to whether a VC choice is preferable if the female patient has a mental health problem. The discussion section presents alternative points of view about whether or not there is a link between psychological health and infertility, something that the participants themselves discussed. As the participants' responses moved beyond the original research question, and IPA is inductive research, all of the participants' responses are considered to be valid and of interest, as embedded in their particular context. As mentioned in Chapter 2, section 2.1, qualitative research can often take the researcher into unexpected territory. However the narratives of my participants illustrate their thinking and understanding of VC in the clinical setting.

5.2 Findings

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5.2.1 Subordinate theme one - The terrible dilemmas of having a genetic illness

There is a similarity in the way that Cathy and Angela discuss their patients' anxiety in relation to congenital disabilities. For instance, Angela is discussing the dilemma faced by a patient, 'E' who was born with a deformity:

> there was some familial repetition of that deformity in a much milder form than hers but it was in... so there was inheritance in there. Whether it was the fear of the actual genetic inheritance or whether it was a bigger fear that she would have passed on to her child, I don't know… em… we talked a lot about her deformity and we talked about that in connection to a possible pregnancy. In the end, she sort of didn't and I think that by then she was 42-43 and so I don't think she's going... [have a baby].Then she finished her therapy quite well.

Angela is making a distinction between the patient's conscious fear of passing on a genetic illness and an unconscious fear of passing on something bigger, perhaps trans-generational psychological problems to potential children. Later on Angela explains how this patient and her siblings 'had various problems' – implying psychological as well as physical concerns. Angela's use of elliptical structure, 'sort of diidn't', could mirror the patient's hesitation and inability to make a firm decision. Angela's understanding of this patient seems to suggest she did not make a conscious decision not to be a mother, but she ran out of time in terms of her biological clock.

Angela continues on the theme of the patient's worry about passing on the genetic condition:

> Was it a positive decision – not exactly as such but on the other hand I think it was right.

At this point, Angela does not make it clear why she thinks it was the right decision for the patient. She gives a clue later in the interview when she states:

> ..and it wouldn't surprise me if she had better relationships with men once she decided not to have children

This implies that Angela understood that the decision of whether or not to be a mother was creating strains in the patient's intimate relationship. Angela refers to an 'act of generosity' with regard to this patient's decision:

> …so I think it was both a generous act and also some concern about herself – what would happen to her – but also what would happen to the child…

It is interesting to note that, when Angela describes this patient's choice, she slips between viewing it as both conscious and unconscious. It would seem that, from Angela's perspective, the physical deformity and fears associated with it could have been overcome by the patient and the child, however the psychological fears would be harder to overcome.

Cathy describes her patient P who had a fear of passing on a genetic illness. This is illustrated in the extract below:

> But again, she has a problem because there is a cancer gene, and her mother has ovarian cancer and she's under terrible pressure to have a gene test, and she doesn't know whether to do it or not. And that is one of the most horrible predicaments I can imagine, actually (yes). If she doesn't have it, there's a danger that not only might she have it but that she might pass it on. If she does have it, then she's faced with – you know – does she have IVF or what does she do instead? Not have children at all?

Cathy's use of language clearly demonstrates empathy in her response to this patient. For instance, the phrase 'the most horrible predicament that I can imagine' contains a very powerful superlative, which shows the participant's feelings as she imagines the difficult decisions that the patient will have to face. In the following extract Cathy gives a strong emotional reaction:

> …yes if she wanted to have a child I'd be really happy for her and I feel very.. as though ..it would be like my baby in a way.

Cathy did not go on to explain how she understood her countertransference/countertransferential reaction. This will be elaborated on further in chapter 6.2.3.

In contrast to Cathy, Angela's statement about her patient in a similar situation where she felt it was the right decision for the woman not to have a child. Both of these statements reflect the ethical concerns about 'who is fit to parent' and the 'right to parent', which are themes that run throughout their narratives. All the while, both the participants demonstrate empathic responses to their patients' extremely difficult dilemmas.

In terms of illness and what might be passed on to an unborn child, Angela describes a different scenario faced by patient G:

> ….if it is a coincidence but the other patient who is now in the throes of the decision is a woman who has a good relationship and has been diagnosed with a very rare but chronic and fatal illness and actually that is why she came to therapy. She said she had thought about it before but she thought no and then she had the diagnosis. And she then she's 35, and the doctors tell her that she can expect 25, 30 years perhaps but she said okay 55. But suddenly 55 seems not a lot and also they can't tell her it's certainly going to be 25 or 30 years in fact she found that its 15 years.

Angela is linking conscious and unconscious processes when she connects the 'throes of decision making' with developing an illness. This is a recurrent theme throughout Angela's narrative. In the above extract, Angela is highlighting how the patient's illness had brought the decision about motherhood to the foreground. The patients illness had propelled her to seek therapeutic help but

itis unclear whether the dilemma about whether or not to have a child arose for the patient during the course of analysis.

In the extract below it is also clear that Angela responds with deep empathy for patient G's predicament:

> It's not, it's not good it's really not good… umm… and she had been not thinking about children, and now she's thinking about children and she says: "what am I going to do"? And her sister says: "well in any case you know you never wanted children". She said to me "I don't know if I ever wanted children, I never thought about having children".

This extract has numerous repetitions, hesitations and unanswered questions that indicate that Angela herself feels in a quandary for her patient. Angela also empathises with the patient's partner:

> On one side, she wants to; on the other, her partner, her long time partner said: 'You know, I don't want to remain alone with a baby, a child', which of course was a terrible thing to say, but it was truthful, and again brought back to her – she doesn't know for how long – she'll be alive. For a few years, yes, but how many?

The above extract illustrates how Angela viewed how complex the decision was about whether to become a parent, both for the patient and her husband.

At the same time using the term countertransference states:

> I wouldn't want to be in her shoes.

This is a similar response to Cathy's phrase, 'the most horrible predicament I can imagine' when she discussed a patient with a fear of passing on a genetic illness. Like Cathy she does not indicate how her countertransference gives her insight into the patient's unconscious. See section 6.2.3 for a further discussion on countertransference,

This fear of passing on a genetic disorder, mental illness or even a psychological problem is a theme in both Angela's and Cathy's narratives. For instance, Angela makes the following observation:

> And this fear – which, I think, is more common than you think – that whatever problems that you have, they will somehow be passed on to the child.

In her discussion of F, another VC patient, who had multiple sclerosis, Angela describes how she tried to explore this choice with her. In the extract below, Angela makes links between stress and developing MS, as well as unconscious fear of passing this illness on to a potential child:

> And I think that this situation plus a few more things was really very difficult, on top of which she developed MS a few months after the termination of pregnancy. Now I'm not say that the onset of the termination caused the multiple sclerosis, but the tension and anxiety might have triggered it.

And then trying to elaborate on any psychosomatic link:

> Em… yes, and I think it is a connection that even though, and I have asked them about that sometimes quite directly, that she was afraid that the same thing would repeat. 'No, not at all, that is done, not all people have children and no problem', but I am not sure that that is the whole story.

Angela did not elaborate on her statement that it was 'not the whole story'. The implication is that according to her professional understanding, there are deeper unconscious conflicts causing the patient to choose VC. She responds by encouraging the patient to explore her VC choice. This is a similar theme to the male patient H mentioned below, about whom Angela speculates that he has psychogenic infertility, and who is happier with a child that was not biologically his own.

> And it is and also it was interesting and I'm not at all saying that infertility has a psychological cause but I think in some cases it may, psychology may influence. It is not a simplistic link that I think is very important it is not a simplistic link.

In the interview Angela stresses that the link between infertility and one's individual psychology is not a direct causal relationship but she believes that there is a link. As discussed in the next section, Angela's understanding was that this patient had a fear of repeating the experiences of bad fathering that he had received as a child.

5.2.2 Subordinate theme two - VC and IVC is a result of having difficult childhood experiences

Angela gives an example of patient D who had experienced difficulties with her mother. This patient was in her forties and had been married for many years 'but still no babies'. Angela does not state clearly whether the patient was VC but does say 'that if one dug deep enough you would find she did want a child'. This is Angela's description of the patient's D mother:

> her mother sounds a really very difficult woman who went on throughout the patient's life threatening to die.

This mother had been abused by her father, then had a baby that was given away, and the whole story was 'hushed up'. Angela twice repeated the phrase 'incestuous baby', as well as other phrases such as 'hushed up' and 'kept totally secret'. This use of language implies that she considers this event to have had a strong impact on her patient. Later on in the interview Angela further describes patient D's mother as:

> …[she was] always regarded as somebody somewhat fragile. But, in fact, she was very dictatorial; in fact, my impression was that she was very cruel.

The patient's mother would frequently be rushed to hospital in the middle of the night because she thought she was having a heart attack. Angela states that her patient can still remember the 'fright in the night'.

> She [the patient's mother] would wake up in the middle of the night saying that she was having a heart attack or something and would have to rush her into hospital. But the patient remembered it but the fright in the night.

Angela uses very descriptive language here to paint the picture of this patient's difficult childhood, with a sense that there were still traces of trauma in the patient's unconscious and conscious mind and body.

Angela also states that D also had great empathy for her mother despite her difficult childhood experiences:

> So, on the other hand, (she has) the sense of enormous sorrow for her mother, because her mother did have a dreadful life. So it was very difficult to be angry with the mother if one sees her so unhappy herself and has always been.

Perhaps Angela's is suggesting that Patient D's VC choice was due to an identification with her mother, as well as her traumatic experiences in childhood. Angela implied that Patient D had an unconscious fear of passing on her bad experiences of childhood to any potential child.

Angela made the distinction between the patients who came to her privately and those who were patients of her supervisees in an NHS setting. She describes the childhoods of her private patients in the following way:

> …for various reasons, one because, sometimes, their childhood was clearly difficult but not so extremely difficult, and also because there might have been other reasons. Not only that sense of not having been... not having had a good internal experience of a good mother.

And this is her description of the patients (A) of the clinicians she supervised in an NHS setting:

> …In the course of the therapy they could, you know, see how their relationships had been very unhappy, or maybe they have several but very unhappy indeed, and their own childhood had been abysmally unhappy and… em… and that made them feel that they couldn't cope with having a baby.

In the second extract Angela twice repeats the word 'difficult' and 'unhappy' three times and then a powerful verb 'abysmally' to describe the early childhood of these patients. Angela makes a clear statement that psychoanalysis enables some of the NHS patients of her supervisees to see that they would not have been capable of mothering a baby.

By contrast, Angela does not say this about her private patients, and the implication is that their experience of 'not having a good experience of being mothered' could be overcome through psychoanalysis. Angela's statement

implies that psychoanalysis can help those with severe developmental deprivation, like some of those in the NHS unit, to come to terms with their deficits – even though it cannot be reparative enough to prepare the some women to become a mother

At the end of her interview Angela conceptualises the importance of the mother to a female child's development. This is illustrated in the extract below:

> I think, for women, the mother is more important, much more, I think, because their identification is with… their very early identification is with the internalisation of a maternal function which we start with the baby… as a baby, as a baby girl. And then it develops and then we can work with it, you know, as a person.

Angela emphasises how important it is to develop a positive identity with the mother in order to develop a 'maternal function'. The implication is that if the maternal relationship is negative, the female child does not internalise positive experiences of mothering. This could result in choosing not to have a child or acting out poor parenting skills on one's own children as an adult. Someone who has been so profoundly damaged by their early life experiences will have difficulties identifying with the maternal role.

Beth gives an example of patient (I) who chose not to have a baby because she spent her early life looking after her parents:

> She was not interested in being any kind of carer. In fact, she's very... in some ways very hostile towards… she thinks that women… and rightly… she's right to think that women often use the fact that they are mothers as an excuse for a whole series of symptoms.

Beth is suggesting that she agrees with the patient who thinks that women often blame their children for the difficulties they are experiencing in their lives.

Beth also demonstrates empathy for patient (I) in the following statement:

> She was a child, actually, who was a mother to her mother for long chunks of time as her mother was quite ill, for a long period of time. She wanted somebody to look after her. Why not?

Beth is very supportive of this patient's VC choice, bearing in mind she had to take the 'little mother role' as a child. This particular patient covered up her fundamental 'gap' by emphasising and promoting relationship complementarity:

> If she could be the only one for her husband, and he could be the only one for her there was a complementarity and no gap, no lack.

The way Beth describes Lacanian theory makes it seem far more inclusive and less pathologising of the childless woman than the other participants. Beth takes the view that regardless of whether individuals are childless, childfree or parents, all humans are subject to the same feeling of lack as a consequence of the human condition.

> Lacan's thesis is that we all have to come to terms with lack that we are not complete, life isn't consistent that our, that we want it to be consistent, we want it to be harmonious but actually it isn't.

The participants also discuss the effect that their patients' fathers had on their decision whether or not to have a child. Cathy discusses patient R who she says:

> ..did identify with a very mad father who was quite brilliant but quite mad, very destructive and very dangerous and finally did go mad.

This is a patient that Cathy refers to frequently throughout her narrative and she describes the woman's body as having a masculine quality too. This was discussed further in Chapter Four 4.2 .

Like the others, Denise refers to her patients as being seriously affected by a difficult relationship with her father in childhood. Here she is discussing patient U:

> ..[she had] a father that was sort of emotionally absent, and then it transpired that he had been having affairs for goodness knows how long and then he... she hardly saw him and then he developed dementia.

Denise was very surprised that this patient made a VC choice as she described her as being very caring. She implied that the combination of her 'cold, withdrawn mother', and the emotionally absent father, left the patient with the lack of desire for a biological child. However like Beth's patient mentioned above, she developed a complementary, if not co-dependent relationship with her alcoholic husband:

> ….the reason she came was because her husband was an alcoholic and what came out through the work was in her, in a way her collusion with the alcoholism. Emm maybe her role, I think her husband felt quite emasculated by her. Emm. But she was always quite adamant that she didn't want children.

Denise implies that this patient took on a dominating role in the relationship with her husband. Despite the patient's difficult childhood that Denise describes in detail, she clearly states that:

> Emm and I think she too at one point kind of talked about ...there was some sadness but I don't think she'd go there... em.. there was something matter of fact about it and I don't think I really understood it.

Bearing in mind, Denise's strong identification with the maternal role, the sadness reflected in this statement might well be her own. It is also interesting that Denise stated that her presenting issue at the beginning of analysis was because of her difficulties in being married to an alcoholic husband. It leaves the question open whether Denise felt the need to explore the patient's childlessness even she states she 'I don't think she'd go there'.

Angela described how Patient H's choice to be a father was very affected by his relationship with his own father:

> Because I think if it had been..... this man having very bad relationship with the father. And the father had a bad relationship with him. And a better relationship with his sister. And I thought that his sense of being a father of a boy would have been like being doomed to be as bad a father as his own father was.

In the above extract, Angela seems to be referring to the patient's conscious or unconscious fear of passing a trans-generational traumatic experience of poor parenting to his children. The word 'doomed' is a powerful expression that portrays the power of the patient's fear. This particular patient was infertile and as mentioned in previous section, 5.3.1. Angela felt that there was a link – although not a direct causal link – between this and his childhood experience. She acknowledges a link between the mind and the body and comments on trans-generational depression in the patient's mother's family:

> But it is his mother that is now dead was very depressed. He is depressed like his mother and like his grandmother.

The effect of the parental couple on their patients' VC was also discussed by some of the participants. Both the mother and the father feature prominently in the following account given by Angela about another patient, F:

> both parents worked, and the mother worked very, very hard to keep the family afloat… em… but they.. the mother somehow relied on the patient who was the eldest child to manage the father. To keep him happy. The father had all kind of paranoid fears which ..em… for a child must have been frightening, but she was Dad's favourite, and she would spend time with him.

Angela shows great empathy for patient F, and the language she uses vividly illustrates the difficulties the patient faced in her early life. There was a great deal of responsibility placed on the patient's shoulders at a young age, particularly in terms of her father. Angela gives further illustrations of the patient's early life in the extract below:

> … if you think in those first five or six years of the patient's life, you know..... There was one disaster after the other –the debts being discovered and the bailiffs almost coming… em… and the patient thinking of sitting on things to prevent them taking away…

In this narrative Angela repeatedly states that the mother did not protect the child from the father. This patient (F) is now in her 30s and does not want children. However, she would adopt one:

> She says she doesn't want babies. She says she could adopt one but not make one, you don't want to make a baby… to put a baby into this world… but she would adopt one, and maybe they should think about that. I don't know.

In the following passage Angela uses powerful metaphors and adjectives to make links between this patient F's early life and her decision not to have a child:

> Not the responsibility of bringing a child into the world… em… as if she's not sure if she would give a good deal to this child, but in any case if it was adopted… in any case, it would be a child who had a very bad deal, you know, maybe, from god forsaken place. She would adopt this child, and it would have a better deal than whatever he or she would have in the orphanage, or something like that.

Angela suggests that the heavy responsibility that was placed on the patient as a child led to her decision not to want her own children. Angela seems to be suggesting that the patient feels that even if she cannot offer much, it will be more than the child would otherwise have had. Angela described this patient's early life as being difficult and she might be suggesting that the patient's wish to adopt a child from a 'godforsaken place' is mirroring an unconscious wish that that the patient herself had been rescued from her intolerable childhood situation. Earlier in her life this patient had a termination Angela suggests that there might have been a link between this difficult decision and the fact that she developed MS shortly afterwards (as mentioned above in section 5.2.1).

Angela also elaborates on her theoretical views about the importance of the father in particular, and the parental couple in general for both male and female children's development:

> Why, for a man, the relationship with the father, I think, kicks in, perhaps, a little later. So the influence is there, but I think for the man… I think that the maternal influence is quite important, and for the girl… for the woman the paternal influence is important. Perhaps… and also the parental couple… how the parental couple is experienced… the two of them together, how they are, you know… there is physical violence, if there is mental cruelty between the two of them. Then the maternal figure or the paternal figure ends up being quite battered.

Angela uses strong metaphors to illustrate how an individual's psyche can be affected by witnessing a difficult relationship between the parents. The

words violence, cruelty and battered evoke images of a child being severely brutalised, even if this had not been inflicted on them physically. Angela's conceptualisation of the effect of the parental couple on the child could be applied to many of the patients described in this section.

Cathy describes a patient J's childhood.

> I would say, though, I'm not sure we've really talked about this enough ourselves in session, that she feels, somehow, because of her physical appearance she is not truly the daughter that her parents wanted.

Cathy suggests that the patient is confused about whether she has a male or female identity, as she has a tough and athletic body. Cathy understands that her confusion is due to the fact that she was not the child that the parents wanted. Cathy also describes the patient's background as growing up with brothers and she was encouraged to compete with them. This patient was also referred to in 4.2.

Cathy elaborates further on how this patient is affected by these childhood experiences:

> …because the relationship with the parents is very complicated, very unhealthy and very stifling and humiliating for her, actually, and, you know, she can't express any of this yet, she really can't. It's beyond her really to to be able to... to be able to admit to these feelings. She doesn't feel that anger she feels about the way she's been.... Well I don't know ... how they perceived her really you know. She blames herself really in some way yet she's very, very frustrated.

Cathy is suggesting that the patient who is now 35 years old and has not yet resolved her relationship with her parents. It sounds as if Cathy is

interpreting the patient's unconscious anger towards her parents, whereas the patient on a conscious level feels she is to blame for her present life difficulties. She wants a child but has not been able to form sexual relationships. This patient is described further in section 5.3.5

Denise refers to Patient S and implies that this patient was affected by the death of the preceding sibling. In this case, the deceased baby was male, and the patient was ignored by her parents and bullied by her sisters and Denise's interpretation was that her patient was not a wanted child.

> I suppose you know I was really trying to understand how such a damaged woman could come into being, really. It seemed to me amazing that she had survived.

And:

> I felt that there was something .... so profoundly missing, developmentally with her, that she just missed a whole chunk of something. And I was always surprised, I was always, I had the other thought about her… I didn't really know what she lived for, because it seemed she had so little pleasurable in life. Very sad.

Denise uses very strong language to illustrate how she as a psychoanalytic practitioner was affected by this particular female patient. Adjectives like 'profound', 'damaged' and phrases like 'whole chunk of something missing' paint an image of a woman whose life is without purpose. Throughout her description of this particular patient Denise employs powerful adjectives to describe the effect that a difficult childhood had on the patient. This patient was VC because of her marriage to a man who was not allowed to have children if he married outside his faith. (see 4.2) Although Denise had fantasies (see section 6.3.5) where she longed for this patient to have a baby, she adds:

> I suppose, I can think of my client in that she would have been damaging actually, not necessarily consciously, but I mean… knowing that she was such damaged goods.

Denise seems to think that the level of damage this patient experienced in her childhood left her incapable of mothering. Denise took the view that this patient has a borderline personality disorder (BPD), so there is a link here with Angela whereby they both question the ability of some of their particular patients with a borderline personality to provide adequate mothering. An IPA study does not seek to generalise so it cannot be assumed that they took the view that this applied to all those diagnosed with such a disorder.

A more explicit reference to an unconscious fear relating to childhood experiences is demonstrated in Cathy's discussion of patient M. In this instance, the patient's mother was told to let her new-born baby die as it was too sick to survive. The mother then subsequently gave birth to the patient and Cathy states that the patient made 'a massive identification with the dead baby'. Cathy illustrates this in the extract below:

> But for her, she never discussed why she never wanted a child or expressed any regret, but it seemed that, for her, a baby was inevitably going to be dead.

Cathy uses emotive language throughout this extract, to portray a picture of a patient who would unconsciously expect her womb to be a coffin for a dead baby.

Denise's explanation for patient P's VC is a 'thwarted childhood':

> .... I think, my understanding of it was that she really hadn't enjoyed her childhood, and she was so relieved to get away from home...so relieved to be an adult...very ambitious parents and she was very compliant...had done endless exams in all sorts of things and even the subjects she studied at university was to get her parents approval, so I think she felt really thwarted by them. (…) Emm… that… her… the bad, you know… her very bad experience of being a child was not one she wanted to repeat for someone else, really.

There is a link here with Cathy's view that patients with oppressive parents who stifled their children's individuality end up internalising negative impressions of motherhood, and may subsequently choose (either consciously or unconsciously) not to have children. In the examples given in this section this seems to be particularly true when the patient is compliant or not able to acknowledge their anger.

Beth also refers to the impact of childhood on an individual's decision to have children. This view is illustrated in the extract below:

> We always transmit to our children at best our neuroses, and at worst something else. The child has to make sense of that in some way. It's absolutely essential, because otherwise the child isn't caught up in the human world (ahah), and it has its strengths and its weaknesses as any symptom does.

Beth is interested in what a child or the absence of a child signifies to the patient. Every human being is looking for something with which to complete himself or herself, and Beth states that this psychic organisation of humans begins in infancy.

> It happens in part by losing bits of ourselves, because the infant takes the breast to be a part of itself even though it may be something that appears and disappears. And it looks for that which will complete it.

Furthermore, Beth implies that some adult individuals have a child to fill the gap, while others deal differently with the human condition:

> [women] may use the idea of not having a child to count for the lack, for example, to justify it, yes – rather than to get to grips with the inevitability of the human condition. It becomes a sort of apparently logical hook on which to hook ....so that's that's Freud's theory of displacement for example.

She takes the view that we are all affected by our childhood and our parents' neuroses and this is part of the human condition. She does not view childlessness to be any more or less of a pathology than choosing to become a parent.

5.2.3 Subordinate theme three - Some individuals are too psychologically immature to become parents

In some cases described below, the participants described patients as being too immature have also had difficult childhoods. However this separate section adds another dimension to how the participants understand the VC decision and childlessness in general

Cathy raises the issue of adoption when she refers to her 'immature' patients whom she considers incapable of taking responsibility for a child. Cathy made the following observation about Patients N's choice of partner:

> He quite consciously or unconsciously chose for his partner a woman who has an adoption agency. And although they didn't adopt children he did spend some time helping her in the running of their business…….. I think he felt that, somehow, that became a surrogate child for him, and the idea that they were working with children, and he took an interest in someone.

Cathy's understanding was that this patient needed a woman to 'adopt' him in order to aid his psychological growth. There is also an inference that the children he worked with also contributed to his growth as he had to think of others outside of himself.

Although not referring to adoption, Denise refers to patient S's choice of partner:

Denise discusses patient S's choice of partner:

> I think it was very interesting about partner choice that she chose someone equally damaged. But I think the point of it is …… at least they had each other. They did a lot to save each other.

This echoes Beth's and Angela's comment about the ability of the individual to fill the fundamental gap with a complementary relationship (5.2.2). Cathy's patient N, was also rescued by his partner.

Throughout her narrative Cathy expresses an opinion that some of her patients are too immature to parent. For instance, she says:

> Usually I just think: 'Thank god they haven't [had children] because they are so unready for it',

And:

> I'm quite relieved when, you know, people aren't rushing to have babies. Unless they have a healthy enough part to look after a baby. It really is an enormous part, isn't it.

Cathy's statements link in with the previous section about the need for people to have internalised good parenting skills from positive experiences in their childhood. This seems to be the healthy part that Cathy is referring to above.

Cathy continues in this vein when she refers to patients who had parents who were too immature to become parents themselves:

> They are so ill equipped that are not ready for it, they've not had much mothering themselves, they've no experience of good mothering probably, parents who were also immature. They are ignorant of mothering.

Cathy uses powerful expressions such as 'no more than babies themselves' and 'ignorant of mothering'. These phrases convey the strength of her feelings about unsuitable people having children. Like Angela she refers to trans-generational problems with regards to parenting that many individuals experience

With regards to a specific patient Q Cathy states:

> But I think, with other people if they were to tell me they were pregnant… which has happened with one young woman. I was very anxious about her pregnancy. I didn't feel she was equipped. I was anxious on her behalf'.

Cathy uses very strong language in all of these extracts with regards to who is fit or ready to become a parent. She did not elaborate on what she meant about her patient not being 'equipped' but one can assume that she did not feel that this woman had developed parenting skills. Cathy's statements also reflect conflicting cultural discourses where on the one hand motherhood is idealised, whilst at the same time there are certain groups of people who are encouraged not to have children. Here she is expressing similar sentiments to those stated by Angela about the irresponsible individuals who 'deliver babies like there is no tomorrow',

as mentioned in 5.2.2. Clearly, this topic is highly charged for all of the participants.

At this point I asked whether individuals with these experiences presented in her clinical practice. Cathy replied:

> Well, unfortunately they are not, not enough of these people.

Cathy's answer seems to suggest that she thinks more individuals/couples who were considering becoming a parent would benefit from analysis. Cathy holds the view that analysis can help individuals to mature sufficiently to become responsible parents. This would be particularly true for those who could commit to longer term treatment.

This is elaborated on in the extract below when she refers to patient R with a strong masculine identity.

> That really means that she can't let anything get inside her, and I think that includes a baby. I mean if you talk about the penis, you're really talking about making a baby aren't you. So I think that is someone who can't… who thinks they want a baby but really psychologically cannot face it. . But maybe after another 10 years or something you know.

.

In the above extract Cathy seems to refer to Freud's theory of the female resolution of the Oedipus complex. The theory states that, as part of coming to terms with the Oedipus complex, the female child should relinquish her desire for a penis as well as for her father. This desire is eventually replaced with a wish for a child. This is seen as a normal development for women (see chapter two 2.2.2 for a further explanation of this theory). Fear of sex, relationships and physical

and psychological penetration are all intertwined in Cathy's explanation of this patient's childlessness. Cathy is suggesting that after 10 years of therapy that the patient may overcome the Oedipal complex and desire a child.

Below Cathy is speaking about her patient M (see section 5.2.2) who made a 'massive identification with a dead baby':

> she's bought a house, she's beginning to make an independent life – and maybe that will bring with it some of the regret that she hasn't got a child – but I think up to now she's been so much still a child herself, and the sense of her relationship to her mother is still unresolved, so merged that she, you know… that her infantile self is still so damaged and so deadly.

This patient was just beginning to find her independence but left psychotherapy prematurely and eventually chose not to have a child. It is possible that Cathy views this choice as a sign of the patient's immaturity, whereas the purchase of a house is a sign of her growing maturity as she links financial independence with a readiness to parent.

Another example of how Cathy felt analysis helped her patient P to mature is and is now ready to have a child is given below:

> She is going to be a psychotherapist, and now she has become… she has matured so much, and she has learnt so much, and she has changed so much, and she's now married, and she does want to have a child.

Below is an extract from Cathy's account in which she describes a 'childlike' male patient N mentioned above who married someone who ran an adoption agency:

> He was absolutely useless – like a child, really. Like a child full of terrible problems which, you know, all were worked through, and by the end he was leading a normal life and was actually ready to be a father (right), but he was already coming up to 60.

This is another example of Cathy using powerful adjectives ('terrible problems' are contrasted with 'normal life') to describe her patient. She does state clearly in this extract that psychoanalysis helped the patient to become more mature and made him 'ready to be a father'.

Several participants refer to the difficulties that some of their patients have in forming sexual relationships and sometimes this is linked to a sign of immaturity. Cathy's description of patient L more specifically links immaturity and relationship problems with having children:

> Well, he's a very immature young man immature young man (sic) who has not established his own home, hasn't got a relationship. Very difficult childhood, still very infantile, really, predominantly infantile, in the way he thinks about things. Very angry with his father who left them. Nothing, I think, just that kind of fantasy that eventually, you know, he will have a child, you know.

Cathy repeats the words 'immature' and 'infantile' in order to emphasise her point that this patient is childlike. She links the fact that he does not have his own home with immaturity, Cathy also refers to this patient's fantasy that he will eventually have a child. This is echoed in her description of patient K:

> . . so, in her mind, the whole idea is – husband/child/house/security – you know, kind of package, really.

In the above examples Cathy is implying that these two patients are out of touch with reality. From her perspective, they are not ready or are too psychologically immature to be a parent.

Throughout their narratives, Cathy and Denise frequently refer to the problems that some of their patients experienced with establishing relationships and making emotional links – particularly with someone of the opposite sex. The participants often link this with the individuals being too immature to parent.

Cathy is referring to patient J and she states:

> She does feel desperately that she wants to have a child, but she has never ever had a partner. I mean she's 35, and she's never had any kind of relationship.

This patient was mentioned in the previous section 5.2.2 and she still had unresolved difficulties with the way her parents did not acknowledge her femininity.

In the extract below Cathy is generalising about some of her male patients:

> So in this case although younger men who are as yet ready for it, again haven't met the woman that they want to mother their children, yet again people who have difficulty making relationships. So it seems to be very much linked, to men in particularly, linked to those relationships or lack of relationship with a woman. I have never yet come across a man who has talked about it as a primary concern yet of course.

Her statement implies that these men don't know the real reason why they come to psychoanalysis. On a conscious level they might believe that they cannot find the right partner, but on an unconscious level they actually have difficulties with

relationships. She also seems to be suggesting that the issue of whether or not to become a parent is not a primary concern for the men who present for analysis.

Denise too makes some generalised statements about the reasons why men might be childless. In her view, the underlying reason is due to their difficulty in forming intimate relationships. She also makes a comparison between men and women:

> I think they feel....a couple who...you know… they see their friends getting married and having children and long for that for themselves... and they almost all come with relationship problems, so there is a ...they've got to have the right relationship. So, perhaps, that's the difference: a woman can decide to have a child on her own, whereas a man's not going... can't decide to have a child on his own, in the same way.

Denise suggests that there is societal pressure for individuals to follow a traditional path, but does not seem to question this injunction. Without naming it directly, Denise states that contemporary society enables women to be less dependent on a relationship to have a child.

Denise lists numerous possible unconscious fears that a VC patient may have, and her statement below emphasises the importance of motherhood:

> I mean once you have a child you are no longer an isolate, really, you know.....It's a, it's a commitment for ever, you know, bigger than you. And I think there's an awful lot about love.

Denise is implying that motherhood provides a special kind of love that is denied to the childless woman Questions that are left unanswered here might be whether Denise feels those who choose not to have children do not have the

capacity for such love or are not willing to make sacrifices to engage in such a life-long commitment.

Beth, on the other hand has her own understanding of the ability to form adult sexual relationships when she makes a generalised statement:

> And I can think of women that I have worked with who say they would have like to have had children but actually didn't and so for those women their reasons for not having them em... were caught up in phantasies of what constitutes a relationship, what constitutes an appropriate way of bringing up a child, and so on.

Here Beth is referring again to the unconscious significance that each individual holds with regards to children, relationships and family life. As mentioned in previous sections Beth's Lacanian view is that people might choose to have children because of different kinds of phantasies. From her perspective either choice is part of the human condition which is concerned with covering up a fundamental 'lack'.

In contrast to the extracts presented above Angela highlights that VC can be seen as a sign of maturity. However she highlights this in the context of those patients who come to realise that they would not be good mothers because of their own 'abysmal childhoods' (see 5.5.2). She is referring to the NHS borderline patients of her supervisee

> Yes it was really an unselfish choice often they were surrounded by women who were delivering babies like there was no tomorrow and feeling that that was the high point of their life. But the way in which those babies children were then looked after sometimes left a lot to be desired. So for a woman to say, no I won't do that that showed I thought a great, great maturity.

In this extract Angela honours those in the unit who chose not to be mothers as generous and mature. This accolade can be read in two ways. On the one hand, Angela suggests that motherhood is not always a sign of psychological maturity, and that some mothers are demonstrating great irresponsibility when 'they are having babes as if there is no tomorrow'. On the other hand, it looks like Angela is reflecting a powerful cultural discourse about an underclass who have large families and are supported by the state. The inextricable link between motherhood and femininity is true only for those who are deemed fit enough to mother. However this raises important ethical questions about who would be responsible for making such a decision?

5.2.4 Subordinate theme four - Mental Health problems render some individuals unfit to parent

In this section sometimes the participants understood the patients mental health problems arose as a result of their difficult childhoods. However having this separate subordinate theme adds further information to how the participants understood and conceptualised the VC choice.

All four participants mention that some of their patients are too mentally unstable to have a child. For instance, Beth stresses that some individuals might be in danger of having post-natal depression or a psychotic breakdown after childbirth. She thinks that it would be a healthier choice for them to remain childfree.

> For some people it is clearly traumatic. I think, it depends on the psychic structure and… em ... [ ]Because it's clear that there are people who are psychotic, for example, who have children, and they don't necessarily have a psychotic breakdown because they have a child. So you can't say: 'Right, all psychotic can't have children', it's

> not that; or, if they do have psychotic breakdowns, it's not that either.

This quote has elliptical sentences ('what…', 'where…') as well as examples of repetition ('psychic structure', 'psychotic'). This could show that Beth is struggling to understand why having a child does not have a negative effect on some mentally ill people, while other seemingly healthy individuals develop mental health issues under the weight of parental problems. It should be noted that Beth does not generalise but states that psychological resilience depends on the psychic structure of each individual, and that it can change over time:

> And so secondly, there are neurotic people who get deeply depressed after they have a child so it has to depend on what that partic...and then there are people who have depression after a child, one child but not other children, yah. So these things are very subtle really, and I think it's always a question of trying to discover what that particular child and that... to answer your question, occupies, at the unconscious level, for the parents at the time, or for the mother or the father or whoever it

Beth's Lacanian theory is more inclusive as she discusses a wide range of individuals: men and women, those with mental health issues and those without. Beth is arguing that each individual has the potential for a breakdown regardless of whether one chooses to become a parent. This stems from our past – as we unconsciously grapple with our childhood experiences and try to fulfil our parents' expectations. There is a fundamental gap between our parents' perception of us and our own self-perception. Beth frequently refers to this gap that appears between our conscious and unconscious which plays out in the way individuals attempt to meet their parent's desire but also find a place for themselves in the world. In another statement Beth adds:

> Of course, it could be a healthy. I think, for some women it would definitely be a healthy choice (for some women not to have a child). There are men who knew they didn't want to have children under any circumstances, and perhaps rightly so. People get ill as a result of having child.

Here Beth states that remaining childfree could be a healthy choice for a man and a woman. However there is the risk that if one choses to have a child it could trigger an unconscious conflict, thus inducing a breakdown. Whereas Beth also implies that for some individuals it is better for them not to have a child but she does not indicate how these individuals might be identified. Beth's narrative might have arisen from a mixture of the prevalent cultural discourse, her own personal history and the differences between her Lacanian and Kleinian training.

At the beginning of her interview Denise refers to patient T who has a diagnosed mental illness

> One woman who I saw for 6 years who was in her late 50s, but who was chronically bi-polar, had a history of mental health issues, emm … and it was quite obvious that she wouldn't have been able to cope with having children. I mean, she couldn't cope with having any kind of relationship really, but I do remember her often referring to the fact that she was on her own, and she didn't have a family….

Denise twice uses the phrase 'couldn't cope' to highlight her view of this patient as being incapable of any kind of relationship – including the parent-child connection. She makes links between the patient's mental health disorder, her loneliness and her lack of family. In the extract below Denise states that the patient herself realised that she would not cope psychologically with having a child:

> And there was a… there was a kind of sadness, there was a regret. I suppose that she was so on her own, but there was also, you know, a

> profound understanding that she couldn't possibly have had them. So, in a way, I didn't give her much thought.

Although Denise does not state this overtly, one can assume that in her countertransference/counter-reaction there was a shared sadness and regret about the patient's childlessness. One can imagine this to be the case because of the importance that Denise places on the pleasure and fulfilment of children in her own life. She did not state whether this patient had made a VC choice. The inference is that this patient did not decide to stay child-free herself, but the decision was forced on her because of her mental health issues. This seems to be a similar forced choice to the patients discussed in the section 5.2.1 above who feared passing on a congenital illness. It is different though from the point of view that this patient T was unable to form any deep relationships. This also links in with those patients who were considered too immature to form relationships in 5.2.3. It is interesting too that Denise uses the same phrase 'sadness' when she refers to patient U's VC decision mentioned in 5.2.2.

Denise's patient T's story links in with Angela's comments about the borderline patients A in the NHS clinic. These women are described by Angela as 'missing something'. She goes on to state that:

> You know they have problems, and they also have problems with having or not having children, but they also have plenty of problems. The ones in the hospital unit, my god they were up to here with problems.

In this extract, Angela uses the word 'problem' four times to emphasise her view of these women as deeply troubled. She does add, though, that they have problems regardless of whether they actually have children. Angela states that

some women are so emotionally damaged that neither motherhood nor childlessness could create stability in their lives. This is similar to the description made by Beth:

> It's maybe a crisis not having a child, but it's a crisis having a child, at best it's a good crisis, and people work their way through it …emm…and at worst they have post-natal depression.

Beth here is implying that having a child can be a crisis for most people, as it is for some people not having a child. In the extract above Beth highlights how motherhood can precipitate depression.

Cathy gives an interesting account of patient O who was training to be a counsellor. She thinks the patient is too psychologically unwell to be a mother:

> And she had children, and I was absolutely appalled when she talked about her children – it seemed like a miracle that they survived this childhood at all. And yet she was so ill herself, she really was so ill and it would be acted out with the children to an incredible extent. Highly competitive without any insight into what it is like to be a child, or how they felt, their wishes. Lacking any kind of understanding or maternal insight. It was dreadful.

Cathy's use of powerful adjectives and adverbs in this description and both her personal and professional opinions are visible in her use of language. Here she is discussing a mother who she feels was not fit to be a mother because of her own psychological problems. This is another example of how the discussion about VC becomes conflated with arguments regarding fitness to parent, as well as illustrating the link made with motherhood and femininity. Cathy also goes on to express her shock that this woman was training to be a counsellor:

> She was training herself to be a counsellor, I don't know how she got on the training quite frankly.

All of the participants it Imply it is better for some people not to have children – both for the sake of their own mental health and that of a potential child. Psychoanalytic work can help patients come to terms with their problems but it does not appear that all participants believed that it could prepare patients for parenthood if there were severe mental, psychological and developmental damage present.

5.3 Discussion

5.3.1 The terrible dilemma of having a genital illness

The first subordinate theme relating to VC resulting as a fear of passing on a genetic illness was a surprising finding of this research. Except for the work by Thomas (1997) on disability and motherhood the literature search did not uncover any discussion about this topic. In my initial definition of what I considered to be a VC decision (see chapter one) I had not considered this aspect of a choice – one could question whether this is in fact a VC choice but one forced on the individual by unfortunate circumstances. Angela and Cathy raised important questions about the role of the psychoanalytic practitioner when faced with these ethical dilemmas presented by patients. Angela and Cathy both discussed their countertransference/counter-reactions (see chapter six, section 6.2.3 for a further discussion on this issue). Both participants acknowledged the very difficult process that their patients faced with regards to making a decision about whether to have a child.

The literature below raises some of the dilemmas highlighted in the findings but it is the sociological perspective that highlights the ethical dilemmas discussed by Angela and Cathy with regards to those who have a genetic condition. The

discussion in this section also focuses on the dilemmas faced by clinicians working in this field and also engages with the debate about who is fit to parent alongside the right to parent. There was a gap in the knowledge in terms of psychoanalytic writing on the dilemmas facing those with a genetic disorder.

Psychoanalytic writers have touched on this fear of passing on a genetic illness but have glossed over the agonising nature of such decision-making as outlined above by Angela and Cathy. Jennifer Stuart in her paper 'Procreation, Creative Work and Motherhood' discussed a patient who was a very successful writer whose decision not to have a child was in small part related to a half sibling who had been institutionalised because of a genetic condition (Stuart, 2011). Benedek and Vaughn (1982) discuss how some VC individuals might have arrived at their decision because of having to care for siblings with a genetic condition. For these individuals the motherhood mystique had been challenged at an early age. None of my participants referred to a VC choice being made because of caring for a sibling with a genetic illness.

There have been IPA papers written by papers written by psychologists psychotherapists and geneticists that focus on the fear of passing on a genetic illness and the dilemmas involved in whether or not to be tested (Chapman, 2002; Kay and Kingston, 2002). Chapman (2002), a psychologist, highlights how her participants have mixed views about screening as it brings up the ethical dilemmas about what life is worth living. Some of their participants perceived their own quality of life as good but they were aware of the social discourse of eugenics used to eliminate disability. Chapman (2002) speculated whether some of these individuals had internalised the cultural stigma associated with disability.

(See 2.6.5 for a further discussion of stigma). However some of the participants stressed that everyone has a right to choose to have more information about the risk of having a child with a genetic condition. This is similar to Carmichael and Whittakers (2007) findings that show VC women have internalised societies stigma mentioned in 4.4.2. Geneticists Kay and Kingston (2002) focus on the guilt and sense of responsibility that their participants felt with regards to having a child with an inherited genetic condition. In both of these research papers the authors discuss how some chose to have children while others chose to be sterilised. Although Angela and Cathy portrayed the sense of responsibility their patients with a genetic illness felt with regard to making a decision about whether or not to become a parent, they did not refer to the cultural discourse or stigma associated with making an affirmative choice to have a child, if one has a genetic illness

Sociological literature adds further insight into the ethical and personal dilemmas described by Angela and Cathy. In her paper, 'The Baby and the Bath Water', Carol Thomas (1997) discussed the disabilism that exists in society rather than focusing on the disability experienced by the women. Disabilism includes the social barriers faced by people with impairments such as the stereotyping and prejudice that is present with regards to undesirable physical, sensory or mentally related difference or abnormality in western culture. According to Thomas, disability is a form of social exclusion and not a product of impairment per se (1997). Thomas carried out qualitative research with women who had a variety of disabilities or who were carriers of genetic conditions as she was

interested in exploring their experiences of making the choice about whether or not to become a parent.

Her results highlighted how many of her participants had a different attitude to risk than that of the professionals involved in their care. Many of these women had lived with risk all their lives so although the decision making process around whether or not to have a child was 'murderously difficult' (Thomas, 1997;362). This portrayal of difficult decision making has the same flavour as that described by Angela 'I wouldn't want to be in her shoes' and Cathy's 'the most terrible predicament that I can imagine'. Angela and Cathy made these comments in relation to their patients who had to make similar decisions with regards to whether or not to have a child. Some of the participants in Thomas' research discussed how they chose to be sterilised after having a child. The women's accounts reflect the considerable emotional work involved in personal encounters with the risk discourse: worry, anxiety, guilt, lost hopes, and unfulfilled dreams. Some of the participants in Thomas' study feared not being 'good enough mothers' and that their children might be taken away from them. Thomas found that family members were seen as more of a threat than professionals. The participants in my research did not report that their patients had these concerns. As part of her research Campion (2005, location 3174), a sociologist, spoke to many hundreds of parents with physical disabilities and a prevalent theme was that their pregnancies and parenting was more likely to be supervised by a professional than parents who were able-bodied. Those with physical disability were also more likely to be offered abortions and sterilisations

than those without disabilities. It is also more likely that women with a disability will be offered sterilisation than a disabled male.

Thomas (1997) highlights that the risk discourse is not a neutral one as some of the questions that are raised are based on judgements relating to social assumptions about the quality of life and intrinsic value of children and adults with impairments. More importantly there is a social discourse around 'what lives are worth living'. The participants in Thomas' study expressed the views that they were fighting for the 'right to be mothers' and she highlights that socially defined obligations of motherhood hit those with impairments particularly hard (1997:636). Angela and Cathy both implicitly referred to the risk element in their in the decisions their patients had to make.

In a moving article about working with disabled and abused patients, the psychoanalyst Valerie Sinason (2008) observes that her disabled and abused patients no matter what their cognitive ability, know the meaning of menstruation, pregnancy, abortion and sterilisation. She strongly objects to the numerous discussions on public media about aborting foetus' that may have some defect when there are thousands of individuals living with disabilities. Sinason (2008) considers these messages to be a psychic minefield for those with a disability. These comments by Sinason highlight how individuals are affected by the cultural discourse around who is fit to parent, and the right to parent.

Another perspective on this debate was the BBC Radio four programme called 'Rosemary's Baby' broadcast as part of the series 'Inside the Ethics Committee' (2013). Rosemary was diagnosed with Ehlers-Danlos Syndrome in her twenties. Despite being in a lot of pain Rosemary always pursued her love of sport, driving herself to ever-harder challenges like competitive swimming. However through the years her condition worsened and now at the age of 36 she is a full time wheelchair user and her breathing is impaired. She receives her nutrition via a tube fed directly into her bloodstream and she empties her bowels into a bag. Now that she is in a relationship she wants to start a family and a range of professionals came together in the programme to discuss her case. The welfare of the child features prominently in the discussions as well as the possible risks for mother and baby. Rosemary was able to counter any of the arguments put to her about the risks by arguing that she could put measures in place to cope:

> If I had a child affected by my condition and then maybe worse affected I would be heartbroken. But equally if I chose not to have a child as a result was I saying that I wouldn't have wanted to have been born? And I definitely don't regret being born and I think that I have a good quality of life and I didn't think it was an unfair risk on the child.

One of the individuals on the ethics panel for this programme was Franklyn who is herself suffering from the same condition as Rosemary. She made an interesting comment that disabled people understand risk in a very different way from people who are not disabled and particularly from clinicians. Like Thomas (1997) Franklyn states that risk is part of a disabled person's everyday life and so they learn to accept that and deal with it. She states:

> I think that the risk is particularly interesting because Rosemary and other disabled people understand risk in a very different way from people who aren't disabled and particularly from clinicians because we live with that risk as part of our everyday life, so we learn to accept that and deal with it.

Franklyn argues that it is the most natural feeling in the world for Rosemary to desire a baby of her own. Referring to the social discourse about quality of life, Franklyn comments that disabled people have a different view from those who are not disabled.

The dilemmas highlighted in the above debate present a different perspective than those offered by the participants in this particular research. Although Angela and Cathy described the dilemmas faced by their patients with regards to whether or not to become a parent, they did not address disabilism in society. This raises an important point about how much psychoanalysis and psychotherapists need to or should be involved with challenging inequalities and prejudices in society. As mentioned before many psychoanalytic practitioners may not consider this their role.

Returning to the programme, two of the experts in the field of ethics and reproductive medicine discussed the dilemma about when a desire for a child is judged as a natural instinct as opposed to a pathological drive. They both encourage Rosemary to unpack this desire in her genetic counselling sessions. One of the experts described how she has refused to take patients on again if they chose to have an abortion after a previous IVF treatment. In her book 'A Woman's Unconscious Use of Her Body', the psychoanalyst Dinores Pines

describes patients who frequently become pregnant only to immediately abort the child (1993:98).

In her paper ‘Are we disabling our clients?’ Michelle Taylor (2014) a counsellor, draws attention to how counsellors need to be more aware of how their attitudes and behaviours create barriers for clients with disabilities. Although she is not referring to working with the issue of ‘to be or not to be a parent’, she echoes Thomas’ (1997) view that it is important not to make assumptions about the experiences of those with disabilities.

Psychologists Smith, Michie, Stephenson, and Quarrell, (2002) discussed how there were contrasting views with regards the purpose of genetic counselling. On the one hand it was seen as providing information for clients whereas the more traditional view was that clients need to use the sessions to explore the complex decision making process and the feelings provoked by facing such dilemmas. Their research with participants was concerned with trying to ascertain what they found useful in their experience of genetic counselling. Their interviews with 12 couples highlighted how they all valued the information giving aspect of the counselling sessions. Concluding, Smith et al (2002) state that it would be advantageous for genetic counsellors to be more eclectic in their approach so that they could combine information alongside more traditional counselling that allows space for individual differences to be addressed. Angela discussed a patient whose presenting problem was concerned with her diagnosis of a fatal illness (see 5.2.2). Angela and Cathy did not suggest they were providing genetic counselling but these problems were presenting for analysis or arising in the course of treatment.

5.3.2 Implications for practice

There are important implications for clinical practice raised by the findings and discussion regarding the ethical and personal dilemmas that patients might face about whether or not to have a child for fear of passing on a genetic condition.. There is a need for further research and contributions from psychoanalytical practitioners regarding best practice for working with patients who either present with these dilemmas or for whom they arise during the course of the analytic treatment. The sociological literature highlighted disabilism that exists in society whilst the work by psychologists and psychotherapists highlighted the guilt and shame felt by many of their participants who were in similar predicaments to Angela and Cathy's patients. Their research also stressed how their participants were aware of the eugenics language in society regarding eliminating disability and what lives are worth living and Sinason (1998) commented on how this is very distressing for those with a disability. Andrew Samuels (2001) has discussed at length how politics and the social inevitably enter the consulting room and numerous writers (Dreher and Sandler, 1995; Ruderman, (2005) have argued that psychoanalysts will also be influenced by these forces as they too are part of society.

It would seem important that these ethical debates are explicitly addressed in psychoanalytic/psychotherapy training. With the advancement in medical procedures more individuals/couples will be facing these dilemmas and these issues will arise in consulting rooms. This will assist psychoanalytic practitioners to be open to exploring the subjective meaning for the patient as well as the often implicit messages in society about 'what lives are worth living'. If the practitioner can be more consciously aware of disablism, stigma and how patients might

have internalised these messages this could possibly assist the patient to also challenge the messages internally as well as externally. Of course it is possible that many trainings already address these issues.

It also raises the question about how much psychoanalytic practitioners should be challenging these messages both in the consulting room and being involved in social action. One of the aims of this thesis has been to encourage the cross fertilisation of ideas such as those proposed by the Association for Psychosocial Studies that seeks to challenge the rigid boundaries that often exist between different disciplines and in this case psychoanalysis and sociologists who have often viewed each other with suspicion. The clinical implications in terms of the aims of psychoanalytic work and how that applies to the particular ethical dilemmas discussed in this section will be discussed further in Chapter six.

5.3.3 VC and IVC is a result of having difficult childhood experiences.

Discussion

My participants discussed a number of factors that occur in childhood that could affect an individual's choice to be a parent. They focused primarily on their female patients. Some of my participants referred to the difficult relationships that their childless patients had with their mothers during their childhood. As mentioned in Chapter two Kaltrieder and Margolis' (1977) study of 33 VC women concluded that a woman may unconsciously choose to be childless or infertile because of the influence of the mother. Pines (1993) observed that many of her infertile female patients had conflicted relationships with their mothers and that unconsciously they did not believe that their mothers had given them permission to bear their own child. This often lead to difficulties in women separating from

their mothers but Chodorow (1998) states that a woman will always have difficulty in separating from her mother as the mother has a greater identification with the female baby than with the male one.

In her paper 'Women's Experiential Journey towards Voluntary Childlessness', Rachel Shaw (2011), a psychologist, carried out interviews with VC women. One of her participants wished to avoid repeating the bad mothering she herself had received whilst another had a mother with a mental illness and thus had to mother her own mother. Shaw (2011) speculates whether unconsciously her participant did not want to repeat the cycle. This was echoed by Rosen (2002) a psychoanalyst, who focuses on a patient who was infertile as she had 'left it too late' because unconsciously she feared she could not mother or love a child. Her own mother was psychotic, and her father was bipolar. Rosen (2002) refers to another patient who believed that her sterility was caused by her negative feelings about her own mother. Even though this woman discovered that this was not the cause of her sterility, she could not free herself of this phantasy. Two of Angela's patients also allowed her the opportunity to note the apparent psychogenic link between emotions and fertility.

Stuart (2011), a psychoanalyst, describes another influence of the mother in discussing a patient whose mother was a high-powered career woman and was very ambivalent about motherhood. The patient was VC as she did not want to replicate this kind of mothering. This patient too had a fear of passing on a family congenital illness and was advised by her father not to have children.

The participants in my study frequently referred to how patients might consciously attribute their VC choice or ambivalence to not being able to find the right partner or wanting to focus on their careers, unconsciously however, the participants believed they eschewed motherhood. Cathy and Angela spoke about the fear that some patients had of having a biological child of their own and a view that is supported by Morris (1997). She refers to women in their thirties who have an emergent awareness of difficulties that have not been resolved with their mothers and this often manifests in fears of being destroyed by a foetus, as it can be perceived as a foreign body that will result in death. Often these patients may also suffer from anorexia or amenorrhea and may want to get pregnant to save a marriage. An observation made by Mori (2012) is that sometimes, infertile women feel less distressed when a pregnancy does not arise as they are saved from harm. Fornari (1981), as cited in Mori (2012 p.175), refers to 'genetic anxieties' that are often transmitted over several generations. This group of infertile women may prefer to adopt a child as this provides more certainty for them. Angela and Cathy refer to patients who are happy to adopt or have surrogate children as an alternative to having children of their own. Chodorow (2003) and Almond (2010) also discuss patients who fear giving birth to monster children as a result of their difficult relationships with their mothers. In 5.5.2 Cathy referred to the VC choice of one of her patients because of the unconscious fear of giving birth to a dead baby.

From a sociological perspective, Veveer's (1980) study of VC shows how some women did choose VC because of what she calls the 'little mother syndrome'. Beth and Angela referred to patients who had spent much of their childhoods taking care of their mothers. As to be expected Veveer's research was much

more focused on the external factors such as pronatalism, cultural discourse, inequalities and prejudices existing within society, including within psychoanalysis.

Three of my participants referred to the relationship that their childless patients had with their fathers. Men are influenced too by our gender-biased society, and fathers, like mothers, are affected by the social, biological and psychological pressure to reproduce. It can be seen that the influence of the father on VC women is very significant. Williams (1986), a psychoanalyst, argues how it is important for a girl to experience her father as nourishing in order to feel creative, while others (Kaltreider and Margolis, 1977; 1980; Ireland, 1993) described how some of the women in their studies identified with their fathers' professional aspirations. Their early identification was one of being achievers rather than 'little mothers'. Kaltrieder and Margolis who were psychoanalysts inferred that these women had not resolved the female Oedipus complex, (see 2.2.2) whilst Ireland, who is also a psychoanalyst took the view that identifying with the father's aspirations was a positive one for the women involved. Sociologist Veveers (1980) supported Ireland's view.

Angela, Cathy and Denise all referred to the effect of the parental couple's relationship on the VC choice, which was highlighted in my literature review. Williams (1986), states: "the triadic configuration is pivotal then for the girls developing object relations and wish to have a baby" (1986:189). Williams states that Klein along with other psychoanalysts ignores the father's attitude towards women. The man's relationship with his daughter will be affected by sexism and racism in society as "fathers like mothers, are agents of social as well as

biological and psychological reproduction" (Williams, 1986:190). Williams supports a biopsychosocial approach to an understanding of VC. Almond (2010) describes a patient who identified with her father and who turned to him for support and approval because of her mother's youth and immaturity. She did not want to be a man but neither did she want to be a mother as this did not figure positively in her conscious and unconscious world. This sounds similar to Cathy's patients who had insecure gender identities.

Both Cathy and Denise took the view that some of their patients were childless because they themselves were not the child the parent wanted. This left them with a confused sense of their own sexual identity. My literature review did not highlight this aspect of my findings so this offers a new perspective on how psychoanalysts understand the VC choice. However, psychoanalyst Alizade (2006) discusses a patient whose father wanted her aborted. She was afraid of having children nor did she want to have abortions like her mother. The patient felt that her experiences in childhood had not equipped her emotionally to care for a child. The patient eventually had tubal ligation, and Alizade interpreted this as an "another expression of a deep rooted desire for life" (2006 p.57). The womb had now become a safe place and Alizade argues that "non maternal desire is usually both a protective defence and the expression of positive development of a psychic stream" (2006 p.55).

5.3.4 Implications for Practice

As can be seen from the above discussion the participants in my study would on the whole agree with the psychoanalytic literature in terms of childlessness being as a result of difficult experiences and relationships with primary figures during

their formative years. It is not always clear which theoretical model these writers adhere to but one can glean from the kind of language that they use whether they focus on phantasies such as proposed by Klein (1957) or object relations such as those stated in Chodorow's (1978) theories. Angela and Beth refer to classic Freudian theory and Beth frequently refers to Lacanian theory. In their review of psychoanalysis Westen, Gabbard and Ortigo (1998) acknowledged that although contemporary psychodynamic theories are far from monolithic they have the five core postulates. Our adult personality is formed by our childhood experiences and mental representations of self and other play a major role in our personality and can explain a person's behaviour in interpersonal and social settings. A healthy personality development reflects a move from a socially dependent state to a mature autonomous one.

My participants, as mentioned in Chapter one, section 1.1 and Chapter three, section 3.8.4, consist of a combination of psychoanalysts, psychoanalytic psychodynamic practitioners and a Lacanian analyst. In their discussion of VC and childless patients all of the participants considered one or more of Westen's, Gabbard and Ortigo's (1998) core postulates. Except for Beth, the participants made little explicit reference to theory but their focus was very much on the intra-psychic world of their patients. Again, all the participants, stressed how maternal desire and fertility was affected by these early life experiences and this was reflected in the literature. The participants agreed with the literature that stated that these early experiences could lead some women to dreading giving birth to their own biological child fearing that the potential child might be damaged in some way. Both the literature and my participants conflated IVC and VC in their

discussion of childlessness, which is similar to a claim made by sociologist Sandelowski (1990) in Chapter two (2.7.1). One of Veveer's (1980) sociological findings was what she called 'the little mother syndrome' which my participants described too. However she focused on the other aspects of such as stigma and pronatalism none of which my participants focused on but was referred to in chapter two, 2.6.2 and 2.6.5.

All of the above examples bring into question the aims of psychoanalysis and how much it can overcome the problems associated with difficult childhoods. Dreher and Sandler's (1995) overview of psychoanalysis has outlined different theoretical perspectives about how psychoanalysts not only respond to their patients' difficult childhood experiences but the degree to which these childhood deficits could be corrected. For example Sandler and Drehers (1995) discuss Freud's (1895) early ambitions of healing patients by correcting the pathology that led to their symptoms. Freud admitted this process could never be complete and stated "much will be gained if we succeed in transforming your hysterical misery into common unhappiness" (1895 p.305). However, proponents of Kohut's (1971) self psychology would argue that the deficit caused by inadequate parenting can be overcome through the empathic bond with the analyst whereby the analyst can internalise the non-traumatic frustration of the patient. Kernberg (1984) would argue that coming to terms with the deficits in our past requires the ability to mourn and to recognise that they may never be able to be fully overcome. Sandler and Dreher (1995) argue that the main aim of analytic work is no longer about bringing to the surface repressed childhood memories but more helping to create an intra-psychic change in the patient so they are better able to

resolve their conflicts. In 1950 Edith Buxbaum drew attention to the limitations of working with some neurotic cases and differentiated between a therapeutically satisfactory and an analytically satisfactory termination of analysis. She argued that for many neurotic patients, analysis was interminable. Eissler (1953) argued that the aims and techniques of analysis depended on the patients presenting problems, their personality, the patient's life circumstances as well as the psychoanalyst's personality.

Some of my participants implied that the level of psychological harm caused to their patients in childhood was so severe that psychoanalysis was insufficiently corrective for them to provide adequate parenting. Angela stated overtly that it was through the course of analysis that the patients themselves came to this realisation. However Cathy stated on two occasions that if her patients had remained in analysis for 10 years then perhaps the treatment might be sufficiently reparative to prepare them for parenthood. The participants did not overtly state what their aim was with these patients and as it was not part of the research question this was not pursued. Although in principle three of the participants agreed that the VC choice could be 'healthy' for some women, Angela stated that these people would not present for analysis. I would not agree with Angela on this point as the literature and my participants' accounts show that the VC choice can be complex. Also an individual may be happily childless but have another presenting problem that they want to work through in analysis. This research has a small sample of psychoanalytic practitioners so it is not possible to generalise across the profession about whether or not a VC choice by a woman would be viewed as a pathological one or accepted as a valid choice

for women in twenty first century Britain. One could imagine that this would be the same for someone who presented as choosing a single or celibate life too because of the emphasis in psychoanalysis and psychotherapy on intimacy and relationships as a sign of a psychologically healthy person (see Ruti and Cocking (2015) 5.3.3). Further research could be carried out into how VC women experienced psychoanalysis and whether or not they felt conscious or unconscious pressure to become a mother.

Interestingly, Fraley (2002) a psychologist, has argued that our ways of relating to others or attachment styles may stem from childhood experiences with parents, but these can be overridden or moderated by positive interpersonal experiences in adulthood. According to Bowlby (1969/1982) human beings are born with an innate psychobiological system, i.e. the attachment behavioural system that motivates them to seek proximity to significant others in times of distress. No-one of any age is completely free of reliance on actual others and that the attachment system remains active over the entire life span. Indeed longitudinal studies have shown only a moderate level of stability in attachment orientations from infancy to adolescence while indicating that life events e.g. parental death can substantially alter a person's working models (Fraley, 2002). Various studies (Simpson, Rholes, Cambell and Wilson, 2002; Davilla and Cobb, 2004) have shown that transition to parenthood brought about changes in attachment orientations, which was influenced by the level of pre-natal support given by their partner. The work of Mitchell (1988) and Aron (2002) has moved away from drive theory to an emphasis on mental representations of self and others and the importance of close relationships with others, all of which have

residues from our past. Developments in neuroscience have provided more information about how these implicit mental processes work (Solms and Turnbull, 2002). There is now a greater emphasis on intersubjective perspectives that consider social experiences rather than more narrowly defined Kleinian (1957) world of phantasies. These developments help to narrow the distances between psychoanalysis and mainstream personality and social psychology (Shaver and Mikulincer 2005). If research in the fields of personality and social psychology adopted a strategy of remaining open to psychodynamic insights, and psychoanalysis embraced contemporary social psychology methods this could provide an integrative theory that would allow for depth psychology to be combined with the knowledge from social psychologists (Shaver and Mukulcincer, 2005). Adhering to theories that are rooted in the past and that do not take account of social changes and new advances in science might be doing a disservice to many VC women who would greatly benefit from psychoanalysis but who could be doubly wounded if the pronatalist pressure existed in the consulting room as well as out in the world.

5.3.5 Some individuals are too psychologically immature to become parents

Some of the psychoanalytic literature in Chapter two (Erikson, 1956): and Kaltrieder and Margolis, 1977) alluded to the idea that some individuals were too immature or were generally not fit to be parents. However what was surprising in some of participants' narratives was how strongly this was emphasised. Cathy and Denise referred to patients who were childless because they were not able to form relationships. This was understood as a sign of immaturity as a result of developmental damage relating to childhood experiences. Erikson's (1956)

theory of psycho-social development includes eight stages that individuals need to progress through from birth to death. The sixth stage involves the need to form intimate relationships and failure to achieve this leads to isolation and loneliness. It is the seventh stage of generativity that he argues is important for adult development, which at its heart is the establishing and guiding of the next generation and where the desire for a child emerges. Erikson does state, however, that for some individuals this generativity might be achieved through creative activity that can be passed on to younger people. Generativity is closely linked to the eighth stage and our sense of mortality and whether one can face death with acceptance or with regret and despair. Christie and Morgan (1993) interpret this as meaning that the individual is mature enough to take responsibility for their lives through separating from parents and individuating. There comes with this, a capacity for deep intimacy with another. Without referring directly to generativity, Cathy and Denise both referred to patients who were unable to form intimate relationships but they implied that analysis might help them to move in this direction, thus preparing them for parenthood.

Social Psychologist Welds (1976) carried out research with 590 professional women between the ages of 30 and 40 and she concluded that generativity can be achieved by those who are not biologically generative or procreative. She found no significant difference between those who were parents or non-parents in terms of the development of their ego. Those who were anxious and undecided about their family size were more likely to have an interrupted ego development. Interestingly she argued that psychologically androgynous individuals do better with regards to ego development than those who identified strongly with being male or female. Her findings would support psychoanalyst

Joan Raphael-Leff's (1997), concept of generative identity that was referred to in the literature review in chapter two, 2.2.4. However, social psychologists McAdam and De St Aubin carried out an empirical study into generativity in 1992, and their findings show that generativity was positively correlated with those individuals who had children. The difference was greater between male parents and non-parents as men who were not fathers had low generativity scores.

Michael Pawson (2003), a psychoanalyst argues that failure to achieve generativity might provide a psychogenic explanation of why some women fail to conceive. Angela also put forth this link when she discussed two of her patients. Leon (2010), a psychoanalyst, describes how some of his patients struggling with infertility describe feelings of getting nowhere. According to psychoanalyst Leon this 'deprivation of generativity' (2010:57) leaves individuals feeling as if their future is taken away from them. Leon suggests that this sense of loss can be alleviated by adopting or nurturing through work. Cathy described this as the case for one of her patients in 5.3.5. Leon (2010) argues too that parenthood provides an opportunity for vicarious healing from earlier childhood conflicts to take place as the adult helps their own children through developmental challenges. Infertility can prevent such a repair. Stuart (2012) also supports this re-working concept, arguing that many women have children as a way of providing a second chance for themselves as they provide good care for their own children. The reparative aspect of parenthood supports Leon's (2010) view above, but Benedek (1959) also supports the view of three of my participants who stated that parenthood could cause pathological regression as described in

chapter two, 2.2.3. Angela too indicated that a positive maternal function needed to be internalised in order to provide 'good enough parenting'.

Regarding VC specifically, Almond (2010:84) referred to a patient who was fearful of intimacy and dependency as this might lead to her annihilating those close to her, so she chose not have children, The patient avoided dependency in the analytic relationship too, and she strove to be in control and autonomous. She perceived her potentially female reproductive body as one to be ashamed of, and neither did she trust a woman's mind. Almond (2010:84) describes how this patient eventually did get in touch with her wish for a child but by then she had 'left it too late'. This patient was similar to Cathy's patient (R) mentioned in in 5.2.3 who feared physical and psychological penetration, the fear of the latter manifesting strongly in the analytic relationship.

Although none of my participants explicitly stated that they saw parenthood as a developmental stage, Cathy did frequently refer to patient's not being ready to parent, which could imply that a mature individual would naturally want a child. Denise too referred to a patient (S) who 'had developmental chunks missing'. As referred to in Chapter two, Benedek (1959) espouses the theory of parenthood as a developmental stage, one that applies to both men and women. Others (Kestenberg, 1956; Bibring et al, 1961) have also described how the developmental stages of life are linked to reproduction. Tyson and Tyson's (1990) overview of developmental models would suggest that most of the different psychoanalytic theoretical schools have normative views of development and they suggest an integrative mode. The relational schools of

psychoanalysis and the more recent neuroscientific approaches are aiming to combine these findings with psychoanalysis and attachment theory have provided a different understanding of development (Renn, (2012). The brain is now seen as highly plastic as it is an open learning system and avoids a reductionist view of the person (Damasio (1999). See Stern (1985), Schore (2011) and Renn (2012) for a further discussion of an integration of these theories.

However there is also opposition to the proposal that these different approaches can be integrated as they fundamentally different views of the person. Psychotherapists Wylie and Turner, (2011 p 2) referred to a clash between Jerome Kagan, a renowned developmental psychologist and attachment theory proponent Dan Siegal. Wylie and Turner state that their clash brought to the surface questions about attachment theories emphasis on the importance of the mother child bond. They propose that attachment theory ignores other important influences on a person's development such as inborn temperament, individuation needs, family dynamics, even class and culture—which all lie outside the mother–child dyad. They refer to family therapy pioneer Salvador Minuchin who suggests that in focusing so intensely on the early mother-child bond, attachment-based therapy neglects other important relationships such as fathers, siblings grandparents and extended family who are also important in the experiences of a child. He argues that by focusing so much on attachment issues that important social and racial issues can disappear. It is important to acknowledge the social and economic realities in which the child grows up. My participants did not refer to attachment theory and although Angela and Denise referred to the importance of the mother/female child bond, all the participants

mentioned the influences of other immediate family members to the growing child. However they did not explicitly refer to those who might be disadvantaged by social, economic and racial issues in society.

Humanistic and organismic theorists have long suggested that increasing self-ownership of one's behaviour is a lifelong developmental task (Rogers 1961 and Ryan 1995) and their research indicated that older people may have accomplished this better. They were more linked to intrinsic values such as self-acceptance, emotional intimacy and community contribution. Their research considered the organismic meta-theory that suggests that growth is built into all living beings (Decci and Ryan 1991, as cited in Sheldon and Kasser, 2001, p 492). My participants did not refer explicitly to the principle of life long growth but focused on the effects of childhood experiences which is not surprising as they were psychoanalytic practitioners.

Although my participants did not refer directly to pregnancy as a developmental stage, Angela, Beth, and Cathy all referred to the fact that many individuals in society were very irresponsible in choosing to become parents because of their immaturity. Cathy referred to a patient who was pregnant and stated that she was very worried on her behalf. The literature below discusses the views of psychoanalysts with regards to the role of pregnancy in relation to psychological development.

Pregnancy is considered by Domash, psychoanalyst, (1998), as cited in Damant (2003 p.82) as a psychophysiological rite of passage, which is considered a crucial stage and symbolises a girls' entry into womanhood. Pregnancy and birth

are considered to be transitional stages just like puberty, menopause, old age and dying. These transitions can cause crises but also build new concepts of oneself and different roles in society. Becoming pregnant and attaining motherhood is seen as an important part of the separation process from the mother. Pines (1993), Allison (1997) and Morris (1997) argue that if the mother/ daughter relationship was not positive enough then the daughter may find herself unable to pursue the final developmental step of becoming a mother. It is a paradoxical task for women as they not only have to identify with their mother's femaleness they must do so whilst simultaneously separating from her by assuming her own sexuality. All of the participants gave examples of women who eschewed motherhood for various reasons and if they adhered to models that saw pregnancy and motherhood as a developmental stage, one can only speculate about the conflict that would have caused them in their professional role. Waterman (2003) a psychoanalyst, states that for those who do not procreate, the path to adulthood becomes harder to define and categorise particularly if a developmental model is applied. According to these psychoanalytic theories a VC woman would find it hard to separate from their mother or may have developed a masculinity complex.

As referred to in Chapter two, Kaltrieder and Margolis' (1977:182) study of 33 VC women concluded that many had difficulties in having relationships and feared responsibility. Sevon (2005), a feminist psychologist, also found support for this view, stating that participants worried whether they were mature enough to become a mother, the suitability of their living conditions and whether or not both partners were ready for parenthood. My participants, like those in Sevon's research, noted that as the years go by a woman is obliged to face the question

about motherhood. She highlights the cultural narratives that define a very tight margin about when it is right to become a mother. Sevon (2005) argues that these prevalent cultural narratives influence a woman's thinking about whether she fits into these mandates in terms of financial security, stable relationship and emotional maturity. This links in with Denise's view about the 'propaganda' regards how much is needed to have a child (see section 4.3.1).

Most of the participants discussed the entangled relationships that their childless patients had with their parents. Cathy described how some of her patients had parents who were immature. Pines (1993) as shown above, has stated that it is important to internalise a positive mother object in order to develop what Mariotti (2012) refers to as a maternal function. Nevertheless there are many individuals who still become parents regardless and go on to provide poor parenting. Some observers for instance (Welldon 2012) have commented on the cycle of deprivation where poor parenting is passed down through the generations. Sociologists Rutter and Madge concur with the psychoanalyst Welldon that children who have abusive parents do not have insight into what is acceptable behaviour as they have not experienced it themselves as children. Almond (2010:209), a psychoanalyst, discusses how mothers who are immature, and have uncontrollable aggression towards their children display the shadow side of motherhood and she considers this to be far worse than murderous acts carried out by mothers when they are in a psychotic state. Interestingly, she argues that parents need to forgive themselves and children need to forgive their parents. She acknowledges however, that it may be an impossible task. Each mother will find a particular stage of child rearing difficult but as the woman matures and as

time passes problems of ambivalence can be alleviated (Almond, 2010).This in contrast to Leon's (2010) view that becoming a parent could be a reparative act.

Leuzinger-Bohleber (2013), a psychoanalyst, states that it is no surprise that what propelled many female patients to embark on psychoanalysis was their unconscious wish for a child. They wished to be free of the trans-generational problems that had been passed on through their family. Analysis could provide what Winnicott (1971) described as an intermediate space so the female patient could deal with their early traumas. The work in analysis would help the patient to prepare for motherhood and therefore achieve generativity. Angela referred to psychoanalysis as an opportunity for women to explore their wishes regarding motherhood.

Campion (2005, Locations 812-820) a sociologist, surveyed literature regarding 'unfit parents' and found that certain terms recur: 'emotional immaturity', 'low self-image', 'unreal expectations of children', 'social isolation' and so on. Campion stresses how abusing and neglectful parents are often depressed and having difficulty in managing their day-to-day lives. Often they have poor support networks and are isolated from their families. She cautions against linking poverty with poor mothering as she states the two to do not go hand in hand, arguing that social isolation seems to be a key factor. Interestingly Campion argues that in the reporting of these concerns with regards to 'who is fit to a parent?' there is a racist element. She says there is an implicit message that black and Asian populations both in the UK and elsewhere do not make responsible choices with regards to having children and need to be guided by Western professions. By implication these groups of people are immature and

irresponsible (Campion 2005, Locations 5610). My participants did not refer to these wider issues mentioned by Campion.

Cathy and Denise referred to how analysis can help to prepare some of their patients for parenthood. This aspect of my findings did not initially arise in the literature review. Leon (2010), a psychoanalyst, writing in the context of infertility argues that adult separation from their mother can be assisted by a therapist, a maternal figure or a partner. Cathy referred to a patient whose partner, alongside analysis, helped him to mature. In clinical case studies Leon (2010) describes infertile patients who are struggling in a search for their own parental/adult identity through separation and individuation. These couples may choose to limit the information about their fertility treatment that they give to their parents, particularly if their parents are intrusive. This action might help them to feel less like children and more like an adult.

Although Angela considered some of her supervisees' patients' choice to be VC as a sign of maturity, this was in the context of them recognising their own inability to mother and thus considered a selfless act. Both Angela and Cathy implied that was very irresponsible that some people chose to be parents when they were not ready for it or were unfit to parent. Feminist writers (Hird, 2003) criticise psychoanalysis for its phallocentric and sexist assumptions about a woman's development as well as for theories lacking empirical validity. Daniluk (1999), a psychologist, states that there is research that indicates the positive mental health of those without children. Ireland (1993), a psychoanalyst, refers to the VC woman as being transformative as she challenges the view that they have to be caretakers. She takes the view that VC women can have more

intimate relationships with others and a deeper sense of self. The VC choice enables the woman to have access to their innate creative potential with more of an ability to live in the now. She argues that this represents a little-explored path of adult identity-development. Once it was the experience of motherhood that was seen to signal the passage of girls into womanhood, today it is the decision all women must make about whether or not to mother that is seen as a significant marker of maturity (Ireland, 1993). Cathy pointed to the fact that this decision about whether to become a parent is complex for everyone. Stuart (2011), a psychoanalyst, raises the important question about how adult development occurs for women who do not have children. She takes the view that this can happen without parenthood through meaningful and creative work but she adds "that this can be informed by, but not fully explained by procreative wishes" (2011, p.419).

As mentioned in Chapter two, sociologists generally present a more positive view of VC women. Kling, Seltzer, and Ryff, (1997) have made a pertinent point that those who do not have children disappear from view as well as those who never marry and remain single. A study on housing by Rubin-Terrado (1994) showed that older childless women were more active in thinking about provisions for their old age than parents who often remained passive waiting for others to make decisions. This finding is explained by sociologist Bateson (1989) who argues that childless women are more agentic than mothers as they have to compose their lives for themselves as there is no script as there is for motherhood. This view is supported by Morell (2000) who states women without children allow for a self-determined focus on important relationships, creative work, political activism, professional development and leisure activities. Lisle (1996:230), a sociologist,

referred to an Australian study that was carried out in 1987 found that seven out of 10 mothers said child-rearing enhanced their personal growth but one in 10 called mothering regressive.

Sociological research carried out by Gillespie (2000) showed that VC women believed that others saw them as not having passed into the normal adult female role and therefore had not made a normal adult decision. They were posited as future mothers who would change their minds with the onset of maturity. Their judgments were considered flawed as they were considered not to be an adult. Other sociological researchers (1996; Black and Scull, 2005), have come to the same conclusions about how VC women perceive that others see them as immature or view themselves in this light. Sociologist Campbell (1999) found that women wanting sterilisation were refused, disbelieved and infantalised by the medical profession over their VC choice. This was recently discussed on Woman's Hour (2014) where women are still being refused sterilisation. As a VC woman, Lisle (1996) argues that women who have not had children feel younger and that their potential will be fulfilled in future. She states too that VC women experience time differently as there are not the same number of transitions as those experienced by mothers. She wonders whether this sense of timelessness for those without children makes them wonder if they are really grown-ups because they are not mothers so may identify with being the perpetual daughter (Lisle, 1996:230).

This view is similar, yet has a different flavour, to the psychoanalytic view put forward by Chodorow (2003) where she regarded women who had delayed childbearing as not being in touch with the realities of clock (biological) time.

Moulton (1979), a psychoanalyst, argues that the most central unconscious reason for wanting children is the need to prove sexual identity or sexual maturity. For Safer (1996), a psychoanalyst, childlessness suggests that she loses a basic identification with one's mother but she says many women conceal the separation they feel by becoming mothers. Safer (1996) highlights an interesting contradiction – women who are childless by choice are typically perceived as self-indulgent and immature while her research revealed that many of her participants cited their sense of responsibility as the factor that prevented them from becoming mothers. Safer (1996) describes how the choice to be childless forces one to seek meaning from within oneself therefore increasing self-reliance. This competing view highlights the complexities of the different perceptions and understanding and conceptualisation of parenthood as a developmental stage and how VC in the modern world is received.

In the context of her own involuntary childlessness Leibowitz (1996) talks about her difficulties as a psychotherapist dealing with other people's views of childless people as being selfish and having unresolved issues with their mother. When she disclosed her childlessness to an older patient, she perceived her patient saw her more as a child. She wonders what kind of therapist she would have been if she had children and whether the caretaking role of being a mother would have helped her to feel more like the elder with her patients. Leibowitz (1996) described her strong maternal feelings with patients and sometimes feeling as if she wanted to adopt some of them. She was also aware of her countertransference/counter-reaction in that she wanted to be loved and appreciated by them in return. She describes her growth as an analyst and how patients force her to grow and develop in ways that she might have done if she

were a parent. She sees the analytic process as an intensely intimate one and she thrives when her patients are willing to struggle to be intimate with her. Leibowitz (1996) regards her work as an analyst allows her to learn about herself in much the way as a mother might discover aspects of herself through her children. She considers that "the mutual dependence and intimacy lead to eventual separation and change with both parent and child, and this is mirrored in analyst and patient" (1996). Liebowitz responses in terms of phantasising about adopting her patients has a similar flavour to some of the reactions of my participants who had strong wish for their patient to have a baby. Like my participants Liebowitz did not use this her emotional responses as a reflection of her patient's unconscious. See Chapter 2, section 2.4. and chapter 6, section 6.3.5 for a further discussion on counter-transference.

5.3.6 Implications of findings

The participants do not overtly state that they consider parenthood to be a developmental stage as in the psychoanalytic literature (Erikson, 1951; Benedek, 1959) but they do consider some of their patients and some people in general to be too immature to parent. This implies a continuum of maturity that is not related to chronological age, for example Cathy's male patient was approaching 60. The new findings of this chapter include Angela's view that VC in the light of knowing that one would not be a good mother because of very difficult childhood experiences, was a sign of maturity. None of the psychoanalytic writers state this overtly but imply that both VC and IVC in their patients are a result of entangled relationships with parents, failure to separate or to not internalising a maternal function because their parents were immature themselves. This trans-generational aspect of immaturity was also stressed by Angela and Cathy. The

psychoanalyst Ireland (1993), along with sociologists Morrell (1993), Black and Scull (2005) stress that VC is a sign of maturity from the point of view of being able to resist the pronatalist messages and have the autonomy to forge a less trodden path for herself. My participants did not stress this aspect of the VC choice. Denise, Cathy and Angela all agreed with the views of Almond (2010) who described her VC patient as having a fear of intimacy and dependency. Like Leon (2010), some of the participants took the view that psychoanalysis could assist the patients on their journey towards maturity but they did not outline how this would happen. None of the participants mentioned how their patients were affected by how others might view them as immature because of their childlessness. The implicit communication from all the participants was their concern about who is fit to parent, which was overtly tackled as a subject by the sociologist Campion (2005).

It is interesting that all of my participants were mothers whereas the work of Leibowitz (1996) drew attention to her childless status and how that influenced her work. She implied that being a psychotherapist allowed her to develop emotionally because of her interactions with her patients. However, she was left wondering if her patients viewed her as less plausible because of her childless state and how different her work might have been if she were a mother. It would be an interesting area to research in terms of the number of psychoanalysts that are not mothers either through IVC or VC and how they feel this impacts on their work, if it does at all. Recently when I was attending a CPD event for relational psychotherapy an older psychoanalytic practitioner approached me to say how her childless state due to infertility was an area in her life that caused her great

shame. If my research had attracted younger participants perhaps some of these might have been VC thereby offering an alternative perspective.

The question that arises is whether the aim of psychoanalysis is to help patients to mature and to prepare them for parenthood. Dreher and Sandler (1995) have highlighted how the concept of maturity is culturally specific and can depend on the analyst's own value system. Cathy links maturity with buying a house and security of income, which may well link to her value system. However in the UK today there are many young adults who need to continue to live with parents because of the high housing costs. Recent government changes to the Living Wage did not include those under 25 so views about maturity can also be affected by economic policy. There are many cultures that continue to live in extended family systems and do not see individuality, autonomy and separation to be a developmental task. None of the aforementioned would classify these young adults as being immature. However, some of the developmental models in psychoanalysis can be viewed as a western-centric model of human development.

Many of the writers from different disciplines Ireland, (1993), Stuart, (2011) both psychoanalysts and Daniluk, (1997), a psychologist, and Hird, (2003) a feminist are calling for a new model of development that can account for women without children. VC is a growing phenomenon and as previously stated, if psychoanalysts remain wedded to the notion that motherhood is the pinnacle of development, a large number of women will continue to be pathologised for their choice. Yonke and Barnett (2001) analysed the writings of 20 female analysts who published in psychoanalytic journals from 1920 to 1980. These writings were

original ideas about female development and sexuality but Yonke and Barnett (2001) claims these writings were not followed up and developed into theories. She argues that the psychoanalytic community clung to Freud's original ideas of women saying that this was partly due to the impact of their primary training and the importance they place in belonging to a professional community.

According to Dreher and Sandler (1995), one of the earlier aims of psychoanalysis was for the patient to renounce repression from an earlier period in development and to put in place more mature reactions. However, the question that they ask is whether maturity is equal to normality? Does Freud imply that psychological maturity is an ideal developmental stage, which patients with psychological disturbances have not reached? The notion of maturity is embedded in the social values of the historical and cultural period. Genital primacy (as explained in chapter two, 2.2.1) was for many years regarded by many analysts as a major goal of psychoanalytic treatment and was equated not only with maturity in the sexual sphere but with maturity in all main spheres of individual functioning. Neurosis is a product of interference with the individual's normal process of growth, and so if it is removed, then normal growth will occur. Indeed, Strachey (1937) argued that analysis helps the neurotics' childish and dwarfed mind to grow towards adulthood. From its inception, psychoanalytic theory was concerned with helping patients to mature but as society has changed, along with developments in psychoanalytic thinking, the concept of maturity has changed. It is therefore important for psychoanalytic practitioners to question their own implicit and explicit views of maturity, particularly in relation to the decision about whether or not a patient wishes to become a parent. As Dreher and Sandler (1995) point out, the analyst may well have different aims

from the patient. Until fairly recently, ‘successful’ treatment of a homosexual patient was conditional on the patient making a heterosexual attachment and some analysts may still believe this today. The important question that this thesis seeks to unravel is whether successful treatment of a woman is conditional upon her wishing for a baby or becoming a mother. One of the questions that Cathy asked was ‘whether I was interested in turning women into mothers?’ Perhaps Cathy meant that she believed that this was an important goal of analysis. Depending on the psychoanalysts theoretical model it is possible that an underpinning of their training will be a developmental model that might well encourage them do so.

On a wider issue relating to how the psychotherapy profession, including psychoanalysts, Samuels (2015) argues that the therapists are a conformist and conventional group. In the clinical setting heteronormative relationships are given value over lone parents, the single life, short-term relationships and same sex families. Ruti and Cocking (2015) argue that psychoanalysis and psychotherapy are out of touch with contemporary queer theory if they continue to see monogamous, permanent and stable as the epitome of ‘healthy’ relationships. Ruti and Cocking (2015) also argue that there is a growing body of work that shows single people, whether gay or straight, are discriminated against in society. They urge psychoanalysts to question their assumptions about relationality and that psychic well-being does not need to depend on the ideological and culturally produced notions of romantic relationships. The aim of this thesis is to highlight the normative view of motherhood as a developmental task, but it is interesting to note the research carried out by others who

underscore other groups in contemporary western societies that suffer stigmatisation.

An interesting reflection of the competing cultural discourses was reflected in recently in Andrea Leadman's statement about how she was more suited to being Prime Minister as she had a stake in the future because she had children (The Times 2016). Teresa May is an IVC woman and her childless state was portrayed as a tragedy. However it was encouraging to note the outrage that Leadman's comments provoked from parents and non-parents alike. This could reflect a changing consciousness regarding the childless woman. Kamalamani (2016) an integrative psychotherapist, discusses research that shows many individuals choose childlessness for ecological reasons which one could argue is a sign of great maturity, selflessness and a commitment to the future of the planet.

5.3.7 Mental illness and fitness to parent debate

Discussion

Angela and Beth make the point that motherhood can be a crisis for many women. The crisis might be more serious for those with underlying personality difficulties and life conditions. Barbara Almond (2010, p.187) refers to the hormonal and biochemical changes that occur during and after pregnancy that give rise to post-partum depression (PPD) She describes extreme cases that can lead to infanticide and cites examples of women who view their children as monsters and kill them, as from their perspective this is an altruistic act as the child would be better off dead. The mother projects her own aggression on to the child and may commit suicide herself.

Almond (2010, p.240) also discusses the shame and guilt that women feel about PPD and may fear exposing it, particularly to professionals. She believes that early clinical intervention is extremely beneficial for mother and baby. The developmental task of motherhood is much more difficult for some women than others and although PND may occur after the birth of the first child, Almond (2010) argues that this should not necessarily deter women from having more children. Therefore in terms of whether or not mental health precludes women from becoming mothers is hard to predict. This is similar to Beth's view about each pregnancy has its own unconscious significance to the mother.

Pines (1993) described a patient who was anxious and depressed before the birth of her first child but then flourished during the first year post-birth. Despite being warned against having further children, the patient had twins and within a year she had a psychotic breakdown and eventually committed suicide. Pines (1993) argues that the pressure of the responsibilities was too much for this woman's psyche which would support Beth's view about how difficult it is to predict whether or not a woman will be affected by PND. Almond (2010) argues that for some women it might be better not to have further children if each birth gives rise to depression. According to Benedek (1959), disturbed mothering turns the symbiotic relationship into a vicious circle and creates the development of the borderline personality. This trans-generational aspect of parenting was discussed in section 5.5.5 of this chapter.

Medical researchers, Ohlsen and Pilowsky (2007) raise the concern about whether or not women should continue with their anti-psychotic medication either

during pregnancy or after the birth of a child. As a result of better, less harmful anti-psychotic drugs, more women with mental health problems are now becoming pregnant. They argue too the importance of close communication with health care professionals for mentally ill women who are planning pregnancy, or are pregnant. None of my participants mentioned a more holistic approach to working with patients who have a mental illness such as working as part of a team of mental health specialists.

The theme of mental illness and fitness to parent was echoed throughout all of the participant's interviews and is also part of the discourse prevalent in our society, often associated with the rights of the child. However Campion (2005, location 683-692), a sociologist, argues that there is a great deal of confusion about the kinds of mental illness that might prevent good enough parenting, thus the role of the psychiatrist is very significant when working with a family. As Oates (1984) has pointed out, a psychiatrist might prioritise the needs of his clients (the parents) while a child psychiatrist might recommend that a child should be removed from the family. None of my participants referred to them being called as 'expert witnesses' in a court of law or having to be involved in such ethical dilemmas. However, Angela was concerned about the 'happy go lucky' attitude of health professionals who 'lightened up' when a borderline patient was pregnant when 'there was nothing to be happy about'. See section 4.3.

Although the main aim of this research was to investigate VC, my participants narratives included wider issues with regards to the effects on individuals of poor parenting. This is highlighted by Campion (2005, location 1605-1611) who has

argued that as a result of psychoanalysis highlighting the negative impact on the child of poor parenting, there is a greater interest in protecting the interests of the child, both in the present and as an investment in their future mental health and well-being. Jeanine Cogan (1998), a social psychologist, highlights how a mother's perceived mental illness and the stigma associated with any label may be an obstacle to maintaining custody of their children. Pregnancy, childbirth and parenting are important life events for women and Cogan has pointed out that research has tended to focus on the high cost of the mother's pathology on child development and well-being rather than on the needs of the mother. She argues that a woman's mental illness has become synonymous with negative parenting regardless of her circumstances and the characteristics of the particular mother. Identifying and appropriately responding to the needs of the mother and child might strengthen parenting skills and positively contribute to the mental health of both parents and children. All of my participants implied that the woman's mental health pathology would interfere with their parenting skills.

A more controversial subject is that of the forced sterilisation of those deemed unfit to be parents due to mental illness. Mark Hanrahon (2015) reported on American citizens living in the State of Virginia who have recently been awarded $25000 compensation for being sterilised against their will decades ago. The authorities had decided these individuals were undesirable or mentally unsound. More than a fifth of those sterilised in Virginia were African Americans. Two-thirds were women, many of whom went in for other procedures and were unaware of what was happening to them. These recent compensations highlight

how history can provide us with insights into the dangers of the Fitness to Parent debate entering into the hands of the law.

Richard Redding (2002) discussed a speech given by Professor Lyken to the American Psychological Association (2001) in which Lyken called for parental licensing, which would require prospective parents to meet certain criteria before they could conceive or adopt children. This would include being employed, without a criminal conviction and being free from any incapacitating mental or physical illness. Single people, as well gay and lesbian individuals would be excluded. Redding (2002) described how this speech echoed a growing number of delinquency researchers who focused on a father's fitness to parent. Although Redding agrees with Lyken's emphasis on the rights of the child over the rights of the parents, he raises serious concerns for an "Orwellian world of social engineering" (2002, p.987). However, he argues that psychologists should support mandatory parenting classes in school, better child protection laws and interventions that might help to reduce divorce. It is interesting that Redding discusses how this project had an interest in the mental health of fathers, as most of the popular discourse is around the woman's mental health and how that relates to fitness to parent. However my participants did consider whether the mental health of some of their male patients would allow them to provide adequate parenting skills. My participants also mentioned how fathers had affected the mental health of their patients.

The participants emphasised that it was better for the mental health of some patients as well as any potential child if they chose not to have a child. They also emphasised how some patients chose not to have children because of their

parents' mental illness. In her study of VC women Rachel Shaw (2011), a psychologist, also reported how one of her participants made a VC choice on this basis. Daniluk (1999) a counselling psychologist, points to evidence that women without children have better psychological health and wellbeing than mothers. Morell's (1993) sociological research supported the notion that VC can promote self-development.

5.3.8 Implications for practice

The literature above provides different views about whether or not those with mental illness should have children. My participants made both implicit and explicit comments about certain individuals not having children for the good of their own mental health and that of any potential child. Unlike Almond (2010), they did not discuss mentally ill patients who were adequate parents because of medical intervention with drugs that help to control their condition. However, this was not part of my research question. They were not clear about what kind of mental illness might preclude motherhood and Campion (2005), a sociologist, cautions against equating mental illness with bad parenting. The other important question that arises is whether VC can be a sign of positive mental health?

Dreher and Sandler (1995) remind us of the significance of cultural norms in trying to understand any version of normality and in relation to the aims of psychoanalysis. Clearly Freud had an idea of normality in his mind but he had grave doubts whether it could be achieved through the course of analysis. Jones (1931) and Hartmann (1939) also gave consideration to issues of mental health and normality. Jones (1931) considered that psychoanalysis was to help the patient to get a better knowledge of themselves, more self-control and

independence. However, Jones (1931) cautioned against the psychoanalyst going beyond these aims by attempting to be a teacher or sage. Hartmann (1939) stated that conflicts exist in healthy people too so health was not just freedom from symptoms and there was a general consensus that a healthy person must have the capacity to suffer and be depressed. Conflicts are part and parcel of human development and often propel individuals towards psychological growth (Erikson, 1951). Other clinicians have put forward their views about what can be considered to be good mental health. Krapf (1961) considered the criteria to be used are those of health and balance but he also warned against those who introduce their own concepts of mental health which are not universally valid.

As Dreher and Sandler (1995) have pointed out, each clinician has their own implicit and explicit view of health. Many of the psychoanalytic views of positive mental health are concerned with independence and autonomy but these are the values of western civilisation in which freedom of choice is highly regarded. Indeed Mitchell (1993), a relational psychoanalyst, argued that a problem of our contemporary society is manifested in the way individuals cling to inauthentic internalised relational configurations. Mitchell (1993) asserted that pseudo-normality is the clinical problem of our time. McDougal (1990) calls for a measure of abnormality in order to avoid developing a normopathic personality that functions to keep psychosis in place. Although not always explicitly stated, there were implicit messages in the narratives of the participants in this study about what they considered a psychologically healthy individual. Cathy stated explicitly

that individuals needed to have a healthy enough part before they could consider being a parent (see 5.2.3).

Dreher and Sandler (1995) describe how the 'classical' view meant that psychoanalysis was the appropriate treatment only for patients with neuroses. This meant their conflict had its origins in the Oedipal phase and was infantile, and this would be repeated in the transference in analysis. The resolution of this transference neurosis was the aim of treatment. It was considered that those who did not have a strict diagnosis of neurosis were not suitable patients for analysis. However Morgenstern (1976) commented on the fact that psychoanalysts now treated individuals with personality disorders and BPD, therefore modifications to standard psychoanalytic techniques were needed. My participants were a mixture of psychoanalysts and psychoanalytic psychotherapists and they all seemed to be seeing patients who were on the BPD spectrum or had diagnosed mental health problems. In the light of the interest of this particular research and its interest in VC a question arises about what explicit and implicit messages that psychoanalysis holds with regards to whether or not VC can be viewed as a sign of positive mental health. It is important that the VC choice is not only viewed through a pathologising lens.

5.4 Conclusion

The findings in this chapter highlighted how the participants viewed VC as fraught with conscious and unconscious conflicts. One of the conscious conflicts was the fear of passing on a genetic disorder and the associated dilemma about whether or not to become a mother. The psychoanalytical literature barely covers

this topic, while the sociological literature (Thomas 1997) presented shows that this area is rife with prejudices and misunderstanding. The participants in my study demonstrated the challenges of working therapeutically with these dilemmas. An interesting area for psychoanalytic research could be around the ethical dilemmas concerning 'what lives are worth living' debate and the disabilism that exists in society.

Psychoanalytic practitioners take the position that the roots of our distress are laid down in childhood, so it is not surprising that my participants made links with reproductive choices being affected by their patients' relationships with their parents; and for women in particular, with their mother. Some of the psychoanalytical literature highlighted how some individuals chose to have abortions, or to be sterilised in order to secure their VC choice. This was not something that my participants raised. Some writers suggest that psychoanalysis can help patients become more aware of their fears and phantasies and this can then prepare them to provide healthy mothering. Some of the psychoanalytic writers supported the idea that if women did not have good relationships with their mothers then they did not develop a maternal function that would enable them to wish for a child. This was conceptualised as a pathology and it was believed that analysis would help the patients become more aware of this developmental damage. VC and IVC arising as a result of difficult childhoods considered the various views from psychoanalytic practitioners about how much psychoanalysis could help the patient to overcome difficult experiences in childhood. Positive psychology (Rogers 1961) puts forward the view that human beings, like all living beings, are naturally drawn towards growth. Attachment

theorists such as Bowlby argue that earlier experiences in life can be updated throughout our life and can correct earlier damaging experiences.

Cathy in particular focused on how some of her patients were VC because of their immaturity and they feared the responsibility of a child. Not wanting a child for fear of the sacrifices involved was seen by some of my participants as an expression of immaturity or unresolved developmental issues, whilst others could relate to the reality of what a woman has to give up in order to be a mother. Although my participants did not state overtly that parenthood was a developmental stage the implication was present in their narratives. The psychoanalytical literature supports this view, with Erikson's (1951) view of generativity, and Benedek's (1959) theory of parenthood as a developmental stage. Although Erikson stresses that one does not need to become a parent to achieve generativity, he states that if one does not achieve this stage, the individual will become isolated and will stagnate. However psychologists such as Ireland (1993) and sociologists like Morell (1993; 2000) and Gillespie (1999; 2000; 2001) highlight VC as a sign of maturity and it is framed in a much more positive and healthy light.

All of the participants except for Beth focused on the intergenerational aspects of immaturity as a result of their patients having immature parents. This meant they had not internalised the mothering function. This was reflected in the psychoanalytic literature that focused in particular on the intergenerational trauma passed down through the female line. However, Angela highlighted how she viewed the VC choice of some of her supervisees' patients to be a sign of

great maturity. Many clinicians believe that the idea of maturity is culturally specific and can lead to the personal values of the psychoanalyst inadvertently affecting the course of treatment. This could be very damaging for a VC individual if this was mirrored in the consulting room. Indeed the view that independence and autonomy are a sign of maturity is a western model of development and will have repercussions for those from other cultures in our society who seek help from psychoanalysts.

The intergenerational aspect of mental illness/distress was highlighted in the participants' discussions, and their concern was for the potential and existing children of their patients. In addition to this they were concerned that some mentally ill patients were not capable of parenting or that having a child would create further mental health problems for the patient. Beth highlighted how motherhood could provoke a psychotic breakdown, whereas Denise, Angela and Cathy took the view that mental health issues would make some individuals unfit to mother. There were conflicting views amongst the participants about whether or not psychoanalysis could be sufficiently reparative for these patients to become parents. Some psychoanalytic literature such as Pines (1993) and Welldon (1988; 2006) discussed patients who became psychotic after having a child. However, the idea that VC was chosen explicitly due to an individual's own mental health problems was not discussed in the literature. Psychologists (Shaw, 2010) and sociologists did show in their research of VC women that some indeed had chosen this lifestyle because of their mother's mental health problems and they had a fear of passing this on to their potential children. Some of the literature relating to infertility suggested that depression was more related to the

diagnosis as opposed to mental illness causing endocrinological failure with regards to infertility. Other psychoanalytic literature made claims that early childhood trauma, mental health problems and depression lead to infertility. The question of whether mental health precludes individuals from motherhood was also considered, as was whether or not the VC choice was a sign of positive mental health. These issues were considered in the light of how psychoanalysts have put forward various views of what is considered 'normal' and again this discussion highlighted how views of health and normality are culturally specific.

This clearly raises serious ethical issues about the role of analysts placed in this situation. The right to reproduce, the right not to reproduce, and fitness to parent are part of the social discourse in modern Britain and the contention throughout this thesis is that psychoanalysts will have internalised some of these messages. This research is highlighting how these dilemmas are present in consulting rooms and how they reflect the cultural discourse. Campion (2005) highlighted the cultural discourse around the Fitness to Parent debate and focused on the ethical concerns about professionals making such decisions about who is fit to parent.

Finally, this chapter highlights a new debate for psychoanalysis regarding the ethical considerations of who is fit to parent and the potential pitfalls of maintaining a deterministic classical Freudian perspective on the VC choice. My participants highlighted some very important questions about the aim of psychoanalysis and how analysts need to respond to this very complex and

conflicting issue. Of particular interest was the view that it is a sign of maturity if individuals chose not to become parents because of their own lack of an internalised maternal function. The mirror side of this view was that many individuals displayed a lack of maturity by choosing to have children without being psychologically ready. All of these views are part of the cultural discourses that are reflected in the consulting room. This thesis aims to make these views more explicit to enable practitioners to engage with complex issues that are inherent in the VC choice.

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CHAPTER SIX – SUBORDINATE THEME THREE – WORKING WITH CHILDLESSNESS IS COMPLEX AND CONFLICTUAL

Subordinate themes	Angela	Beth	Cathy	Denise
a) Our role is complex and we need to attune to our patients' unconscious.	x	x	x	x
b) Personal views versus professional views.	X	x	x	x
c) Managing counter and understanding countertransference	X	x	x	x

6.1 Introduction

This chapter will address the third superordinate theme called 'Working with Childlessness is Complex and Conflictual. The focus will mainly be on how the participants respond to the phenomenon of VC both professionally and personally. In the narratives presented below, the participants elaborate on their own views about maternity, paternity, parenthood and those who are childless. They also discuss the ramifications for their patients of 'leaving it too late' or as Chodorow (2003) calls them: 'too late' patients, as a result of delayed childbearing. The participants describe how they help their patients to make difficult decisions with regards to infertility or whether or not to become a parent. Whether VC is seen as a positive choice or pathological will inevitably affect how the analyst responds to each patient.

My initial interest, as described in the introduction, in VC lies in two categories of VC women: those who have made a conscious decision not to have children because they want something different for themselves and those women who have not made a conscious decision either way about whether to become a parent and do not feel compelled to respond to the biological clock. However, three of my participants focused on patients and women in general who had 'left it too late' and they were left with feelings of deep regret. This aspect of

childlessness had not been discussed in my Literature Review so psychoanalytic and sociological literature relating to this topic will be introduced in the discussion. My participants also referred to infertile patients so literature relating to this finding will be included in the Discussion section of this chapter. Consideration will be given to what appears to be missing in the literature, and those aspects that could be taken forward into further research.

The discussion will also include literature that shows how psychoanalytic practitioners struggle with keeping the professional and personal separate. Like the participants, some of the literature conveys how practitioners' personal feelings about motherhood and how their own childhood and life choices might affect the analytic work. Literature will be included to discuss the countertransference/counter-reaction that might arise when working with infertile patients, VC patients and those patients who are undergoing ART. The discussion will also address the different interpretations of countertransference and whether or not it is useful or obstructive as was discussed in section 2.4 of the Literature Review. The authors in the literature discussed below describe the powerful feelings that can arise for analysts when working with childlessness in its different manifestations. Sociological literature will also be introduced to provide a different, non-analytic perspective. Finally at the end of each section I will consider the implications for practice concerning whether or not the participants agree with the literature and how this will affect the status of the VC female patient in psychoanalysis.

6.2 Findings

6.2.1 Subordinate theme one - Our role is complex and we need to attune to our patients' unconscious

Whilst discussing their role, the participants discuss different facets of how they respond professionally to childless patients. One of these is relating to patients who have delayed childbearing.

In the following interview extract Angela is making a generalised statement about her older childless patients:

> ''Oh my god I'm 45 and now I can't have babies". […] Poor me, I haven't thought about it and I've had some patients who came to me and about 44, 45 when it is too late and then they look back and say it hasn't happened. And then there is a sense that there hasn't really been a choice.

Angela is summarising some of her patient's realisations, and the use of 'Oh my God' is powerful. In this instance, Angela uses this to portray the shock and regret that these women feel about their childlessness, particularly as they approach the menopause. Angela's understanding is that this lack of choice is an unconscious decision on the part of the women. The 'poor me' statement indicates that she feels that a great deal of pain and confusion could be avoided if these women were more aware of the importance of consciously considering this issue at a younger age. In the extract below Angela speaks movingly about how the psychoanalyst needs to be sensitive to the exploration of choice:

> But somehow it would be useless and painful to see that she had thrown away an opportunity.

Here Angela is referring to patient D and there are different interpretations that

can be placed on this statement. On the one hand Angela is responding empathically as she highlights the sensitivity that is needed when one is working psychoanalytically. She was aware of something that was outside the patient's consciousness but she was mindful of not imposing her insights on the patient. One could argue that she was attuning herself to the needs of her patient. Alternatively the statement could mean that the patient did not allow the awareness of her 'having thrown away an opportunity' to come into her conscious mind. This patient was in her early 40s and Angela describes her as:

> she's very alive, very lively, she has partner, she has husband that she has yet for many years. but no babies.

Angela elaborates about the patient's early life, which was dominated by a mother who was deeply troubled, and the patient could only feel great sorrow for the mother but not anger (see section 5.5.5). Angela does not state overtly that these early childhood experiences gave rise to the patient's childlessness but more as a way of trying to understand the choice. Throughout this explanation Angela's tone of voice and her choice of language demonstrates empathy for the patient's difficult early life. Angela states too that:

> if one dug deep enough you would find that she really did want a child.

In this extract Angela highlights that she believed that the patient had made a choice that was based on a deeper unconscious wish. Angela did not make it clear how she came to this conclusion about the patient's unconscious and it could reveal her allegiance to psychoanalytic theory that conceptualises that motherhood is necessary for a woman's psychological development.

Denise discusses a patient (U) (see 5.5.2) who was married to an alcoholic, and the couple had made a 'policy decision' not to have a child. Denise refers to a 'window of opportunity' for the patient to have changed her mind about wanting children. This implies that Denise understood that unconsciously the woman did want a child despite her conscious choice that she was 'adamant that she did [not want children].' This is a similar theme to Angela's statement above about 'if one dug deep enough' that most women would really want to have a child. The extract below suggests that Denise's understanding was that the patient consciously or unconsciously sacrificed having a child in order to care for her husband:

> The patient could not possibly have had a child while she stayed with an alcoholic husband.

This could present Denise with a conflict with regards to her belief that motherhood is the natural path for a woman whereas she considered that the patient's relationship did not provide the right conditions to fulfill this role.

There is an overriding sense in Angela's and Denise's accounts that participants are trying to protect their patients from disappointment. Denise states:

> Certainly, when I'm seeing young women in their early 30s who, you know, talk about children, I encourage them to take it very seriously. I suppose because in my own life I've known people who have left it too late and you know how devastating that can be.

This excerpt reveals that Denise's personal vision of motherhood as an important aspect of female life is influencing her therapeutic work. There are many accounts in the media of career women who have left it too late to become a mother and some of them have not found the 'right' partner. For some women

this is clearly devastating as Denise points out but she is making the assumption that this is how all her female patients will experience their childlessness later on in their lives. However it is clear that she sees that her role is to encourage women to consider the consequences of life choices made at a younger age. In the use of the words 'and you know' Denise is perhaps assuming that, as another woman, I share her views with regards to motherhood.

Cathy implies that her role is to help her female patients to face the decision about whether or not to be a parent. This is not dissimilar to Denise and Angela who also considered that more conscious decision-making was important. It would seem that this response to the decision-making is coloured by Cathy's own experience of being ambivalent about being a mother (discussed in Chapter four 4.4.3).

> I'm sure there must be very few who make it very easily. Don't you think, even the ones who opt not to.

In the above extract, Cathy highlights her belief that the decision about whether to be a parent is unlikely to be 'cut and dried'. Three of the participants discussed the notion of childlessness as a result of 'leaving it too late'. An inference could be made that they see delayed childlessness as an unconscious expression of ambivalence about motherhood and is therefore a form of VC.

Another aspect of their role that the participants discussed was that sometimes they felt they needed to support their patients' VC choice. Beth believes that a woman's choice to have a child should be respected and this is illustrated in the following statement about a VC choice:

> And for me each person is different, each person's choice, either

> way, to have a child or not have a child that's their... that's their right to make that choice and for it to be respected. You might at a certain point try to unpack it and see where it ...emm....or you might not. It may be irrelevant, you know she might choose not to have a child and it may not become a subject, particularly for the analysis.

Beth discusses 'unpacking' the patient's reason for the choice and in contrast to the other participants Beth does not assume that it is a natural path for a woman to be a mother. Beth made it clear in her interview that she did not agree with her original Kleinian training that automatically pathologised a woman's choice to be childless (see section 4.4.3). However she adds:

> I would say needs analysing and it's a very delicate thing and its not something that you rush into and it's not something that I think necessarily will emerge or would emerge until very late .... in the analysis,

This statement has echoes of Angela's phrase 'useless and painful to see she had thrown away an opportunity'. Both of these participants highlight the importance of sensitivity and timing in their role. It would be interesting to know how Beth's life experience and her choice to train as a Lacanian have influenced her views on working with the continuum of childlessness.

Angela provides a contrasting view about when VC can be a positive choice when she compares irresponsible mothers with mature and generous VC women. Angela raises an interesting ethical point about her role in decision-making with her patients (which was also discussed in sections 5.2.3 and 5.3.4 but from a different perspective). In the following extract she is describing her work as a clinical supervisor in an NHS unit for borderline patients:

> Yes it was really an unselfish choice. ….. So for a woman to say, no I won't do that … that showed – I thought – a great maturity.

Throughout her description of these patients, it was obvious that Angela felt moved by the terrible experiences that these patients had in their early lives. She clearly respected the difficult choices regarding motherhood that these women had to face as they recognised the damage that had been inflicted upon them as children. These are complex issues that Angela is struggling with, as this is an ethical concern about whether or not psychoanalytic practitioners need to intervene if they believe that the individual will be a poor parent. Angela also sees the empathic aspect of her role as an analyst working with VC clients, feeling that these women's experience of being mothered:

> …had been so damaging to them that they felt that they were unable to,... would have been unable to provide a better experience for their children.

Angela's highlights in the above extract that some women realised through the course of therapy that they would not be good mothers due to:

> their abysmally unhappy childhoods, that they could not cope with having a baby.

It is interesting to note that Angela did not see that therapy could be reparative for those patients who realised they 'had something missing'. In the interview Angela gave a moving account of the difficult lives some of these patients had experienced, and although she credited them with great insight, from her perspective this would not have been enough to overcome the effects of poor mothering. Her use of the word 'abysmal' indicates the extent to which she considered these patients as damaged by their mothers as opposed to the more usual 'not good enough mothering'. It was not clear if Angela saw her role as a clinical supervisor was to highlight the concerns she had to the psychoanalytic practitioners she supervised. These are contentious issues as they draw on

prevalent cultural discourses which define who is worthy of becoming a mother and who is not. These competing discourses were highlighted in chapter two, four and five.

Beth discusses another important aspect of her role which is to help patients to come to terms with their past highlighting how she believes psychotherapy works:

> The only reason psychoanalysis and psychotherapy can work is because actually we can change, we can't change the past – the past has been and gone, you know if you had lousy parents you had lousy parents, nothing, in a way there's nothing you can do about it except work through the pain of it and the hostility of it and so on and then find a way with that. You can rewrite your relation to the past but you can't actually rewrite it.

Beth is not referring directly to VC patients but she is making a general statement about how she works. She describes how psychoanalysis works:

> …because you can actually change your grasp of your place in the world through thinking about what place you made for yourself and maybe using that place in a different way because once you can grasp how you come to be in a particular psychology.... psychic position you may not, it may still move you in a way but you might be able to have a different relationship with it and move it..

In relation to VC, Beth states that whatever decision an individual makes with regards to 'being or not being a parent', Lacanian psychoanalysis can help with understanding the decision making process and acceptance of one's situation.

She also sees her role as;

> listening emm..... for what it is for what it is to make interventions to allow that person subconscious to stay open.

Beth discusses how she is not listening in the ordinary sense but for 'the slips of tongue' that reveal the unconscious. Linking this back to the importance of sensitivity and timing one can imagine that Beth uses such 'slips of tongue' to help her to decide whether or not the choice about VC needs to be explored further with a patient. She also states that it is better for some individuals not to become parents because they can be precipitated into a psychotic breakdown (as discussed in chapter five, section 5.2.4 and 5.3.4)

At other times the participants saw their role as trying to unravel the reasons for their patients' VC choice as they considered it to be pathological. Denise is also trying to provide an explanation for the choices her patients make in the following statement:

> I would wonder what someone.... in choosing not to have children wasn't wanting..... what they might be avoiding.... what they might be frightened of. Is it a dependency?

The question that Denise holds in the background is clearly an important one. Some individuals may well choose not to have children because of unresolved unconscious conflicts. Interestingly enough, Denise does not ask why women choose to mother; and her whole interview is a narrative that weaves together motherhood and femininity.

Both Angela and Cathy give powerful and moving descriptions of their patients' decision-making process in regards to having children in the face of a life threatening or genetic illness. This is dealt with in much more detail in Chapter five, subordinate theme one, but from a different perspective. Brief extracts will be given here to illustrate how the participants see their role in these

circumstances. In the following extract Cathy refers to her patient (P) who has a cancer gene in her family:

> she's under terrible pressure to have a gene test and she doesn't know whether to do it or not……. If she does have (a gene test) then she's faced with you know does she have IVF or what does she do instead.

This extract highlights the personal challenge for Cathy in holding her patient in this very painful life choice. My sense was that she sees her role as being one of a witness and supporter. Her empathy for her client is clearly evident in the statement below

> That is the most horrible predicament I can imagine.

Similarly, describing a patient (G) with multiple sclerosis trying to make a decision about having children, Angela uses an equally powerful empathic statement:

> I wouldn't want to be in her shoes.

And then goes on to state:

> Because one doesn't know what is...remotely what is the best decision. One never knows but for another person it's just a question of trying to help the person to make the best decision but one just doesn't know but in a half daze. I feel that I know even less than for. I don't know.

The data extract above reveals that sometimes the participants felt confusion about their role as a therapist working with VC clients, which is not surprising when one considers the range of contributing factors and the complexity of the dilemma. The metaphor 'in a half daze' evokes a strong image of Angela wrestling with confusion in her attempts to help her patient. Angela expresses

humility by not knowing what is the 'right' decision for her patient. It is an illustration of the depth of her empathy as she sits alongside her patients who are dealing with such complex existential concerns. However Angela does state that analysis is a good opportunity to make a decision.

> Because it's a good opportunity to decide to make a difficult decision but make it.

These dilemmas were explored more in Chapter five, 5.2.1 and 5.3.1.

Cathy sees one of her tasks as a psychoanalytic psychotherapist as to help the patient to 'grow up', to become more psychologically mature. This may or may not result in a biological child of their own but at the very least they are ready to be a parent. Cathy makes a general statement:

> I think of my patients as being quite childlike – infantile as this is the part they bring to therapy

Here Cathy is illustrating how she helps her patients to heal the wounds of their infantile self through the process of analysis. In the extract below she gives an example of a male patient (N) that shows how she believed that psychoanalysis did indeed help him to become psychologically mature enough to parent even though the children were not his own:

> … by the end he was leading a normal life and was actually ready to be a father ….(coming up to 60)……

This is a powerful illustration of how Cathy considers chronological age not to be an indicator of maturity and in fact that it does not matter what age you are, that it is never too late to enjoy the process of caring for another generation. The

parental role can be fulfilled through means other than through a biological child of one's own. This was explored further in section 5.2.3 and 5.3.3.

6.2.2 Subordinate theme two - Personal views versus professional views

All of the participants discussed their views with regards to who was fit to parent, and about the reasons for VC. Sometimes it was unclear whether the participants were expressing personal or professional views. An example of this blurred boundary between the professional and the personal is demonstrated in an extract taken from Angela's interview. Here she is referring to her work as a clinical supervisor in the NHS:

> they lightened up when a patient was pregnant even if there was really nothing to be happy about…

Angela is implying that health professionals are unconsciously caught up in the inextricable link between motherhood and femininity. These comments about the 'fitness to parent' and the 'right to parent' are part of the social discourse in society and these themes are woven throughout the narratives of the participants.

Later on in the interview Angela makes the following statement about motherhood:

> There is a lot of heart rending stuff going on senses of guilt, you've never done enough, you've done the wrong thing always and so on.

The powerful expression 'heart rending stuff'' conveys a sense of Angela's own experience or views about motherhood combined with what she has witnessed in the consulting room (see 4.2).

In response to a question about whether she ever considered VC to be a healthy choice, Angela referred to her sister who was happily childless.

> I have a sister who is childless and she is very happy and she would have had a chance I think. She has been married for donkey's years with a man who would have loved children - but she couldn't have them. But she didn't try very hard medically she just they didn't come didn't come.

It sounds as if Angela was surprised that her sister did not do more in terms of seeking professional help to aid her fertility. However, her sister seemed happy with her childless status.

Beth echoes Angela's sentiments in her statement that reflects both a personal and professional opinion:

> Children are very disturbing creatures, they bring up mounds of stuff.

Beth also reflects on the reasons why women want children:

> ….people have children for the most awful dreadful reasons really……. You know, those of us who have children, you know, why do we want to do it?

At the end of this statement Beth laughs which conveys a sense that Beth – like Cathy – does not buy into the 'myth of motherhood' (see section 4.4.3). Both Cathy and Beth imagine a fulfilled life for women without children. Both of the participants are reflecting on the conscious and unconscious decisions about whether to become a parent are often very complex and conflicted. People may choose to have children for 'healthy' reasons that involve wanting to care for and succour a child while others may have children for a whole range of unhealthy reasons, such as a narcissistic wish to have an extension of themselves. On the

other hand individuals may choose not to have children as they have decided it is better for their own mental health or that of a potential child, or because they have made a considered choice that they do not need a child to be fulfilled as a woman. However, it is equally true that women may unconsciously choose not to have a child as for example revenge against their parents, or as a denial of their femininity. The decision to be or not to be a parent can be very complex and fraught with conscious and unconscious conflicts for some women.

Despite her own personal experiences, when Cathy is asked whether she considers that VC could be a health choice, she responds by asking me 'how do you know it is voluntary?' She then goes on to say:

> you have a feeling that if they could sort their head out a bit, they wouldn't say that any more (emm), you know.

Cathy also makes a generalised statement:

> But I've also heard it in the context of somebody who feels they are so fucked up they wouldn't want to pass that on to a child.

Throughout her interview, Cathy gives confusing messages about motherhood. Reflecting on her own life and personal views, she considers it perfectly acceptable for women to find fulfillment through other avenues; but when the conversation turns to her patients, she takes another stance which is that analysis can help them to prepare for parenthood.

It is interesting that later on in her interview, Beth makes a distinction between her professional and personal self when she comments on a newspaper report

about an Indian woman of 70 years having a baby. She states:

> I mean there was something about that that you just had to say there was something mad about that Oh really (yeh) really. What's that? Denial of mortality? I've got no idea, depends on the individual. I don't know what I think about that, (whispers.... in the 70s... I mean it's very difficult not to be very judgmental about it in an ordinary way but going back about your world, you haven't got that person your consulting room and you know you are working from a different place.

Interestingly Beth is making a clear distinction between her personal and professional self as she clearly states that when she is working as a psychoanalyst, she leaves these moralistic views outside the door. Of course one can question if this is ever possible. At other times the participants are clearly expressing personal views rather than purely professional ones. Denise is unequivocal in her view that motherhood is the natural course for all women. She says:

> I think most women at some stage think they want children.

However she also adds where she echoes Cathy's view:

> Yes, ...yes .....maybe many people are too fucked up *laughs* that many people are too fucked up themselves to have children, or they need to sort themselves out first – or all sorts of things need to be sorted out first.

Denise is clear throughout her interview that motherhood is important to her and she reflects on how she tries not to project this on to her patients. She gives her personal view about modern day society that has made it difficult for women to be mothers because of what she refers to as the 'have it all society' (see section 4.4.3).This theme is resonant throughout Denise's interview. She admits to feeling 'quite moralistic' as she goes on to describe mothers who are selfish for

wanting high powered jobs as well as children.

> So I think I feel quite moralistic, that you have to make choices and particularly you have to make choices when you have little beings

She considers that everyone misses out in this scenario and some of these women end up as patients in her practice because they feel like they've failed in all aspects of their lives. Cathy was open about not wanting children when she was younger:

> My children were quite late, and really and truly I didn't want them. It was my partner who wanted children; he was really keen on the idea.

Cathy also referred to the fact 'there is a lot of pressure on women' and that her training placed 'a lot of emphasis on the mother' (This was explored further in Chapter Four, 4.4.3). Cathy makes a clear distinction between her personal and professional view in the following statement:

> Well you'd think so, I mean I can't speak to you professionally, but it would seem to me from what's going on like with my kids and their friends (I've two sons who are now both married with children and their friends); they are all breeding like there's no tomorrow – all my friends children....I'm amazed at how many are... not all, of course, but the women particularly.... having babies.

The phrase 'breeding like there is no tomorrow' echoes Angela's statement above about patients who were 'delivering babies like there was no tomorrow' (see 5.2.2). These are expressions that are used derogatively in social discourse around 'the fitness to parent' debate. Cathy elaborates further:

> Well I think, you know we're all ambivalent probably, ambivalence is healthy. I think we are all ambivalent about it. At times we're pleased about it, and at other times we just can't bear it.

All of the participants except for Beth referred to personal anxieties they felt towards their patients. Cathy neatly describes this below:

> .
> I was very anxious about her pregnancy. I didn't feel she was equipped. I was anxious on her behalf'.

Cathy then makes a generalized statement:

> You see, I mean the biggest tragedy of them all is - babies being born to people who are not more than babies themselves, really.

In this statement she is using strong language to suggest that there are many individuals who would be better off not having children. The implication here is that the tragedy relates to the potential child and the parent, in contrast to the powerful cultural discourse that portrays childlessness itself as a tragedy. This was explored further in Chapter Five, section 5.2.3.

Personal involvement with the issue of 'to be or not to be a parent' is present across all four interviews. For instance, Angela expresses both delight and anxiety for two of her patients. Here she is describing her responses to patient F:

> You see for instance with this patient the MS does worry me slightly. Even though she's right sometimes patients with MS do have children. Quite enthusiastically without realising that actually and then they get progressively more ill.

And her response to a male patient H, who had a child via surrogacy:

> It was delightful to see him so happy with a girl.

Denise uses the following strong language to convey her shock about her patient S's reasons for choosing not to have children:

> And when she gave the reason for not having children – it was the fact that her husband was (was of another faith) – I was completely gobsmacked really.

Denise appears to be expressing personal views in this extract and she frequently referred to this patient in her narrative. Bearing in mind that Denise stated that being a mother was her most important life experience, it seemed impossible for her to understand why a woman would choose not to have a child for the reasons given by the patient.

6.2.3 Subordinate theme three – Managing counter-reactions and understanding countertransference

All of the participants referred to a phantasy that they wished that their childless patients could have a baby.

With reference to patient S, Denise's awareness of her own life position about motherhood is clearly illustrated in the following interview extract:

> I mean I had I had a longing for her to have a child but I… I felt very compromised by that feeling because she…would have been completely incapable I think to know how to mother a child but there was some sort of deep wish in me for her to know some sort of emm unconditional love I think. I don't know what it was about but emm, you know obviously I never voiced any of this, these were just thoughts that used to go through my mind.

There is a lot going on in the above extract as Denise grapples with her personal views of motherhood and her longings for her patients. She is in a double dilemma as she feels that her patient is entangled in an unrealistic phantasy and, from Denise's perspective, is simply incapable of mothering. In addition, Denise

is aware of the dangers of projecting her wishes onto her patient. Denise also uses the space provided to her during the interview to reflect upon another VC patient, U:

> … I don't know if I felt… I don't know if I might have compromised myself because I felt so strongly about having children that you know I didn't want to project my own stuff onto her. ... I wonder, ….and I think I might have avoided it actually.... in hind sight.

In her desire to avoid influencing her patient, Denise wonders whether she may well have not pursued a theme that could have been beneficial to her patient. This wish for her patients to have children is resonant throughout her interview, and it is clear that this creates great personal challenges for Denise as is illustrated in the extract below as she discusses Patient S:

> and there was one session where she talked about not having a child, and it was very difficult for her to cry, but she was almost tearful and it felt exquisitely painful. Emm… I found it all, its very upsetting.

The repetition of the word 'very' indicates the degree to which Denise was affected by this patient's story. Bearing in mind Denise's openness about the importance of her children in her life and her belief that motherhood was a natural, biological path for women, it is not surprising that she found a patient's childlessness to be 'exquisitely painful'. Denise's emotional responses to this particular patient would suggest they were counter-reactions as she did not seem to be using them as a means of interpreting the patient's unconscious. She overtly stated that she was keeping them in check in order to avoid her responses influencing her work with the patient.

Angela too refers to the pressure she feels inside when she knows she does not

want to project her own wishes on to her patients. Here she is discussing patient F who said she did not want children:

> I wouldn't want to push her, I wouldn't want to push her, I really wouldn't. But yes, it is difficult for me not to feel that 'well it would be nice for her to have a baby'.

The repetition of the phrase 'I wouldn't want to push her' might indicate a conflict for Angela particularly as she is aware of her own wish for the patient to have a baby. Angela did not explain how she understood her own countertransferential/counter-reaction wish for the patient to have a baby. In retrospect I wish I had pursued this line of enquiry as this Angela's reflections could have contributed further knowledge to this thesis.

Cathy too had a wish for her patient to have a baby. Patient P had a genetic illness, and was trying to decide whether it was worth running the risk of having a sick child:

> if she wanted to have a child I'd be really happy for her and I feel very.. as though ..it would be like my baby in a way.

Like Angela, Cathy did not explain how she understood her countertransference/counter-reaction of feeling that the baby would be like her own. Clearly Cathy felt deeply involved with her patient's process and it could reflect how she saw her role to help patients to prepare for parenthood as discussed previously.

By contrast, Beth would ask herself the following question:

> ….now I want this woman to have a child, let's say then I have to ask myself, so what is this, what is this patient for me, really. You know what is it that she signifies for me and why would I want her to have

a child or not to have a child, really.

Beth added a proviso that if she had a feeling that the person would make a 'dreadful parent', she would find it much harder to keep out of the analytic work. As the narrative unfolds, Beth states that it is 'the aim of the work' that helps her to manage her countertransference/counter-reactions or in this instance it sounds as if she meant counter-reaction. Unlike the other participants, Beth appeared to be more detached from her patients' stories. One can speculate that the research question was less emotive for Beth than it was for the others as part of her Lacanian training theorised that all human beings were faced with a fundamental sense of 'lack' regardless of whether they had a child or not.

6.3 Discussion

6.3.1 Subordinate theme one - Our role is complex and we need to attune to our patients' unconscious

Three of my participants referred to the 'leaving too late' aspect of childlessness. Chodorow (2003) stresses that she does not think that motherhood is a natural path for all women but is specifically referring to women who regret not having a child because they have left it too late. She highlights the contradiction in psychoanalysis, which on the one hand is a slow unfolding of a patient's unconscious phantasies and conflicts whilst also needing to acknowledge our mortality and time passing, particularly in relation to childbearing. She states that one of the roles of the psychoanalyst is to help to reduce the feelings of self-blame that a patient might feel when they realise that by leaving it too late they feel a strong sense of shame. Denise and Angela both stated that they felt the

need to warn patients about the ticking of the biological clock. Angela implied that she did not want to cause unnecessary pain to one of her patients by pointing out the missed opportunity of having a child. None of my participants overtly mentioned that they saw their role as reducing their patients' feelings of self blame.

Chodorow (2003) conceptualises 'too late' childlessness as a result of deadened aggression towards mother and siblings that is turned against oneself and an unconscious belief that time has stood still. Furthermore the cultural trends that encourage women to pursue careers before motherhood can obscure the intrapsychic conflicts about denial of motherhood, ageing and time. She argues that we live in a narcissistic culture that denies biological ageing and considers that everything is possible.

Morris (1997) also refers to modern society arguing that it does not allow women to develop a maternal ego and she concludes: "By being attuned to the presence of the issues in our clinical work, we can assist women in fulfilling their unique bio-psychological potential and continue to refine our developmental theory" (Morris, 1997 p.127). Both Chodorow (2003) and Morris (1997) acknowledge the impact of society on the intrapsychic conflicts regarding motherhood experienced by many women. The notion of a narcissistic society is one that recurs throughout the literature in my discussion of the three superordinate themes. Morris (1997) clearly takes the view that motherhood is a natural path for women, thus her response is to help her patients to develop a positive maternal ego. It is also interesting that she refers to 'refining developmental theory' but does not go on to explain the shape this might take. Denise in particular focused on how

modern day society makes it difficult for women to fulfill their motherhood role, while Beth focused on the denial of mortality and Angela and Denise focused on how patients might regret having left it too late to have children

Rosen (2005) too argues that it is imperative that psychoanalysts bear in mind the realities of the biological clock otherwise they can cause irreparable damage to their patients. Like some of my participants, she echoes the sentiment that it is a profoundly delicate topic and timing is crucial. She advocates that analysts need to be curious about why their patients have not thought about whether or not they want to become a mother. She acknowledges that this can have a negative effect on treatment but she would recommend erring on the side of caution. From her perspective the role of the analyst is not to reassure the patient but instead focus on the personal significance and meaning of the lived experience of delaying childlessness in the face of the biological clock. However, as Chodorow (2003) points out above, this creates a contradiction in the role of the analyst as warning patients about the 'clicking of the biological clock' is not following the gradual unfolding of the patient's unconscious process. Two of my participants focused on childlessness as a result of the biological clock and the conflict about when, how and if to raise this issue with their patients.

As mentioned in my literature review, 2.5 health professionals Cooke, Mills and Lavender (2012) stress the circumstances within which women may find themselves, e.g. lack of a partner, finances, or commitment to a career. They argue many women lack awareness of the risks associated with delaying childbearing to after the age of 35 and recommend that there is more sensitive

pre-conception education. Additionally they stress the importance of health professionals and the media becoming more aware of the complex interplay of factors with regards to women's reasons for delaying childbearing. They also argue that women are not aware of their own autonomy with regards to decision making around having a child. Two of my participants discussed the external factors that can impact on a woman's desire to become a parent. For example, Denise mentioned the pressure to have material wealth and Cathy referred to the difficulties some individuals have in finding the right partner.

As mentioned in Chapter five section 5.3.1 none of the psychoanalytic literature had discussed that people may choose to remain childless because of the fear of passing on a genetic illness. From this perspective it was an unexpected finding that two of the participants discussed patients who were VC because of this fear. The participants implied that their role was to hold the client through what was an extremely difficult decision making process. This was not something that I highlighted in my literature review as this was not included in my original definition of VC as it feels more like a forced choice. There is an absence of psychoanalytical literature on this, but it has been discussed on the radio four program 'Inside the Ethics Committee' (2013) which was referred to in Chapter Five Subordinate theme one. Three of the participants also discussed patients who chose to be childless because of mental illness or extremely difficult childhoods. Again, they viewed their role as helping their patients come to terms with the fact that it would be a healthier option for them not to become a mother. This view is supported by Kaltrieder and Margolis' (1977) study of VC women, but the researchers did not discuss the role of the psychoanalytic practitioner in any decision making process. The ethical dilemma that such a decision can

present was discussed in Chapter five, subordinate themes one and two.

If the clinician views the development of a positive maternal desire as a sign of health then its lack in a VC woman will be considered pathological. Denise was clear throughout her interview that motherhood was a central part of her identity and she assumed this was the same for most women. De Marneffe (2004) a psychoanalyst takes the view that motherhood, like therapy, offers one of life's great opportunities for growth and new insight. Harsch (2006), a psychoanalyst, argues that a woman's unconscious identifications with their mother will affect their decision of whether or not to have a child. If the mother has been idealised or undervalued the woman may find it difficult to develop the maternal role. The analyst's role in this instance would be to uncover resistances, defenses and unconscious fantasies that inhibit maternal desire. Three of the participants spoke in detail about how their VC patients had difficult relationships not only with their mothers but sometimes with their fathers too. Angela pointed out how the parental couple's relationship will also affect how an individual will internalise the parental role. See chapter five section 5.3.2 for a discussion on this issue.

Kulish (2012) a psychoanalyst, argues that it is through therapy that a patient may realise that they wish to have a child. Both Angela and Denise referred to patients who they believed did unconsciously want children but did not stay in analysis long enough for this to come into consciousness. In her paper on infertility Mori (2012), a psychoanalyst, discusses how suddenly patients may become pregnant, despite many years of infertility treatment. Mori suggests that this occurs as the psychoanalytic treatment helps to overcome defenses and create more positive psychological functioning for the patient. Referring to

women who are VC, Mori (2012) states that analysis often reveals early deprivation in the patient's past and strong feelings of loneliness in the present. The role of the analyst is to provide the space to uncover the roots of deep-seated conflicts. See 6.3.5 for a further discussion.

The absence of maternal desire interests Legorreta (2009) a psychoanalyst, who feels there is a kind of taboo in trying to get close to examining this phenomenon. It is interesting that my participants did not focus on VC during their interviews but tended to place emphasis on the poor parenting their childlesss patients had experienced. Whether or not the lack of maternal desire in their patients was taboo for my participants is a question that I can only speculate on as the participants continually diverted their attention away from my research question about VC.

Some of the participants took the view that one aspect of their role as psychoanalysts is to help their patients with the decision-making process around choosing parenthood or non-parenthood. Each participant placed a different emphasis on this process and this, one can imagine, depended on their theoretical orientation and personal biases. In addition they would need to consider the mental and physical health of the patient. Several psychoanalytic writers (Chodorow, 2003; Alizade, 2006; Welldon, 2006; Kulish, 2011; Stuart, 2011) make a clear statement that not all women need to have children in order to lead full, creative lives. They support Erikson's (1951) view that the developmental stage of generativity can be achieved through means other than having your own biological child. Therefore, a VC choice is not always seen as pathological. This was true of three of the participants who stated that they did

not think all women needed to be mothers and indeed Cathy stated that she would not have been a mother if it was not for her husband wanting children. As Morris (1997) states, there is still disagreement amongst psychoanalysts as to whether motherhood is an important developmental stage for all healthy women. This was elaborated upon in Chapter five, subordinate theme three.

This raises important questions about the assessment process and how the theoretical and personal biases that the analyst holds could affect the outcome of the treatment. Stuart (2011), a psychoanalyst, argues that analysts are inclined to associate products of the mind with products of the womb and it is important that analysts do not equate creativity with a baby. She argues that if the woman is freed of the superego that is associated with the social motherhood mandate, which demands that the normal path for a woman is to have children, then a VC choice can be negotiated with fewer feelings of guilt and shame. This appears to be an overt challenge to the motherhood mandate, both to psychoanalytic theory and to societal messages. Alizade (2007) argues that if the analyst can accept that women can lead a fulfilled life without children, then this will affect not only the course of treatment but also the interpretations made. She supports my contention that this openness will allow the detection of pathological states in both the desire for a child and the absence of maternal desire. Alizade (2006) states too that mothers can use babies as substitutes for gratifying creative work and consequently the children can suffer from the lack of recognition as distinct, autonomous beings. Therefore a patient's pathology or state of mind is quite independent of the desire for a child. Alizade (2006) argues that a non-maternal psychic space implies that the mind is separate from bodily functions. Therefore freedom of choice is possible and women can express their creativity in many

ways as opposed to only through motherhood. As the further propagation of the species is no longer a mandate, Alizade (2006) stresses the importance of this attitude filtering through to clinical practice.

Kulish (2011) states that psychoanalysts have turned their attention from a more normative view of motherhood, to trying to understand the meaning and experience of childlessness in individual cases. Kamalamani (2009) was mentioned in chapter two, 2.5, and is an integrative psychotherapist who emphasises the importance of providing a spacious environment to allow the complex decision-making to unfold. She herself is a VC woman and a Buddhist nun. Some psychoanalysts in this section are overtly calling for a change in how VC are assessed and treated, and the importance of not pathologising their choice. These analysts are therefore challenging the motherhood mandate.

As mentioned earlier the participants conflated VC, IVC and 'leaving it too late' childlessness and they discussed how they worked with patients who were infertile. Two of the participants discussed how they helped their clients make decisions about surrogacy and fostering and Angela in particular was very supportive and empathic of a male patient who chose the surrogacy route. Leon (2010) supports the analyst's role in infertility decision-making, arguing that it is important for the analyst to explore the underlying meanings that guide the patient's decision-making process. This might involve deciding to undergo ART or to stop treatment, to adopt, or to accept and grieve for their childless state. Although Leon acknowledges the importance of support groups and sexual counselling to manage the stress of infertility he argues that a psychodynamic approach provides the most penetrating vision for empathically understanding

the individualised suffering of infertility. He recommends an eclectic psychodynamic approach where Kohut's self-psychology is utilised as he sees empathy as crucial for dealing with the narcissistic wound of an infertility diagnosis. Leon argues that integrating self-psychology with attachment theory can be helpful in affectively attuning to the patient's inner world. Kernberg (1975) states that if a therapist empathically absorbs the patient's pain, then this offers a model for containment and regulating suffering. By interweaving the intrapsychic, psychosocial, interpersonal, and societal strands the therapist can help the patient to feel less alone. Leon (2010) states that his recommendations are similar to gay affirmative therapy as it also acknowledges the societal and internalised prejudices that co-exist for infertile patients. Leon seems to be supportive of a biopsychosocial approach to understanding to IVC whereas I am suggesting this approach for understanding VC.

Throughout this thesis, various writers from different academic and professional disciplines have discusses the stigma associated with childlessness in general. None of my participants referred to this in their narratives. As highlighted in my literature review sociologists such as Lisle (1997) and psychoanalysts such as Ireland (1993) acknowledge the pain and stigma associated with childlessness and yet give many examples of women who can live full and creative lives without children regardless of how this situation may have arisen. Psychologists Lampman and Dowling (1995) carried out research that showed there is more stigmatisation of the voluntarily childless than those who are infertile. Acknowledging the pain and stigma associated with VC that might be present for patients would seem to be an important role for psychoanalysts. See Chapter two 2.6.5 for a discussion on stigma.

6.3.2.Implications relating to practice

My participants were a combination of psychoanalysts and psychoanalytic/ psychodynamic practitioners and except for Beth who was Lacanian, it was not clear what was their theoretical orientation. Angela referred to Freudian theory and object relations, whereas Cathy referred to Kleinian as well as Freudian theory. All of the participants referred to the effects of early childhood on the VC decision and to how psychoanalysis can help bring unconscious conflicts about motherhood to the surface. From that perspective there was no difference in their approach. However each participant placed a different emphasis on the kind of conflicts presented by their patients, which could reflect their clinical practice or their own personal and professional understanding of the VC choice.

As Dreher and Sandler (1996) have pointed out however, it is difficult to clarify aims because different schools of analysis have different psychoanalytic models, which differ with regards to their theoretical orientation. The Kleinians for instance might want to help the patient to work towards the depressive position, while ego psychologists might encourage a greater integration of self. However, Dreher and Sandler (1996) draw attention to conscious and unconscious aims that the analyst might hold which could also be considered the implicit and explicit theories that they follow. Sometimes the analyst may unconsciously not always follow the theoretical framework that supports their work. This could be because they do not identify with the theory or that they are being influenced by something in their own development or environment that is outside of their

awareness. The explicit theories are often those that are promoted by the psychoanalytic organisations and often they express the differences between the different schools. Sometimes my participants referred to explicit theory such as the Oedipus complex, the maternal function, masculinity complex and Beth frequently referred to Lacanian theory. All of the participants explicitly stated that motherhood was not the right path for all women and they each had their own particular angle. Three of the participants implied that they did not always agree with the psychoanalytic theory that linked motherhood and femininity. Denise and Cathy acknowledged openly their own biases whereas it was not clear how Angela's and Beth's own personal histories entered into their interpretation of theory.

Dreher and Sandler (1996) argue the implicit theories are often more pragmatic ones and may mean there is less difference between the psychoanalysts from the different traditions. This seemed to be the case with my particular participants who were working with complex and existential issues regarding patients deciding whether or not to be a parent. Of course there is another issue of whether or not the patient and analyst have different aims and there are dangers that each will be working towards different goals. There were times in the narratives of the participants it was unclear whether or not the issue of childlessness was raised by them or their patients.

Some psychoanalytic writers (Alizade, 2006; Stuart, 2011) made clear statements about the importance of not pathologising the VC choice and how this

view needed to filter down into clinical practice. Although Angela, Beth and Cathy all explicitly stated that the VC choice could be a healthy one, they implied that these would not be the kind of patients presenting for treatment. I would not agree with their view as individuals may be reconciled to their choice but have other areas in their life that they may want to explore in analysis. Other writers (Morris, 1997; Chodorow, 2003; Rosen, 2005) stress the importance of uncovering the unconscious conflicts regarding delayed childlessness and VC to enable women to fulfil their motherhood role. Clearly the professional opinion amongst psychoanalytic practitioners is divided on the issue of motherhood as a developmental task for women. My participants also had contradictory views in their own narratives as well as between themselves. As Yonke and Barnett (2001) has pointed out and mentioned in Chapter five 5.3.3 the history of psychoanalytic theorising about women's development has not changed greatly since the time of Freud, despite many female psychoanalysts putting forward new theories. They put forward their views about psychoanalysis being similar to a 'thought community' as proposed by Fleck (1981) and that individuals found it hard to challenge the taken-for-granted views of their training organisations and academic and professional community.

As can be seen the participants discussed a range of aims varying from helping with very difficult decision-making and unravelling unconscious conflicts arising in childhood that might affect the VC decision. In addition some participants discussed how they needed to raise the question about motherhood with their younger patients as a way of warning them against leaving it too late, and others spoke about helping patients to mature sufficiently so they are able to provide

adequate parenting. On the other hand, some participants discussed helping patients to come to terms with the VC choice on the basis that their childhood experiences had left them unable to provide adequate mothering. The literature provided additional aims such as helping patients to manage their superego with regards to the motherhood mandate, the shame around leaving it too late and Leon (2010) provided aims about how to work with infertility by using an integrative approach similar to gay affirmative therapy.

There were also challenges to the profession about the dangers of narcissism if the analyst were to unconsciously or consciously to suggest to a patient that they could cure psychogenic infertility. As mentioned previously, there was an implicit message from the participants that they see their role as helping some patients to become more aware of whether they are psychologically ready to become parents. This was not raised explicitly in the psychoanalytic literature in this section but was tackled by the sociologist Campion (2005). Psychoanalysts Welldon (2006) and Almond (2010) have written about women who had become mothers and were providing cruel parenting and it seemed an implicit message from some of my participants that they were trying to prevent this happening. My research findings have shown how VC and childlessness is a complex this issue, how enmeshed it is within the cultural discourse and that the psychoanalytic theory may not be providing adequate support in how to understand and work with VC in a clinical setting.

6.3.3 Subordinate theme two - The personal self and the professional self

The participants described their personal feelings with regards to childlessness and who was fit to parent. At times, there was a blurring of the boundaries between the personal and professional self. It is inevitable that psychoanalysts will have their own feelings, reactions, opinions and biases as part of being a human being living in society. As an example from the literature, Basescu (2001) describes how her own lifestyle, values and choices may interact with the patient's values, lifestyles and choices. Interestingly, Chodorow (2004) describes how her own strong maternal identity leads her to believe that there is no substitute for motherhood. Therefore she states that when working with a patient who is childless as a result of the biological clock it can be hard not to agree with the patient that on some level "there is something absolute and irretrievable in her situation" (2004, p.1182). In this research, Denise was very aware that given that parenthood was so important to her, she did not want to impose her wishes on her patients.

Thomson (1956) argued that the totality of the analyst, including the analyst's values, influence the work. There is an ongoing theoretical discussion about how the therapist's experiences as a child and an adult impact on their work with patients. Gerson (1996) states that there is now a general understanding that the analytic interaction is like all other relationships in that it is co-created by two people. The blank-screen therapist as advocated by Freud is no longer considered to be possible from most psychoanalytic perspectives. Some psychoanalytic writers (Rosen, 2005; Alizade, 2006; Ruderman, 2006) argue strongly that female psychoanalysts need to be aware of their own unresolved conflicts with regards to their own femininity and how these manifest in their

social and professional life.

Angela and Beth expressed the view that being a parent can create turmoil for some individuals, a view which is supported by Pines (1993). She discusses the inner turmoil that pregnancy and the birth of a baby can provoke for some women. She describes how pregnancy, particularly the first, is a crucial stage in the search for a female identity. The woman is now no longer just responsible for herself but will also be part of a mother-child relationship. This can provoke earlier unresolved developmental conflicts for women, which in turn can affect the new mother-child relationship. The view expressed by Pines is written from a clinical perspective whilst the ones given by Beth and Angela had the added personal dimension.

Denise's view that we live in a 'have it all' society is supported by De Marneffe (2004) who also makes general statements about the cultural imperatives that drive women to combine high powered careers and motherhood, where everyone loses out. Beth's view about older women denying their own mortality by having children through IVF is supported by Chodorow (2004) who argues that Western society in the twenty first century encourages the narcissistic view that time stands still and that we can avoid the ageing process. Cathy's alternative standpoint was that society puts pressure on women to have children through the motherhood mandate, which has been discussed at length by sociologists such as Morell (1994:200) and Gillespie (2000) and explored in chapter four, 4.4.3. The view held by some of my participants, that many individuals have children for 'all the wrong reasons' has been expressed by many authors. In particular Welldon (1988) has explored the dark and pathological side

of mothering which cracks open the motherhood myth. Cathy held the view that all women were ambivalent about motherhood and this has been well document by Parker (1995) in her book 'Torn in Two', as discussed in Chapter Four.

See 4.4.3 for a further discussion on views put forward by Welldon (1988) and Parker (1995).

6.3.4 Implications for practice

Dreher and Sandler (1997) amongst many other writers have pointed to how it is impossible for analysts not to have their own implicit aims and ideas about the course of treatment and often these are outside of awareness. Analysts will also carry their own culturally determined values and prejudices that have also developed during their development and social environment. There is no way they can escape these influences nor can they be completely neutral and it is generally accepted that it is an impossible task. As mentioned in Chapter two, section 2.4, countertransference needs to be reflected upon by the analyst in order to consider whether it is helpful or obstructive to the analytic relationship. My participants used the interview to express their own personal and professional views about childlessness in general as well as who is fit to parent, and the right to parent and not to parent. Many of these views reflected the cultural discourses in society and each participant placed a different emphasis on these topics. Some of the dominant cultural discourses are concerned with the rights of the child, responsible and irresponsible parenting, and who is fit to parent. As the literature in this discussion has shown, this is an inevitable aspect of the analytic work as psychoanalytic practitioners are also part of society. Relational psychoanalysts such as Mitchell (2000) argue that minds are

inseparable and relationships are co-created, which is just as true in the consulting room as in other non-clinical settings.

One can only speculate about how much of my participants' own personal views entered the consulting room either consciously or unconsciously. Beth and Denise and Beth overtly stated how they attempted to keep their personal views separate from their professional views. All of the participants showed their personal responses with what was happening in the lives of their patients. This shows them as not only being very human but also shows that the four participants did not seem to be blank screens with their patients, which would support the literature. This situation however makes it even more crucial that the questions arising from my research regarding fitness to parent as well as the right to parent and the right not to parent need to be addressed in training organisations. This will enable individual psychoanalytic practitioners to bring unconscious views regarding these issues to the surface and thus there is less likelihood of the course of treatment being adversely affected.

6.3.5. Subordinate theme three – Managing counter–reaction and understanding countertransference

Although the participants did not mention the term countertransference, except in response to a question from me, I have used two terms to describe their strong emotional responses to particular patients who were childless. These are countertransference and counter-reaction as discussed in Chapter two, section 2.4 and further below. The literature included in the discussion includes all aspects of different understandings of the psychoanalytic practitioners' emotional responses to working with childlessness. My main research area was in VC but

as IPA aims to follow the words of the participants, this additional area has been included as IVC was not included in the Literature Review in Chapter two.

The analyst's emotional response to a patient is known as countertransference and within the profession the term has been used to describe quite different phenomena (Cashdan, 1988). Spotnitz (1985) made a distinction between the 'objective' and 'subjective' countertransference: the former being what the therapist experiences as emotional contagion from the patient, and the latter is everything else. Freud (1912) considered any countertransference as the analyst's neurotic conflicts that needed to be overcome. However these two phenomena can both be experienced strongly and can be difficult to distinguish from one another (Cashdan, 1988). A more standard way of defining countertransference in the profession is used by Greenberg and Mitchell (1983) who state that it is "an inevitable product of the interaction between the patient and the analyst rather than stemming from the analyst's infantile drive-related conflicts" (Greenberg and Mitchell 1983:389).

In object-relations work, countertransference is seen as the therapist's response to projective identification and is viewed as a valuable tool (Heinmann 1950: Cashdan, 1988). Projective identification refers to patterns of behavior that induce others to behave or respond in particular ways (Cashdan, 1988). However, despite the widespread acceptance of countertransference by Kleinians, Klein herself stated, "it was elevating subjective feelings into a virtue" as cited in Rycroft, (1995, p.29). Donna Orange (1995), a relational analyst, refers to 'co-transference' as a way to explain how the therapeutic relationship is very complex and is an intersubjective field between the client and the therapist

and therefore it is a co-created space. She would argue that it is time to dispense with the terms transference and countertransference as both have negative connotations (Orange, 1995). Burns (2005) argues that all psychoanalysts are walking a tightrope between restraint and spontaneity with regards to their use of their countertransference. However, an in depth discussion on the subject of countertransference is beyond the scope of this thesis. In this thesis, I have used the term counter-reaction to refer to what might be considered unhelpful countertransference. See Chapter two section for a further explanation of this term.

In terms of countertransference/counter-reaction as a result of working with patients who are IVC, Mariotti (2012) argues that for the analyst working with infertility there might be an implicit belief that psychoanalysis should overcome psychogenic infertility. According to Wischmann (2003), a Jungian psychoanalyst, in the past it was assumed that there was a psychopathology at the root of why couples might have medically unexplained infertility. Mariotti (2012) cautions against the psychoanalyst's sense of omnipotence in the face of a patient's strong desire for a child. One can see that psychogenic infertility is very controversial, with Apfel and Keylor (2000) arguing that this concept is very unhelpful in treating people with infertility. The three aforementioned authors are suggesting that is very important that psychoanalytic practitioners do not assume that these emotional responses give insight into the patient's unconscious but may well be counter-reactions. Rosen (2006) discusses her countertransference in working with infertile patients who were struggling with pain and anger, describing the physical discomfort she felt in the face of such despair. When faced with these feelings analysts may be pulled towards wanting to rescue the

patient by problem solving or becoming the expert, thus avoiding the loss and helplessness being experienced by the patient. The explanation by Rosen points to how psychoanalytic practitioners might avoid the patients conscious and unconscious feelings, if their countertransference is not interpreted carefully. This could explain Denise's deep wish for her patient (S) to have a baby so she could experience unconditional love, as mentioned in 6.1.

Rosen (2002) too warns against the overt and covert psychoanalytic messages that promise an increased probability of conception as a result of psychological intervention. If the female patient does not become pregnant there might be a subtle message from the psychoanalyst that they are to blame for their predicament. These would be counter-reaction responses. Rosen (2006) highlights the economic inequalities that exist in terms of fertility treatment as most often it favours white, middle class, heterosexual, married couples. She argues that psychoanalytic theories can inadvertently depoliticise important cultural issues and that clinicians can get caught in contradictory cultural and personal dilemmas. This is a theme that I have been highlighting throughout my thesis in terms of the VC decision.

In her paper about infertility in the age of technology, Blum (2012) describes how she had to examine her own ideas about the patient's decision to have medical procedures to conceive, as the patient may pick up subtle clues to her feelings and may be influenced by them. She argues that male analysts are less likely to be affected by their female patients' predicaments but they are not immune to them as procreation touches on a universal concern. Blum states that analysts would also need to be aware of their own attitudes towards single or homosexual

patients who wish to undergo ART as their interpretations may contain a subtle but negative message. None of the other participants discussed their attitude to gay or single parenting and when mentioning those who were undergoing ART they did not express any personal conflict. However Beth did say that if a woman really wanted a baby being single need not deter her and Denise said that in our contemporary society women did not need men to bring up children.

Denise expressed the view that the female VC choice was rare and that most women want children. She clearly struggled with some of her patients' choices in this direction but she was honest with herself about this. Kamalamani (2009), an integrative psychotherapist, and a VC woman. talks about how important it is for therapists to know their own conditioning, biases and preferences with regards to the link between motherhood and femininity and to be aware of how these can affect their work. This theme understandably engenders strong feelings and it can take courage for us to face those feelings. She stresses the importance of therapists being honest with themselves about how they feel with regard to the potentially deviant otherness of this cultural phenomena.

In her narrative, Denise discussed how she felt judgmental about women who felt they 'could have it all' in terms combining high-powered careers with motherhood. When discussing the conflict that many women in Western societies have with regards to combining motherhood and a career, Ruderman (2006) stresses the importance of female analysts being aware of their own ambivalence and attitudes to success in order to enhance and enrich learning in the analytic experience for both patient and analyst. This would echo the relational stance on countertransference as previously mentioned. She goes on

to argue that psychoanalysts can help to forge a new vision of a woman's role in society. This new vision could include a more positive view of the VC woman.

6.3.6.Implications for practice

A question that has been underlying this thesis is how canpsychoanalytic practitioners and psychotherapists take a more active role in challenging the motherhood mandate and the associated stigmatisation of VC women that is so prevalent in Western societies? However as mentioned earlier many would not consider this to be their role. I would argue along with Ruderman (2005) and Kamalamani (2009) that becoming conscious of our prejudices is the starting point. Another is that the inextricable link between motherhood and femininity needs to be questioned more in psychoanalytic and psychotherapeutic training organisations.

It is interesting that none of the psychoanalytic writers discussed in this chapter used the term countertransference as a means of interpreting the patients unconscious. However, Stuart (2011) and Alizade (2006) warn of a counter-reaction if analysts assume that a woman's creativity can only be expressed through the birth of a biological child. My research findings show that the countertransference/counter-reaction that might well arise is that the analyst has a strong wish for their VC patient to have a baby. Indeed Cathy stated that if her patient was to choose to have a baby it would feel as if it her was her baby. Beth also overtly stated how she would find it hard to keep her personal responses in check if she felt her patient was likely to be an unfit parent. On the other hand in her desire to not to impose her personal views about the importance of

motherhood, Denise felt she may not have sufficiently explored her patient's VC choice. Angela showed how she kept her personal responses in check by her statement 'I would not want to push her'. None of my participants reflected whether their responses might have been useful countertransference in the sense that it gave them insight into the patient's unconscious. The literature referred more to the unhelpful countertransference regarding working with infertility and the dangers of psychoanalysts falling into the trap of omnipotence by either consciously or unconsciously suggesting to patients that analysis could cure psychogenic infertility.

Diethelm along with Horney (1951) as cited in Dreher and Sandler (1996:61) argue that the aims of psychoanalysis will depend on the analyst's 'Weltanschauung'. This is the particular philosophy or view of life or the world-view that the individual holds. Of course this particular study could not unfold the weltanschauung of my participants but one can get a brief glimpse of this through their personal responses as shown in the findings. What seems to be clear is that the topic about whether or not to parent evoked strong personal and professional responses. As Dreher and Sandler (1996) point out: analysts need to consider that what they may see as resistance in their patient may well be the analysts own value laden countertransference/counter-reaction. Therefore if psychoanalytic practitioners link motherhood and femininity, these messages could be passed implicitly or explicitly to VC patients, which would not be respectful of their choice.

6.4 Conclusion

The findings in this chapter have focused on how the participants view their role when working with childlessness and the decision about whether or not to become a parent. The participants did not see the VC choice as a 'cut and dried' decision but one that was fraught with unconscious conflicts. Some of the participants emphasised that their role was to help their patients become more conscious of these defenses in order to develop a maternal ego.

Some of the participants highlighted how problematic their role was in the face of terrible dilemmas such as if the patient was fearful of becoming a parent because of the fear of passing on a genetic illness. Other participants focused on helping patients to make difficult decisions with regards to a diagnosis of infertility, particularly with regards to adoption or ART. Cathy in particular viewed her role as helping her patients to become sufficiently mature so that they were ready to parent.

All of the participants raised the question about who was fit to be a parent but they did not elaborate on how they saw their role in this instance. However Angela spoke more generally about how through the course of psychoanalysis some patients would come to the realisation that their very poor experiences of being mothered as a child left them unfit to become a parent themselves. Beth referred to the need for patients to come to terms with what had happened to them in their childhood.

Another aspect of their role that they discussed was how to respond to women who had not made any decision about whether to become a mother, particularly if they were reaching an age when it might be biologically impossible. Some of

the participants felt that they should raise the issue as a way of helping their patients to avoid the disappointment and regret of leaving it too late. However, both Angela and Denise raised the concern about the timing and delicacy of this kind of intervention and whether or not it could be harmful for the patient. An important point that was highlighted by the participants' views was that the way they perceived their role depended on whether or not they took the view that motherhood was a normative path for women.

Chodorow (2003) Rosen (2005:2006) and Mori (2012) all raise the dilemmas presented by the myriad of choices available to women in the modern age, that may well compromise their chances of becoming a mother. Just like the participants, they themselves grapple with clinical interventions seeking to encourage women to consider their reproduction choices, which is in conflict with the slow unfolding of the unconscious through the process of psychoanalysis..

Like some of my participants Leon (2010) considers that an important aspect of an analyst's role is to help patients with decision-making in the face of the challenges of infertility. Apfel and Kepler (2000) and Mariotti (2012) warn against analysts giving subtle messages to clients that analysis can overcome psychogenic infertility as this could result in the patient feeling to blame for their condition.

Pertinent to the research question and aims of this research, psychoanalysts Alizade (2006) Ruderman (2006) and psychotherapist Kamalamani (2009) argue for the need for psychotherapists, both male and female, to become far more aware of their own prejudices and views with regards to the importance or otherwise of parenthood. Denise was openly judgmental about mothers who

expected ‘to have it all’. However there is no evidence to suggest that the personal views of the participants in this study interfered with the treatment of their VC patients. Some participants expressed their general concerns for women who delayed childbearing but then had left it too late due to their biological clock. Chodorow (2003) highlights the pressures from our narcissistic society that encourages individuals to believe they can defy mortality and overcome the biological clock.

The participants gave descriptions of their emotional responses to their patient’s childlessness but they did not reflect on how this gave them insight into the patient’s unconscious as in the contemporary view of countertransference. They tended to be more concerned that their emotional responses might interfere with treatment and in that sense they were counter-reactions.

A theme that emerged for some of the participants was their wish for a particular patient to have a baby. This phantasy was often in conflict with the patients’ wishes or may not have to have been in the best interests of the woman or a potential child. The child as a symbol is a powerful one in society and has many layers of meaning – hope, the future, vulnerability, freedom, responsibility, innocence, tainted with original sin, and a messenger straight from God. The participants did not explore in depth this countertransference/counter-reaction but Denise and Beth both commented how they had to be mindful of imposing their own wishes on a patient. There is much literature on countertransferential issues for analysts when working with infertility but much less relating to countertransference in the face of VC. On the latter issue, the writers stress the importance of remaining open to different choices and not equating creativity with a baby. There was an absence of literature relating to the dilemmas of those

faced with a life threatening illness or genetic disorder

There is a recognition that analysts have to suffer with the patient, but not suffer like the patient. The participants have demonstrated that there is a fine line between identifying with the pain of their patients yet not rendering oneself ineffective by over-identifying with them. Certainly all of the participants showed an awareness of this dilemma and one can see why psychoanalysis has been referred to as the 'Impossible Profession' (Freud, 1937).

This chapter has shown that there are conflicting aims with regards to how to work with VC individuals. This has been shown not only from the participants themselves and their particular patients but also the literature presents different theoretical perspectives and recommendations. These aims range from encouraging analysts to challenge the motherhood mandate that exists in the profession, to encouraging patients to think about the timing regarding motherhood so as not to leave it too late. There is also reference from both my participants and the literature that psychoanalysis should help the patient to uncover their resistances to becoming a mother in order to fulfill their feminine role. Another aim that the participants mentioned was helping their patients to mature sufficiently so they were fit to parent. These are far reaching aims and would fall in line with Dreher and Sandler's (1996) view that psychoanalysis is not monolithic, so as a profession cannot be seen as having single aims. However what is clear is that in both the literature and my participants' narratives there was no theory from within psychoanalysis that they could refer to that would help them to affirm the choice of the VC patients.

CHAPTER 7 CONCLUSION

7.1 **Introduction**

This chapter seeks to remind the reader of the research question that this thesis set out to answer and consider the ways that my research findings have or have not provided answers. Next, I shall consider the subsidiary questions that will be examined to consider the degree to which my findings have shed light on these lines of enquiry. The aims of the research will also be examined to ascertain if these have been met. Then, I will outline the findings of my research reminding the reader of the superordinate and subordinate themes that were presented in chapters four, five and six. Contributions to knowledge shall be presented and I will show how these have been met in my findings. The implications of the findings will be further explicated demonstrating the role and value of this particular research. A critical reflection shall be presented where I will give a reflexive statement on the research process and will consider the limitations of this research. Following on, this research will be critiqued for quality, validity and rigour as outlined in chapter three, section 3.8.8 and will consider the degree to which these have been achieved. Consideration will be given to the scope of future research and closing remarks will be presented.

7.2 The Research questions:

The primary research question in this thesis is to explore how psychoanalytic practitioners understand, conceptualise and respond to VC in the clinical setting. Each part of this question will be considered individually.

Understand: The findings show that the participants understood VC in various ways:

1. The VC choice was made as a result of difficult experiences and primary-caregiver relationships in early life. This often led individuals to have difficulty in forming intimate relationships and fearing the responsibility of children.
2. Some individuals choose VC due to the fear of passing on a congenital illness, poor parenting or a mental health problem.
3. It is better for some individuals to choose VC because they could not provide adequate parenting because of their own difficult childhood experiences or mental health problems.
4. Three of the participants indicated that VC can be a healthy choice for women but it is unlikely that they would present for analysis.

Conceptualisation: There was no unified way in which the participants conceptualised VC.

1. Angela, a psychoanalyst, referred to the Oedipus complex, the parental couple and to the maternal function. She used these concepts to explain how they contributed to the VC choice. For example, she intimated that unsuccessful negotiation of the Oedipal stage could give rise to VC. If the parental couple had a difficult relationship the child would be likely to internalise a negative view of parenting. If the female child did not have a positive enough relationship or modelling from her mother, then the maternal function would not be developed, potentially resulting in a VC

choice. Here Angela is referring to classical Freudian theory and object relations theory.

2. Cathy, a psychoanalytic psychotherapist, referred to Kleinian theory to suggest that VC was an unconscious attack against the patient's mother. She also referred to the masculinity complex, which is a classical psychoanalytical theory (see chapter two, section 2.2.1 and 2.2.2 for an explanation of this term).

3. Denise, a psychoanalytic psychotherapist, made reference to developmental theory to account for her female patients' VC choice. She stated that 'something was missing' in this patient's development but it was not clear which theory she was referring to. (See section 5.3.3 and 5.3.5 for further elaboration on developmental theory).

4. Beth, a Lacanian analyst, referred to theory throughout her narrative and often this related to human development in particular. She did not refer to any particular theory to conceptualise VC but she did say how childless individuals might account for their feeling of lack through their childlessness. She did refer to the Freudian theory of displacement. There was a sense that she was referring to IVC individuals in this instance.

Respond: My participants responded to VC in a variety of ways.

1. All of the participants considered that the VC choice needed to be unpacked and explored. Some of the participants explicitly stated that this exploration might enable the patient to realise that they really did want a child.

2. Some participants encouraged younger patients to consider the consequences of the biological clock and 'leaving it too late' to have a child. The implicit and sometimes explicit message was that if a younger patient had made a VC choice, the participant would question this choice.

3. Helping some patients to come to terms with the VC choice as a better option either because the patient feared passing on a genetic illness or because through the course of analysis the patient realised they could not provide adequate parenting.

4. All of the participants implied or explicitly stated that if the patients worked through difficult childhood experiences it would allow the unconscious reason for their VC choice to come to the surface. The patient could then re-examine their VC choice.

5. All of the participants implied or explicitly stated that analysis might help the patient to develop a healthy enough part of themselves so they would be ready to become an adequate parent.

7.2.1 Subsidiary questions:

The first subsidiary question is whether there is binary thinking in the consulting room with regards to parenthood/ non-parenthood and mother/ non-mother, male/ female. This was not an easy question to answer as there were such a mixture of results from my participants.

1. One participant suggested that she was surprised that one of her patients made a VC choice as she was so 'caring'. The implication is

that a VC woman would be ‘non-caring’. All the participants made implicit or explicit reference to ‘good’ and ‘bad’ mothering/parenting but they also stated that parenting was difficult for most people.

2. All of the participants assumed that my main research interest would be in the VC choice of women even though I did not specify this in my summary of research given to the participants (see appendix 5). However, once prompted, they did include a discussion of male patients. However two participants stated that in their experience the decision whether to parent was not a primary concern for male patients.

The second subsidiary question is whether modern day psychoanalytic practitioners make an inextricable link between femininity and motherhood. The views were mixed on this question.

1. All of the participants referred to the biological urge, or the biological clock that face women in particular. One participant stated that every woman has to face the decision about whether to have a child at some point and it is never easy.

2. The VC choice was questioned by all of the participants and they stated either implicitly or explicitly that the choice was rooted in unconscious, conflicted childhood experiences. The implicit message was that if childhood relationships had been ‘good enough’ then motherhood would follow naturally in adulthood. The participants also reflected the view that it was better that some women should not be parents.

The third subsidiary question is whether or not psychoanalytic practitioners are affected by pronatalist culture and does this enter the consulting room. The participants narratives would suggest that this is the case.

1. The personal views expressed by some of the participants reflected the anti-natalist cultural discourse around older women having children.
2. Some participants referred to particular individuals being thoughtless in their decision to parent,
3. Some participants referred to career mothers and how difficult this was for these patients and women in general to combine both roles. One participant in particular considered these women to be selfish as they did not put the needs of the child first. This is an ongoing aspect of a cultural discourse in our society.

7.3 Aims

One of the aims of this thesis is to contribute to existing knowledge on VC by highlighting the possibility of the pathologisation of VC in the clinical setting and how this might undermine the agency of female patients.

This research has already contributed to knowledge as I have presented at conferences and written articles for psychotherapy journals on VC. I have drawn attention to the potential pathologisation of female patients as outlined 7.2 and throughout this thesis. The findings have also highlighted how the subject of VC is very complex and how it was difficult to keep the participants focused on the topic. Their narratives included a discussion of how the choice to be a parent might also be pathological. All of my participants considered the VC choice

needed to be unpacked and the patient could well experience this as a pressure that could undermine their agency.

Another aim is to propose a biopsychosocial approach to working with VC that could be developed in further research. This thesis has set out to bring together literature from a wide range of sources on the subject of VC. From that perspective it has introduced the biological pressure that women may experience to have children. This has included the psychoanalytical developmental theory based on drives (2.2.1). However some of the literature points to the lack of biological drive for a child (2.2.3). This thesis has also highlighted the psychological pressure that individuals experience to have children and from a psychoanalytic perspective having children is seen as an important stage in a woman's development (Benedek 1959). Other literature has shown the other psychological reasons that women might choose to have children such as narcissistic reasons or to repair childhood experiences 2.2.3 (Welldon. 1988). Sociological reasons have highlighted how women might choose VC as a sign of their maturity as they have the strength to defy cultural messages and do not define their femininity as linked to motherhood (Morrell 2000). The sociological literature has challenged the stereotyping of VC women being career driven and child haters (2.6.2, 2.6.3). The psychological costs might be the stigma that is experienced by those who choose VC. The sociological literature has highlighted the pronatalist pressures on women and how this might be reflected in the psychoanalytic theorising (2.6.5). My findings have shown that the participants focused mainly in the intraspsychic conflicts regarding the VC choice but some participants also mentioned the societal changes that have allowed women this

choice or make it difficult to become a mother. See 7.9 for suggestions for further research.

The third aim is to highlight the complexity of the subject by considering literature from other psychological therapists besides psychoanalysis as well as contributions from sociologists, feminist and other health professionals involved in the field. This thesis has highlighted how when the psychoanalytic practitioners in my research discussed the decision whether to become a parent that they conflated VC, IVC, 'leaving it too late', fitness to parent and right to parent. It was very hard to keep the participants focused on the primary question of VC. This could suggest that this subject evokes very powerful conscious and unconscious feelings in the participants and the researcher. Another possible understanding is that the participants felt experienced internal pressure as does not seem to be psychoanalytic theory that supports the VC choice.

7.4 Summary of findings

This thesis is comprised of one empirical study whereby four psychoanalytical practitioners were interviewed regarding their understanding, conceptualisation and response to VC, and analysed using IPA methodology. The themes that arose as a result of these studies were;

Theme one: Biopsychosocial and professional pressures was the superordinate theme and the subordinate themes were the biological urge and the myth of maternity. The findings and subsequent discussions and implications were presented in chapter four.

Theme two: Ethical dilemmas and fitness to parent was the superordinate theme. There were four subordinate themes that were the fear of passing on a

genetic illness, difficult experiences in childhoods, some individuals were too immature to parent and mental health. The findings and subsequent discussion and implications were presented in chapter five.

Theme three: The superordinate theme was working with childlessness is complex and conflictual. There were three subordinate themes: to attune to the patient's unconscious, the personal versus professional views, and understanding countertransference and managing counter-reactions The findings, discussion and implications were presented in chapter six.

7.5 Contributions to knowledge

Due to the paucity of knowledge with regards to VC in the psychoanalytical clinical setting, this thesis extends our knowledge on this topic. This research will also provide a base for future studies as outlined below in section 7.9.

1. The psychoanalytic literature discusses the countertransference/counter-reactions that might arise for practitioners working with infertile patients (Rosen, 2006). Some of the literature (Stuart 2012) cautions clinicians against assuming that all women should be mothers as this could influence the course of the treatment. This research highlighted how one of the possible countertransference/counter-reactions responses to VC was the practitioner's strong wish that their patient have a baby. One of the participants in this research understood her countertransference/counter-reactions as wanting her patient to know unconditional love.

2.. Much of the literature suggests that patients realise that they do want to have a child or do become pregnant as a result of analysis despite a

diagnosis of infertility (Morris, 1997). However one participant suggested that analysis may allow a patient to realise that they should indeed not have a child because they have not internalised adequate parenting skills. Thus, rather than a child being born as a result of analysis, a VC choice may indeed arise as a result of analysis.

3. Another finding from this research that was not found within the psychoanalytic literature was the complexities of working with those who had a genetic illness or a life threatening illness and how that affected the choice about whether or not to become a parent. Psychotherapists and psychologists (see 5.3.1)) have researched these issues and have indicated that these individuals seeking psychological help need an eclectic psychotherapeutic approach.

4. The findings in this research also drew attention to how cultural discourses in society with regards to VC enter the consulting room and how their personal values relating to this issue may well influence the course of the treatment. There was no evidence to suggest that my particular participants allowed their own values to influence the course of the treatment. Neither is there a suggestion that their personal biases explicitly entered the consulting room. This thesis is highlighting the potential for this to happen if practitioners are not consciously aware of these biases. See implications sections in Chapters five and six for a further discussion.

5. The findings outlined the breadth of the role of the practitioner when working with VC and how this might include: helping with decision making regarding the VC choice, helping the patient to mature in readiness for

parenthood, intervening, and in some cases challenging the motherhood mandate, or upholding the motherhood mandate, and encouraging younger patients to think about motherhood so they do not leave it too late in terms of the biological clock..

6. The degree to which psychoanalytic work could be sufficiently reparative for individuals who had experienced traumatic experiences in their childhood was also raised in this research. The implicit communication from some of the participants was a query about whether psychoanalysis/psychoanalytic psychotherapy could help all patient to develop adequate parenting skills and a positive maternal function. This was particularly the case if the patient had experienced traumatic experiences with parents in their childhood.
7. This particular research is novel in that it is the first at the time of writing that has asked the views of psychoanalytic practitioners their understanding of VC.

7.6 Implications for practice

The implications of my findings were discussed in chapters four, five and six and here I would like to highlight the main points.

1. Regardless of whether the participants were psychoanalysts or psychoanalytic psychotherapists there seemed to be no difference in the way they took a case-by-case approach to their patient's childlessness. Their aims seemed to be dependent on what they considered to be the needs of the patients and these aims were not monolithic but multifaceted.

See appendix one for a discussion of the difference between psychoanalysts and psychoanalytic psychodynamic psychotherapists

2. Various psychoanalytic-developmental theories have been discussed in this thesis. My participants did not refer explicitly to developmental theories but did make general statements about whether or not patients were sufficiently mature to parent. Most of the participants suggested that motherhood was a normal path for most women because of the biological urge but they were not explicit about whether or not they viewed motherhood as a developmental stage. Therefore VC patients could well be subject to a form of 'conversion therapy' that is psychoanalytic practitioners consciously or unconsciously turning the VC patients into mothers. Until relatively recently, homosexuality was treated as a pathology in psychoanalysis and conversion therapy was considered to be acceptable by some psychoanalytic practitioners. Transgender issues are now reaching public discourse and guidelines have been given by the UKCP and BACP about how to address these issues in counselling and psychotherapy. One potential outcome of this research would be the recommendation that such guidelines need to be provided for working with VC so as to inform practitioners about the complexity of the subject.

3 As discussed in Chapter five Yonke and Barnett's (2001) overview of women's contribution to psychoanalytic theory has continued to reflect the link between femininity and motherhood. As shown in some of the literature discussed in the previous chapters psychoanalysts such as Raphael-Leff (2015) have highlighted the choice women have about motherhood because of contraceptive methods. Therefore it is possible

that female patients may present for psychoanalysis having made a VC choice, however it cannot be assumed that it is rooted in pathology. It is time for a new theory of women's development that includes the life cycle of women who do not have children. Mardy Ireland's studies (1998) and much of the sociological research (Morell 2000) shows that it is possible for women to continue to develop psychologically even in the face of IVC. Humanistic psychotherapists such as Rogers (1902-1987) have argued that it is an inevitable part of being a human being that we continue to grow through our life cycle regardless of our particular circumstances. It is possible that some psychoanalytic theory can hinder practitioners in viewing the human potential and in this case for women's development to proceed with or without children. It will be interesting to see if the new developments in neuroscience as mentioned in 5.3.4 will shed further light on why some individuals have a stronger biological urge than others.

4. In Chapters Five and Six the work of Sandler and Dreher (1997) was referred to as a way of considering whether the different aims of psychoanalysis as they are outlined are reflected in the findings of this study. Freud's (1912) view was that psychoanalysis was designed for neurotic patients who had not resolved the Oedipus stage. Although the sample is small in this study is small, it can be seen that the way in which the participants describe their role is much broader than helping patients to resolve the Oedipus complex and achieve genital primacy. Some of the patients that were presenting for psychoanalysis were presenting with complex issues as a consequence of our post-modern age and changes in medical science and reproductive technology.

5. Although psychoanalysis has developed with many theoretical models and schools, Sandler and Dreher (1997) have highlighted that there is still a strong resistance to changing theory. Yonke and Barnett's (2001) analysis of the theory relating to women's development has shown how it has been particularly resistant to change. It would appear that psychoanalytic training organisations and individual practitioners need to continue to examine the unconscious processes that tie the profession to Freud the symbolic father.

6. The findings in this research are highly significant for clinical practice as they suggested that participants were influenced by the competing cultural discourses in society. However as mentioned previously, it is not evident in my findings that these influences affected the course of the treatment. It is very likely that psychotherapists and counsellors will be equally affected by these messages. Alongside these messages, psychoanalytic practitioners and psychotherapists are likely to be affected by existential issues concerning whether or not to be a parent and how one creates meaning for one's life. It would seem highly pertinent that psychotherapy and psychoanalytic training institutions encourage an open reflection regarding theory that typically views parenthood as normative. Some of the participants in this research implied that their psychoanalytic theory training encouraged pro-natalism. The sociological (Morell, 1993) feminist (Hird, 2000), and more recently some research from psychotherapists (Bonnici, 2010 Kamalani, 2009) and psychologists (Shaw, 2009) have highlighted how the VC choice can be life-enhancing for women. However, the decision-making and the consequences of such a choice

might propel individuals into psychotherapeutic help. Some of the participants in this research highlighted how they felt pressure to encourage their patients to reflect on motherhood regardless of whether this was of concern to the patient at that moment in time. Sociological writers (Morell 2000) focus more on the need to challenge the social discourse rather than locating the problem as an intrapsychic difficulty within the individual. I am recommending a biopsychosocial approach to working with VC that includes the biological, psychological and social influences on the individual in order to understand childlessness in all of its manifestations.

7.7 Quality and validity and rigour

In Chapter three, 3.8.8, I discussed Yardley's (2000) suggestions for assessing the quality and validity of qualitative research. In this section I plan to outline how I have endeavoured to achieve her four characteristics of good qualitative research: sensitivity to context, commitment and rigour, transparency and coherence, and, impact and importance.

With regards to sensitivity to context, I have given a considerable number of extracts from the participants' interviews to enable the reader to check that the interpretations made are grounded in the data set. In addition I have referred to existing literature in relation to the topic in question as well as the reasons why I have chosen IPA over other methodological approaches. There is also an acknowledgment of the sociocultural setting of the interview location, the participants as psychoanalytic practitioners, with their particular theoretical training and understanding. In addition, consideration has been given to the

wider society influences of pronatalist messages whilst at the same time there are a growing number of women who are making a VC choice. Through my reflexive journal I have considered how my life story and theoretical training have affected the research process. In any research process there is a power imbalance, generally in favour of the researcher who is often viewed as the 'expert' and she is often the one that will benefit from the research findings. Although I held the power with regards to how I interpreted the data, my participants were the experts in the field of psychoanalysis. Yardley (2000) discusses how some qualitative methods encourage the researcher to check their findings with the participants. Riessmann (1993), as cited in Yardley (2000, p.221), encourages researchers to ask the participants' views of the findings but warns against allowing these views to compromise the interpretations and analysis of the researcher. I did ask my participants to read their transcripts after they were transcribed. Angela did offer some further thoughts about her transcript, whilst the others were happy and did not want to add further comments to their transcripts. I did not ask them to read my findings in case this compromised my interpretations.

In order to demonstrate my commitment to the research process, I spent four months immersing myself in the data to allow the themes to emerge. I spent time discussing these themes with colleagues and I consulted with experts in IPA to ensure that these themes reflected the data collected. I attended a one week intensive training in qualitative research methods at Oxford University and a two day IPA Master Class at the University of the West of England. I also attended meetings held by the IPA group in London and presented my themes in order to receive feedback from fellow researchers. I have also presented at Student

Research Conferences in order to receive further responses from other professionals and academics. The titles for each superordinate heading continued to be refined throughout the research process and the findings and discussion have been re-written several times as I deepened my understanding of the topic being researched. This process not only demonstrates my commitment to the research process but also rigour in terms of the analysis and writing up stage. I have endeavoured to display the nuanced perspectives that each participant took with regards to the research question, while at the same time showed the commonalities across accounts. In the discussion sections of each theme I have presented a variety of perspectives on the findings including psychoanalytic, psychological, psychotherapeutic, feminist, geneticists and sociological literature.

I have endeavoured to abide by the principal of transparency and coherence and to provide clarity and cogency by seeking feedback on my writing style, as well as whether I was being 'fair' to my participants' voices. The research question fits with the IPA method as I was interested in how the participants made meaning of VC in the clinical setting. I have been transparent by describing in detail the research process including the data collection and analysis. I decided not to include a full transcript in order to protect the identity of my participants and their patients, as described in Chapter Three, section 3.8.1. I have provided details in the appendices 11, 12 and 13 of how I arrived at the final three superordinate themes. My research position considers that there are multiple perceptions of reality and that my experience of being in the world will affect my perspective and assumptions. Therefore I have continued to be reflexive about how I will have inevitably affected the research process.

In terms of the impact and importance of this research, one of the aims was to raise the awareness of psychoanalytic practitioners and fellow psychotherapeutic professionals regarding the complexity surrounding childlessness and decision about whether to parent. More importantly this research has endeavoured to highlight how both pronatalist theorising and societal messages might impact on the clinical encounter. However, this research will also be of interest to those outside of the therapeutic communities as its discussion of the findings will be relevant to many individuals in society. Much qualitative research has a political or socio-cultural objective and is interested in giving voice to those who are marginalised or stigmatised. The literature review in chapter two highlighted how some VC individuals do experience marginalisation in society and how popular media can encourage the stereotyping and stigmatisation of women who make a VC choice (2.6.5). The research findings and subsequent discussions have highlighted and elaborated upon some of the very complex decision-making involved for some individuals who make a VC choice on the basis of a genetic, physical or psychological condition. The sociological literature (Campion 2005: Thomas 1997) has highlighted the ethical debates concerning 'who is fit to parent', the 'right to parent' and the 'right not to parent'. From this perspective, this research is addressing socio-cultural and to some degree, political concerns about how much professional and political intervention there should be in what is essentially often a very private matter.

7.8 Critical reflections

As commented upon in Chapter two, section 2.1 qualitative research can take the researcher into unexpected territory and this has certainly been the case with

this particular research. In the first year of my studies I was focused on both VC and IVC. I was interested in the experiences of both men and women as well as the experiences of British Asians who were childless for whatever reasons. However, the Supervisory Board suggested that I narrowed the focus down to one area only as it was too broad in its original conception. As an IVC woman it was interesting that I chose to study VC. As I researched further, I became very curious about the complexity of the subject and also interested in why there was very little psychoanalytic literature on the subject of VC. This was particularly apparent after completing my literature review when I discovered there was a stark difference in the way that sociologists understood VC, in comparison to psychoanalysts. I was very interested in the clinical implications of VC and although I was being encouraged to interview VC individuals by my supervisor I felt there was an abundance of sociological research and I was not convinced that I would add anything new to the area even though it would add a psychotherapeutic perspective. I wanted to know if psychoanalytic practitioners still made an inextricable link between femininity and motherhood.

The interviews with my participants took me down routes that I had not imagined and raised very important ethical dilemmas about the right to parent and who is fit to parent. Initially, I was unable to find words to express my findings or to understand the feelings that were evoked in me by the results. Campion's (2005) book 'Who is Fit to Parent' helped me on this journey as it gave me a framework to understand my findings and process my discussion. I understood this feeling of strangulation as a kind of silencing which mirrors the finding from some of the sociological literature (Parks 2000) that suggests many VC people do not feel the reasons for their choice is believed or understood. What became

very apparent was that the subject of childlessness in all of its manifestations is full of judgments and I was not immune to this. I found myself caught between identifying with the participants' patients and the participants and was aware of my judgmental feelings. Therefore it was important that I found a way to disentangle myself so that I could present my findings and discussion in a reflective and as balanced a manner as possible. This has not been an easy process and from the point of view of this thesis being a symbolic child, the gestation period has been protracted and at times very difficult.

Although I have received very positive feedback about my research interest, the topic relating to childlessness and as it turns out parenting, is one that evokes very powerful feelings, not only on a personal level. I am consciously aware of my biases towards the psychoanalytic view of motherhood as a normative path for women and I do not want to identify with the tragic figure of IVC woman that is sometimes portrayed not only in the psychoanalytic literature but also in the popular media. In order to help with processing these powerful feelings I engaged regularly in process and academic supervision and invited colleagues to give me feedback on my work.

The most difficult aspect of writing up this project has been to keep the thread throughout, as my participants took me back to my original research question about infertility. I had not expected findings to include themes regarding VC as a result of mental illness and having a genetic illness. The literature from Thomas (1997) and the information from the Ethics Panel on Rosemary's baby (see chapter five, 5.3.1) also challenged my own views and this thesis became as much about the right not to have a child but also the right to have a child.. The

contrasting views from the participants about whether or not psychoanalysis could prepare patients for parenthood was an interesting finding and not one that was directly discussed in the literature review. Neither had I expected the subordinate theme of immaturity to feature so highly. I found myself deeply affected by some of the literature that questions whether one can be generative without children and whether one is seen as mature by others, particularly in relation to work as a psychotherapist. It was interesting to read the paper by Liebowitz (1996) who reflected on how her childlessness impacted on her work as a psychotherapist. I became very interested in the Beth's understanding from a Lacanian perspective that the sense of loss experienced by IVC can be used as an explanation for the loss we all feel as part of the human condition. At times I have felt stigmatised and isolated by my lack of children and in particular have experienced how they provide social capital for mothers. However, I have had to face the existential issues before others and to find meaning and creativity without children of my own. As such, this thesis is a generative act of mine. However sometimes it is difficult to disentangle one's own internalised stigma, and marginalization from the external pro-natalist messages in society. The process of completing this thesis has highlighted my resilience and ability to keep my focus in order to allow my symbolic child to enter the world

As a part of my own personal journey in terms of childlessness and the knowledge gained from undertaking this particular research, I would agree with Erikson (1950) who states that it is conflict and suffering that can propel us forward in to the next stage of our development. However, the psychoanalytic developmental theories do not account for those who are either VC or IVC but my own experiences and those of friends, colleagues and the literature

presented in this research, indicates that childlessness that the pain and conflict of surrounding this experience can be transcended, transformed and channelled into creative acts that do not involve giving birth to one's own biological child. From that perspective it is a new stage of life for the individuals involved.

The strengths of this research are in its originality in that I have interviewed clinicians whereas most of the research has been carried out with VC individuals. Although others such as Kamalamani (2009) and Bonnici (2010) have addressed the clinical issues of working with VC, to date no research has been carried out where psychoanalytic practitioners have been asked directly about how they understand, conceptualise and respond to VC in the clinical setting. This research has highlighted how complex the topic of childlessness is and how it is fraught with conscious and unconscious judgments and conflicts both for patients and the analysts.

The limitations of the research are that there are only four participants all of whom are women over 50 living in the South of England. My research may have produced different contributions to knowledge had I interviewed younger female psychoanalytic practitioners. Also it would have been interesting to include the view of male practitioners as this might have given a different perspective. However IPA encourages the use of a small, purposive and homogenous and seeks to make a comment about what that specific group of people say about their experience of a specific phenomenon. The gender/age narrow sample both reflects the psychoanalytic profession as a privileged field. There are always limitations to sampling.

In addition in my Researcher Profile (appendix 11) that was given to the participants before their interviews, I had included information about my IVC status. On reflection I wonder whether this might have affected the knowledge collected as the participants might have felt a need to protect me, thus withholding certain aspects of their experiences. Although the participants appeared to speak freely to me I have also reflected on whether I might have gained different knowledge if I was a psychoanalytic practitioner. My outsider status may, on the other hand, have been a strength, as the participants might well have felt more at liberty to be critical of some of the theories within psychoanalysis to an outsider. I do also feel that the fact that I was a fellow female clinician enabled them to talk openly about their personal views and countertransference/counter-reactions. As an IVC woman who has explored the link between childhood experiences and my current status it was sometimes difficult to be objective about the psycho-pathologising of infertile women. However throughout the research process I have been reflective about how my subjectivity might affect the findings. This research set out to understand how psychoanalytic practitioners understood VC but as explained in Chapter three, 3.8.3 I needed to expand my research interest to include patients who were childless for reasons other than medical ones. I had hoped that this would direct participants to discuss VC patients but their narratives conflated IVC and VC. Therefore my research has become much broader than initially intended but this could be seen as a strength as it highlights the complex and competing cultural debates about motherhood mandate.

Another limitation of this research is that I did not expand on the Lacanian theory

as highlighted by Beth. To provide an in-depth understanding of how richly Lacanian theory has provided to a contribution to women's development would have been outside the scope of this thesis.

7.9 Suggestions for further research

This particular research has highlighted some gaps in the psychoanalytical literature with regards to a wider exploration of VC and the decision of whether to parent. Some of this was outside the scope of this research and the following are suggestions for future research.

- Research might explore how VC women experience psychoanalysis, psychotherapy and counselling in terms of helping them with the decision making and managing the possible stigmatisation or social pressure that might result.
- Further research could be carried out into how psychoanalytic practitioners work with the decision making about whether to become a parent if one has a genetic illness.
- Over the last several years sociologists (Lunneborg, 1999; Tenturri and Mencarini, 2008) have carried out research into male VC but there is an absence of psychoanalytic literature on this subject. Psychoanalysts such as Pawson (2003) and Christie and Morgan (2003) have given their attention to male infertility but these studies have often been part of case studies into IVC in couples. A psychoanalytic or psychological research focusing solely on male VC would contribute to existing knowledge.

- This research was interested in how psychoanalytic practitioners understood, conceptualised and responded to VC. The same research could be carried out with psychotherapists from other modalities.

- A topic for future research could be to interview male psychoanalysts about how they understand, conceptualise and respond to VC as all of the participants in this research were female.

- Another suggestion for future research would be a psychoanalytic/ psychotherapeutic research into how the female and male VC choice was made because of the individual's mental illness problems or because their parent had a mental illness. My particular research highlighted the competing debates and ethical concerns around 'who is fit to parent?' which could be explored through further research.

- Some of the participants in my research implied how they sometimes felt under pressure to conform or were in conflict with their professional theoretical training. Therefore, another interesting area of research could be an exploration into whether or not psychoanalysts/psychotherapists feel constrained by the theorising in their profession, how so, and how they reconcile this within themselves. This links with Dreher and Sandlers (1996) views about implicit and explicit messages that come from psychoanalytic training organisations.

7.7 The End Note

This research has highlighted the complexities surrounding individuals' decisions about whether or not to parent as well as the competing cultural discourses surrounding this topic. The findings and subsequent discussions under each theme have provided insight into how these dilemmas, complexities and cultural discourses are played out in the consulting room. The starting point of this research was an interest in how VC was understood in the consulting room but the end point has provided a far richer, broader and diverse understanding of why individuals might be childless.

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time."
— T.S. Eliot, *Four Quartets*

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List of Appendices

APPENDICES

APPENDIX ONE

A discussion of the differences and similarities between psychoanalysis and psychoanalytic psychotherapy

Rangell (1954) outlined the differences and similarities between psychoanalysis and psychoanalytic psychotherapy. In his paper he was attempting to summarise the debates that had been occurring in psychoanalysis since 1947. He alluded to studies that had been carried out that doubted the universal nature of the castration and Oedipus complex (see chapter two, section for a further discussion of these theories). However, Rangell was more concerned with the method of therapy highlighting how some considered psychoanalysis and psychoanalytic psychotherapy as on a continuum and there was no clear dividing line between the two approaches as both were utilising the same psychoanalytic concepts. The treatment could be modified to suit the individual needs of the patient which might address goals or specific character change and the sessions might be twice a week rather than four times a week. The aim of psychoanalysis at the time was to bring about the resolution of the transference (see chapter two for a definition of this term) in the therapeutic relationship, whereas in psychotherapy they might employ a 'corrective emotional experience'. However, the basic goal of psychoanalysis – to confront the ego with repressed conflicts – would be addressed in either approach.

However Rangell's (1954) view was that the two were in fact distinct entities. He argued that the psychoanalytic psychotherapist viewed childhood development in

terms of interpersonal relations rather than from the libido theory that considers psychosexual development (See chapter two for a discussion of these terms). The goal and the methods are different in each but Rangell concludes by stating that neither one is better than the other.

Sandler and Dreher (1995) argued that there was a reluctance to relax the dividing line between psychoanalysis and psychoanalytically orientated psychotherapy. In part it was political as psychoanalysts did not want to endanger their professional status by endorsing psychotherapy which was seen as a manipulation of transference for therapeutic ends. However Alexander (1954) who was not an establishment figure, argued in the direction of de-emphasising any sharp distinction between psychoanalysis and psychoanalytically orientated psychotherapy. Psychotherapy was seen as carried out by therapists not training in the British Psychoanalytic Society or by analysts who saw their patients less than four times a week. This thesis will consider whether the findings reflect any marked differences in the way that the different practitioners understand, conceptualise and respond to VC in the clinical setting.

Title 1 - Psychiatry is a medical speciality, requiring medical training and psychiatry specialism training. It is regulated by the British Medical Association and the Royal College of Psychiatry.

Title 2 - Psychoanalyst - as mentioned in Appendix one does not cover one theoretical school they are mostly registered with the British Psychoanalytic Society. The British Psychoanalytic Council is a professional association and voluntary regulator of the psychoanalytic psychotherapy profession, publishing a Register of practitioners who are required to follow their ethical code and meet their fitness to practise standards

Title 3 - Psychoanalytic Psychotherapists – As outlined in Appendix one this is a contested title. These practitioners are usually registered with the BPC and may also belong to the UKCP or to their own professional training organisation.

Title 4 – Psychotherapist and counsellor - There are now many schools of psychotherapy and counselling and there is not always a clear distinction between the two disciplines. Counselling tends to be shorter term and focused on external events whereas psychotherapy is often in more depth. Psychotherapists are normally expected to undergo their own personal therapy whereas this is not always the case for those undertaking counselling training. In terms of registration each training body has its own requirements before the practitioner can be registered with them. Many psychotherapists are registered with the UKCP which covers a broad range of different psychotherapeutic organisations and schools of psychotherapy. Others may be registered with the BACP and in 2012, the BACP established a public Register, which was

accredited by the Professional Standards Authority for Health and Social Care, as a way of 'regulating' members in a profession which is not statutorily regulated. The BACP Register of Counsellors & Psychotherapists is a public record of therapists who have met their standards for registration. These standards cover training, supervision, continuing professional development and a commitment to our Ethical Framework. From 31 March 2016, all practising BACP members must be on the Register (or working towards registration).

Title 5 Counselling Psychologist – These practitioners have to be registered with the Health Professional Council and may choose to register with the British Psychological Society as well.

Appendix 3 – Ethical Approval Form

Appendix 4 – Consent Form

Participant identification number:

Title of Project: A Phenomenological Study of Psychoanalysts Experiences of Working with Individuals Who Do Not Have Children for Reasons Other Than Medical Ones.

1. I confirm I have read and understand the information sheet provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactory. …….

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. .....

3. I understand that my data will be recorded using an audio-recording device, and that anonymised use of my data may be used for verbatim quotation in the write up of this study. I consent to my interviews being recorded and verbatim quotation used.
…….

4. I agree to take part in the above study.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

Appendix 5 – Information Sheet for Participants

Summary Information for Potential Participants

Working title of the research thesis: If you decide to take part in this research study you will be contributing to my PhD thesis, provisionally entitled: 'Elective childlessness and the clinical implications for psychotherapists.'

Researcher: This research study is being carried out by Sheila O'Sullivan. I am a part-time PhD student at the University of Essex. You can contact me in the following ways:

Post: 12 Glenmore House
Brambleside
High Wycombe
HP11 IJE

Tel: 07921585305

Email: sheila.osullivan@btinternet.com

Purposes of the research: The experiences of women who are involuntarily childless has been extensively researched and documented both by psychoanalysts and sociologists. More recently the male infertility has also been included in the research literature. Sociologists have contributed widely to the study of female voluntary childlessness but psychoanalysts have often only alluded to this phenomenon, and sometimes it has been pathologised.

The purpose of this research is to explore the contemporary views of psychotherapists to voluntary childlessness in the clinical setting. I am curious to know if there is a difference between the views of psychoanalysts compared to humanistic psychotherapists. This research might also highlight if male and female voluntary childlessness is perceived differently by the psychotherapists or in fact whether this is influenced by the gender of the practitioner. This research is important because it seeks to address the lack of discussion of voluntary childlessness within the therapeutic communities. My intention is to draw attention to the clinical implications of the 'choice' made by individuals. I hope this research will lead to a more broad based inclusive theory of this growing phenomenon.

Use of your contributions to this research: I am interested in hearing your clinical experiences of voluntary childlessness. I would like to know how you 'make meaning' of this phenomenon and how this impacts on your work and you as an individual practitioner. With your permission I will include your contributions in my research.

Use of your contributions to this research: The clinical material, as well as your professional views, that you consent to being used in this research will contribute to the writing of a thesis. I will submit the thesis for the research degree of Doctor of Philosophy (PhD) at the University of Essex. A copy of this thesis will be stored in the University library and therefore will be available in the

public domain. Furthermore, it is likely that I will use the outcomes of this research study in future publications, conference papers and training activities.

Potential benefits of taking part: I hope that taking part in this research will be an interesting and enjoyable experience for you. I hope you will experience satisfaction in knowing that your stories are contributing to a unique piece of research. Your involvement will help to increase awareness of the experiences of voluntary childlessness individuals and how sometimes they might seek help from a psychotherapist to either work through making the choice or to deal with its consequences.

Potential risk in taking part: It is anticipated that taking part in this research will not present any significant risk to you. However, it is important to remember that being part of this research will involve you sharing your clinical experiences of voluntary childlessness. You will need to ensure that your clients cannot be identified and I will endeavour to liaise with you on this matter. As issues relating to having or not having children are one that affects us all in some way or another, the interview might well bring to the surface your experiences in relation to the subject matter. In recognition of this the research conversations that we share will be carried out in a respectful way. Therefore, you are entitled to not answer any question you feel uncomfortable with, request that the digital recorder be turned off at any time during our research conversation and withdraw any sections of your contribution that you no longer wish to include in the study. You can take a break or end the conversation at any point without having to give a reason.

Although I come to this research with extensive experience as a psychotherapist, it is important to recognise that our research conversations are not therapy or supervision sessions. Therefore, it is useful to consider where you can access support if you do experience distress as a result of taking part in this research. We will discuss this at the beginning of our first meeting.

Participation: You do not have to take part in this research study: your participation is completely voluntary. You will not receive payment for taking part in this research.

Right to withdraw from the research study: You have the right to withdraw from this research up until the year that I begin to write up my research findings, which will be September 2014. You will be given several opportunities during the research processes to limit or end your involvement. If you decide to withdraw from this research study, all of the information you have provided and your contributions to the research will be deleted or destroyed.

Time commitment: If you decide to take part in this research, I hope you find it interesting rather than arduous. It is, however, important to be aware of the possible time commitment that is likely to occur as a result of being part of this research study.

Taking part in this research will probably involve us being in contact at least up until I submit my final thesis. Currently, I am aiming to do this at the end of September 2015. The nature of our contact will vary during this period. Initially

we will either meet or have a discussion over Skype for up to an hour or an hour and a half. We will then be in contact by email or post to discuss the transcript of that meeting. I would also like to invite you to be involved in how your contributions to this research are used in the final thesis. You can, of course, decide to limit the amount of contact we have or ask for no further contact to be made.

It is therefore difficult to calculate exactly how much time you will need to commit if you decide to take part in this research study. We will meet for an hour to an hour and a half for the first meeting and I will ask you to read the transcripts of our meeting and ask you to make any amendments or alterations to their content before I proceed to use them in this research. Again, it is not possible to predict how long this may take.

Confidentiality: All the information you share with me will be treated with respect and protected from unauthorised disclosure. When we meet, we will discuss the boundaries of confidentiality and you will have an opportunity to ask any questions you may have. As a clinician you will need to abide by your organisation's code of ethics in terms of ensuring the confidentiality of the clinical work you discuss with me.

My commitment to upholding your confidentiality and that of your clients is at the heart of the decision I make about protecting your anonymity, recording and storing your contributions to this research.

Anonymity: You are invited to choose the name by which you wish to be known in all presentations of your contribution to this research; you can choose either to use your forename or a fictional name. In addition, in order to protect your identity and that of your clients, I will ensure that you have opportunities to read the transcripts of our conversations and my proposed presentations of your contribution in the final thesis. You will be invited to alter and/or delete any details that identify you or others who appear in the thesis. I will however be stating your gender and your therapeutic modality e.g. psychoanalytic or humanistic.

Recording our research conversations: I will ask for your permission to make an audio recording of our research conversation. No recording will be used for any purpose other than the completion of this research study. I will personally transcribe the recording of our conversations and return the full transcript to you for any comments, amendments or alterations that you may wish to make. Please let me know if you would like to receive an audio copy of our research conversations. I can provide you with a copy in either MP3 or CD format.

Storage of information: Throughout this research, I will be following the principles set down by the Data Protection Act (1998) and guidance given by the University of Essex's 'Research Guidelines'.

Your contributions to this research, along with your personal information and that of your clinical material, and the recordings of our conversations, will be stored securely. Written materials, such as transcripts, will be stored in a locked cabinet, separate from any information, such as consent forms, contact details and

biographical information which may identify you or your clients. Electronic information will be password protected and stored on a personal computer used solely by me. I will delete the recording of our research conversation when I submit the final copy of my PhD thesis to the University of Essex.

Ethical research: My research is carried out within the University of Essex ethical framework for research. In addition, my research practice is informed by the British Association for Counselling and Psychotherapy's 'Ethical Framework for Good Practice in Counselling and Psychotherapy (Revised edition)' (2008). If you are interested in receiving a copy of this document, please let me know.

Expressing concerns regarding the conduct of this research: I bring a strong commitment to integrity, respect and professionalism to all aspects of this research. However, if you have any concerns regarding your involvement in this research you can contact Dr Aaron Balick, my principal research supervisor at the University of Essex. Dr Balicks contact information is:

Dr Aaron Balick
Centre for Psychoanalytic Studies
University of Essex
Wivenhoe Park
Colchester
Essex CO4 3SQ

Tel +44 1206 874554
Email cpsasst@essex.ac.uk

Consenting to take part: It is important that before giving your initial consent to take part in this research study, you read this information sheet carefully.

Issues regarding consent will be discussed throughout the research process. However, before our first research conversation, we will discuss points relating to your initial consent. If you decide to take part in this research you will be asked to sign a 'Participation Agreement' form, which summaries the main points of that discussion. If you have questions regarding your involvement in this research study, you are encouraged to discuss these with me at any stage of the research process.

Later in the research process your consent will sought for the transcript of our research conversations to be used in a way that you find acceptable. You will also be asked at a later date to choose the level of involvement you wish to have with respect to how your contributions to this research are analysed and used in the completion of the final thesis.

Appendix 6 – Inventory of Patients

Cathy	J A 35 year old woman who desperately wanted a child but she has never even had a relationship A very successful business woman.	K A Woman in her 30s without a partner who wants children.	L An immature young man who has not established his own home He hasn't got a relationship	M A woman in her mid 40s who has never had a relationship, never wanted to have a child. She made a massive identification with a dead baby born before here.	N A 60 year old male who felt he was ready to be a parent	O A woman in her 40s who was training to be a counsellor and Cathy was worried about her parenting skills.	P A trainee therapist and she wants to be a mother but there is a cancer gene in the family.	Q A young woman who was pregnant but Cathy felt she was ill-equipped to be a parent.	R A woman in her 40s whom Cathy felt had made a masculine identification with a mad father.
Denise	S This is a patient that appears throughout Denise's narrative. She was born after her mother had lost a male child in tragic circumstances. Later the mother gave birth to a boy and the patient was upstaged by him.	T A woman who was biopolar whom Denise inferred that she was VC due to her mental health condition.	U A female patient who did not want children and was married to an alcoholic.						

Participant	Patient	Patient	Patients	patient	Patients	Patient		
Angela	A – borderline patients in an NHS setting where Angela was involved with clinical supervision	B A female patient who had an abortion earlier in her life and then left it too late to have a child. .	C A patient who was frequently ill and although happily married and not made a choice either way to have children. .	D A female patient who wa in her 40s, with a good career, and happily married. Angela doubted the patient's VC choice.	E This patient was born with a deformity. She was in a dilemma about whether or not to have a child mainly because of the fear of passing on a genetic disorder.	F Patient with MS who had termination earlier in life. Doesn't want her own biological child but would be happy to adopt.	G A female patient that was diagnosed with a rare genetic disorder and did not know how long she was going to live. She was trying to decide in analysis whether or not to have a child.	H A male patient who did not want children and he discovered he was infertile when his partner wanted a child. He agreed for his partner to have donor sperm..
Beth	I A female patient who did not want children as she had spent many years looking after her ill mother.							

Appendix 7 – Email sent to psychoanalysts as part of participant recruitment stage

Have you worked with anyone who has chosen not to have children? As part of a PhD study at the University of Essex, Centre for Psychoanalytic Studies, I am undertaking a small-scale qualitative research study, exploring the experiences of psychoanalysts who have worked with individuals who are voluntarily childless.

The study maintains the confidentiality and anonymity of both the Client and the Psychoanalyst at all times and will only involve a single one-hour interview to discuss how you think about and understand such clients.

If you would like to hear more about the study please contact me on this email for further information.

The University address is University of Essex, Centre for Psychoanalytical Studies, Wivenhoe Park, Colchester, Essex CO4 3SX - email cpsadmin@essex.ac.uk. My supervisor is Dr Aaron Balick who can be contacted on 01206872746.

I hope you are able to participate in this interesting research and I look forward to providing you with more information.

Appendix 8 – amended email sent to psychoanalysts seeking participants

Have you worked with anyone who has chosen not to have children? As part of a PhD study at the University of Essex, Centre for Psychoanalytic Studies, I am undertaking a small-scale qualitative research study, exploring the experiences of psychoanalysts who have worked who are voluntarily childless.

The study maintains the confidentiality and anonymity of both the Client and the Psychoanalyst at all times and will only involve a single one-hour interview to discuss how you think about and understand such clients.

If you would like to hear more about the study please contact me on this email for further information.

The University address is University of Essex, Centre for Psychoanalytical Studies, Wivenhoe Park, Colchester, Essex CO4 3SX - email cpsadmin@essex.ac.uk. My supervisor is Dr Aaron Balick who can be contacted on 01206872746.

I hope you are able to participate in this interesting research and I look forward to providing you with more information.

Appendix 9 - Demographic and Clinical Information Sheet

Participant identification number:

1. Age: ……..

2. Sex ……

3. Do you have children ……..

4. Registration …….

5 Profession ……

6. Years of clinical experience ……

7. Years of clinical experience of working with focus client group ……..

Appendix 10 – Interview Schedule

1. Can you tell me about the kind of clinical setting you work in? e.g NHS, private work.
2. Can you tell me about your experiences of working with patients who do not have children for reasons other than medical ones>

   Prompt

   How do you think the experiences of men and women are different?
3. How do you understand their decision?

   Prompt

   What kind of themes arose for these individuals?
4. Can you describe how you might work with these individuals?
5. What theories help you to work with and understand these patients?
6. Can you describe your countertransference in working with any of the patients you have described?

Appendix 11 – Biography

About the Researcher

My name is Sheila O'Sullivan. I became a part-time doctoral research student at The University of Essex Centre for Psychoanalytic Studies in October 2009. Previously I gained my MA through the Open University, with modules in Research, Psychology and Childhood Development. I aim to submit my research no later than July 2015.

I came to my current professional role from a background in Education and Psychotherapy. I am currently registered as an Integrative Psychotherapist with the United Kingdom Council for Psychotherapists. Presently I manage a School Counselling Service in the West of London and I also have a private psychotherapy practice in High Wycombe. For many years I taught in schools and more latterly taught Counselling and Psychology in colleges and with the Open University. It has been in my role as a psychotherapist and as a woman without children that I began to recognise that the decision 'to be or not to be a parent' was in fact very complex for many individuals. This issue is not confined to women, as both my clinical experience and discussions with colleagues and friends, has emphasised how men often grapple with this decision. My reading as well as my experience of running a number of workshops on the theme of whether to be childfree highlighted how many individuals seek therapeutic help in order to explore these issues more deeply. Despite the plethora of clinical material on infertility there is striking lack of discussion about the clinical implications of voluntary childlessness.

Some of the early psychoanalytical writers described a woman's wish to be childless was in fact a 'masculinity complex' so alongside society at large, individuals without children, particularly women, were seen as immature and selfish. Sociologists have written extensively about voluntary childlessness and have highlighted how for many this 'decision' is not without consequences. It is for this reason that I have chosen to focus my qualitative research on to psychotherapeutic practitioners to see how they 'make meaning' from the growing phenomena of voluntary childlessness. I am interested in their clinical experiences and whether there is a difference the different modalities.

I am an interpretative phenomenological researcher which means that I am interested in the individual and particularities of their understanding, so will not necessarily assume that I know what questions to ask. I therefore, choose to work collaboratively with each research participant to explore their understanding of how they make meaning from those who present with dilemmas around whether 'to be or not be a parent'.

Appendix 12 – Initial analysis of themes arising from Denise's transcript

Theme	Descriptors	Data Sample theme
Not being able to cope	Illness	One woman who I saw for 6 years who was late 50s but who was chronically bi-polar, had a history of mental health issues, emm and it was quite obvious that she wouldn't have been able to cope with having children line 16-18 but there was also you know a profound understanding that she couldn't possible of had them line 22-23
	Relationship	but there ..it was the kind of policy decision that she and her husband had decided that they didn't want line 61-62 I can also wonder that the relationship was so difficult with the drinking, she couldn't possibly have contemplated having children with a husband that, with an alcoholic .line 63-65, I mean she couldn't cope with having any kind of relationship really, but I do remember her often referring to the fact that she was on her own and she didn't have a family line 18-20 and a more socially inept person you can't imagine actually line 116-117
	Not knowing how to relate	(men)and they almost all come with relationship problems, so there's a ...they've got to have the right relationship line 247-

		248
The Analyst's Desire	For the patient to know love	I suppose it's it's... because I have children... and inevitably they are such an enormous part of my life... I thought she'd have made a good much mum line 44-45 but there was some sort of deep wish in me for her to know some sort of emm unconditional love I think.line 131-132, I I wonder where my wanting her to have a child, which wasn't actually real it was a little fantasy, that if you could have a child maybe you'd have something, something real in your life whereas everything else..... is such a struggle line 195-197, I
	Not to leave it too late	I suppose there would have been a window of opportunity because I can't remember because she could just about have had children, if she decided to line 60-61. I mean certainly when I m seeing young woman in their early 30s who, you know, talk about children, I encourage them to take it very seriously.
	Whether or not to be a mother	12.22 But she was always quite adamant that she didn't want children. Emm. And I think I was surprised by that she was a very kind of caring woman, she really like looking after other people line 29-31 She was very good at looking after relatives and I think you know I have a feeling that

		some of the maternal role was taken up with her husband line 69-70
The analyst's responses	To the patient	she was someone I grew to be very fond of emm and it sort of very painful work she the reason she came was because her husband was an alcoholic and what came out through the work was in her, in a way her collusion with the alcoholism line 26-28 I was absolutely amazed that she was married I really was. Line 119-120. . Line 126-128... ..I think there's a lot of propaganda about how much you need in order to have a child ....line 227-228
	Judgements	So I think I feel quite moralistic, that you have to make choices and particularly you have to make choices when you have little beings ...not that you can't work and bring up children, its woman who do very high powered, pressured work, jobs line 239-241. No I do remember one session where I think I thought there was a great sense of sadness and about not having children and I'm thinking now why I didn't pursue that more in a way. Emm
	Reflections	I don't know if I felt..., I don't

		know if I might have thought compromised myself because I felt so strongly about having children that you know I didn't want to project my own stuff onto her. ... I wonder..and I think I might have avoided it actually.... in hind sight. Line 76-80

Appendix 13. – Bringing the themes together

interview	themes	descriptors
1	Comparing	Men versus women Private v nhs patients Feckless versus selfless women
	Considering ethical issues	Pronatalism Knowing and not knowing
	Pathlogising	Patients somatising Patients in analysis
	Empathising	Seeing the dilemma Painful decision making For the patients childhood
	Looking after clients	Protecting Helping them to make decisions
	Making links	Illness and decision making Conscious and unconscious choices Fear of passing on genetic illness/bad parenting Bad parenting and not wanting child When your own child is not the best option
2	Criticising and praising different trainings	The benefits of Lacanian training Pronatalism in Kleinian training Contributions of Freud Coming to terms with the human condition
	Treating everyone as an individual	It is a crisis either way Each individual has their own relationship with the gap Internal pressure
	Exploring the meaning of choice	External influences Conscious versus unconscious choice Understanding her countertransference
	Reflecting on her role as an analyst	Diferentiating between herself as analyst and private person Unpacking Older women

	Supporting and judging an individual's choice	Why women have children? Why should women have children?
3	Blaming early family life The consequences of one's upbringing Blaming pronatalist pressure Conflating VC and IVC Giving contradictory messages	Father Mother Siblings Identification with the male Not feeling fully feminine Difficulties with adult relationships Fear of having a child tients too immature to have children Society Family Myth of motherhood Decision making Questioning Describing women who want children.or who have children Whether or not patients should have babies What adults need to be fulfilled How psychoanalysis can help
4	Viewing VC as an unnatural choice Advocating that women should be mothers	The patients had difficult childhoods They are not psychologically ready to parent They have difficulties with adult relationships Unconscious choices It is a biological urge Having a wider range of experiences Helps them to separate from their mothers

	Judging the have it all society	Revisiting childhood experiences Children bring meaning to life The pressures on working women Children miss out
	Reflecting on her dilemmas as a therapist	Society's propaganda Not wanting to project Dealing with her fantasies Dealing with her pain
	Describing her role with patients	The maternal role The protector The helper
	Contradictions	Motherhood takes you back to mother Women have children for selfish reasons VC women can sublimate

Appendix 14 – Initial Master Table of themes

Superordinate themes	**Subordinate theme**	**Subordinate theme**	**Subordinate theme**	**Subordinate theme**
1.The therapist's attitude towards VC clients *'I really wouldn't want to push her, I really wouldn't'* –	a) Attempts to define the role **-** *'Certainly, when I'm seeing young women in their early 30s who, you know, talk about children, I encourage them to take it very seriously'***.**	b. Expressing personal views on maternity and VC '*I can't speak to you professionally.. but I have two sons who are now both married'*	c. Being objective – recognising the danger of projections and the importance of boundaries '*I felt very maternal towards her'; ''I wouldn't want to push her'; 'I was anxious about her pregnancy'*.	
2 Discussing the reasons clients' child-free choice**.** '*Maybe people are too fucked up'* –	a. Fear of passing genetic diseases**.** '*fear of the actual genetic inheritance'***.**	b. Difficult childhood**.** *'their own childhood has been abysmally unhappy'*	c. Mental health issues**.** *'you can be precipitated into a psychotic breakdown by having a child'***.**	d. Psychological immaturity/not ready to parent**.** *'It is a tragedy that children are being born to parents who are no more than children themselves'*.
3. Social pressure ' *it's interesting t see if women ar allowed to not to be mothers without feeling that they haven' fulfilled their potential'*.	a. Female body and biological destiny *'she does not believe she is a proper woman anyway'*.	The myth of motherhood *'Women have to swallow the whole myth as you like, virtually from infancy onwards if you like, that's what women do'.*		