'There will be lots of child psychotherapists who have had babies': What can be learned from focus group interviews with child psychotherapists who have been pregnant during their clinical work?

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Abstract

This research explores the pregnancy experiences of child psychotherapists, commencing with a literature review examining pregnancy through a psychoanalytic lens. Existing published literature concerning pregnant therapists working with adult patients is examined, and particular focus is given to papers addressing child psychotherapists' pregnancies.

The present study engaged eight child psychotherapists in focus groups to gain insight into their pregnancy experiences. The interview data underwent thematic analysis, leading to the identification of six key themes: ‘belonging to the child psychotherapist’, ‘knowing and not knowing’, ‘related to time’, ‘something changed’, ‘space to think’ and ‘therapist patient dyad’. These themes are explored in-depth, drawing connections to concepts from the existing literature. The study highlights research gaps and provides recommendations for future investigations in this field.

Key words: child psychotherapy, pregnancy, motherhood, thematic analysis, focus group**.**

This project is dedicated to my family

For Tharik, no words could be enough.
For Amani, for inspiring me every day.
For Anaiya, for everything you are.
For Maya, and the light you bring.
For our baby to be, and all you may become.

With my gratitude for supporting my professional training,
tolerating my academic commitments, and enabling my personal growth.

Contents **Page**

1. Introduction

During my training as a child and adolescent psychotherapist (CPT), I became pregnant. I was surprised that I could not find any articles in the Journal of Child Psychotherapy exploring the topic of a therapist's pregnancy. This research project began as an attempt to understand why this might be.

This thesis begins with a literature review examining pregnancy from a psychoanalytic perspective. The majority of existing papers describe work with adult patients during the therapist's pregnancy. Themes from this research are explored, and papers mentioning the child psychotherapist's pregnancy are discussed in depth. A conclusion to this chapter summarises key themes, noting gaps in the literature that have informed this research enquiry.

The research methodology chapter describes the design of the study, and the philosophical assumptions of the researcher. I explain the rationale and processes involved in shaping the project. Eight child psychotherapists were invited to focus groups to discuss their experiences of pregnancy. The description of data analysis, employing thematic analysis, resulted in the identification of six distinct themes. Each theme is introduced through excerpts from the data, followed by a discussion that connects to concepts found in the current body of literature.

In the thesis's concluding chapter, the primary discoveries are outlined, the study's constraints are discussed, and recommendations for future research are suggested. This chapter explores possible practical applications of the findings within the profession, which could prove valuable for purposes such as training, recruitment, and the enhancement of professional resources.

2. Literature Review

This literature review explores research discussing the topic of pregnancy for psychotherapists. With the exception of a paper by Hannett in 1949, early psychoanalytic literature scarcely touched upon this topic. Articles that existed tended to refer to therapist's pregnancy as an interference, or an intrusion to the patient's treatment. Historical and cultural factors, encompassing attitudes towards women's bodies, may have contributed to the relative silence surrounding this topic. Since the 1970s, more women entered psychoanalytic training, making noteworthy research contributions, including discussing the topic of pregnancy. This literature review will examine recurring themes within this body of work, exploring how pregnancy impacts therapeutic processes, considering the unconscious communication and transference themes that occur within the psychoanalytic relationship. It also takes into account the individual characteristics of both the pregnant therapist and the patient.

Papers that focus on the impact of a therapist's pregnancy on her work with children are discussed in detail. The final chapter of the review considers factors which have been infrequently explored in published literature, making recommendations for further research.

2.1 Process

To begin, in the autumn of 2019, I searched the Journal of Child Psychotherapy for articles that mentioned child psychotherapists pregnancy (appendix 1), generating 333 articles. However, most titles did not closely connect to the search topic, and focussed general terms of ‘therapy’ or ‘pregnancy’.

I used the research database ‘EBSCO’ to source more relevant articles, completing an advanced search using the term pregnan* (to include terms pregnancy, pregnant) and therap* (to include the terms therapy, therapist) as subject terms, first selecting the Journal of Child Psychotherapy as the source and then expanding the search to include other journals. I experimented with several search terms (figure 1) to widen and narrow search boundaries, attempting to find articles with direct relevance to the topic.

S6	TI pregnan* AND TI therap*	Limiters - Full Text Expanders - Also search within the full text of the articles; Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCO Discovery Service Search Screen - Advanced Search Database - Tavistock and Portman Library's collections	5,887
S5	TI pregnant therapist	Limiters - Full Text Expanders - Also search within the full text of the articles; Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCO Discovery Service Search Screen - Advanced Search Database - Tavistock and Portman Library's collections	26
S4	TI pregnant therapist	Expanders - Also search within the full text of the articles; Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCO Discovery Service Search Screen - Advanced Search Database - Tavistock and Portman Library's collections	124
S3	TI pregnan* AND TI therap* AND SO journal of child psychotherapy	Expanders - Also search within the full text of the articles; Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCO Discovery Service Search Screen - Advanced Search Database - Tavistock and Portman Library's collections	0
S2	SU pregnant therapist AND SO journal of child psychotherapy	Expanders - Also search within the full text of the articles; Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCO Discovery Service Search Screen - Advanced Search Database - Tavistock and Portman Library's collections	4
S1	SU pregnan* AND therap* AND SO journal of child psychotherapy	Expanders - Also search within the full text of the articles; Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCO Discovery Service Search Screen - Advanced Search Database - Tavistock and Portman Library's	22

Figure 1: EBSCO literature search

I continued this process several times (appendix 2) using variations on search terms, and saved relevant articles. (appendix 3).

This exercise generated approximately 100 studies, which were reviewed. Themes in the literature were noted (appendix 4). This was an iterative search, 'rolling in motion', collecting further, and more specific materials as it developed. Bibliographies of articles signposted further related studies. Over the course of the project, I repeated the search several times, checking for newly published articles. Whilst the therapist's pregnancy was rarely mentioned before the 1970's, interest in the topic peaked in the 1990's. More recently, there has been a decline in research in this area (figure 2).

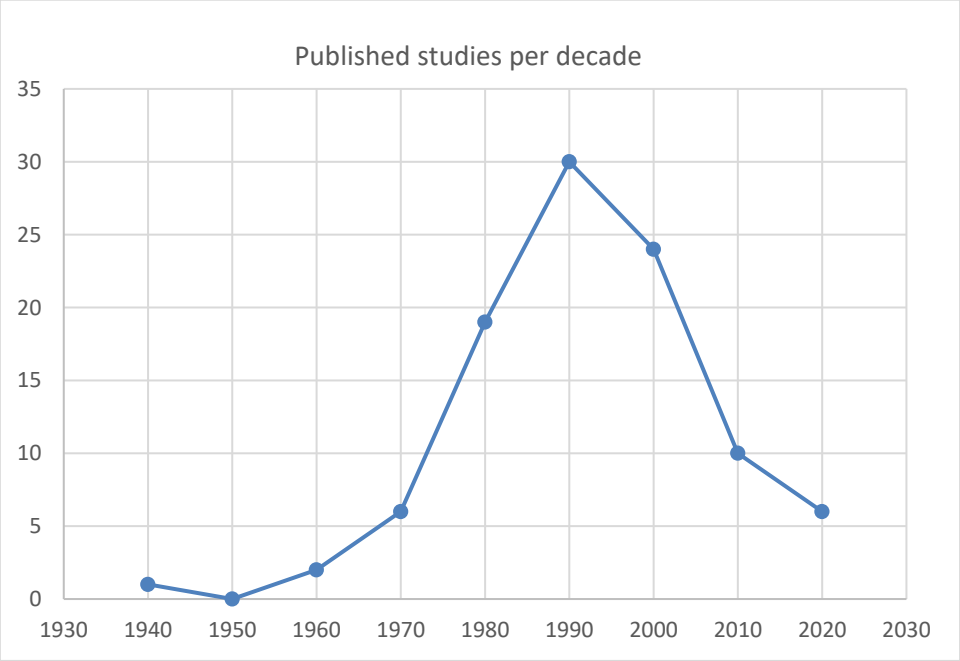

Figure 2: Studies exploring the topic of a therapist's pregnancy published by decade

Most early papers tend to be personal accounts of the therapist's pregnancy and almost all of the studies found are qualitative papers. I returned to the literature review after my data had been collected, this time searching for specific themes that were raised by participants in the focus groups, such as therapist motherhood and the impact of the Covid19 pandemic.

2.2 Pregnancy and psychoanalysis

Psychoanalytic writing has often been criticised for undervaluing female experience (Bassen, 1988). Balsam (2003) suggests the pregnant body 'vanished' from psychoanalytic theory. It is puzzling that whilst pregnancy and childbirth are universal experiences, for a long time, relatively little was written about this crucial time from a psychoanalytic perspective (Clarkson,1980). Although Freud's mother had many pregnancies throughout his childhood, he gives the experience of pregnancy relatively little attention, mentioning it only thirty times throughout his extensive body of work. Freud's theories remain rooted in concepts primarily related to phallus. He does mention children's curiosity about where babies come from (Freud,1909), acknowledging that this process may be of great concern and conflict for his young patient. He also proposed that the experience of birth is the primary experience of anxiety. Otto Rank (1924) later suggested that the analytic situation involves a repetition of 'the trauma of birth'. He viewed psychoanalysis as an opportunity for a 'second birth', as the patient uses the transference situation to move from state of womb-like fusion with the analyst, to positions of separateness.

Winnicott (1949) also considered birth trauma, theorising that the relationship between mother and infant begins before birth. He suggested the maternal physical environment lays the foundation of an individual's mental health and emotional development. Whilst he, too, did not write in detail about pregnancy, he acknowledged it as a period of preparation for motherhood, terming it a 'useful nine-month period in which there is time for a gradual change-over from one kind of selfishness to another' (Winnicott, 1988, page 5).

Like her father, Anna Freud did not write very much on pregnancy or the female body in general, but did place importance on children's reactions to a new sibling

(Rocah, 2008). Similarly, Melanie Klein did not write about pregnancy in great depth, but her theories consider an infant's exploration of his mother's body to be central to mental development. She elaborated upon Freud's Oedipal theories, suggesting fantasies of pregnancy and envy of the feeding breast precede penis envy. Klein's work shifted from an approach which centred the father, to one that placed mothers at the centre of internal processes. Her object relations theory is based upon the infant's relationship to the maternal object, understood through interpretations of the transference relationship with her young patients. She stressed the importance of mother -infant observation (Klein,1952), which remains a core component of psychoanalytic training.

Bion's work does not focus upon maternal experiences of pregnancy, but does consider the experience of birth and intrauterine life, and the unconscious communication between mother and foetus. He stressed the importance of maternal containment, experienced initially as physical holding in the womb (Bion,1962). Child psychotherapy research continues to place importance on the experience of babies in utero, remaining interested in the connections between our earliest experiences of life and the impact on psychology, personality and relationship development. Growing interest in the role of the body has developed in contemporary psychoanalytic writing. This includes examining phantasies about the female body, as well as understanding the importance of how emotional states and trauma link to bodily responses (Kolk, 2014; Music, 2019), connecting psychoanalytic theory with contemporary neuroscientific research (Emanuel, 2021).

In the latter part of the twentieth century, more women entered into psychoanalytic training. Combining family life with the profession, they began to record their experiences of pregnancy, exploring the impact upon the therapeutic relationship, maternal transference, and the nature of their changing bodies in the consulting room. The women's movement, and feminist contributions to psychoanalytic research, broadened an understanding of female perspectives, offering a critical stance to a historically phallocentric understanding of human developmental processes. By 2004, an issue of the Journal of Psychoanalytic Psychotherapy was dedicated to the topic of the therapist's pregnancy. The editor pronounced the subject to be of '*immense clinical and theoretical importance'* (Steiner, 2004, page 4).

Like puberty or menopause, pregnancy involves powerful physical and psychological changes, creating a disturbance in the equilibrium of the body, generating a 'normal psychological crisis' (Dyson and King, 2008, page 28). It has been described as a period of emotional upheaval and intrapsychic reorganisation (Bassen,1988), involving somatic and psychological shifts, between self-representation and object representation (Bibring, 1961). Researchers suggest pregnancy can reactivate a woman's ambivalent feelings towards her own mother (Cole,1980; Friedman, 1993), reviving infantile conflicts. During her pregnancy, a woman may begin to reassess her relationships (Fuller, 1987), recalling her own experience of being mothered, and contemplating the mother she may become (Clarkson,1980, Perlman, 1986). She may feel emotionally and physically vulnerable, experiencing limitations in her health or increased levels of stress or anxiety (Gerson,1994), as she attempts to balance the cathexis to her baby, and her professional identity (Diamond,1992).

Themes in the literature suggest that issues aroused by the psychotherapist's pregnancy appear specific to the intimate therapeutic dyad. Failure to acknowledge the significance of the therapist's pregnancy could lead to difficulties in treatment (Shrier and Mahmood,1988). Avoidance of psychic processes may relate to fears about the impact of pregnancy, denial of mortality and vulnerability, and a wish to protect the privacy of work (Dewald et al, 1993). Idealisation of neutrality in the analysis may indicate avoidance of countertransference awareness due to phantasies of omnipotence, denying weakness and reluctance to confront both the patients, and the analyst's own, hatred and hostility (Imber, 1990). Professional reluctance to write about countertransference could inhibit learning about impact on the pregnancy on the therapeutic relationship.

Reviewing the literature, I came to feel that a therapist's pregnancy can powerfully impact upon the therapeutic encounter, presenting an unusual opportunity (Bassen, 1988), that differs from the ordinary analytic situation. This may allow previously unexplored factors to emerge within the treatment process. Whilst early papers traditionally focussed on complications to treatment, more recent papers suggest pregnancy can be a unique opportunity to deeply explore conflicts involving rivalry, loss, and sexuality, that may otherwise remain unexamined (McGarty, 1988). Some authors suggest that no other event in the therapist's life could impact the patient as powerfully as her pregnancy (Wenderkopp,1990), and the implications for clinical practice are vast. The current body of research indicates there is a continued need for psychoanalytic studies to explore ordinary phases of women's lives, such as pregnancy, (Rubin, 1980; Blum, 1977).

2.3 The mysterious female body

Balsam (2003) suggests that an absence of the female body in early theory is rooted in a view that all bodies are essentially male. Conscious and unconscious motives may have omitted female sexuality and the pregnant body from psychoanalytic studies (Clarkson,1980), perhaps linked to concern about the mysteries of pregnancy, and what happens inside female bodies (Mariotti, 1993).

In post-Freudian psychoanalytic thinking, feminist theorists suggested that the pregnant female form may be a reminder of the primal scene, castration anxieties and phantasies of omnipotent female genitals (Yakeley, 2013). Myths of the 'vagina dentata', a toothed vagina, can be traced back to ancient folklore, appearing in cultures across the globe (Otero, 1996). Rank (1924) suggested neuroses in men may stem from anxiety about the vagina, linked to the trauma of birth. These ideas were further explored by Ferenczi (1925), who discussed phantasies of women robbing men of their semen. A woman's pregnancy symbolises her reproductive ability (Diamond,1992), serving as visible reminder of genital sexuality, the Oedipal couple and the potent penis (Hopkins, 2004). The pregnant female form may cause great anxiety, threatening an omnipotent phallic ideal, creating envy of the mother's womb (Van Leeuwan, 1966), and her power (McDougall, 1986). Envy of maternal functioning may have led to a trend to pathologize pregnancy (Dewald et al, 1993). Primitive hatred and jealousy of mother, preoccupied with 'other babies', envy of fertility and reproductive capacity to create and sustain life (Birksted-Breen,1986), might explain an unconscious reticence to write about pregnancy. In early literature, pregnancy was often framed as a crisis or disruption, frequently connected to illness and disability. The increase in research by women has expanded perspectives about

the topic, countering an outdated prejudice, that suggested women were incapable of offering ‘good enough’ psychoanalysis (McGarty, 1988).

2.4 Intrusion

Traditional psychoanalytic practice positioned the analyst as a 'blank screen' upon which a patient could project internal conflicts, to be examined with a neutral, somewhat anonymous stance. Such notions of analytic neutrality have shifted over time, encompassing ideas around the importance of exploring differences in identity, including race, class, gendered and sexual bodies. There is increasing recognition within the profession that social identity, privilege and intersections of race, culture, religion, and gender impact upon the clinical encounter, and that the social context of both the therapist and patient is relevant and should not be ignored due to concerns about self-disclosure (Prout et al, 2019b). During pregnancy, the idea of a blank screen becomes impossible, and an 'optimal projective screen' may develop (Lax, 1969, page 372), allowing exploration of core aspects of an individual's pathology.

Pregnancy has often been framed in the literature as a breach of anonymity and a violation of rules (Stuart,1997), challenging the analytic attitude, bringing aspects of the analyst's personal life, relationships and sexuality into the therapy room (Etchegoyen, 1993). The analysts changing body and growing pregnant stomach has been described to:

> *'Push and distort the therapeutic frame, increasing in size until the frame shatters. It brings with it a reality to the therapy room of a world beyond'* (McGourty,2013, page 27).

Patients may become preoccupied with Oedipal rivals – the therapists imagined sexual partner, the father of the baby, and with the new baby, as rivals for her undivided attention (Goldberger et al, 2003). The therapist's position may shift as she is perceived as a sexual being (Mariotti, 1993). This reality may shatter a

phantasy of a devoted analyst mother, solely dedicated to her patient's needs. Patients who have experienced tremendous deprivation and neglect can find the notion of a loved, wanted baby to be very painful (Sharma, 2019).

A new phase of treatment may begin, distinct from the intimate dyad of the patient and analyst. A third is introduced to the couple, and this new triangular space must be navigated. The patient's response to a third object can indicate aspects of their internal object relations (Gibb,2004) and capacity to manage separations, endings and loss (McGarty,1988).

2.5 The introduction of pregnancy

Psychoanalytic theory proposes that silent, unconscious communication develops within the therapeutic dyad. Many authors suggest it is possible that patients may become aware of a pregnancy before it is physically obvious, or verbally introduced (Stuart, 1997), perhaps even knowing about the pregnancy before the therapist herself (Raphael-Leff, 2004). Tinsley and Mellman (2003) remark that patients who use primitive defences appear to recognise the pregnancy at very early stages. Allowing the patient to notice the pregnancy first may be useful, as the time before a pregnancy is confirmed can offer an important window into a patient's unconscious. This period of knowing or not knowing can relate to the ability to tolerate separateness and capacity for symbolic thought (Zeavin, 2005). However, not mentioning the 'elephant (baby) in the room' could be experienced as a cruel betrayal, or understood as an event so awful and worrying, that it cannot be spoken about. A patient's denial of the appearance of a pregnancy, seeing or not seeing, may give valuable insight into their early history, object relationships, experiences of maternal care and perceptions of their own bodies (Yakeley, 2013). Pregnancy can shift both the external and internal setting (Dufton, 2004) and there is much to be learned from a patient's response to this change.

Western 'pronatalist' (Clarkson, 1980) attitudes may presume that pregnancy, and family life is expected and valued. However, idealised notions of pregnancy and motherhood may deny unconscious conflict and hostilities. Pregnancy is surrounded by myths in almost all cultures, and the concept of an 'evil eye' emerges in the literature (Clemental-Jones,1985), involving superstitions that pregnancy should be concealed lest the baby is harmed by envious attacks. Taboos and social etiquettes involve protecting a pregnant woman – but defending against repressed feelings

may mean they are acted out in unhelpful ways (Perlman, 1986). Some papers describe supervisors, particularly men, ignoring or actively disapproving of the analyst's pregnancy, causing difficulties for the therapist and her patient (Goldberger et al, 2003). Colleagues may also have complex reactions to a therapist's pregnancy, perhaps experiencing feelings of resentment or abandonment and defend against their feelings by responding in similar ways to a patient – becoming demanding or overly attentive to conceal their displeasure (Dyson and King, 2008).

2.6 Patient responses

Many studies describe patient's negative reactions to pregnancy. Violence, aggression, rage and somatisation are frequently referenced, and connected to Oedipal rivalries (Dewald et al, 1993). Patient hostility may be linked to infantile wishes to be the only child in the therapist's mind (Simonis-Gayed and Levin, 1994). The intimate couple that developed in therapy is threatened with a separation or ending, to accommodate a new baby. This rejection can be felt as humiliating and unbearable (Waldman,2003). The patient is confronted with their dependence on the therapist-mother and their vulnerability to separation and abandonment (Deben-Mager,1993). For individuals who have suffered intense trauma and early loss, pregnancy can be experienced as a gross betrayal, reactivating states of intense despair and suffering (Gibb, 2004). The therapist may be experienced as an unavailable, or abusive mother (Cole,1980). The patient may regress or terminate treatment (Clemental Jones,1985). Pregnancy may feel provocative, a painful attack from a bad object preventing the restoration of their good objects (Hopkins,2004). This process of ending therapy has been likened to a form of grieving, feeling as absolute as death (Dufton,2004).

A patient may respond to these disturbing feelings with manic defences, ignoring the pregnancy or denying any significance, to protect themselves against the pain of loss (Mariotti,1993). Some authors describe sadistic fantasies emerging in the material, of killing or damaging the rival baby who symbolised their pain and devastation (Gerson, 1994). Patients may intensely identify with the pregnant mother/analyst, wishing for symbiosis (Dewald et al, 1993) denying separateness and longing for umbilical fusion (Mariotti, 1993).

Denton (2012) reviews 28 clinical case studies, and notes that of the 49 patients described, 9 became pregnant, and 3 impregnated their partner during their analyst's pregnancy. It is interesting to consider how the patient's pregnancy is framed within the literature, often positioned as a reactive response to the analyst's pregnancy. These interpretations appear to parallel attitudes towards the analyst's pregnancy in earlier literature, pathologising pregnancy, and framing them as obstacles and disruptions. Interestingly, Denton's paper references one of the only quantitative study encountered in this review: Berman (1975). This study investigated destructive behaviours during pregnancy, using data from nine pregnant psychiatrists. Experimental data from 130 case studies during the psychiatrist's pregnancy was compared with control data of 129 cases during a different time period. This study describes pregnancy as a risk to therapeutic treatment, citing major 'disturbances' such as suicide attempts and unplanned pregnancies. Simultaneous pregnancies in patient and analyst are often understood as rivalries (Van Leeuwen, 1966), feminine identifications (Al-Mateen, 1991), and attempts at merging with the therapist (Atlas-Koch, 2008). Patients who are overly solicitous towards the analyst may feel frightened at the strength of their hostility, attempting to disguise this with neurotic idealization (Cole, 1980).

Some theorists suggest this research topic has been neglected, due to worry that pregnancy complicates, distorts and disrupts the therapeutic process (McGourty, 2013). Dufton (2004) described her pregnancy as challenging the rules of the setting and betraying the therapeutic ideal. The impact of a pregnancy can feel distressing and difficult, leading to heightened resistance (Stuart, 1997). In the following chapter, the nature of the transference is explored, examining the theory that pregnancy prematurely arouses conflicts that interfere with the analytic process.

2.7 Transference

Transference has been described as a shifting of feelings towards early figures on to a therapist (Clarkson,1980). Through the course of therapy, exploring displaced projections can offer insight about the quality of an individual's relationships with their internal objects. Pregnancy appears in the literature as a potent stimulus for transference (Goldberger et al, 2003), potentially enhancing therapeutic treatment (Fuller,1987).

In a review of 51 studies, pregnancy was found to facilitate transference (Schmidt et al, 2015), as the transference figure is more readily accepted (Bibring et al, 1961). Reducing transference resistance can allow opportunities for internal conflicts to be explored with greater depth and clarity, revaluating relationship models (Miller, 1992). The therapist's survival of hateful attacks can reduce splitting, facilitating integration of good and bad objects, both loved and hated, envied and feared. The physical presence of a pregnant belly may be understood as unavoidable evidence of sexuality, and often experienced as 'permission' to discuss sexual issues (Stockman and Green-Emrich 1994), allowing exploration of erotic transference (Diamond, 1992). During this time, ordinary psychic boundaries may diminish, and therapists may feel more in tune with the patient's unconscious mind (Clementel-Jones, 1985). Pregnancy may present a window offering insight to a patient's internal world, aspects often obscured with strong resistance and defences (Raphael-Leff, 2004). Contemporary papers indicate the therapist's pregnancy could be a beneficial time, offering opportunities to work within the transference, through conflicts, separation, sexuality and rivalry.

2.8 Countertransference

Traditional understanding of countertransference involved ideas about the analyst's intrusive reactions, associated with guilt and shame, but developments in psychoanalytic thinking highlight the usefulness of examining the therapist's emotional response to their patients (Heimann, 1950). A therapist's response to her patient may intensify during pregnancy (Simonis-Gayed and Levin, 1994). Sensitivity to the transference material and discomfort with countertransference reactions may explain reluctance to write about the experience (Uyehara et al, 1995). A therapist's avoidance of the countertransference and denial about the impact of their pregnancies may relate to personal experiences of pregnant mothers, rivalries, and unconscious responses to the patient's material (Lax,1969). The potent feelings evoked by a pregnancy, such as hostility, hatred, and aggression towards the baby, belonging to both patient and therapist, may feel difficult to contemplate or write about. Avoidance of countertransference may be a defence against the distress caused by a pregnancy for both therapist and patient. If the analysts guilt stems from their infantile conflicts and wishes to maintain an omnipotent, idealised fantasy figure, the patient could remain dependant and regressed (Searles, 1979).

Heightened sensitivity to transference and countertransference is interwoven with external realities of the therapist's pregnancy (Bassen, 1998). Becoming pregnant whilst working with distress and disturbance may feel exposing and unsettling. The therapist may feel vulnerable whilst managing her own feelings about her pregnancy, worry her professional commitment may be questioned, and fear real harm to her baby. Ending treatment may reignite earlier experiences of grief and loss, for both therapist and patient.

2.9 Characteristics of patient and therapist

Many factors that are unique to the dyad between the therapist and her patient are significant when considering the impact of the pregnancy, including the therapist's individual style and technique, the degree of resistance, and capacity to confront and work with the transference themes (Bassen, 1988). Characteristics of both therapist and patient may impact how the pregnancy affects the therapeutic relationship, and if it is perceived to facilitate or disrupt treatment.

> *'Client reactions will vary in type and intensity depending on their life experiences, internal object relations, investment in therapy, character strength, ego and cultural background'*
> (Dyson and King, 2008, page 34).

Male patients may be more likely to experience of incestuous fantasies (Van Leeuwen,1966) and Oedipal rivalries (Fast, 1994), whilst women may identify with the mother, their childbearing wishes compensating for penis envy (Diamond, 1992). Experiences may differ depending on a patient's sexuality (Genede, 1988). Sachs (1986) discusses responses of lesbian patients to her pregnancy, some seeing it as a betrayal of the intimate relationship they shared in the therapeutic dyad, and others feeling a gay therapist to be trailblazing and inspirational.

Other factors, such as a patients age, the stage of pregnancy, and phase and type of the treatment can impact reactions to the pregnancy and receptivity to analysis (Deben-Mager,1993; Maat, 1995). Lax (1969) found that patients responded to her pregnancy with reactivation of conflicts related to their pathological development.

Neurotic and borderline patients may experience the therapist as a withholding object (Cole, 1980), whilst psychotic patients often identify with the mother (Dewald et al,1993). A patient with borderline personality disorder, and post traumatic stress disorder reacted with intense distress following the tragic death of author's still born baby, screaming that she wanted to see the baby (Korenis and Billick, 2014). The authors discuss the importance of the ensuring therapist's own stability before such sensitive and distressing issues can be explored. The impact of patients with eating disorders (Chiaramonte,1986) is largely neglected in existing literature. Further exploration of responses to working with a pregnant therapist, could extend Chernin's (1986) understanding of Klein's theories of early mother-infant feeding experiences, in relation to women with eating disorders.

Few papers focus upon the pregnant therapist's perspective (Beuno, 2009), or characteristics of the therapist. Lax (1969) discusses the importance of an analyst having worked through psychic conflicts in order to be fully available to treat her patient's transference material. If psychic reorganisations and resurgence of Oedipal feelings (Bassen, 1988) are not effectively considered in analysis and supervision, she may struggle to contain the infantile states of mind for her patient. Whilst many papers report increased receptiveness and intuition (Clementel-Jones,1985), others suggest lapses in attentiveness (Simonis-Gayed and Levin,1994), withdrawal into her inner world (Paluszny and Poznanski, 1971), and becoming more self-absorbed (Bassen,1988). This connects to the concept of Primary Maternal Preoccupation (Winnicott, 1975) as the therapist prepares for motherhood and becomes immersed and consumed with the needs of her growing foetus.

Risks and anxiety about complications to the pregnancy are highlighted in the literature, expressing worry the baby may become damaged (Birksted-Breen, 1986) by violence and aggression felt in the consulting room. A therapist may experience heightened sensitivity to the emotional states of her patients, feeling compelled to protect them from her own anxieties (Mariotti, 1993). Her style may shift, becoming more self-revealing (McGourty,2013), struggling to hold the therapeutic frame, or reacting more intensely (Etchegoyen,1993). Conversely, she may be more reserved, tempering interpretations and becoming less active (Gerson,1994). Tinsley and Mellman (2003) consider various therapist responses, including taking a protective stance, wishing to be nurtured, guilt, and denying sexual issues.

Pregnancy may be perceived as a confirmation of the therapist's heterosexuality (Korol, 1995). Sachs (1986) discusses issues around primitive ideas of immaculate conception for the lesbian therapists, as well as identification, taboos, and prejudices. Silverman et al (2001) suggests a pregnant lesbian may not experience positive responses to her pregnancy due to a lack of social acceptance, suggesting a therapist's sexual orientation can impact their work, and their countertransference feelings – particularly in relation to vulnerability and exposure. Very few papers discuss race, although Sharma (2019) mentions a child's association to her race, and Paluszny and Poznanski (1971) mention racially imbued responses to Black therapists as maternal figures. White patient's transference associations to Black therapists have been linked to offensive racialised depictions of Black motherhood as 'ever indulgent 'Mammy's'', tolerant and forgiving, and idealized maternal objects (Grier, 1967, page 1590).

2.10 Complications

Very few papers discuss difference in relation to experiences of pregnancy, or explore difficulties conceiving, assisted pregnancy, adoption, or surrogacy. There is infrequent mention of complexity, such as Piovano's (2008) account of the birth of her disabled baby. Infertility and elective abortion are infrequently explored (Balsam, 2003) perhaps due to cultural taboos related to the terror and dread of the death of a baby, the pain of loss and the intense longing to be a wanted child (Perlman,1986). One account of miscarriage describes the patient's relief at the loss of a therapist's baby, feeling that her capacity to survive helped them to process their own losses (Dewald and Schwartz,1993). Hannett (1949) describes patient's reactions to her miscarriage, observing that those who made therapeutic gains were those who had specific transference reactions to the event of her loss. One sobering paper explores the unfortunate stillbirth of a full-term baby, and the patient 'hysterically shouting, screaming and crying' (Korenis and Billick, 2014, page 380). This presentation highlights the intensity of working through intense trauma and loss, and the impact upon patients who may feel re-traumatised by such events. The need for protection and support for the patient and the therapist appears critical. In instances when supervision or analysis are not available, the therapist's internal third position is vital in managing to contain painful experiences (Cullington-Roberts, 2004).

2.11 The pregnant child psychotherapist

The present study was motivated by the limited number of studies mentioning pregnant therapists work with children (Clementel-Jones, 1985; Simonis-Gayed and Levin, 1994). A meta-synthesis of the literature suggests that personal and professional challenges experienced by pregnant therapists are more pronounced for those working with children and for first time mothers (Way et al, 2019).

One overview of literature about pregnant therapists (Schmidt, et al 2015), reviews fifty-one studies in considerable depth. The lack of child psychotherapy studies is mentioned, noting studies described are all qualitative, and were more than twenty years old. None of these papers discuss the child or family of the therapist. This review suggests that children's reactions to the therapist's pregnancy are more physical, and that they develop an intense transference related to their dependence upon adults. It is proposed that the psychological processes that occur during childhood, involving the ongoing formation of the ego, Oedipal struggles and navigation of separation, offer opportunities to work through developmental difficulties whilst they are still malleable and less entrenched than they may be in adulthood (Schmidt et al 2015, page 58). Similar themes were identified across studies, relating to maternal transference, sibling rivalries and fears of abandonment, as well as differences in response according to characteristics such as age, gender and pathology.

The authors consider the paucity of papers available, suggesting the therapist's guilt, self-absorption and distracted state may mean she is less available to understand unconscious communication or to study the topic in more depth. Strong countertransference responses may feel difficult to experience and to write about.

The therapist may experience guilt about the disruption to the work, given that children referred into modern day therapeutic services have often experienced chaotic and inconsistent caregiving in early life. This review suggests that working through issues around endings and separation should not be avoided due to the therapist's guilt. When thoughtfully approached, the experience may be useful and need not repeat earlier patterns of sudden, unexpected abandonments.

The earliest paper referencing a child analyst's pregnancy is a case supervised by Anna Freud in 1966. Rocah (2008) describes intensive therapy with a six-year-old boy, Sam, during her analytic training. Anna Freud's commentary notes the complexity of the analyst as a transference object as fantasy merged with reality. She suggests Rocah's pregnancy was felt as repetition of the child's original trauma – his sibling's birth and his mother's lapse in maternal attention. She doubted the child could be helped to benefit from the repetition of this event, as the transference fantasies linked so closely with reality, even suggesting a pregnancy can 'spoil' analysis and the child may be better off transferred to a male therapist. Rocah considers the child's struggle with sibling and Oedipal rivals, reacting strongly to her pregnancy with feelings of intense betrayal. She describes his disillusionment: 'You are full of holes, you are not perfect, you betrayed me' (Rocah, 2008, page 15). However, she concludes that she observed a beneficial shift in the analysis, suggesting that the use of the transference situation and her verbal interpretation of defensive patterns provided opportunities for the child to use expressive language to reflect upon his emotions and behaviour. Unusually, this paper discusses returning from maternity leave, with candid descriptions of the therapist's angry responses to the child's provoking behaviour.

Paluszny and Poznanski's (1971) study describes a number of case studies of pregnant therapists working with children as well as drawing upon their own experiences of pregnancy. The methodology of this study is unclear, and may relate to cases the authors supervised, as they note the lack of case reports available. The study groups reactions to therapists' pregnancies into three categories: those who attempted to resolve childhood conflict, those who were defensive, and those who integrated the pregnancy into new material, which the authors believed enabled the patient to make therapeutic gains. The youngest patient described is a child aged seven, who brought projections of mutilation, fears of being destroyed and concern at the destruction caused by birth. They suggest the therapist's heightened awareness of her maternal state may have acted as unconscious stimulus to explore sibling rivalries and infantile identifications with the baby.

Ashway (1984) discusses the therapist's vulnerability during pregnancy, proposing that experiences of psychic regression and infantile conflicts can be reactivated during this time. She considers transference issues, describing her pregnancy as a 'catalyst' for her child patients to work through unresolved conflicts. She believes that the traditional neutral analytic stance differs when working with children due to the intimacy of the dyad. She suggests personal analysis is crucial during pregnancy, so that the therapist's issues do not get confused with the patients. She believes children perceive pregnancy earlier than adults. Describing a latency child, she writes:

> *'Her intense sibling rivalry, oedipal strivings, and overt hostility were apparent. Her bitter wish to destroy my unborn baby, as she had wished to kill her sister, was not at all disguised. She even tried to act out these murderous fantasies and impulses. Ruth's very real fear that the baby would 'hear us'*

meant a fear of the loss of her confidential, privileged status with me'

(Ashway, 1984, page 11).

The article mentions parent work, suggesting pregnancy can enhance a therapeutic alliance with parents.

Fuller (1987) presents vignettes from 45 adult and child patients from her own pregnancies, and material from eleven supervisees and colleagues collected over twenty years. She offers a model of pregnancy consisting of five distinct phases and details material from patients relating to characteristics of each phase – planning, each trimester, and post pregnancy. In the first case, she describes how the therapist was initially idealised and then denigrated. The pregnancy introduced the element of sexuality, perceived to be 'dirty', but allowed exploration of sexuality and conception. She notes that adolescents can be much more direct about phantasies of the primal scene, expressing their disgust and embarrassment, perhaps disguising their fascination with matters pertaining to sex. This paper suggests that although pregnancy is perceived as an abandonment and betrayal, it presents opportunities to observe impregnation phantasies, pregnancy wishes and envy in male patients, and identification with the mother in female patients, as they develop in childhood – rather than retrospectively discovering this process in adult analysis. An example of group therapy for latency children conveys strong transference reactions – fear of potential aggression from the children, and countertransference responses of wanting to enact violence against them. Whilst children may not deny Oedipal wishes, they may have genuine difficulty distinguishing fantasy from reality: one child became terrified that he was the father of the therapist's baby. Responses from adolescents included sexual acting out and wishing to become pregnant themselves.

> ‘*Child therapists have found their pregnancies can evoke greater disorganization in a seriously disturbed child during early phases of pregnancy, but a resolution can be achieved as the patient improves’* (Fuller, 1987, page 22).

Weintraub (1990) discusses treatment of a child whilst she was unwell during pregnancy. The patient had experienced a prolonged separation when his mother became unwell after the pregnancy of his sibling, and the author felt her pregnancy revoked this early trauma. She describes his worry about his mothers’, or her own death. Although she could only offer telephone appointments during her pregnancy, she resumed face to face sessions a week after giving birth. The therapist’s commitment to this difficult work is evident, but it is notable that the brief maternity leave might relate to the powerful quality of the transference, and an anxious urge to reassure her patient that she was still alive and well after childbirth. The author believes that her ongoing contact with the patient enabled the resolution of his conflict.

Miller (1992) discusses two cases of play therapy with children, believing her pregnancy highlighted broader maladaptive coping strategies. She suggests defences were more readily available to treat. She describes a four-year-old patient becoming interested in her body and gender, and notes her own physical limitations and exhaustion. The ending of this work was very painful, and the therapist was felt acutely to be cruel and abandoning, making her question her own effectiveness and the progress the child had made. She describes feelings of inadequacy, guilt and shame, as well as the difficulty in admitting to her distress in supervision, as she was so closely attuned to her patient, and heavily defended against the notion of cruelty. She candidly observes her own ‘narcissistic fragility’, (Miller, 1992, page 633),

struggling to stay in touch with anger in sessions and to understand and use it effectively. She concludes that her pregnancy accelerated the pace of the treatment for a seven-year-old girl, allowing her central issues to be worked through. Traditional boundaries of therapy became blurred, as children expressed intense periods of desire for physical contact with a mother figure. Both children seemed to identify with her baby, appearing not to express ideas of rivalry or intrusion. It is possible the author guarded against aggressive impulses to her unborn baby in the same way that she struggled to recognise and cautiously defended against angry wishes she later understood as related to her.

Three cases of child analysis are discussed by Etchegoyen (1993). A twelve-year-old girl's contempt of her pregnant therapist is described. When parents decided to prematurely end the work, the therapist examined her countertransference response, feeling anger and envy at the omnipotent parental couple. In her work with a six-year-old boy, the author notes her reluctance to transfer the patient to another therapist. She relates concern about complicated institutional dynamics and connects this with her own anxiety about abandoning her patient, as well as a feeling of omnipotent triumph over colleagues with her pregnancy. Insight into the transference dynamics supported work in both cases to come to a healthy resolution. A seven-year-old girl's drawings of mazes and labyrinths are interpreted as intense worries about being lost and abandoned by an unavailable mother. Supervision was felt to be crucial in holding on to the psychoanalytic attitude, as the analyst may unconsciously identify with the child or the parents and need support in understanding these dynamics and the impact on her work.

Simonis-Gayed and Levin (1994) identify themes in the existing literature, grouping reactions to the pregnancy as acting out sexually, denial of the pregnancy, sibling rivalry, and intensified maternal transference. Six vignettes are presented, from children aged between three and sixteen years. The first patient became closely identified with the baby, and extremely anxious that the baby may die, as he had been told how close to death he had been at birth. He became overwhelmed at the prospect of damage to the baby, and prematurely terminated treatment. An adolescent girl began to act out sexually, and an adolescent boy struggled with sibling rivalry, becoming envious of the therapist's baby. An abused three-year-old boy became destructive, provoking a desire in the therapist to restrain him. Acting out his wish to eat the therapists baby allowed him to work through his experiences of being utterly vulnerable and powerless. An adolescent experienced the pregnancy as an intense rejection and repetition of maternal abandonment, but was able to work through the mother-daughter transference. The author's state:

> *'Pregnancy is at times a tool to promote growth and at times a wrench in the fragile alliance'*
>
> (Simonis-Gayed and Levin, 1994, page 199).

They note the strength of countertransference in work with children who continue evoke their immense need for protection and nurture in the therapist, particularly when experiences of abuse and neglect have been recent. Practical recommendations are discussed, including leave, preparing colleagues, and responding to children's questions about the pregnancy. They recommend using toys and creative materials as tools to allow children to work through issues around siblings, childbirth, and babies. The authors conclude that the therapist is no longer a blank slate and must be aware of the mother transference. The value of reflective

supervision is stressed, to support the therapist to understand the transference and countertransference responses, so these can be usefully worked through in the therapy.

A book chapter explores the impact of a child psychotherapist's pregnancy on her clinical work, describing interviews with child and adolescent therapists who had recent experiences of pregnancies, and with consultants who had supervised pregnant child psychotherapists (Sharma, 2019). The lack of current literature is discussed, as is the distinct nature of the life experience and pathology of children seen in modern child and adolescent mental health clinics. Sharma reflects that;

> *'Reviewing my caseload while I was pregnant highlighted how many of the children's histories consisted of massive life catastrophe, complex trauma, transgenerational adversity, and illness of parents and parental figures. Over three quarters of the patients discussed in my interviews with clinicians were either adopted, in foster or kinship care, or had an absent parent. For such children, phantasies of abandonment, rejection, and rivalrous sibling dynamics were very daunting'*
>
> (Sharma, 2019, page 272).

A detailed case study of a highly traumatised ten-year-old boy is presented. The therapist noted his acute need for a creative parental couple in his mind, and his deep worry about the loss of an available parent. When the pregnancy was announced, the child movingly told his therapist that he hoped her baby would not be like him, illustrating his sense of being an unwanted, unlovable baby. As the pregnancy progressed, he took on a protective role, perhaps linked to his wish to repair a fractured maternal relationship. The therapist was briefly able to see the

child on her return from maternity leave, noting that her ability to reengage and advocate for the child was hindered by the considerable demands of returning to work.

In interviews with pregnant CPTs, Sharma suggests the dominance of the maternal state can eclipse the importance of the Oedipal couple, noting fathers were often described as angry or intrusive. Analysis of the interviews showed the pregnant therapist experienced as an abandoning maternal object, neglecting the needs of her patients. Many interviewees struggled to recall clinical material, perhaps linked to their preoccupation with their pregnancies, but seemed more able to describe their countertransference responses, suggesting that the therapist is more receptive to transference phenomena during her pregnancy. This study is an important investigation into this under researched area of the literature and provides a foundation for the current study with CPTs exploring the topic.

None of the studies found in the literature refer to group interviews, and the majority described are single person case studies. Few studies refer to the therapist's reflections on the experience for her unborn baby, and any impact she may have felt her therapeutic training may have had on her feelings about her pregnancy or her approach to becoming a mother. The current study seeks to explore these aspects in more depth, and to attempt to open up a space for dialogue for child psychotherapists to consider aspects of their pregnancy that are currently under explored within the literature.

2.12 Maternity leave and post pregnancy

A few papers focus on practical concerns such as breaks, timings and endings (Deben-Mager,1993), offering tips for planning maternity leave, and matters to consider during each trimester (see Barnett and Herrmaan, 2001; Gerber, 2005; and Adames et al, 2023), suggesting a desire for an instruction manual, and the guidance of a ‘uniform therapeutic technique’ (Korol, 1995, page 162).

Papers considering maternity leave mainly focus on the ending of therapy or arrangements for cover therapists. As most of the literature is a number of decades old, and predominately from the United States, it is unsurprising that most reference short maternity leaves, or even none at all (Weintraub, 1990). One survey showed the average length of maternity leave for psychotherapists as two months, with several therapists later reflecting that they regretted returning to work so quickly after birth (Naparstek, 1976). Better health insurance and growing recognition of the importance of the postnatal period and opportunity for bonding and attachment in the early stages of life have led to extended leave in recent years. Most child psychotherapists in the UK National Health Service (NHS) are entitled to maternity allowances, often up to a year. Chairamonte (1986) explores experiences of cover therapists who worked with adult patients whilst their therapist was on leave, describing the complexities of interim arrangements, usually arranged for only the most vulnerable and fragile patients. It can be surmised that for children, multiple transfers could be confusing and are avoided. Many CPTS are unlikely to resume work with the same patients upon return, and there is scant mention of bridging work after maternity leave, although this may occur more often in private practice. Standardised maternity leave within the NHS mean it is unlikely for those working in

the public sector to be able to transition back to work gradually, for example returning to see one or two patients for a few hours each week.

Contact with patients during leave needs careful consideration. Accounts of returning to work include one unusual example of patients meeting the therapist's baby. This is presented as therapeutic, as the patient was reassured that the baby had not been damaged by hatred expressed in the therapy (Deben-Mager,1993). Korol (1995) suggests conflict resolution only becomes possible after the therapist returns from leave, as therapeutic growth is consolidated. However, returning to work is complex, and Lax (1969) noted that many pregnant therapists had a desire to stop work entirely so that they could be completely dedicated to their new babies. One author discusses in depth the difficulty in negotiating her role as a mother and therapist, particularly complicated by her child's disability (Piovano,2008). She documents her dread and anxiety in returning to work, and these sentiments are echoed by other therapist's descriptions of the personal and professional conflicts they experienced after birth (Gottlieb,1989).

Some authors describe a greater tolerance of confusion and uncertainty after becoming mothers, feeling more able to be neutral and less identified with patients (Bassen, 1988). One article discusses the therapist's deep empathy to suffering after having children, and the painful separation, feeling she was 'abandoning' her own children whilst attending to patients (Waldman, 2003). Whilst most papers focus on the profound experience of the primigravida (first time mother), Bueno (2009) describes her sixth pregnancy as her most challenging. A few papers describe second pregnancies, noting the impact of successive pregnancies on work with patients, suggesting that as pregnancy can reawaken original experiences of rivalry

and envy, there could be repeated opportunities to process and resolve these difficulties (Halton, 2004) resulting in important intrapsychic shifts (Adelson, 1995).

A few authors discuss the complexity of integrating personal and professional identity, and aspects of the female therapist's motherhood, eroticism, sexuality and femininity (Diamond, 1992; Wilkinson, 1996). Shifts towards exploring these topics may begin to address the gender imbalance identified in earlier literature, when issues pertaining to women were largely ignored. Conversely, the profession has often been accused of focussing on the maternal relationship and 'mother blaming' (Parker, 2005, page 16). Melanie Klein's complex relationship with her own children appears further confused by her analysis of them, blurring the lines between her personal and professional identity (Grosskurth, 1985). Perhaps child psychotherapist's reluctance to write about personal experiences of pregnancy and motherhood relates to the legacy of the fraught relationship between Klein and her daughter, Melitta Schmideberg, who publicly criticised her theories (Sayers, 1989).

Birkstead-Breen (1986) suggests that the women who cope well with the experience of having a baby are those who have been able to modify their idealised fantasies of mothers, to more realistic standards. This may be particularly important for pregnant therapists, considering narcissistic idealisations of the analytic encounter, split perceptions of internal and external maternal figures, and unconscious, persecutory anxieties about their professional and personal identity.

2.13 The Real Baby

Very few papers refer to an actual baby, developing in the womb and after birth. This is curious considering how crucial psychoanalytic theory considers prenatal life to be, and the wealth of research that indicates the importance of mothers physical and emotional health during her pregnancy for infant development. Perhaps including the actual baby into reflections of pregnancy has been felt to be too exposing, not just challenging the traditional 'blank screen' but removing it entirely. A few papers express the therapists concern about harm or damage for her baby, and one paper describes the therapist's perception of her foetus as the third person in the room (McGourty, 2013).

> *'Another alteration to the setting, quite unique to pregnancy, is that the fifty minutes in the consulting room, in the space shared by patient and analyst, a third living being is present: a little foetus is there, living away inside the analyst, an alive presence no matter how tranquil that may be.*
> (Mariotti, 1993, page 151).

Others refer to their patient's worry that the baby was listening to their session (Ashway, 1984). Considering how the unborn child may experience the therapy and how the pregnant mother's awareness of her babies' response to her patients in the consulting room is rarely explored. One author recalls:

> *'During sessions I was increasingly aware of my baby kicking, as if all vigour and vitality were located in my unborn child who was filling the space and*

pushing my patient out'.

(Yakely,2013, page 94).

Bueno (2009) describes feeling torn between attending to her unborn babies punches and kicks and focussing on her clients. One paper notes the therapists worry about losing her child, and her unconscious wish to terminate the pregnancy, resenting the presence of the baby and interruption to her life and clinical work (Cole, 1980). Adelson (1995) documents the impact of hatred towards her baby, describing difficulty nursing her child after sessions with a particularly angry patient. Waugaman (1991) discusses his blind spots surrounding his patient's murderous wishes towards his child, describing how discomforting this felt. One paper (Cartwright et al, 2018) describes therapist's heightened sensitivity, conflict and increased emotional distress working with sex offender patients who have abused children after having had children themselves, and the therapist's worry that their own children may become targets for attack. The need for increased safety protocols for therapists and their families is stressed. Way et al (2019) highlight the need for supportive containment, as their study found first time mothers, trainee therapists and child therapists were more likely to experience unbearable feelings of guilt and to consider resignation. These issues are especially sensitive as they are so embedded with shame and cultural taboos, perhaps contrasting a therapists own unconscious wish to feel, and be perceived as, a perfect mother.

The context of child psychotherapy training involves a two-year observation of a mother and infant dyad, as soon after the birth as can be arranged. The task is to use Esther Bick's (1964) model of infant observation to observe an 'ordinary' family,

and one wonders how the idea of ‘ordinary’ is understood by trainees– this may be imbued with particular ideals of culture, ethnicity, class, gender and sexuality. Klauber (2012) explores these issues, as well as the complex task for the observer, who often can find being in the presence of primitive interactions exceedingly painful. She notes that within infant observation groups, students can find themselves becoming overly identified with the baby, feeling the mother to be neglectful, and this can often result in highly critical discussion of the material, particularly of the mother (Klauber, 2012, page 16). The experience of infant observation can put the observer in touch with infantile states, and students can express feelings of distress, helplessness and anger (Schraer, 2021). A child psychotherapist may feel particularly sensitive during her pregnancy, feeling reluctant to write about her own experiences, protecting herself from the observing gaze of her colleagues which she may anticipate as critical, and even persecutory.

2.14 The emergent mother

Research investigating the psychological changes that occur for women as they become mothers is still in infancy, and very few studies consider the transition as a child psychotherapist becomes a mother. Early notions of therapeutic neutrality appear to underestimate the importance of exploring matters of individuality, identity and difference.

Pines (1978) discusses the experience of becoming a parent, exploring the change in identity, shifting of relationships, re-enactments and re-emergence of Oedipal conflicts that are likely to be reawakened during this time. She reminds us that even Winnicott's (1975) 'ordinary devoted mother' is described as experiencing feelings of boredom, loneliness, rage and hatred towards her baby. Sharma (2019) asserts more research needs to focus on matters of integration of a personal and professional identity for the therapist mother, noting that there is little written about the return to work after maternity leave.

Hollway (2015) explores maternal identity change in depth, using psychanalytically informed interviewing methods and recognises explorations of mothering are often obscured, partly due to a preoccupation with infantile development. The absence of papers on this topic may link to the difficulty in accepting the intensity of the emotional states a mother is likely to experience – including her feelings of hate and aggression towards her baby (Kramer, 1996). Hollway (1997) suggests maternal ambivalence is;

> *'determined by complex interactions of external and internal reality and must be socially and culturally located. Hence, we cannot simply apply theories of*

infantile ambivalence to maternal experience'

(Hollway 1997, page 19).

Raphael-Leff's (2008) work explores the complexity of internal conflicts that arise during pregnancy and motherhood. She proposes that encounters with babies evoke more primitive aspects of ourselves, awakening strong emotions and the 'wild things' of infantile experiences that have been defended against (Raphael-Leff, 2005).

Baraitster (2006) proposes that psychoanalytic theory is beginning to recognise the shift from a unitary self when a woman becomes a mother, to transform into states of psychic interdependence with her infant. This is consistent with the work of Beebe and Lachmann (1988) who conceptualise the relationship between mother and infant as an 'interactional', intersubjective system. Baraitster (2006) evocatively describes this interaction, remembering the pressure, exhaustion and shifting of significant relationships which she believes can challenge a new mother's capacity for reflective thought:

'In this immediacy, I am brought face to face with the patched over, broken bits of myself, the cracks in relations with mother, lover, siblings, friends. Everything is challenged, like in analysis, painfully peeled back'

(Barister, 2006, page 227).

2.15 Matrescence

The professional, psychological, social, and neurological reorganisation that occurs when a woman becomes a mother are beginning to be explored in neuroscientific literature. Research indicates that there are significant changes in brain architecture during pregnancy (Kim, 2016) that appears to continue during the postpartum period (Martínez-García et al,2021). These studies suggest these neural changes facilitate attachment, bonding and responsiveness to infant cues (Hoekzema et al, 2017).

> *'The rapid and extreme hormonal and environmental changes of pregnancy mark the transition to motherhood as a major biosocial life event, representing a sensitive neurocognitive developmental period: matrescence'*
> (Orchard, 2023, page 313).

Whilst traditional discourses about 'baby brain' have alluded to negative impacts upon women's cognitive capacities after giving birth, contemporary research indicates the adaptive neuroplasticity during pregnancy actually improves memory and brain functioning (Callaghan, 2022), and that the ability to read facial expressions and emotional perception is enhanced during this time (Geddes, 2009). Further research suggests that;

> *'Motherhood and the coping process can enhance women's knowledge, skills and capacity, while strengthening women's mindset, willpower, and overall emotional intelligence'*
> (Ma et al, 2022, page1).

However, the intensity of these enhanced hormonal changes and emotional experiences can feel overwhelming, and this can be a highly vulnerable period for

women. Some research has suggested that preparation and support during the antenatal period can reduce rates of postnatal depression (Spry et al, 2021). Oakley (2012) discusses the medicalisation of distress, suggesting that experiences of childbirth, and changes in identity during motherhood, can involve a grieving period that is rarely discussed. A recent book explores the concept of matrescence in depth, suggesting the topic is largely unexplored, leaving women unprepared for the extent of changes in identity, career, relationships and position in society. The author believes there are ‘structural and systemic failings’ (Jones, 2023, page 259) within cultural discourses about the transition to motherhood, and a historical sexist lexicon has resulted in a lack of vocabulary to describe the intricacies of the maternal experience.

2.16 Maternal ambivalence and the therapist mother

Whilst there has been a shift in academic research and societal attitudes in regards to the complexity of the role of motherhood, historic legacies of hostile depictions of 'refrigerator mothers' (Kanner, 1949) and mother's personalities as 'the disease provoking agent, as the psychologic toxin' (Spitz,1965, page 504) have not been erased from conscious and unconscious negative attitudes towards the maternal figure. Parker (2005) states motherhood has been both idealised and denigrated within psychoanalytic theory, and the opportunity to understand the experience of motherhood, from the mother, rather than the infant's, perspective, is often overlooked. She offers an in-depth exploration of necessary maternal ambivalence, suggesting that conflicting feelings can feel unbearable, and so the strength of hostility evoked by pregnancy and motherhood is often denied. The impossibility of living up to a maternal ideal, particularly in the context of the shifting cultural attitudes towards working mothers, has resulted in 'women struggling with social and economic circumstances which of necessity magnify maternal guilt and stretch a woman's psychological and practical resources sometimes to breaking point' (Parker, 2005, page 66). Parker illuminates the mother's emotional experience, involving the complexity of sacrifice, frustration, resentment, hatred, aggression, passion, envy and guilt. For the therapist mother, and in particular, for the trainee therapist, invested in observations of the maternal attachment relationship, it may be difficult to reflect upon their own experiences of motherhood, and to fully recognise the depth of emotional toll involved in the process of attachment and separation.

A book exploring the analyst's pregnancy describes conflicts arising when integrating motherhood and career, but proposes that the experience of being a parent can enhance clinical practice. The therapist may feel less enmeshed with her patients,

and better able to protect herself by establishing distance from her personal and professional roles (Lax, 1969). As described in this review, cultural idealisations of motherhood, and lack of time and space for reflective thought, may offer some explanation for the lack of papers exploring the topic. There may be an overestimation about envy and competition from colleagues when considering the intricacies of the therapist-mother identity. Leibowitz (1996) describes her experience as a childless analyst, discussing the impact upon the transference relationship, phantasies, and relationship dynamics, noting that examining this aspect of her identity has enabled exploration of different positions within the therapeutic encounter.

Friedman (1993) writes about therapist motherhood, describing her feelings of inadequacy and overwhelm, in a refreshing shift from accounts which seem to locate the split off, bad mother imago into others. During the process of psychoanalysis, the analyst can represent the maternal object, offering functions such as holding, containing and responding to the patient with a degree of symbiosis. In the maternal relationship, the mother offers her body, eye contact, and facial expressions, adjusting her voice to support emotional regulation in an intimate and intricate dance with her infant (Stern, 2009). The symbolic nature of the therapeutic relationship can mirror these crucial early experiences and in attempt to repair ruptures and disturbances there may be literal overlap in responses, causing confusion. Distinction between these roles is important:

> *‘‘The analyst's task is not to be or become the mother.…What we do provide are some of the functions of the mother as a protective shield and auxiliary ego’*
>
> (Slochower, 1996, page 67).

Rosenthal (1990) suggests a pregnant therapist may become overly invested in work, to counterbalance her uncertainty in her new role as a mother, or to distract herself from worries about labour and birth. Basescu (1996) discusses overlaps in roles, suggesting:

> *'There is a continual, ongoing interplay of ideas and feelings between office and home. We are doing the same thing at home and at work: we are involving ourselves, immersing ourselves in the processes of growth and development of other human beings'*
> (Basescu, 1996, page 102).

She discusses ways maternal identity can be felt to interfere in the work or can be a useful tool. Civin and Lombardi (1996) discuss sharing their experiences as adoptive parents and an unconscious recognition of struggles with maternity, fertility and concepts of 'damaged' mothers. An apparent reticence to explore the topic of maternal ambivalence may relate to the concept of 'Primary Maternal Persecution' (Raphael-Leff, 1990), and this sense of persecutory anxiety may hinder a mother's ability to think about her situation (Parker, 2005).

2.17 Motherhood during a pandemic

This study began during an unusual period of history, during the Covid19 pandemic. Some research has examined impacts upon pregnancy, and mothering, during this time. This included less social support, reduced access to prenatal care, and a detrimental impact upon psychosocial health (Aydin and Aktas, 2021) as well as a heightened potential for prenatal depression (Claridge et al, 2021).

Cavalier and Regus (2022) found that the pandemic appeared to lead to a more pathologised understanding of pregnancy, resulting in a more medicalized model of antenatal care. Sussman (2023) describes her experience in training as child and adolescent psychotherapist during a pandemic, whilst also becoming a parent, writing:

> *'Babies born in 2020 and 2021 entered the world at a time of deep crisis. Their lives in utero and as babies and toddlers were deeply affected by the circumstances of significant restrictions, lockdowns, and profound anxieties about the safety of ordinary human contact'*
> (Sussman, 2023, page 25)

Whilst there may have been some unexpected benefits to the pandemic, such as increased time at home and opportunities for bonding, experiences were individual and relate to issues of privilege, power, race and class. Studies on breastfeeding behaviour suggest whilst some mothers found lockdown increased the time, they

were able to spend establishing breastfeeding, others encountered barriers to support, ending breastfeeding before they had hoped to (Brown and Shenker, 2021). Families were affected financially, socially and psychologically, without the protective factors of schools, social support and community services (Cluver et al, 2020). Pregnant therapists are likely to have observed impacts upon their clinical caseload, whilst also managing their personal experiences of new motherhood with reduced social support.

2.16 Literature Review conclusion

This literature review has highlighted the value in exploring the pregnancy of the child psychotherapist. Whilst there is a useful body of literature which has been fascinating to explore, most existing papers are several decades old. More recent exploration of the topic highlights that some findings appear outdated and need updating (Schmidt, 2015). Stockman and Green-Emrich (1994) noted the lack of empirical studies investigating the subject, and this review confirms this finding, even thirty years on. Whilst qualitative methodology, and case study data are appropriate for the subject matter, analysis of the literature suggests:

> '*Most enquiries into pregnant and post- partum therapists' experiences of pregnancy have often lacked methodological rigour'*
> (Way et al, 2019, page 451).

This review found many studies do not describe their methodology or process of data collection. Most accounts are retrospective and could be affected by memory lapses. Further research could make use of contemporary advances in qualitative data analysis, creating an evidence base that is robust and ethically sound.

Accessing relevant studies can support pregnant child psychotherapists to be attuned to their own transference responses and conflicts (Cole,1980), enhancing understanding of themes that appear in clinical work, and optimising outcomes for patients. Addressing ordinary life events such as pregnancy should be part of psychotherapy training, helping therapists to prepare for different stages of their professional life. Confronting the issues faced, can mean they are not avoided or obscured with feelings of isolation, guilt and shame.

This review concludes that with careful exploration in analysis and supervision, pregnancy may facilitate the resolution of conflicts that may not otherwise have been possible. However, it is possible the positive effects may have been overemphasised in later literature (Deben-Mager, 1993) as the therapist may have an investment in writing about beneficial impacts of her pregnancy. She may find it difficult to share experiences where her pregnancy was connected to negative outcomes for her patient, such as termination of treatment, or a decline in their mental well-being. Whilst a therapist cannot prevent a rupture caused by her pregnancy,

> *'her ability to accept and tolerate feelings of loss, rage, despair, and mourning is at the heart of success in the repair phase'*
> (Denton,2012, page 111).

Sharma (2019) suggests a dedicated issue of the Journal of Child Psychotherapy would go some way to addressing the gap in literature. Insight into this area could enhance the therapist's sensitivity to the patient's responses to her pregnancy and explore aspects of supervision, patient perspectives, and the process of returning to work. This is particularly pertinent for child psychotherapists working in the UK, in National Health Services (NHS). This thesis sought to explore aspects of a child psychotherapists pregnancy which appear to currently be under-explored, in order to further understanding of the unique aspects of this topic.

Limitations of the scope of this project meant I have not been to explore in depth matters of difference, and diverse experiences of becoming a parent, such as surrogacy, assisted pregnancy or the topic of fatherhood for psychotherapists. However, the importance of social identity should not be underestimated, and there

is increasing recognition within contemporary psychoanalytic literature that patients, including children, are curious about the intersectional identities of their therapists. Rather than striving for therapeutic neutrality, acknowledgement of difference can support the transference relationship and strengthen the therapeutic alliance (Prout, 2019b).

Gaps in the literature are highlighted by Guy & Guy (1986), married therapists, who offer an account of their experiences when expecting their first child together. Fatherhood for therapists has been explored by very few authors such as Waugaman (1991), Guinjoan and Ross (2000), and Almond (2015). These studies suggest that although the arrival of the child may be not physically obvious to their patients, men may experience similar changes in style, preoccupation and heightened transference and countertransference experiences as therapists who are mothers. Issues around adoption and paternity leave are discussed by Barnett and Herrmaan (2001).

This review highlights the need for an individualised response to each patient, considering how the pregnancy is perceived by them and related to unique aspects of their psychology, the therapeutic relationship and impacts on the transference dynamics. Very few studies mention fertility difficulties, assisted or surrogate pregnancies.

Whilst an institutionalised response would not be helpful, further research could support greater understanding, avoiding unhelpful acting out or negative therapeutic outcomes. The impact of returning to work after maternity leave is rarely mentioned, perhaps because it is rarely possible to return to seeing the same patients. It is possible that this return could be therapeutic and allow consolidation of earlier

difficulties. Perhaps the topic is underwritten about, as therapists are aware that ending prematurely with young patients can leave conflicts painfully unresolved. Many authors note the helpful process of writing their paper, as well as the importance of personal analysis, supervision, reading, and discussing their pregnancy with colleagues (Beuno,2009). In contrast to the majority of papers in the existing body of literature, this thesis does not present a single, first-person account, but sought to interview groups of child psychotherapists in attempt to provide a degree of objectivity in relation to the topic. The current study provides a novel perspective, electing to conduct focus groups to facilitate an opportunity for a deeper curiosity about the topic, through conversation between colleagues. When considering the design of this project, I came to hope that participating in a focus group may counter feelings of isolation and invisibility for a pregnant child psychotherapist. When reviewing the literature, I came to feel that there were a number of aspects of a child psychotherapists pregnancy that had not yet been explored in depth. These included a psychoanalytic perspective of prenatal life and personality development, the unborn babies experience of the internal environment and presence in the consulting room and the therapists understanding of body states and any changes within the transference relationship that she may have experienced when working with young patients. Some of these themes formed the semi structured interview schedule (appendix 12). This literature review provided a useful foundation that illustrates the current landscape of existing research, and I was curious to discover if the current study may extend understanding of the topic, creating new avenues of research enquiry.

3. Research Methodology

3.1 Aims

The primary motivation for this study stemmed from a realisation that had been no published articles investigating this area in nearly sixty years of the Journal of Child Psychotherapy. The project was designed to generate new information that might be helpful for the profession. This is considered good ethical practice and justification for new research (Silverman, 2014). Qualitative research felt most appropriate to address the research question, as the study aims to expand understanding in this area, rather than to confirm an existing theory (McLeod, 2001).

As the topic is under-researched, the study is interested in the novel data that develops from the participant's narratives, rather than proving a particular hypothesis. This study interviewed CPTs who had experienced pregnancies whilst working with children to learn about their experiences considering the experience of pregnancy for both the therapists and their young patients. The most effective method to meet the aims of the project was to conduct group interviews, designed to encourage CPTs to think with one another about experiences of being a pregnant child psychotherapist. Thematic analysis was selected as the methodology, as it allows for the consideration of psychoanalytic ideas, such as the intersubjective experience between therapist and patient, which underpin psychotherapy practice. Participants could be confidently expected to have a shared understanding of the meaning of concepts, such as transference dynamics, that are of interest to this study.

The research question, 'What can be learned from focus group interviews with child psychotherapists who have been pregnant during their clinical work?' was carefully

revised and refined through the research process (Biggerstaff, 2012) to ensure it remained faithful to the aims of the study. This research does not attempt to imply causality or generalisations, but to focus on the meaning of an experience (King and Hurrocks, 2010).

3.2 Research Design

When contemplating research design, I considered the possible weaknesses of conducting a qualitative, rather than quantitative, study. Early psychoanalytic papers were presented as case studies, and theories were based on the clinical presentations of patients in Freud's consulting room. Even at this time, Freud contended with the notion that investigations into the internal world of his patients were 'unscientific', and believed that all scientific knowledge, including psychoanalysis, was 'one sided' (Freud, 1991, page 71), stressing that one discipline's approach to research did not diminish or replace the value of another.

Whilst research methods have evolved over the last century, there is still a great deal to be learned from the meticulous attention and analysis of data within qualitative research. The purpose is to extend learning about a specific experience, whilst recognising the limitations of being retrospective and reliant on memory. This type of research may once have been dismissed as being untrustworthy, susceptible to researcher-bias, and generally unscientific. Kuhn (1962) counters this rather narrow understanding, as scientific research is continuously evolving, and dependant on paradigm shifts that revolutionise theory, offering novel ways to understand phenomena. Over time, there has been greater appreciation for the benefits of using qualitative methods within social psychology, and acknowledgement that applied research can increase understanding of contemporary issues (Richie and Lewis, 2003).

Shifts in attitudes have implications for child psychotherapy research, underscoring the need to recognise the value of curiosity and uncertainty (Fonagy, 2003, page

113). The strength in the psychoanalytic approach to research is in the tolerance of *not* knowing:

> *'characterized by a wish to understand unconscious phenomena, and a recognition of valuing the importance of what is not understood'*
> (Reid, 1997, page 542).

Insight from psychoanalytic studies is disseminated not only through journals and conferences but through shared thinking, discussion and recognition of the phenomena observed within the clinical setting (Rustin, 2001). The efficacy and value of psychoanalytic research is peer –reviewed, evaluated by those within the field who are interested in the ongoing pursuit of observing and discovering the unique complexities of mental processes.

3.3 Research philosophical assumptions

This project explores what a group of people say about the nature of their reality. The epistemological question might be phrased as ‘what can we know about the reality of being a pregnant child psychotherapist through focus group interviews?’ The validity – or ‘truth’ (Silverman, 2014, page 176) of the study is not achieved by proving a hypothesis, but in the efforts made in the analysis of data, and reporting as faithfully as possible to the true responses of the participants. The study findings are not presented as absolute clinical facts, but as a report on the exploration of the topic, recognising that other truth formations are possible (O’Shaughnessy, 1994, page 941).

This study does not aim produce a definitive answer to the research question by assuming that the responses of participants will be generalized to a larger group, nor will it reflect the experience of every child psychotherapist who has been pregnant. Instead, it is hoped the study will be an in-depth exploration of the topic, significant because the participants have an opportunity to relate their honest lived experiences. Reliability will be tested not by the exact replication of results to similar studies, but in the detailed analysis of the responses, and careful extraction of themes from the data generated. The ontological stance of this researcher stems from a realist framework, recognising that there is a reality that exists that is distinct from beliefs, with an epistemological interpretivist stance – a belief that the research and social world influence one another (Snape and Spencer, 2003).

This study is not value-free, as findings are linked to my personal experiences of pregnancy and motherhood, my philosophical perspective, and my training as a psychoanalytic child psychotherapist, which incorporates underlying assumptions of

the existence of an unconscious reality and the importance of the transference relationship (O'Shaughnessy, 1994, page 947).

3.4 Researcher as an instrument

To create depth to the data, and to triangulate (Richie, 2003) findings from interviews with an additional source of information, I kept a research diary throughout study. This attempted to take a reflexive stance, with the initial aim of separating my personal feelings, and experience of the topic, from the interview data. My understanding of a reflexive approach has shifted over the course of my research. Brown (2006) discusses the pre-clinical infant observation training for CPTs, asserting it involves a high level of self-awareness, gaining recognition as a qualitative research method in its own right. She argues that a reflexive stance is needed in both a researcher's empirical work, and in relation to the academic context. She proposes that whilst there are limits of reflexivity:

> *'We can still use psychoanalytic concepts and methods in order to understand our subjects further'*
> (Brown, 2006, page 193).

I came to understand reflexivity not as bracketing off my own experience, but as a tool utilising relational sensitivity, in connecting with my research subjects. The role of supervision mediated this experience, creating a third position from which to observe and discuss the study. This active role as 'researcher as a presence' determines that

> *'This mode of consciousness requires the researcher move beyond self-awareness and beyond the act of interpreting. It involves the ability to let go of*

preoccupations with self and to be in a place of complete attention'

(Doanne, 2004, page 99).

This can enhance the researcher's involvement in the subject of study, deepening knowledge. I was influenced by Hollway's work researching maternal identity change. This method was designed to elicit responses that invited participants to explore the topic beyond what they were consciously aware of (Hollway, 2000). Elliot's (2011) work interviewing mothers was also instrumental in shaping my approach, employing a co-creational approach between interviewer and subject. The psychoanalytic interview is a useful model for qualitative research but caution must be applied:

'As researchers, therefore, we cannot be detached but must examine our subjective involvement because it will help shape the way in which we interpret the interview data".

(Hollway and Jefferson, 2000, page 30).

Child psychotherapy is the only core profession which requires personal analysis is a requirement of training. This tradition encourages the exploration of one's own internal world as a reference point to begin understanding the world of another. Exploration of the relationship, and the use of transference and countertransference dynamics, are cornerstones of the work. Therefore, as a child psychotherapist researcher, I am familiar with examining my own reactions to material, and the experience of attempting to bracket assumptions, whilst also understanding my response to patients can offer an insight into their psyche.

I became interested in this research topic after realising there was a dearth of literature about the experience of being a pregnant child psychotherapist. This impacted upon my ability to approach the topic with a degree of distance, attempting to ensure that the investigation remained true to the participant's contributions, rather than coloured by my own experiences or views on the subject. The extensive literature review highlighted themes that I felt especially curious about and intrigued by. Whilst these areas have been included in the semi-structured interview schedule, I attempted to facilitate a discussion led by the participant's reflections and interest in topic. I initially approached the focus groups feeling it was important for me to stay rather anonymous as a researcher, in order not to influence responses with my own opinion or thoughts about the topic. This idea of an entirely neutral researcher parallels the myth of a neutral analyst discussed earlier in the literature review. It would not be possible to approach research entirely impartially.

Reflecting on my personal experience allowed consideration of assumptions that I may consciously or unconsciously hold, before approaching the focus groups. This is especially important bringing together a group, in relation to Bion's (1952) understanding of group processes. There was a possibility that the group could cement and connect through a process of creating an 'out group' – perhaps in this case, a fantasy of disapproving, unsupportive professional body that rejects or ignores pregnancy. Without sensitive management, any ambivalent or negative feelings surrounding pregnancy could be projected externally, in attempt to defend against unwanted feelings, to protect the baby and guard against any notion that it may be unwelcome.

3.5 Ethics

Kvale (2007) considers issues around morality, informed consent, dignity and ethical codes in research interviews. He highlights the importance of balancing the contribution of research with the sensitivity of the inquiry, and the researcher's duty to ensure the welfare of participants is prioritised at each stage of process. For this study, ethical approval was sought from the Tavistock Research Ethics Committee (TREC) (appendix 5). This involved setting out a description of the study and the requirements of participants, stating the rationale and the proposed benefits to the research community. The application included consideration of any positive negative impacts of the research and consideration about the vulnerability of participants, ensuring that participants were not harmed in the process of data collection (Flick, 2009). This required careful thought regarding issues around confidentiality, anonymity and debriefing. The committee made some recommendations (appendix 6) before granting approval for the study to proceed (appendix 7).

3.6 Confidentiality

All participants signed consent forms (appendix 8) confirming they understood the aims and objectives of the research and their right to withdraw their consent to participate up to the point of data analysis. All data has been appropriately stored to ensure that confidentiality of the material is maintained. Interview transcripts were anonymised. Each participant was given a pseudonym to ensure that their data cannot be identified by anyone other than the researcher. It is customary practice for child psychotherapists to anonymise the names and detail of their cases when presenting their work, but as a further safeguard to protect patient confidentiality, any reference to patients has been further de-identified, using pseudonyms or initials. I did not interview any direct colleagues, friends or family members. I understood that some participants may know one another through their work in the field. Before each group, I verbally reiterated the confidential nature of the task and clarified the boundaries of the discussion. A consideration of hosting group interviews was that participants would be sharing their responses with one another, which raises issues around their privacy and willingness to share their contributions (Morgan, 1988, page 40). However, child psychotherapists are familiar with the nature of psychoanalytic dialogue with colleagues, as their training involves continuous participation in work discussion groups that promote shared thinking space and high levels of discretion to promote patient and therapist confidentiality. It was felt that participants may appreciate the opportunity to participate in group interviews, and value the opportunity to share their experiences with one another.

3.7 Recruitment

This study used purposive sampling (Silverman, 2014), actively recruiting twelve participants who met the required inclusion criteria. The sample size was intentionally small, in part due to the limitations of time and scope for the project, but more importantly, to allow for consideration of the uniqueness and complexity of responses (Barker et al, 2002) and in-depth analysis of the data which would not be possible with a larger scale participant sample.

When ethical clearance was confirmed, a recruitment advert (appendix 9) was sent to the professional network of registered child psychotherapists. Potential participants were provided with an information sheet describing the study, explaining the aim to offer CPTS an opportunity to reflect upon their experience of pregnancy through participating in academic research (appendix 10). Participants suggested colleagues who might be interested in participating. This method of recruitment is sometimes termed as a ‘snowball’ trajectory (Barker et al, 2002).

It was decided to conduct two groups of six participants, as smaller focus groups of 4-8 people can generate both a higher volume of comments, and group involvement (Morgan, 1988, page 43). Participants were randomly assigned to one of the two groups offered, and this was impacted by practical considerations, such as the day or time they were able to attend, given their personal and clinical commitments. Unfortunately, four participants did not attend the final groups. The responses of eight participants have been included in the final study.

3.8 Inclusion Criteria

The primary inclusion criteria for the study specified that all clinicians who took part were registered with the Association of Child Psychotherapists and were offering child psychotherapy treatment during the period of their pregnancy. Demographic information around ethnicity or sexuality was not recorded, but it is hoped that the sample represented a range of female clinicians that practice as child psychotherapists. It is expected that each individual's background, including their ethnicity, cultural heritage and personal history enrich the findings of the study. In recent years there have been increased efforts to attract people from diverse ethnic backgrounds to the profession. Some studies that have highlighted that Black woman often experienced gendered racism, racialised stigma and reduced care during pregnancy, which can contribute to poorer health outcomes (Mehra et al, 2020). It is understood that aspects of intersectional difference, included race, class and sexuality may impact upon pregnancy experiences.

All participants had been pregnant within the two years prior to the study, and two were currently pregnant. It was hoped that recent experience of pregnancies would enable participants to discuss experiences that felt lively and vivid. Exclusion criteria included child psychotherapists who were not currently working with children at the time of their pregnancy, those who did not meet the inclusion criteria specified above, and those who withdraw their participation consent up to the point of data analysis.

3.9 Interview conditions

Due to the Covid 19 pandemic, focus groups were held virtually to ensure participants were kept safe and that there was no physical health risk associated in participating in the study. The use of online focus groups is increasing (Bloor et al, 2001). Virtual groups offer convenience for scheduling and negating travel time, and broadened the potential geographical boundaries of who could participate. One participant was based in a European city, others were recruited from across the UK. Whilst remote interviewing method is useful, and cost effective, there are some drawbacks. Visual and body language cues are reduced, so interviews may feel less naturalistic. The camaraderie and intimacy of being physically in the room with others, may allow groups to feel more relaxed and forthcoming in their responses. The medium of video conferencing and recording could potentially pose technical difficulties or mean participants felt the group to be more formal, and so be more guarded (King and Hurrocks, 2010, page 46).

There were other practical considerations related to the pandemic. Child psychotherapists were required to navigate the complexities of moving their work online, changes in referrals and higher risk work, and reported higher workloads and levels of exhaustion (Webster, 2020). Potential participants may have felt less able to offer their time, and mental space, to think about participating in a research study. This could explain why some participants ultimately did not attend their interview. Collectively, the profession had to adjust to working online, and whilst this means participants were likely to be familiar and confident attending a virtual group, there can difficulties with internet connectivity and technological hitches that needed to be expected and taken into consideration (Hutchinson, 2020). Whilst these are certainly

challenges, this was also a novel opportunity to explore how the pregnancy of a child psychotherapist was experienced whilst she worked remotely. This topic has not been previously explored in the literature, aside from one account of a therapist who provided telephone sessions during her pregnancy (Weintraub,1990) so will add to growing interest and understanding within the field about unconscious dynamics, body states, and transference dynamics in virtual work (Hart,2020; Kohon, 2020; Paiva, 2020; Shillito, 2020).

The interviews were conducted by video conferencing software 'Zoom', selected as the encryption software protects data, in line with the Trust policy for information governance. Each meeting invitation was password protected, and additional security measures were taken such as locking the meeting and preventing recording by anyone but the host. Before the interviews, all participants were asked to confirm they had a private space to use that ensured all information shared by the group would remain confidential. Participants confirmed that they would abide by the confidentiality agreement of the study (appendix 2), agreeing that they would not share the responses of participants in the group, beyond the parameters of the controlled session.

3.10 Questionnaires

Once consent forms had been returned and participation had been agreed, each participant completed a short form that requested some general information about themselves and their pregnancy (appendix 11). This form gave participants an opportunity to request any specific themes to be included in the focus group. These questionnaires were prepared to provide some contextual information about each participant, and to help the researcher have some understanding of the various characteristics of individuals. It was felt that this information would also be useful data – for example, if the study focussed on trainee experiences, or if people were more likely to be interested in participating in the group if it was their first pregnancy. It may be interesting to examine if there were links to number of years of experience, and how much support each person felt they needed, personally, and in their clinical work.

3.11 Observations

King and Hurrocks (2010) discuss interview role conflicts, sensitivity of topics, and the importance of recognising that even for the most experienced researchers, things often might not go as planned and may veer off topic. The use of the research diary has an important function in acknowledging various conflicts, involving the role and reflexivity of the researcher, the aims of the study, and the willingness of participant to explore new and potentially challenging topics. Excerpts from my research diary include my apprehension about hosting the group, and a desire to create a space that felt safe for participants to openly share their experiences in confidence. During the recruitment process, my notes include my anxiety about my inexperience hosting a focus group, and reflections about the difficulty in members finding time and space to set aside to think together.

Research Diary excerpt

I feel mindful of time constraints of a group. Whilst up to ninety minutes feels like an adequate period, and not too onerous an expectation for a busy child psychotherapist to attend – it may be that hosting a group involves specific dilemmas and difficulties. The topic of pregnancy and motherhood is highly evocative and could potentially feel exposing or emotive for those who contribute. I feel conscious of the skills involved in containing the group, holding the structure and allowing a natural, discussion to develop in an environment that feels safe.

As noted in my research diary, I was conscious of my own inexperience in this new role as a researcher. I considered what was required of me –a long list of attributes that created a ‘good interviewer’: such as listening skills, a clear, logical mind, quick thinking, good memory, offering understanding and empathy, and the ability to establish a good rapport with participants (Legard et al, 2003). I concluded it may take a lifetime to develop and hone these skills but hoped that my psychotherapy training has increased my ability to listen with openness and curiosity, and to approach interactions eschewing ‘memory and desire’ (Bion, 1995, page 43) in the effort to allow responses to the interviews that were not driven by my own expectations or experiences but belonged to the participants authentic reflections.

3.12 Semi structured interviews

I was interested in creating an opportunity to consider individual's experience and to facilitate a discussion of common themes and differences. I aimed to address what appeared to be gaps in the literature, and I grouped these topics into themes that I planned to use as prompts for discussion (see appendix 12). I wanted to explore how the experience of pregnancy might feel for a child psychotherapist who has spent many years training, researching, and observing early life, and the relationships between infants and their mothers. I asked the participants to think about how they felt their training may have impacted on their developing baby, and conversely, how their baby may have impacted on their clinical work.

I intentionally included themes that had had been mentioned rarely in the literature review. These included asking questions about reactions to pregnancy from colleagues and supervisors, encouraging participants to think about their body states, their patient's interest in their bodies and possibly the unconscious, preverbal connections they had made. I hoped to offer a space that felt safe to share their challenges and opinions. As there was very little written in the literature about the return from maternity leave, I included a question about this. I became particularly interested in ideas around maternal identity. An advantage of this qualitative research design is the flexibility of the approach, creating an opportunity to develop the roots of a researcher's topic of study, with the branches of the participant's responses, allowing the pursuit and development of data that is of interest (Charmaz, 2014). The use of semi-structured interviews allowed for

'the diversion of the interview into new pathways which, whilst not originally considered as part of the interview, help towards meeting the research objectives' (Gray, 2014, page 386).

Within this method of interviewing, the researcher is guided by the interview schedule, but free to divert from it based on the participant responses, offering probes or clarifications as needed (Lyons and Coyle, 2016).

Participants were invited to suggest themes they were interested in discussing. These included the experience of having psychoanalysis whilst pregnant and working remotely (figure 3).

Group 1	***Participant A***	***Participant B***	***Participant C***	***Participant D***
	Endings and Returns Support from clinics and training school Acknowledgement of sacrifices which need to be made as a parent and trainee- in relation to home and work life.	*Decisions about when to let patients know. Managing painful projections from patients.*	*Awareness of pregnancy, especially before patient is informed, and impact on therapy*	*No response*
Group 2	***Participant E***	***Participant F***	***Participant G***	***Participant H***
	Attending analysis while on maternity leave.	*Delay starting a family on the training, mainly in order to qualify. Impact on fertility and family planning*	*The decathexis of energy from the training to motherhood. Find a balance on return of home/clinical work*	*Being pregnant and working remotely*

Figure 3: Themes suggested by participants prior to focus group

When scheduling the groups, one participant explained she had limited time available to attend, describing difficulties in balancing commitments at work, alongside the training requirements and organising childcare for her young baby. I suggested that these were important practical issues that it might be helpful to discuss in the group. The irony was not lost on either of us that the participant, whilst keen to contribute, was doubtful that she could find the time to attend.

3.13 Data collection

Participants were made aware that each group would be audio and video recorded to enable transcription and data analysis. Midgley (2006) discusses complexities in psychoanalytic research, including the potential intrusion of using recording devices. Whilst this discussion is mainly related to the clinical setting, the use of video recording may consciously or unconsciously inhibit the natural responses of interview participants, who may be more guarded and aware of an 'audience presence'. The researcher's psychoanalytic stance, considering the emotional exchange, transference and countertransference responses is useful to consider- both verbal, and non-verbal cues, and extensive layers of meaning that may not always be immediately obvious, or available for data analysis even when exchanges are recorded.

3.14 Group interviews

Group interviews were chosen as the qualitative approach for this study, in attempt to allow participants to consider their individual experience with a group of their peers. The opportunity for interactive reflection and discussion between participants can add depth to interviews, as they consider their viewpoints and build upon one another's contributions to the discussion.

> '*A feature of focus groups is the spontaneity that arises from their stronger social context in responding to each other, participants reveal more of their own frame of reference on the subject of study'*
> (Finch and Lewis 2003 page 170).

Group interviews are a novel way to investigate this topic, as previous studies have focused on case studies or individual interviews. The use of group interviews as a qualitative research method stems from social science and market research, and later use in social psychology studies. Morgan (1988) suggests that the use of group interviews creates interactions that generates data and insights that would not otherwise be accessible

There is some evidence that pregnant psychotherapists have found groups to be a useful source of support, helping them to make sense of their experiences and to understand their patients' projections (Steiner, 2004). Groups create an opportunity to collect large amounts of data fairly quickly and efficiently, through facilitating a guided discussion on a specific topic, wherein participants are able to candidly build on one another's responses (Leung and Savithiri, 2009). Given the lack of published literature on this topic, it was hoped that through providing an interactive space, a

dialogue might emerge between participants that would engender elaboration to one another's' responses, creating depth to the discussion (King and Hurrocks,2010). Child psychotherapists are familiar with group discussion, as these reflective spaces are a core component for training within the profession, offering space to explore unconscious and conscious dynamics in their clinical work (Rustin, 2008). It was hoped that participants would feel comfortable using the group space for shared thinking on the topic, due to their extensive experience in psychotherapy training of participating in meaningful group discussions. In additional to the audio-visual recordings, detailed notes of the focus group recorded some of the unique features of each group, and the nature of the discussion that unfolded.

A special edition of the Journal of Psychoanalytic Psychotherapy in 2004 was entirely dedicated to papers discussing the impact of the therapist's pregnancy on her adult patients. The authors had come together during their pregnancies in a regular seminar group, and were joined by John Steiner, who noted the important function of the group:

> *'The seminar seemed to be particularly helpful since the support of colleagues made the therapist feel less guilty about defending her own integrity and sanctioned the inevitable priority which the therapist gave to her unborn baby. At the same time, if the therapist was less guilty, she could make some room in her mind for the actual needs of her patient. The group could in this way, moderate the intense emotions that the situation gave rise to, and both the patient and therapist were supported. In this respect, the group functioned like a third object, perhaps like a father who could on one*

hand allow the mother to be protected from the attacks of the child, but who could also take on the child's on as his responsibility'

(Steiner, 2004, page 3).

When reflecting on the experience of being in the seminar, which met for three years, Editor Nollaig Whyte (2004, page 136) noted that the opportunity allowed the therapists to reflect on recurring themes that arose in their work, such as issues of sexuality and separation. The accounts of pregnant therapists indicate that the seminar group was immensely helpful in supporting their thinking about the patient's responses to their pregnancies, and the impact upon the therapeutic relationship. It seemed to me that a similar thinking space might feel helpful to child psychotherapists who felt curious about the topic, and who might feel that they could benefit from a group space to explore their experiences together.

I referred to the format for focus groups outlined by Finch and Lewis (2003), (figure 4). This model offers guidelines for a researcher, considering the group process, development phases, and the task of the researcher in moderating and facilitating the group discussion.

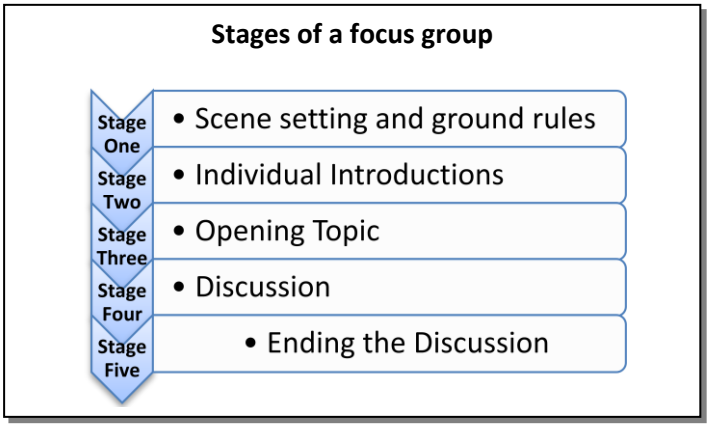

Figure 4: Stages of a focus group (Finch and Lewis, 2003)

3.15 Work discussion groups

The decision to use groups as the method of data collection was influenced by the tradition of infant observation and work discussion groups, that form an integral part of the child psychotherapy training model. The first work discussion groups were developed by Martha Harris (1987), who described them as opportunities for participants who were interested in the unconscious dynamics of the workplace, to explore ideas together. This involves a process of exploration and discovery, with no one expert or authority. Students are encouraged to open reflect on the detail of their experience in order to deepen their understanding of the meaning and significance of their experiences in the workplace. Rustin (2008) notes how the Tavistock clinic values working in groups, and describes the evolution of group work, with influences from Balint, Bion and Bowlby to Esther Bick's (1964) development of the infant observation model, training students to be attentive to the nuance and detail when observing the development of a baby from birth until they are two years old. She notes the usefulness of the group setting to hone these observation and reflective skills:

> *'In the seminars, a very common occurrence is for the group to try and unpick – and slow down – the events by asking themselves about each step a little further'*
>
> (Rustin, 2008, page 10).

The practice of learning through group discussion and reflection, and the conventions of openness and curiosity about internal life seemed a good foundation upon which to build a focus group. Child psychotherapists are skilled participating in groups that exploring both the internal and external dynamics, as well as

understanding the importance of confidentiality, discretion and professional boundaries. Whilst work discussion groups are familiar; the role of researcher/group facilitator was new to me. Agent's (2008) discussion of the complexity of facilitating a work discussion group resonated with my experience. She describes the interplay of holding the group, encouraging contributions, whilst noticing her own emotional responses to the material, as well as keeping her own notes about the process. The practice of recording session process notes connects to the custom of keeping field notes, or a research diary.

3.16 Debriefing

At the end of each group, participants were asked if they had any further questions or additional points they felt had not already been covered (Gray, 2014, page 397). They were invited to contact the researcher if they had further thoughts on the topics discussed or wanted to discuss any aspects raised in the discussion. Consideration was given to sensitive material that may have been raised in the interviews. Reflecting upon experiences of pregnancy may stir up issues for participants relating to difficulties surrounding pregnancy and birth (for example, infertility, miscarriage, stillbirth, loss, and birth trauma). Pregnancy can evoke a powerful emotional response for women, and this may be particularly poignant when working with children who have had extreme experiences of deprivation, abuse and trauma. Whilst trainee child psychotherapists are expected to be in analytic treatment throughout the period of the training, and have high levels of supervision, qualified CPTs may not have as much support. Post interview information was offered to participants, acknowledging the sensitivity of the topic and signposting to appropriate support should this be needed. The information provided to participants reminded them that participation in the study would be entirely voluntary and that they had a right to withdraw from the project without needing to give a reason, up to two weeks after participating.

3.17 Analytic method

The material from the group interviews was transcribed and coded used Thematic Analysis (TA). This method is considered particularly suited for psychotherapy research as it involves flexibility in incorporating the researcher's theoretical stance, (McLeod, 2011), allowing for the inclusion of shared clinical concepts to be employed. The purpose of TA is to identify patterns of meaning across a data set that provide an answer to the research question being addressed. This study uses Braun and Clark's (2013) reflexive method for capturing themes, where patterns are identified through a rigorous process of data familiarisation, data coding, theme development and revision.

> *'A qualitative orientation usually emphasizes meaning as contextual or situated, reality or realities as multiple, and researcher subjectivity as not just valid but a resource. We characterize this school as reflexive TA to emphasize the active role of the researcher in the knowledge production process.... In reflexive TA, themes are conceptualized as meaning-based patterns, evident in explicit (semantic) or conceptual (latent) ways, and as the output of coding – themes result from considerable analytic work on the part of the researcher to explore and develop an understanding of patterned meaning across the dataset.'*
>
> (Braun and Clarke 2013, page 848).

The use of TA allows close attention to be paid to the participant's narration, and themes can be drawn from individual experiences. Concepts linking themes may be identified across groups. Just as psychoanalysis is interested in both the conscious and unconscious meaning of communication, TA allows for both latent and semantic

development of themes – those that are explicit and concepts and assumptions that are implicit, underpinning the data. The data analysis employed follows Braun and Clarkes six stage process of familiarisation, coding, searching for themes, reviewing themes, defining themes and writing up the report (figure 5).

Phase	Examples of procedure for each step
1. Familiarising oneself with the data	Transcribing data; reading and re-reading; noting down initial codes
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the data-set, collating data relevant to each code
3. Searching for the themes	Collating codes into potential themes, gathering all data relevant to each potential theme
4. Involved reviewing the themes	Checking if the themes work in relation to the coded extracts and the entire data-set; generate a thematic 'map'
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme; generation of clear names for each theme
6. Producing the report	Final opportunity for analysis selecting appropriate extracts; discussion of the analysis; relate back to research question or literature; produce report

Figure 5: Thematic analysis phases (Braun and Clarke, 2006, page 87)

Whilst the authors stress the fluidity of this sequence, that can involve movement back and forth through each stage, it provides structured phases that allow for a rigorous analysis of data. The following chapter will describe the process of data analysis in more depth.

3.18 Reflexive Thematic Analysis process

Phase 1: Familiarising oneself with the data

During this phase, I watched the recorded interviews several times and the data was transcribed using a transcription service recommended by the University of Essex, adhering to confidentiality and data protection protocols. All interviewees were given a pseudonym, and any identifying details such as names of clinics, patients, or therapist's children were removed or changed. I read the transcripts a number of times and noted down initial codes.

Phase 2: Generating initial codes

Initially the transcripts were analysed using an Excel spreadsheet, the date coded line by line, for as many codes as possible (Braun and Clarke, 2006, page 89). This generated 490 codes for Group 1, and 121 codes for Group 2. Coding evolved throughout the analytic process, so there was less overlap of codes with similar wording when coding the second transcript. Data from both groups was combined, resulting in 493 distinct codes. Codes were then edited, combining similar or repeated codes, and some codes were collapsed into one another to reduce the total number**.** This resulted in a total of 213 distinct codes across both data sets.

In the second coding phase, many codes were eliminated as they were too brief, lacked context and were not sufficiently specific enough to capture the underlying concepts of the data (Braun and Clarke, 2016). The evolution of the code iteration development was complicated, as I attempted to ensure each code sufficiently captured the content and depth of the data but was not overly specific to ensure it pertained to more than one than one data item (Braun and Clarke, 2013). The first phase of the coding process could be described as semantic coding, primarily

describing the content of the data. These initial codes did not feel sufficiently rich in detail, and data was recoded in attempt to capture the latent meaning. This coding phase requires a more active role of the researcher, in attempt to identify themes that are relevant to the research question. The process is termed reflexive thematic analysis, as involves careful consideration of the interpretation of theoretical meaning:

> ‘The researcher is encouraged to embrace reflexivity, subjectivity and creativity as assets in knowledge production, where some scholars, such as Boyatzis, may otherwise construe these assets as threats’
>
> (Bryne, 2022, page 1393).

During the second phase, I used the coding software package Nvivo, importing the data transcript and then recoding it systematically. I did not use the software to autocode, as I wanted to ensure latent meaning was retained. I coded larger sections of the text, which enabled to the concept of the data to be captured, as line-by-line coding had broken down sections of data until into such fine detail that there was a risk of meaning becoming lost. Nvivo software organised the data efficiently, creating consistency across codes, and allowed merging of codes when there was overlap. The 213 codes generated in the first coding phase were refined into 44 distinct codes (appendix 13), and a codebook was created (appendix 14). This process catalogued the frequency of coded items (appendix 15), improving accessibility, instantly linking codes to the referenced data. A word cloud provided a visual representation of frequently used terms (figure 6).

Figure 6: Word cloud of frequently used terms

Phase 3: Searching for themes

After the coding process was completed, individual codes were first listed and printed, and grouped together according to similarities and connections. Nvivo software was used to group codes under subheadings, creating ‘parent’ and ‘child’ codes, clustering codes under an overarching theme in a codebook (appendix 14). It should be noted that some codes appear in more than one theme, this may have been because they held both latent and semantic meanings, or simply because they cut across more than one theme. For example, the code ‘being pregnant’ had multiple meanings – related to the therapist discussing her own feelings about her

pregnancy, but also acknowledging the reality of a change. Therefore, this code appears in two themes, ‘Belonging to the Child Psychotherapist’ and ‘Something Changed’. In Reflexive TA, codes that cut across multiple themes are not undesirable overlaps, but can help to provide a unifying framework that demonstrate coherent concepts across an overall data set (Braun and Clarke, 2012, page 63-65).

Phase 4: Involved reviewing themes

To ensure each theme retained congruent to the data, each code was revisited, pertinent extracts from the data were selected that illustrated the conceptual idea. I reviewed the transcript, bringing the participants responses back to the fore of the process. Six central themes were identified (appendix 16), and coupled with particularly evocative quotes from each code, to ensure that themes were sufficiently connected to each code, and accurately depicted the true contributions of respondents.

Phase 5: Defining and naming themes

In the final stage of theme definition, a thematic map was developed using the ‘Mind Meister’ programme, creating a graphic representation that illustrates how central concepts encompass groups of codes (figure 7).

Figure 7: Thematic map

I experimented when naming each theme, ensuring they directly corresponded to participant's responses. I revisited the transcript and selected data excerpts (appendix 17) that illustrate how each code connects to the final themes.

Phase 6: Producing the report

I thought carefully about how to present the findings, aiming to avoid repetition and to produce a cohesive report. I decided to present each theme, followed by a discussion that linked to the literature review. I chose to organise the report in this way in attempt to orientate the reader, and to illustrate how key aspects of the findings link to concepts within existing research.

4 Findings and Discussion

This research study set out to explore the topic of the pregnancy of a child psychotherapist. Two focus groups were conducted, with eight child psychotherapists who had been pregnant during their clinical work. Previous research studies in this area are primarily singular interviews or case studies. I was interested in exploring the way child psychotherapists discussed the topic of pregnancy with one another. The transcripts of both groups were combined during the process of creating codes and searching for themes, but there were distinctions in the composition of participants in each group (figure 8). This chapter examines themes that emerged from both groups.

Group Name	Number of group members	Number of qualified members	Number of trainee members	No of pregnancies	Notes
Group 1	4	2	2	3 first pregnancy 1 second pregnancy	Three participants were known to one another, and had been pregnant at the same time
Group 2	4	1	3	3 first pregnancy 1 second pregnancy	Three participants were known to one another

Figure 8: group composition

The groups were held in August 2021, whilst social distancing measures were still in place, and took place virtually. It became clear during the discussion that some members knew one another and been pregnant at the same time. Upon reflection, this added a different dynamic to the nature of group one, as it is likely they had discussed their thoughts about their pregnancies together previously, and there was

a sense of an experience that had been shared that they were continuing to explore and think about together.

> **Alice:** *I was the first one to get pregnant and then quickly there were kind of [a number] of us...I think we would chat in a kind of informal way but maybe [to] have a space that's available would be really nice, because I think a lot does come up, and actually just from hearing today lots of similar things came up for all of us, and it would have been quite reassuring to think about that together maybe along the way.*

In group 2, one member was currently pregnant and another on maternity leave after recently having given birth, and there was a sense that they were attending the group to find a space to think about their current situation. An introductory question asked about their motivation to take part in the study. Responses were very similar, mentioning curiosity and desire to have a space to think:

> **Sara:** *I'm interested…to hear other mums being pregnant and being a child psychotherapist*
>
> **Victoria:** *It still sort of early days in terms of…being pregnant…so I'm just really interested to come and talk about it, and have a space to think about it, and hear your thoughts as well*
>
> **Emily:** *Yes, interested to see what comes up, what people have, what other mums observed, the trainee mum's observed, and yeah, it'll be quite useful maybe, for all of us just to have this space, so yes.*
>
> **Kate:** *So, I suppose it's partly just to kind of link up with others that have been in the same position and sort of share experiences, and hear others, and that sense of community as well*

Sophie*: I think for me this feels really interesting because I think it did have an impact on my work. I suppose I'm sort of curious about other people's experiences.*

In the following chapter, reflexive thematic analysis will be described, examining the codes that were extracted from the data, and describing the themes that were generated from the analytic process

4.1 Reflexive Diary

Focus Group 1

I wonder about my ability as a trainee to facilitate a cohesive group that could come together to create a constructive thinking space. I feel conscious of preserving the confidentiality of the material shared. The lack of published research on the topic suggests the topic is rather taboo, and I feel particularly aware of the possibility of the group becoming rather like an illicit gang, meeting to complain about institutions and established norms.

Focus Group 2

Just before this focus group began, I received two cancellations from participants, and felt a mixture of disappointment and anxiety. Once the group began, I noticed I felt more relaxed the second time around, as the format and discussion felt familiar, and I had a better sense of what to expect. I had more confidence in my own ability to host the group, and more faith that the technology would work. However, I was conscious of the skill needed to weave in my interview questions, offer space for each group member to participate, whilst encouraging a natural flow of the conversation. When later re-watching the interviews, I was aware of my attempts to connect the group and of my language. For example, when speaking about the profession, I used the term 'we' several times, perhaps in attempt to create a sense of group unity, recognition of sameness and to facilitate a sense of being understood. I later wondered about this eagerness, perhaps avoiding the discomfort of being in a group and speaking about the unfamiliar topic. The real baby was rarely mentioned, and in particular a lack of discussion about

any potential ambivalence towards the therapist's pregnancy and her own child. Perhaps a more intimate, anonymous space may have opened an opportunity to consider the individual experience in greater depth and allowed room to disclose more about her internal conflicts.

Upon reflection, I feel the use of groups was beneficial to the study. Although this is the first research project I have undertaken, I feel I was able to facilitate the groups to enable participants to engage in way that felt organic and free flowing. Group members expressed their keenness to participate and encouraged one another through their use of language – agreeing, affirming, and connecting their thoughts and ideas. I felt a responsibility to ensure that the contributions of all group members were included so their views were represented. Some members gave particularly evocative examples, and seemed able to eloquently capture the broader ideas of the group, in a way that occasionally seemed to summarize or appear as they were able to act as a spokesperson.

When facilitating the groups, I was aware of the multiple roles I held – as research designer, group facilitator, and the data analyst for the study. It felt important not be become too overwhelmed with these multiple tasks, in order to remain present in the group without becoming preoccupied concerns regarding the analysis of data in the next stage. The process has parallels to the tradition of writing up case notes following a child psychotherapy session for a peer supervision seminar. At times, the knowledge that the content of the session will be scruntinised in the supervisory group can feel inhibiting, and potentially even alter the therapist's responses to the patient in anticipation of potential criticism. However, after many years of attending such groups, I have come to appreciate the duality of remaining present and authentic within the therapeutic dyad, whilst holding in mind the knowledge that the

content of the session will undergo analysis in supervision. I feel that this experience enhanced my ability to become invested in the process and to facilitate an organic discussion. However, there were also more technical aspects of group facilitation that were important to manage. I felt a responsibility to keep the group to task in terms of time keeping and navigating the discussion, so it did not stray away from the research enquiry, whilst not being overly directive.

Although I did not code my own contributions, I was careful about self-disclosure and did not discuss my own experiences of pregnancy. However, I did share with participants that part of my motivation for the study was because I had not found much research about the topic and this could be said to be evidence of my own biases, and investment in the process. I was aware of that the dynamics of interviewing mean participants often give the research what they assume the researcher wants to hear and felt conscious to frame my questions in such a way that invited participants to share their depth and detail of their individual experiences, rather than speaking generally or theoretically about the topic (Chase, 2003). Reviewing the transcripts, it felt feels clear that participants were keen to be constructive and that whilst I attempted to be a benign facilitator, I was not an entirely neutral presence.

> **Interviewer:** *{After introductions]. Thank you so much. You've touched on the sort of reason that I was interested in doing the study just because I couldn't really find very much written about this area from a child psychotherapist perspective. So, I'm really curious to see kind of what comes up in the course of the discussion. And just thinking about some of the things that you've touched on already. I'm just thinking about where to start. One of the themes that was suggested by you [in pre-interview questionnaire] was thinking about the*

treatment and how and when you began telling patients about your pregnancy, and how you made that decision. So, I don't know if anybody has any thoughts about that.

The process of facilitating focus groups created pressures in my stance as interviewer, as the participants discussed a topic, I had intimate experience of. My reflexive diary and access to supervision, created a third position from which the participants, and my own, responses could be examined. This encouraged depth to the discussion, producing layered, meaningful data, providing an ideal landscape for thematic analysis.

4.2 Codes and themes

Thematic analysis of the data from the focus groups found 44 codes (appendix 1), which were grouped into six thematic categories (figure 9), which will be discussed in depth. It seemed to be pragmatic and efficient to code the data from group one and group two separately, and then to combine codes from both groups when creating themes.

Codes	Theme
Being a trainee, Being pregnant, Being qualified, Personal professional conflict, The baby, Therapists feelings	Belonging to the child psychotherapist
Being pregnant, Characteristics of the patient, Positive and negatives, Related to the pandemic, Responses from others, Responses from patient, Returning from maternity leave, Separating, Something changed, Something important, Something useful, Trauma	Something Changed
A beginning, Conception, An ending, Loss	Related to Time
Reality, Something explicit, Something hidden Unconscious fantasy	Knowing and Not knowing
Being interested, Being preoccupied, Lack of research, Making a connection, Related to analysis, Related to a challenge, Related to supervision, Something complicated, Something painful	Space to think
In the room, Intrusion, Therapist as mother, Therapists body, Unconscious fantasy	Therapist Patient Dyad

Figure 9: List of codes and final themes

The thematic map provides a visual illustration of how codes link to each theme (figure 7). In this chapter, each theme will be discussed in detail, giving examples of participants responses and considering their accounts of their experiences. The data will be further examined considering how each of the final themes may relate to

theoretical concepts and existing literature on the topic, or potentially indicate areas where further research is needed.

4.3 Theme 1: Belonging to the child psychotherapist

Causing damage by becoming pregnant

This theme captures the thoughts expressed by the child psychotherapists that connected of their own feelings and ideas that 'belonged' to them. Participants spoke about their experiences of being pregnant, and some expressed fears and worries that they may have somehow caused damage by becoming pregnant. This theme groups together six distinct codes (figure 10), and includes participants feelings about their pregnancies in general, the impact upon their identity as a trainee, the meaning of pregnancy for qualified child psychotherapists, professional and personal conflicts, and thoughts about their unborn babies.

Theme	**Belonging to the child psychotherapist**		
Codes	Being a trainee	Being pregnant	Being qualified
	Personal professional conflict	The baby	Therapist's feelings
Quote:	**Lina:** *I guess I think there's an idea during training that you're giving up your life to do your training, and people sort of, so many sacrifices for your patients, and I think that changes a little bit.*		

Figure 10: Theme 1

Participants spoke about the demands of child psychotherapy training, and feelings of guilt that their pregnancies had disrupted their clinical work with patients. A few trainees mentioned feeling a sense of concern that becoming pregnant was unwelcomed, and 'not allowed on the training'. Emily remembered her analyst telling her *'trainees a long time ago…were given the choice between being pregnant and*

doing the training'. Aisha worried the pregnancy might mean she could not qualify, and there was much discussion on the personal and professional conflict that came with being a pregnant child psychotherapist. Trainees spoke of attempting to manage the demands of motherhood, their clinical work and studies, and trying to reconcile the expectations and limitations of their roles. Kate described feeling that her pregnancy created another loss for her patients, so difficult when they already had '*such high levels of deprivation and need'.*

> **Lina:** *'Some supervisors sort of expect you to put your patients before anything, and just naturally, your baby comes first'.*

Responses from qualified child psychotherapists differed slightly, as they tended to speak more about their pregnancies, and maternity leave, as expected events within the course of their working life. A qualified child psychotherapist articulated some of the conflicts shared by the group, and reflected a rather more optimistic perspective:

> **Mona:** *'I think there's a lot of anxiety about whether we are causing damage to them [patients] by becoming pregnant, but on the other hand I also believe that it's a very, very hopeful thing for them to have a pregnant child psychotherapist: because in some ways, it can confirm that they haven't damaged us really, that we are able to carry on having our own happy separate lives and that we are able to, to have babies, that they haven't really ruined our internal resources and that you know, we have enough of resource to, to have another baby'.*

4.4 Discussion of theme 1

Belonging to the child psychotherapist *Causing damage by becoming pregnant*

Participants explored ideas around the impact of their pregnancies, on their clinical work, their relationship with patients, and upon their career and training commitments. These aspects of the discussion were coded and grouped into the theme ‘Belonging to the child psychotherapist’. They spoke of their worries, discussing an idea that becoming pregnant could cause damage to their patients, create difficulties in the consulting room, and would necessitate juggling competing priorities. These themes echo findings discussed in the literature review (e.g. Tinsley and Mellman, 2003) connecting pregnancy to ideas of something very dangerous, and the therapist’s desire protect the infantile aspects of her patient, as well as her baby, from attack.

Participants shared thoughts that pregnancy is seemingly taboo within the child psychotherapy profession, and this perhaps helps to explain why so few papers have been published on the topic. Whilst it is documented that pregnancy often coincides with psychotherapy training (Goldberger et al, 2003) the literature review demonstrates relatively little research has explored evolving personal and professional identities, seemingly so changed by the pregnancy.

The group discussed a real dilemma of feeling they must decide between training as a child psychotherapist or having a baby, wondering together if it might be possible to achieve a more realistic, integrated identity as a ‘therapist mother’.

Perhaps this research project, offering a thinking space about the topic, indicates changing cultural norms within the profession. It has always been dominated by women, but in previous years training routes in the UK were entirely self-funded. The

context has changed as trainees are now public sector workers within the NHS and are governed by standardised HR policies. Some participants mentioned they had been asked about their plans to have children during interviews for the training and felt outraged and upset this, particularly as the question seemed to be rarely posed to men. Whilst it is important to be realistic about the real complexity of being pregnant and raising small children whilst undertaking the enormous demands of the training, such questions raise concerns about discrimination. It is possible that ideas of choosing between having family and beginning psychotherapy training still exist. However, it is also possible that traditional tropes have stayed within the culture of the training, and trainees may be particularly sensitive to projections related to their pregnancies and experience powerful feelings of persecution. It is interesting to consider the timing of pregnancies. Perhaps the experience of working with children who have suffered great deprivation and loss can compel urges to be creative, reparative wishes, and to mother a loved baby. Idealised fantasies of motherhood may obscure any ambivalence associated with pregnancy, and it could be possible that this may become located within the training institution.

The role of supervision appeared important – whilst some of the literature has indicated therapists often encounter disapproving or disappointed responses from colleagues (Goldberger et al, 2003), most trainees spoke of the support they had received from their training school, and the warmth and excitement shared by their supervisors when they announced their pregnancies.

There seemed to be a collective attempt to challenge together a preconceived notion of a pregnancy signalling a great crisis, and the group shared their thoughts about ways they felt pregnancy might have facilitated psychotherapy treatment, considering how becoming a mother may have enriched their skills as a therapist.

The idea of pregnancy facilitating emotional growth for both the therapist and the patient is considered by Etchegoyen (1993), who suggests this only becomes possible through careful analysis on the effects of the pregnancy.

The group spoke about being an expectant mother, and how this had profoundly impact upon their theoretical understanding of motherhood, but also upon their identity and their therapeutic practice. These issues are discussed in depth by Robinson (2013), who reported that therapists expressed feeling a greater depth of understanding towards their patients, felt more in touch with their patients' internal world, and states of regression after they had become mothers, but often experienced a great struggle attempting to balance personal and professional life. Personal and professional conflicts were discussed in some depth, participants voicing how changed they felt by their training as child psychotherapists, their deep connection and commitment to their work, but noting the ongoing negotiation between home and work life felt extremely challenging. Diamond (1992) suggests a pregnant therapist must work find a new balance of the cathexis towards her baby and her profession. This seemed to feel more acute for trainee therapists, who described their feelings of *'giving up their lives to do their training' and* could be understood as still developing their professional identities. Qualified child psychotherapists seemed to express less conflict about becoming pregnant, noting they no longer needed to be concerned about stepping away from the training school, and feeling maternity leave was an expected and accepted part of a woman's professional life. However, they also indicated there was less supervision available for them to be able to think about the impact of their pregnancy on their work.

4.5 Theme 2: Something changed '*Everything was more heightened'*

Theme 2 encompasses the highest number of codes as participants discussed a variety of changes related to their pregnancies, and their clinical work (figure 11).

Theme	**Something Changed** *'Everything was more heightened'*		
Codes	Being pregnant	Characteristics of the patient	Positive and negative
	Related to the pandemic	Responses from patient	Separating
	Something important	Something changed	Something useful
	Trauma	Responses from others	Returning from maternity leave
Quote	**Emily:** *I think for me I'm really dealing more with the post pregnancy now, a new mum trainee state of mind and it's really taking time for me to adjust and just make sense of the work which I am familiar with, because I have done three years of the training, but also I've changed: it's been a really wonderful experience to become a mum, I think it helped me to be a better clinician, and I'm just really thinking about whether that change in me is in the material present somewhere.*		

Figure 11: Theme 2

Participants shared their memories of responses from patients, the children's parents and carers, and noted shifts in ways that colleagues, as well as patients responded to the pregnancy:

> **Aisha** '*It was the professional network that maybe were struggling, even my supervisor really…I think it was a very difficult process for them to acknowledge my pregnancy'.*

The group discussed how responses to their pregnancy differed depending on the characteristics of their patients and noticed responses varied depending on the factors such as age, gender, and pathology. Many participants referred to patients who had suffered enormous trauma, and a feeling that the introduction of a pregnancy could feel as a repeat trauma of abandonment and loss, for a child who was learning how to be in a relationship with their therapist. This also linked to patients who struggled with difficulties in coming together and separation, and the ending of the work and return from maternity leave was considered in some depth. Whilst being sensitive to these complex issues, there was a sense of hope prevailing. The group spoke of feeling they had given children opportunities to express their anger and fury at being left, and an idea that this may help to increase their capacity for resilience in negotiating separations and endings. There was a candidness in sharing both the positive and negative aspects of the impact of the pregnancy on their patient, and how it could be felt as a crisis, but potentially could allow an idea of reparation, survival and repair.

The impact of the Covid19 pandemic was considered, with a feeling that the world had also changed, leading to changes in clinical policies and practice. The group shared thoughts about the stress of having a pregnancy during a pandemic, considering the increased risk to the mother and her unborn child, and the uncertainty and worry during this time. There were high numbers of references made to changes experienced to the women themselves – in their bodies, their relationships, their work, their identity as a mother and this being an important topic for the group to have time to think about, and process. One therapist voiced how important she felt this was:

Lina: '*Everything feels, well for me, everything felt quite sensitive and quite significant…But also that it felt quite important to make sure that you know, you were giving enough, thinking enough, really being a good enough mother, as Winnicott might say.'*

4.6 Discussion of theme 2: Something Changed

'Everything was more heightened'

The high number of codes encompassed within this theme indicates that participants were interested in change, and the impact upon their work. Change was associated with disruption and creating technical difficulties. This theme incorporates reflections about changes in the ways in which others responded to the pregnancy of a child psychotherapist, shifts in their own state of mind, and within their own pregnant bodies. The group reported experiences of powerful intensity within the transference relationships with their patients, and in their countertransference responses, which is consistent with previous research as detailed in the literature review. A significant feature of this study is the exploration of the particular quality of the transference relationship when working with very young patients. Considering the implications for children who have suffered great trauma in their early lives and who had already experienced great disturbance and disruption to their attachment relationships has only been begun to be explored in a few published studies (e.g., Rocah,2008, Sharma, 2019).

The group considered how characteristics such as the patient's age, gender, history and pathology might have impacted upon responses to their pregnancies. The impact of a therapist's pregnancy for children who are fostered and adopted barely featured in the published literature. This aspect of their work was considered particularly sensitive by participants, with suggestions that the pregnancy was experienced as a repeated abandonment. CPTs seemed struck by the ways in which parents, colleagues and supervisors responded to their pregnancies, and considered the meaning of their pregnancies to others, as it seemed to evoke more primitive responses around sexuality, Oedipal rivalries, envy and triumph. This linked

to themes in the literature about the revaluation of relationships for pregnant therapists (Fenster,1986) and the way both the role of the therapist (Uyehara et al, 1995) and her therapeutic style (Bassen, 1988) might change during her pregnancy.

Whilst participants spoke at length about the positive and negative changes that they had observed, there was a general sense that the pregnancy had created useful, although at times very painful, shifts in their role, thinking and practice. They described feeling especially in touch with aspects of separation and loss and considered how these central concepts within psychoanalytic theory could be understood in connection to their periods of maternity leave. A few therapists described their worries about their break from practice, wondering about how they may have changed, and might find it difficult to adjust to shift in the priorities when they became working mothers.

A particularly interesting aspect of this research was the impact of the Covid19 pandemic, and the changes this necessitated to traditional child psychotherapy practice. As within most professions, there was a necessary shift towards virtual working which was previously highly unusual for the discipline (Garcia, 2020), although some accounts of telephone sessions when a therapist was unwell during her pregnancy have been published (Weintraub,1990). Virtual work posed extraordinary challenges, attempting to navigate uncertainty during an unprecedented and highly unusual period of history. The participants noted the complexity of working through the screen, which is beginning to be explored in the literature (Hart, 2020; Hutchinson, 2020; Webster, 2020). Participants shared the worry of having a baby during the period of lockdown, with reduced support and increased anxiety about the way the world was changing, often beyond recognition. Early studies about the impact of the pandemic on pregnancy and infant

development describe concern about prenatal mental health and attachment relationships between mothers and their babies during this time, with reduced extended family support, limited opportunities in participation in community activities and access to healthcare provision (Aydin and Aktas, 2021).

Heightened anxiety is understandable during a pandemic, particularly for expectant mothers, and ordinary experiences of pregnancy and the cultural rituals surrounding pregnancy and birth (such as baby showers, christenings, naming ceremonies and family visits) were not possible in the usual ways. Studies exploring the impact of Covid 19 on infant development, note the concerns that parents had about the decreased social opportunities and activities to promote development and communication (Synyder et al, 2022). Mask wearing impacted on infants' ability to recognise facial expressions and process emotions (Johnson, 2022). An ACP (2022) article entitled 'ordinary experiences of motherhood during extraordinary times' documents challenges faced by mothers during the pandemic. Child psychotherapists who were pregnant during this time were likely to be conscious of the importance of family, community and support for new mothers and the impact on infant development, both during pregnancy and in the post-partum period.

4.7 Theme 3: Related to time *'The conception of the work as well as my child'*

The theme of time, and timing, featured throughout the discussions, and codes for beginnings and endings appeared frequently throughout the data (figure 12). This related to the start and ending of training, the beginning of work with individual patients, and the endings that in some cases, were felt to be premature, due to pregnancy.

Theme	**Related to Time: '**The conception of the work as well as my child'	
Codes	A beginning	An ending
	Conception	Loss
Quote	**Mona:** *It felt like a really, a big moment that constantly trying to keep up with really, and you're on a time limit at that point, once you're pregnant, you know you've only got a certain amount of months left in therapeutic work with the children and young people that you're working with.*	

Figure 12: Theme 3

Participants discussed the conception of their pregnancies, and the shift in focus from patient work to the therapist's life outside of the clinic. There was an idea that the pregnancy had introduced a new aspect to the work, and the therapist was now understood by others to be a sexual being and the possible meanings of this for the patient, and for the surrounding network.

Victoria spoke of feelings that were evoked by her pregnancy that involved both '*triumph and guilt'* – ideas that the pregnancy was confirmation a biological, and perhaps cultural and relational, success – but that it also signified something highly personal that was possessed, and not to be shared with patients.

Pregnancies also brought powerful feelings connected to endings and loss. Sophie spoke of the loss of close people in her life and her worry of miscarriage and stillbirth:

Sophie: '*From the moment I found out I was pregnant I was just worrying all the time, was this going to stay or was I going to lose it. it didn't really feel real and I couldn't really feel like this is really going to happen, you know, that there's a life sort of coming rather than all this death that's kind of been around'.*

Complex themes of life and death, endings and beginnings were central aspects of the discussion. A pregnancy has a fixed timeline that dictated the ending of work with patients, and the therapists described needing to make space for their new babies.

Mona: '*So you know that there is an endpoint, they know that there is an endpoint and so there is a bit of a pressure I think to continue the therapeutic work while also continuing to help them think about what this might mean as well'.*

Participants also referenced the ending of their training, and a feeling that they may have to choose between continuing to work after maternity leave, and the possibility that they may not be able to return. This also connected to discussion around ending their personal psychoanalysis due to time and practical arrangements.

4.8 Discussion of Theme 3. Related to time

'The conception of the work as well as my child'

Ideas related to time were more frequently referenced by participants than any other theme, particularly issues of beginnings and endings. This related to the beginning and ending of their child psychotherapy training and personal analysis, the start and end of work with their young patients, beginnings associated with pregnancy and birth, and thoughts around conception, loss and death. Child psychotherapy, and psychoanalysis, is unusual within psychology modalities in that there is often no end date stipulated for treatment, with an understanding that the decision to end will depend on the needs of an individual. Within current NHS economic restrictions there are limitations to this, but traditionally it is not unusual for patients to seen over extended periods, often for many years. This tradition of an open-ended approach is encouraged for child psychotherapy trainees, who might have more flexibility and support to see a patient for the entire duration of their four-year training. However, the end of training, and funding for clinical posts, can also dictate the end of therapy for patients.

Participants described feeling that their pregnancies had brought about a premature end to their patient's treatment, and the associated complex feelings of guilt and loss that came with this. Some participants spoke of their patient's treatment as coming to a natural end that was not due to their pregnancy. In these situations, the therapist seemed to feel less concerned about the impact of their pregnancy on the treatment and in some instances, they did not disclose their condition to the patient, with an idea that it was not really relevant. This connection to ideas of premature, or natural birth, concepts that are particularly heightened in pregnancy, as links to birth and death are so closely connected.

Guilt and regret at endings may indicate ‘blind spots’ in the literature (Clemental-Jones, 1985), perhaps linked to discomfort with transference dynamics and avoidance to working with emotive material so close to the end of treatment. There may be a worry that pregnancy may stir something up for patients that the therapist did not have the time to explore. The literature review suggested that the phase of the patient’s treatment significantly impacts how the pregnancy is received -those who have been in therapy for longer periods of time, are more likely to tolerate a pregnancy (Deben-Mager, 1993). It is therefore interesting to consider the challenges faced by the child psychotherapists who shared the experiences of starting work with patients at the beginning of their pregnancies:

> **Aisha:** ‘*The girl who I’d actually started to see at the point of me realising my own pregnancy, so the conception of the work as well as my own child’.*

This linked to announcing pregnancies to supervisors in order to plan their work. One trainee shared that she had to let her clinic know she was pregnant earlier than she may have liked, as at the time, the guidance was for pregnant women to isolate during the pandemic.

The group touched upon ideas about patients’ ideas and phantasies about conception, how something appeared to have been created together, or perhaps entirely independently to the therapeutic couple, and made tentative links to the primal scene, bringing ideas around sex, intimacy and birth into the relationship. The pregnancy seemed to counter implicit notions of asexual therapists, but may connect to myths of immaculate conception (Sachs, 1986). Discussion involved gestation, something growing and changing each week, initially unperceptively, but over time more present and available. The metaphor for a growing life inside the expectant

mother could have many applications to the growth of therapeutic treatment; related to expectations, excitement, frustration, fatigue, dread and wonder. Victoria's ideas about triumph link to ideas of a resurgence of Oedipal conflicts that might be felt in pregnancy (Bassen,2003), and a sense of victory associated with successful coupling and conception.

References to time and thoughts about planning pregnancies, linked closely to trainee identity, and sacrifice. A number of participants raised the idea of loss – mentioning that their pregnancy had followed a significant loss in their personal lives, and this may link to Freud's theory of the life drive, a compelling instinct towards sexual reproduction, and the desire to preserve and propel life, but also to the death drive, a primitive instinct drawn to destruction and aggression – perhaps an unconscious wish to disrupt or disturb the course of the clinical training, rebelling against a perceived rule prohibiting pregnancy. Melanie Klein's (1946) theory of the paranoid schizoid position describes an infant dividing his life and death instincts into separate parts of the mother. The pregnant child psychotherapists described their work with aggressive, disturbed and often violent children who may work hard to appear 'unlovable'. Perhaps uncomfortable feelings of hatred might be split off or avoided within the creation of a new relationship with their own loved and wanted child.

The end of therapy due to pregnancy has been likened to death (Dufton, 2004). This notion was echoed by the group, but they also raised issues around the opportunity to process separations as being potentially very helpful to their young patients, whose previous experiences of separation and endings may have been abrupt, without adequate opportunities to work through feelings of deep abandonment, rage and despair.

Ideas around opportunities for reparation are consistent with the work of Simonis-Gayed and Levin, (1994) who suggested that the experience of working through these issues for child patients of pregnant therapists could be easier than attempting to work through unresolved conflicts later in life. The group considered aspects of separation in relation to their maternity leave, with a worry shared that they may not be able to return to work at all following the birth of their babies. Evidence on the literature (Korol, 1995) suggests that restorative work is possible when maternity leave in bridged. This seemed to be rare within child psychotherapy training, perhaps due to the demands of time and caseload management, although one participant indicated she may return to see one patient after maternity leave. Another participant remembered hoping to continue seeing one patient intensively each week during her maternity leave, but due to NHS policy, it had not been possible to arrange this. Qualified psychotherapists, or those working in private practice, might have more flexibility when planning for longer term work to continue, or be able to arrange to see select patients. No participants spoke of a handover with a new or interim therapist, indicating this may rarely be possible. In her extremely useful paper on endings, Wittenberg (1999) draws on the work of Meltzer (1967), suggesting the end of analysis is not a termination but a period of weaning. She suggests that if a therapist can go on thinking when a patient attacks the end of the therapy, together they may be able to work through a process of mourning and offers the possibly of helping them to understand that endings and losses can be grieved and survived.

4.9 Theme 4: Knowing and not knowing '*Something unspoken'*

This theme brings together the participants' responses that connect to ideas of knowing, and not knowing (figure 13).

Theme	**Knowing and not knowing** *'Something unspoken'*	
Codes	Reality	Something explicit
	Something hidden	Unconscious fantasy
Quote	**Aisha:** *'For the patient that real sense of knowing something about you…So, it was always there even when it wasn't always in my mind, there was that continued sense of knowledge whereas patients that I've started with since, you know, they might have fantasies about whether I'm a mum or not. But they don't know for definite. It's that idea of definite which can get in the way, that concreteness I think sometimes.'.*	

Figure 13: Theme 4

Participants frequently described a sense that becoming pregnant felt akin to carrying a secret.

> **Kate:** *'The baby starts kicking, this can happen in the middle of the session and the patient doesn't know but you know. So, there's something kind of unspoken'.*

This linked to an idea of something being hidden, and a feeling that personal lives, previously having been anonymous, were now more obvious, and feeling rather exposed.

A few participants spoke of not explicitly telling their patients about their pregnancies, as their training was ending. Others mentioned the difference in working virtually, especially since patients could not see their changed bodies, was felt to be a

particularly strange experience. The idea of a hidden pregnancy was also echoed in a feeling that a child psychotherapist's pregnancy is not talked about, or written about, and the participants spoke strongly of their pregnancy bringing a change, and an aspect of the external reality.

> **Victoria:** '*No psychotherapists that are pregnant seems kind of absurd and [for a child] to be with a therapist that's pregnant and thinking about them, it's something so powerful, I think you know there's so many positive things that could come out of that, and I think there's not enough written about that'*.

The therapists were in touch with ideas around what might be consciously known, and said, and what might be unconsciously felt. They spoke of the meaning of their pregnancies being different depending on the patient's history, pathology and circumstances. The complexity of this process was described in a vignette of a patient playing out a life and death scenario, compelling her therapist to choose between her and her unborn baby.

4.10 **Discussion of Theme 4:** Knowing and not knowing *'Something unspoken'*

The theme of knowing and not knowing related to ideas about what might be consciously known, and what might be unconsciously felt within the relationship. These ideas connect to Bion's (1962) theory of thinking, and the differences in 'knowing of' and 'knowing about'. Bion proposed that knowledge emerges through non-verbal, emotional experiences that create a psychological reality.

Codes in this theme included an idea of what Kate described as '*a kind of sharp reality entering the room'*. There was much discussion for the group about reality, of something real and explicit – for example, concrete statements about their pregnancies, or the emergence of a growing bump for those who had done face to face work.

This contrasted codes that related to ideas of 'something hidden': pregnancy likened to having a secret that the therapist may prefer to keep to herself, particularly if she was coming to end of her training, her work with patients, and especially if she was working online. This can be understood within the context of a traditional understanding of the analytic encounter where the psychotherapist is positioned as a 'blank projective screen' (Lax, 1969). The introduction of a pregnancy may be felt to counter this, 'betraying the therapeutic ideal' (Dufton,2004, page 112) perhaps felt as an intrusion – not just to the patient, but to the therapist herself, who may feel that her personal life can no longer remain anonymous, and the patient now has some knowledge of her life outside of the consulting room. Some participants admitted they had not disclosed their pregnancies to their patients:

> **Sophie:** '*It was never explicitly said but obviously as time went on it was kind of explicitly there and I think there was a really sort of naïve part of me that imagined that some of them didn't know'*.

Lax (1969, page 373) discusses what she terms 'analytic blind spots', noting in her study cases of therapists attempted to hide their pregnancies by covering their bodies with knitting or embroidery, fearing hostile attacks from their patients. Victoria's statement that that the idea of no pregnant child psychotherapists is absurd links to an idea that the profession, and the therapist herself, may unconsciously collude with a child's fantasy of an anonymous analytic mother, who is ever present and available to her patients. Yakeley (2013) explores these ideas, considering discomfort around the female form, and in the cases studies she presents, the pregnant body is linked to unconscious phantasies and castration anxieties. She suggests that that the visual perception of a pregnant form can offer an opportunity to transform 'external seeing into internal seeing', which can allow helpful shifts for an individual's object relations. Silence surrounding pregnancy related to ideas that it is a taboo within the profession.

> **Mona**: '*The profession needs to catch up a bit...there will be lots of other child psychotherapists out there who have had babies'*.

There was a shared understanding that child psychotherapists work with not only what is verbally communicated, but also unconscious, non-verbal communication. The literature review suggested a therapists' pregnancy might intensify transference experiences, and a patient might know of a pregnancy even before it is verbally announced, and this was echoed in the experiences relayed by the focus group, concerned that their young patients could sense their preoccupation.

4.11 Theme 5: Space to think *'I guess you can't be that present anymore'*

This theme compromised of nine codes (figure 14), that related to ideas about opportunities for thinking about a child psychotherapists pregnancy.

<table>
<tr><td>Theme</td><td colspan="3">Space to think 'I guess you can't be that present anymore'</td></tr>
<tr><td rowspan="3">Codes</td><td>Being interested</td><td>Being preoccupied</td><td>Lack of research</td></tr>
<tr><td>Making a connection</td><td>Related to analysis</td><td>Related to a challenge</td></tr>
<tr><td>Related to supervision</td><td>Something complicated</td><td>Something painful</td></tr>
<tr><td>Quote</td><td colspan="3">Kate: I felt anyway that the sickness was quite intrusive because you couldn't forget about it. It was there the whole time. And then I think as that got better it was sort of tiredness and not feeling as- thinking as clearly or maybe having as much space in your mind.</td></tr>
</table>

Figure 14: Theme 5

The group discussed participating in the study due to wanting some space to think about their experiences with others.

> **Aisha:** '*In terms of why I've been drawn to the study, both sort of get a deeper understanding sort of in my own mind about the experiences that I've had, good and bad. As pregnancy is anyway. But also, just because there isn't a lot of research out there and I think it's something really interesting, and really important given the work we do to give some thought to the pressures that there are out there, particularly as a trainee, and the impact it can have on your training'.*

Data was recurrently coded as ‘Making a connection’, as participants built upon one another’s responses, noticing similarities and differences in their experiences, with a sense that the group was providing an important thinking space that they could appreciate. They expressed curiosity in hearing about one another’s experiences and being eager to learn more. Codes that linked to this theme involved a desire to make connections, both in their own minds, and with others, in effort to provide meaning to their experiences. The trainees discussed the usefulness of their personal psychoanalysis and clinical supervision in helping them to process the strength of the emotions evoked by their pregnancies. Qualified psychotherapists mentioned that they had less supervision, and so perhaps had fewer opportunities to consider the impact of their pregnancies. A lack of research on the topic was mentioned a few times, with a hope that more studies would be published on the subject. Participants mentioned how challenging their experiences had been and feeling mindful of not having enough space to think about their patients, a worry that they were full up with their babies, a sense of not being as available as they would like, preoccupied with the life growing inside of them. There was an implicit idea of space being taken up the presence of the unborn baby, and how complicated this felt.

Participants showed interest in examining the lack of thinking space more, considering how the pregnancy connected to something that could feel quite painful, and perhaps was often avoided. This also connected to ideas about how others responded to their pregnancies, and one participant shared there was a sense of her pregnancy being very unwelcome, and that she had been on the receiving end of jokes that felt quite cruel:

Lina: '*For [someone] who really struggled to get pregnant, it was meant on a jokey way and they immediately apologised after they had said it, it was quite painful and hurtful actually'.*

Others noted how helpful it was to have some space to think with others about pregnancy, a sense of being quite alone in the experience, expressing a desire to connect with colleagues.

4.12 Discussion of Theme 5 Space to think

'I guess you can't be that present anymore'

A unique aspect of this research into the pregnancy of a child psychotherapist was the facilitation of a focus group, and an opportunity for women in the profession to speak to each other about their experiences of pregnancy. Within this theme, codes connected to the therapist being keen to take part in the study as they were interested in topic, feeling curious about one another's experiences, and interested in making connections with others. A few participants mentioned that they had been disappointed that there was a lack of research in this area, and many mentioned using their personal psychoanalysis a space to think through some of the issues raised by pregnancy – although they also noted the pregnancy necessitated an end, or break, to their own psychoanalysis. Lasvergnas-Garcia and Avdi (2020) suggest that personal analysis provides a reflective space that allows child psychotherapists to tolerate strong feelings evoked by their patients, so they are less likely be able to think about difficulties, rather than acting out. There were indications from the group, and in the literature, that pregnancy precipitates a lapse in attentiveness (Simonis-Gayed and Levin 1994), and a turning inwards (Bassen, 1988) as mothers become preoccupied with the new life they are growing. The group were frank about this, suggesting:

> **Lina**: *'I guess you can't be that present anymore"*

The idea of distraction was coupled with a sense of guilt and regret:

> **Aisha:** '…*wanting to give your full mindful attention to a patient needs it but being constantly, sometimes unhelpfully, reminded of the position you are in as well'*.

Within the theme of having limited space to think, participants mentioned how painful they had found some experiences, and feeling that colleagues and supervisors had shown responses that were perceived as being disapproving, or disappointed. There were thoughts shared about missed opportunities to create space to think about what might be happening – though others spoke of how useful they had found supervision. One participant mentioned a supervisor who had had different experiences when they had been pregnant themselves, prioritising work, and how this had been considered thoughtfully, as the therapist considered her pregnancy her primary focus. Qualified CPTs seemed to share that they felt they now had a more balanced relationship to their work, and that they felt more able to have space for a more integrated identity.

Participants frequently used phrases such as *'similar to what X said...'* or *'adding to that idea'* as well as saying '*My experience was slightly different'*. It would be very interesting to examine further the linguistic features of the dialogue used within the group discussion, as they used collaborative thinking, constructive overlaps and rapport building, drawing upon one another's ideas to think in depth about the topic. The group itself created a space to think. This manner of collaborative thoughtfulness and curiosity echoes the tradition of work discussion groups within the child psychotherapy profession (Bradley and Rustin, 2008).

The creation of thinking space seemed particularly useful for those who spoke about how challenging they had found the process of juggling the training, clinical work, often commuting long distances, and the academic requirements of the clinical training course. This relates to literature that suggests whilst therapists who had been pregnant were interested in the topic, they might have limited time and space to write about it (Uyehara et al, 1995).

4.13 Theme 6: Therapist patient dyad

‘*What kind of Mummy are you actually?’*

This theme centered around the therapeutic couple and the significance of a pregnancy considering depth of this relationship and grouped together five codes (figure 15).

<table>
<tr><td>Theme</td><td colspan="3">Therapist Patient Dyad ‘What kind of Mummy are you actually?’</td></tr>
<tr><td rowspan="2">Codes</td><td>In the room</td><td>Intrusion</td><td rowspan="2">Unconscious fantasy</td></tr>
<tr><td>Therapist as mother</td><td>Therapists body</td></tr>
<tr><td>Quote</td><td colspan="3">Aisha: It so powerfully put in touch the absolutely crisis catastrophe of what the knowledge of my own very real pregnancy had upon her phantasies. And I think that’s so- that’s what sort of stayed with me, is how the phantasies can really be brought out in a helpful way but also could be really shattered.</td></tr>
</table>

Figure 15: Theme 6

The phrase ‘In the room’ was coded, as it was frequently mentioned and related to a concept of not just the physical space occupied by the therapists and her young patients, but her reflections of what it felt like to be in the relationship with individual children, and ideas about thoughts and emotions that were felt to ‘fill the room’.

Ideas of intrusion were frequently repeated throughout the discussion, which included the notion of the unborn baby as the uninvited ‘third’ into the space previously felt to be occupied exclusively by the therapist patient dyad. They described feeling intruded upon, restricted from having an ‘ordinary’ pregnancy, having to consider the meaning for her patients, and how intrusive the pregnancy also felt for her young patient:

Sara: *'He was being pushed out by this baby, and that's a real fact for him as well, because our sessions have to come to an end because I'm going to go off and have a child*'.

Child psychotherapists are practiced in working with both the conscious difficulties experienced by the child in their real life, and considering the unconscious processes experienced in their inner world, hoping to understand what type of 'internal parents' the child might have developed.

Mona: '*I wondered what their fantasy was... there's this kind of otherness in the room with us, and working with you know, as we all do really, working with children who've had really disrupted early lives you know, have very complex relationships with their parents and then you're, you're telling them that you're going to be a parent and that fantasy really of, what kind of mummy are you actually going to be, let alone the mummy that you are to them in the therapeutic situation as well'.*

4.14 Discussion of Theme 6 Therapist Patient Dyad

'What kind of Mummy are you actually?'

The group thought together about what it meant for them to become an expectant mother and considered what this meant for the children they were working with. They made use of the concept of being a 'therapy mother' to their patients, acknowledging patients used their therapy to explore and challenge their internal models of mothers, testing out their ideas and working through their difficulties. In some instances, the introduction of a pregnancy created an element of reality to what had previously been understood as an unconscious fantasy. Some studies have referred to a patient's wish to be the therapist's wanted child and identification and rivalry with the unborn baby (Simonis-Gyaed and Levin, 1994).

Participants discussed what was felt to be an immensely painful departure from an idea of a devoted mother, imbued with symbiotic womb-like qualities – ever present with subsistence and attention. The pregnant therapy mother was felt to be distracted, neglectful, and even abusive – themes which have also been explored in the literature (Miller, 1992). A shift seemed to occur from the intensive mother-infant therapeutic dyad to allow a third into the room, often felt to be an unwelcome intruder. Ideas about the unborn baby's presence in the room have only tentatively been explored in the literature, in papers such as Hjalmarsson (2005) accounts of her work with adult patients. She details her patient's responses to the idea of a baby, and their complex reactions to the news of her pregnancy. She terms instances of a therapist's pregnancy as a potential 'transference opportunity' and presents vignettes that explore ideas of the new third in the room, and her patients' envy at baby's relationship with the mother, their wishes to return to an infantile state, phantasies of harming the foetus, and wishes to steal their therapist from the

baby. This paper is unusual as it places the idea of a baby in the centre of the study, and considers the patients worry about their unconscious attacks – what impact this may have on the therapist as a mother, and how their destruction may affect the unborn child. One therapist shared a similar experience of her work with a latency child:

> **Aisha:** '*There was a real fear from him of what had he done to me in his mind really. And within that there was the aggression. There was lots of talk of abortion, and miscarriages within the room, increasingly as my pregnancy became more obvious'.*

The idea of tolerating a third is considered as an important developmental milestone in psychoanalytic theory, usually achieved by the acceptance of the paternal position, and is conceptualised as 'triangular space' (Britton et al, 1989) where the Oedipal couple is acknowledged, and tolerance and appreciation of multi-faceted object relations might become possible. A new baby may provide insight into intense Oedipal and sibling rivalries, and an opportunity to work through murderous and envious feelings that may be evoked. The opportunity for focus groups, and for published studies, may begin a discourse with 'sibling colleagues', sharing a dialogue about experiences.

Participants discussed not only their patient's ideas about their capacity to mother, but their own fantasies about what kind of mother they might be, mentioning their experiences of infant observation and studies of child development as being useful, but ultimately quite different to their lived experiences of motherhood.

> **Sophie**: '[All] *I'm going to do with my baby is try my very best and be there to support. And I think there probably some internal pressure… you're a child*

psychotherapist so you should know what to do. And of course, it doesn't work like that. I think generally I sort of think there's something about just taking in something good, and I think that's what I've aimed to provide for my baby'.

In emerging literature, there are recurrent themes of therapists fantasises of wishing to be ideal mothers, both to their patients and their own children. Robinson (2013) discusses the ways in which being a therapeutic training may influence what kind of mother a woman might become. The focus groups spoke of their knowledge of child development and psychoanalytic theory as being both a benefit and a hindrance, due to their insight of what may 'go wrong' in the mother infant couple, and possible idealisation of themselves as mothers. The group made a number of references of Winnicott's concept of 'good enough mothering', and of the useful role in analysis in supporting thinking about this:

Kate*: 'I think since having the baby I just always come and obviously help in analysis about good enough mothering, and I just hold on to that and I have to remind myself of that'.*

Some papers have suggested that the transition to motherhood has enabled therapists to feel more able to create personal and professional boundaries, and to feel more neutral towards her patients and less 'over identified' with their difficulties (Bassen, 1988). This sentiment was present in the focus groups:

Aisha: '*I think it's been really difficult, but it's actually been really helpful for me to realise that there is life outside of the training'.*

> **Emily:** '*I've changed: it's been a really wonderful experience to become a mum, I think it helped me to be a better clinician, and I'm just really thinking about whether that change in me is in the material present somewhere'.*

There has been limited exploration in the literature of therapist as mother, including the challenges and complexities touched upon in the focus group, and in considering the possibility that being a mother may be beneficial to a woman's clinical practice, and her professional knowledge and experience may contribute to shaping the mother she becomes. Further exploration into this topic, particularly considering contemporary feminist dialogues of the nuance and complexity of modern motherhood, and the role of maternal ambivalence, would be fascinating.

5. Conclusion

My own pregnancy created a curiosity about experiences for other child psychotherapists. The lack of published papers about the topic in the Journal of Child Psychotherapy led to this research enquiry. The literature review gathered together key themes to explore the matter in depth. Although pregnancy is a universal event, encountered by all humans, historically there appeared a reluctance to write about the topic from a psychoanalytic perspective, perhaps adhering to a traditional analytic stance of keeping personal and professional life separate, in order to retain a sense of neutrality. An increase in research in literature describing work with adult patients indicates there has been a steadily building interest in the subject.

My interviews with psychoanalytic child psychotherapists suggest that pregnancy can be an opportunity to explore aspects of the transference relationship, a child's object relations, and use of therapeutic sessions to work through their difficulties. Participant responses noted 'something changed' during their pregnancies, and they welcomed the space to consider the meaning of this shift. The intimacy of the therapeutic encounter with very young children is unique, illustrated within the theme 'therapist patient dyad'. The child's relation to their therapist, her changing body and the symbolic encounter with the maternal figure is fascinating, and of great clinical significance. The theme 'related to time' explored aspects related to beginnings and endings, and finite opportunities to work within a designated time frame. Issues around time-limited work are of interest for most CPTs working within the NHS, where shorter term work is frequently required within their generic caseloads.

A legacy of unconscious reluctance to discuss the pregnancy of a child psychotherapist may have had implications for recruitment into the current research

enquiry. Four participants dropped out of the study, perhaps indicating after initial enthusiasm, they may have experienced uncertainty or conflict about their decision to take part. Group interviews were selected as it was felt that the group conversation would be useful and thought provoking for participants, and that the content of the discussion would offer a rich landscape of themes for analysis. This appeared to be appreciated by participants, and evident within their discourse around ‘space to think’. Previous research in this field has primarily been case study data, and there has been value in taking a different approach to data collection to develop and enhance existing literature. However, it is possible that individual interviews may have had a more intimate feel, and participants may have appreciated the opportunity to anonymously contribute to the study, which is not possible in group discussions. This factor is particularly relevant when considering matters around maternal ambivalence and identity which are only beginning to be fully explored within contemporary discourses and so may have felt discomforting or exposing to discuss within a group.

Demographic information was not taken for the study, but there is a clear need to explore cultural and social issues related to pregnancy, and to better understand intersectional aspects of experience for a diverse range of individuals, in regards to gender, ethnicity, religion and sexuality as these experiences are likely to be under represented within the literature. This is important for training schools to consider as they attempt to ‘widen participation’ into the profession and consider routes into training. There is no doubt that child psychotherapy training can entail many sacrifices and life adjustments, often involving relocation, long commutes according to placement availability, and significant financial commitments. There may be concern that maternity leave would impact upon funding for training placements, and

perhaps tropes around an ‘ideal trainee’ remain. This could potentially limit access to the profession unless taboos around matters such as pregnancy, and other life events, both ordinary and significant, are not considered and openly discussed by training schools. Matters around trainee identity appeared to be particular interest and concern for participants, and the provision of resources, such as reading lists, professional supervision, and peer discussion groups could be of great benefit to CPTs balancing their professional roles with changes in their personal lives.

The findings of this study corroborated and expanded learning from adult therapists who had written about their pregnancies. However, there is a need to update research as the collective experiences so generously shared by participants in this study, has not been previously been documented in professional journals, and could be made more accessible to others in the profession. The usefulness of the focus group, recognising similarities and variations in their knowledge and experiences, could be usefully shared on a wider scale. Exploration of the topic in relation to current referrals into modern CAMHS clinic would further expand knowledge in the area – what is it like for children who have experienced adoption, for those who struggle with gender dysphoria, or who have an eating disorder, to be with a pregnant therapist?

This study was undertaken during a worldwide pandemic, a period of significant social adversity. The focus groups provided a thinking space to consider the impact of a child psychotherapists pregnancy, during times of Covid19 when anxieties around survival were critical. This is the first study of its kind to provide a space that facilitates group discussion, and has provided rich and layered data. It is one of the only studies of pregnancy in current literature that has been able to interview some child psychotherapists during their pregnancies, and others upon their return to work,

examining some of the differences that may be felt to arise during and after pregnancy, for first- or second-time mothers, and both during and after the training experience. My hope is that ongoing discussion will allow uncomfortable themes around the unconscious dynamics during pregnancy around sexuality, the female sexual body, maternal ambivalence and envy, to be explored in more depth. Further research is crucial to support child psychotherapists who become pregnant to feel they are not alone. Exploration of supervision, navigating maternity leave, and transition into motherhood are topics which could be explored in more depth to increase understanding of this fascinating time. Research investigating the period of matrescence in the literature (Jones, 2023) provides helpful context highlighting the complexities of pregnancy and motherhood, considering social and cultural taboos. The denigration and idealisation if motherhood, both historically within the psychoanalytic profession and apparent within cultural discourse, cannot be overlooked. Contemporary representations of the maternal in popular culture, tabloid press and in social media continue to provide a rather polarised glossy or grotesque depiction of motherhood – devoted or abusive, incredible or inadequate. Greater recognition of the strength of the loved and hated aspects of motherhood, and the ordinary ambivalent emotions evoked, are only beginning to emerge to present more realistic and nuanced understanding of the maternal role.

Supervisory support, particularly for trainees, who may feel heightened states of intensity of experience and expectation, appear vital. In particular, the containing function of supervision, psychoanalysis, and peer groups can provide space for an expectant therapist mother to process her experiences.

Child psychotherapists who become pregnant may feel more familiar with identifications with their child patients, very often referred to CAMHS after

experiencing failures in containment and abandonment from their biological mothers. Reconciling feelings of ordinary maternal ambivalence may feel particularly difficult when working within a transference relationship, where she is positioned as cruel or unavailable to a young child. There may be a wish to distance oneself from this painful work, and a fantasy of becoming an idealised ‘good mother’, perhaps explaining why so few child psychotherapists have documented their experiences of pregnancy and motherhood. The exploration of conscious and unconscious wishes and feelings around pregnancies, planned and unplanned, natural and assisted, are intimate matters that may feel exposing to explore in depth.

The theme ‘belonging to the therapist’ illustrated some of the complexity of a child psychotherapists professional identity, particularly during her training, and the myriad of feelings that can be evoked within the intensity of such intimate analytic work. The requirement of personal psychoanalysis can offer useful thinking space during pregnancy although contact with more infantile states of mind may also feel extremely challenging. Vicissitudes of identity, involving the juxtaposition of infantile states often evoked in analysis, the role of the student, often deferential to experienced supervisors, in contrast with an emerging adult maternal identity, both personally and within the consulting room, may be particularly complicated to navigate.

Parker’s (2005) refreshing study of maternal ambivalence provides refreshing recognition of the frustration and distress involved in the maternal relationship, in the creation of identity for both mother and infant, and in facilitating separateness and growth. I felt inspired when reading Hollway’s (2015) research approach to understanding maternal identity formation. This method employs psychoanalytically informed epistemology in the collection and analysis of data, drawing upon Bion’s

concept of learning through experience. The participants recurrent theme of ‘knowing and not knowing’ expanded my understanding of subjectivity, allowing me to recognise and examine aspects of my own experience when it was articulated by others. The process of connecting and untangling personal experiences of motherhood from those described by research subjects requires complex emotional labour, and has been described to offer new insight into data collection (Elliot, 2011). The method and development of this study has been a creative exercise, perhaps stemming back to Klein’s early understanding of an epistemophilic drive, and I experienced an increased sense that true knowledge is only attained through the tolerance of uncertainty and appreciation of infinite possibilities (Bion, 1962, page 94).

During the process of writing this thesis, and even during my Viva examination, I came to notice my reluctance to share or discuss my work, and to understand that my interest in the topic appeared to be shrouded in a deep sense of shame and guilt. I feel these feelings are possibly replicated in the lack of child psychotherapy literature and compounded by an apparent silence within professional discussions about the topic, creating a sense that matters related to the child’s psychotherapists pregnancy are too personal to be discussed. I hope that that this thesis may begin to help shift attitudes towards professional discussions about deeply personal matters that impact upon the therapeutic encounter.

As I conclude writing this thesis, I am pregnant again. Like many of my fellow child psychotherapist peers, the pregnancy was carefully timed, delayed to coincide with the end of my training journey. One afternoon, my toddler, who grew alongside this research project, presents me with a special gift: a carefully decorated paper Easter egg. She then reverently hands me a number of blank egg templates, declaring them

to be: ‘For the children at your work’. This tiny exchange stays with me, her growing realisation and acceptance of these other parts of me, much like this project, brief mergers of my personal and professional life. A mind and body full of unknown eggs, other babies, unwritten blank spaces. Elements shared, aspects that remain mysterious, and still other, more sacred parts. This creative endeavour recognises the fragility of developing connections that exist within intimate encounters, with hope that we might allow ourselves to become receptive and curious to explore new experiences with one another.

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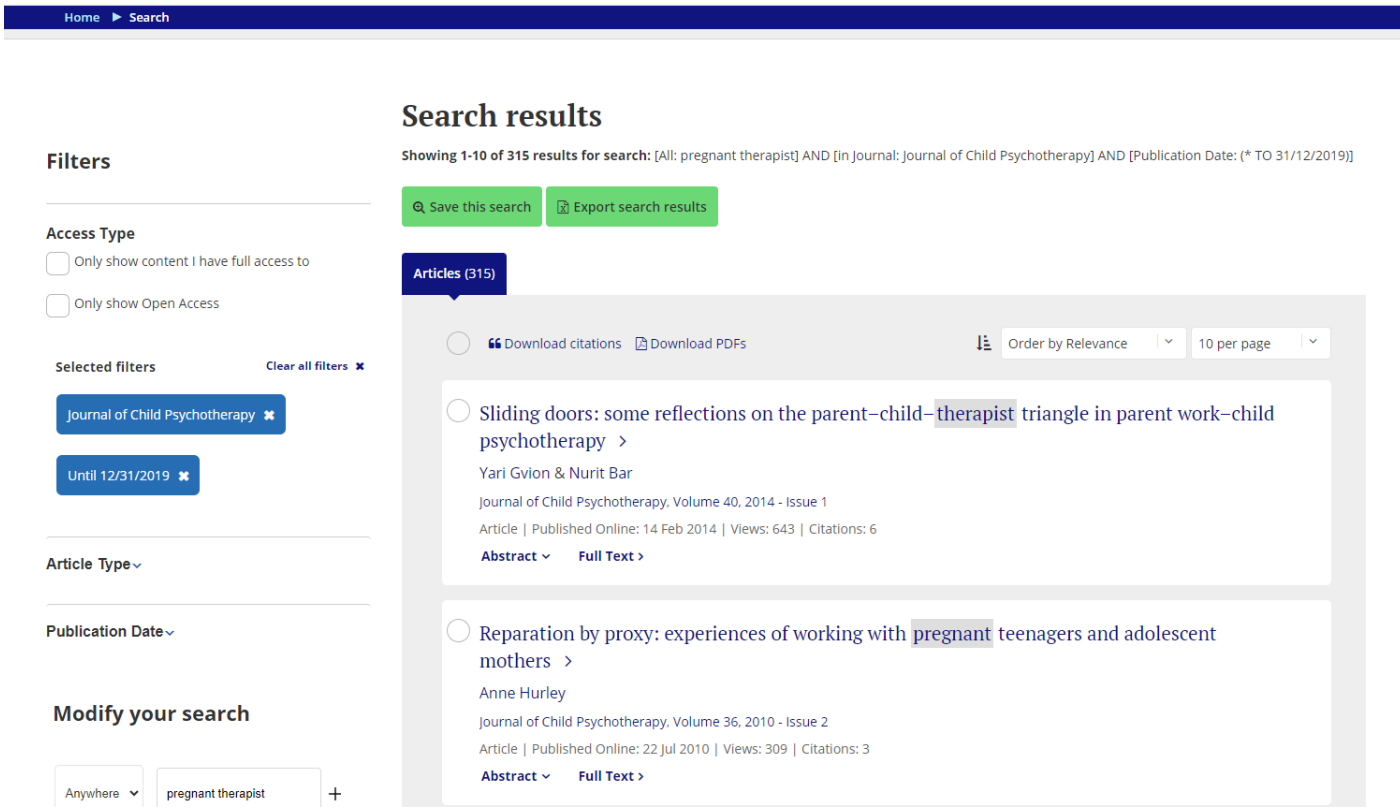
Appendices

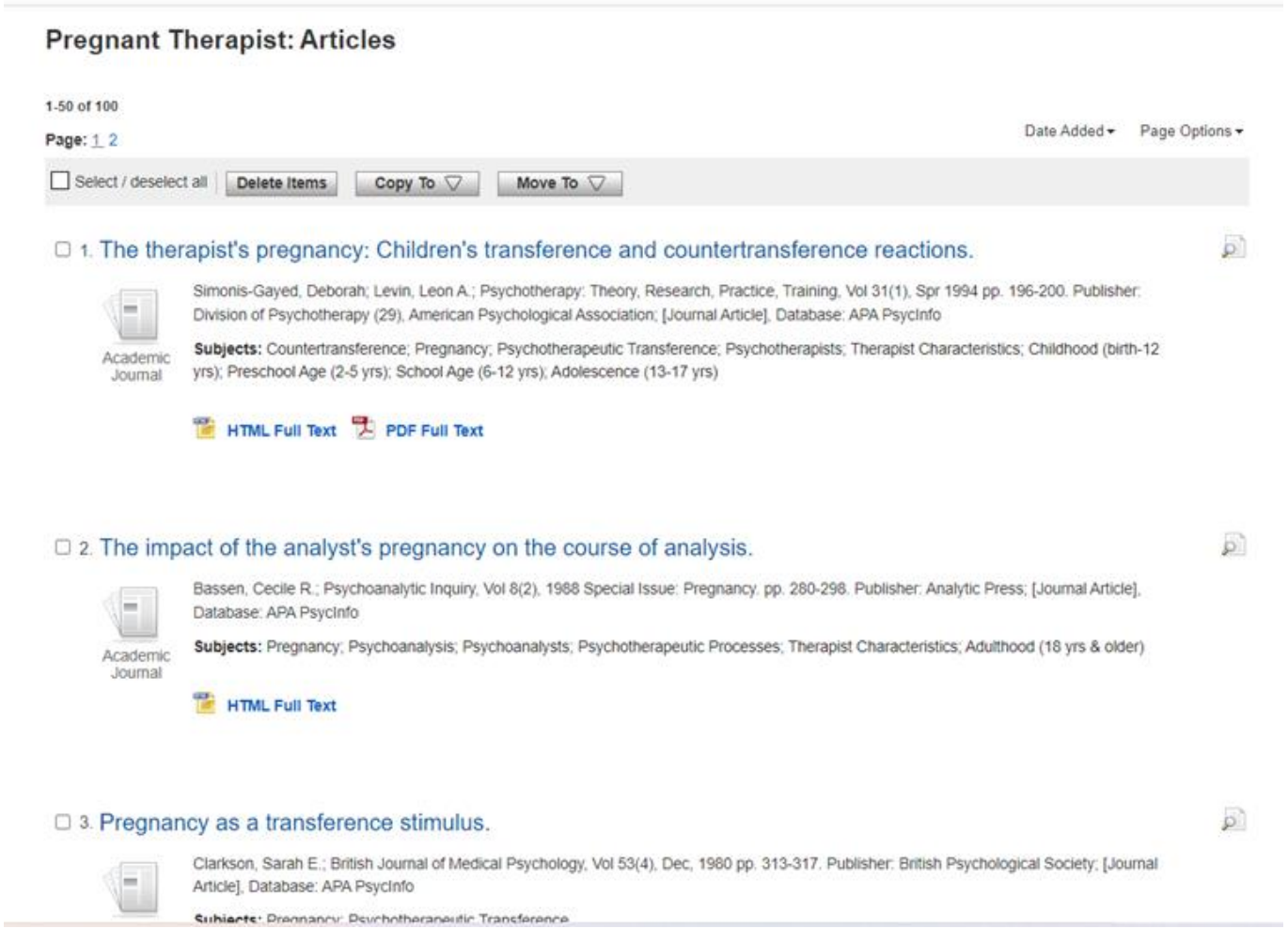
Appendix 1 Initial search in the Journal of Child Psychotherapy



Appendix 2: Database search

Search number	Field 1	Field 2	Field 3	Results	Notes
S1	Subject: Pregnan*	Subject: Therap*	Source: Journal of child psychotherapy	22	These articles were focussed on the topics of pregnancy and therapy more generally, and none were specifically focussed on the therapists pregnancy
S2	Subject: Pregnant Therapist	Source: Journal of Child Psychotherapy		4	None of these articles related directly to the topic
S3	Title: Pregnan*	Title: Therap	Source: Journal of child psychotherapy	0	
S4	Title: Pregnant Therapist			124	These articles were mostly directly related to the topic. 26 were available to read in full. 58 were academic journal articles, 3 were magazines, 2 were books or book chapters, 1 was a report and 1 was a dissertation thesis.
S4	Title: Pregnan*	Title: Therap*		5887	Some of the initial results related to the topics, but there were a number of initial results in this search that were related to medical intervention or drug therapies.
S5	Subject term: pregnan*	Subject: psychotherap*	psychoanalys*	111,178	This search brought up a range of articles on the general topic of psychoanalysis.
S6	Title: pregna*	Psychotherap*	Psychoanalys*	3888,667	The initial few pages of this search brought up many relevant articles, but there were too many to review in detail
S7	Title: Pregnan*	Title: Psychotherap*	Title: Psychoanalys*	41,858	These articles broadly focussed on the topic more broadly of the topic of psychotherapy or psychoanalysis for pregnant women
S8	Title: Pregnant psychotherapist			8	All of these articles were directly relevant to the topic
S9	Subject: Pregnant psychotherapist			12	9 of these articles had direct relevance to the search topic
S10	Title: Pregnant child psychotherapist			0	
S11	Subject: Pregnant child psychotherapist			2	Both of these articles were directly relevant, but one was a dissertation and unavailable to read online
S12	Title: pregnan*	AND Title: Therapist	OR analyst	73,808	Many of the initial page of search results were directly related to the topic, but upon examination many were related to other types of therapy – e.g yoga, physical therapy or speech therapy

Appendix 3 : Examples of relevant articles



Pregnant Therapist: Articles

1-50 of 100

Page: 1 2

Date Added ▾ Page Options ▾

Select / deselect all | Delete Items | Copy To ▽ | Move To ▽

1. The therapist's pregnancy: Children's transference and countertransference reactions.

Academic Journal

Simonis-Gayed, Deborah; Levin, Leon A.; Psychotherapy: Theory, Research, Practice, Training, Vol 31(1), Spr 1994 pp. 196-200. Publisher: Division of Psychotherapy (29), American Psychological Association; [Journal Article]. Database: APA PsycInfo

Subjects: Countertransference; Pregnancy; Psychotherapeutic Transference; Psychotherapists; Therapist Characteristics; Childhood (birth-12 yrs); Preschool Age (2-5 yrs); School Age (6-12 yrs); Adolescence (13-17 yrs)

HTML Full Text PDF Full Text

2. The impact of the analyst's pregnancy on the course of analysis.

Academic Journal

Bassen, Cecile R.; Psychoanalytic Inquiry, Vol 8(2), 1988 Special Issue: Pregnancy. pp. 280-298. Publisher: Analytic Press; [Journal Article]. Database: APA PsycInfo

Subjects: Pregnancy; Psychoanalysis; Psychoanalysts; Psychotherapeutic Processes; Therapist Characteristics; Adulthood (18 yrs & older)

HTML Full Text

3. Pregnancy as a transference stimulus.

Clarkson, Sarah E.; British Journal of Medical Psychology, Vol 53(4), Dec, 1980 pp. 313-317. Publisher: British Psychological Society; [Journal Article]. Database: APA PsycInfo

Subjects: Pregnancy; Psychotherapeutic Transference

Appendix 4: Themes in the literature

Patient Response 25, 8,9,15	Transference Themes	Counter Transference	Lack of Literature 3,8,	Female Body/Gender	Therapist Withdrawal 9	Maternity leave 5,
Pre-Oedipal 1,11,22,28,37,49	Description of transference 8	2,5,11,20,43	9,10,11,18,20,22,25,30,31,32 42,49	14,25,4,6,8,48,49	Increased Intuition 9	30,10,11,14,15,17
Rivalry 1, 8, 10, 12, 22,28,	Potent stimulus 17,34	Intense CT 36	Reasons:	Feminist movement 48	Lapse in attentiveness 1	Short leave 9,10,11,17
30,39, 14,47	Dramatic ?	Increase 1	Denial by therapist of pregnancy 17	Sex difference conflicts 14	Less Active 36	Birth
Wish to be wanted child 1	Facilitating 22 44	Heightened sensitivity 41	Increase in female therapist 1970+	Pregnancy as a 'crisis' 6,13	More active 13	announcement/patients
Hostility 10,16,22,49	Enhanced treatment	Lack of lit 41	10,17	Pregnancy as a problem 49	Primary Maternal	meeting baby 10
Acting Out 8,10,16,29	1,2,5,8,13,15,29, 37,42	Self Revealing 13, 25, 36, 42	Privacy of work 11	Psychological disturbance 39	Preoccupation	Post pregnancy 5, 9, 14
Somatisation 8	Parental sexuality 9	Guilt 1, 10,12, 2535,41,47,49	Pregnancy as taboo 10	Male Envy9,11	10,11,18,20, 27,30, 41	25,26,31,36
Sexual acting out 1	Erotic	Avoidance 2, 19,20,21,41	Lack of curiosity in material 9	Ignoring women's perspective 8,25	Self absorbed 5	Second Pregnancy 10,
Aggression17, 36	Neurosis	Need for narcissistic	Professional reluctance to write	Female sexuality 12,32,46	Enjoyment 5	27,47
Violence 44	Pregnancy as a tool 1,37	gratifications 21	about CT 2 11 41	Freud 14,31	Anxiety about	Dread at resuming work
Vulnerability 2443,47	Advanced transference 5,10	Denial 20,22,25	Resistance to CT 20	Primal Scene 18,28,3047	complications 5,16	27
Abandonment 1,10, 5, 16,24,43	Intensifies transference 5, 10,11, 17,	Blind spots 20, 21, 22, 30	Narcistic idealization of analysis 11	Pregnancy as illness/disability 11,20	Worry baby will be	Personal/professional
Separation 2	26,29,36, 39	Defending against distress	Denying own mortality/humanness	Klein 24	harmed 7, 20, 40,41,	Conflict
Envy 10,11, 42,49	Increased transference 5,22	caused 2	11	Women in workplace 35 37	Risk to baby 42	Greater Empathy 31
Triumph 12	Strengthen transference 9	Response to murderous feelings	Analysts phantasies of omnipotence	Physical form 42	Therapist skill 37	Greater tolerance of
Penis Envy 10	Greater clarity 9	5	20	Missing female/pregnant body 4,48	Therapist mental stability	confusion and
Womb envy 11	Accept transference figure 6	Patients response triggered by	Need to defend against outdated	Uncs dread of pregnant female body	40	uncertainty
Loss 13,15,47	Resolving Conflicts 3	therapists states? 9 26	view of analytic neutrality 9	Female body as source of anxiety	Change in role 40	In touch with patients
Rage 16,22,26,49	Effective 12 49	Fearing harm to baby 41	After birth, little time/mental space	4,42	Change in style 2	infantile needs 31
Rejection 42,47	Beneficial 10		to write about the topic 5,30, 44	Phallic ideal 3,44	Sensitivity to change in	More able to feel
Panic 47	Reevaluating relationships 14,23		Less isolated 41	Potent penis 46	therapist emotions 1	neutral post partum 5
Death/Grief 47	Making Peace w/childhood 2		Therapist should be a blank screen	Hatred and jealousy of mother 7	Anger at leave 1	Less overidentified with
Identification with analyst 10,	Erotic Transference 11,12		(see b) 43	Male tendency to pathologize	Narcissistic fragility 2	patients 5
11,14, 26	Neurosis 22			pregnancy 11	Resurgence of Oedipal	Who copes well? 7
Taboo 25	Special Relationship 36			Reproductive power of women 12	feelings 5	Integrating identity
Boundaries 26	Permission to discuss sexuality 37			What happens inside womens	Therapists own	(personal and
Sadistic fantasies 11	Therapist as human, 3D 43			bodies? 24	relationship/mother 15	professional 12)
Damage to Baby 7,10,29,36	Disintegration of psychic boundaries			Female analysis – good enough? 25	26,39	
Betrayal 30,29	therapist more intune with patient				Fears of retaliation 5	
Regression 2, 22,39	uncs 9				Cathexis towards	
Humiliation 31	Wanting to be ideal mother 10				baby/profession 49	
Secrecy 28	Survival of hatred aided process				Struggle containing	
Men vs women 11,12, 14,17, 44	10,11				infantile states of mind	
Therapist as an abusive mother	Tolerating separateness 33				17	
2 48 39	Window to uncs communication 34				Analyst worked out own	
Non available mother 9,46	Opportunity to work through conflict				conflicts? 22 42	
Attack from bad object 46	49				Wish to protect patients	
Ignoring/Guilt 8,10					24	
Phases of pregnancy 37						
Neurotic Idealisation 8, 39,41						
Symbolizing pain/destruction 8						
Sympathy , solicitude 10						
Wish for symbiosis with						
mother, denial of separateness						
11,17,24,36						
Fusion with object 24,32						
Magic defences 24						

Appendix 5: Application for Ethical Approval

Tavistock and Portman Trust Research Ethics Committee (TREC)

APPLICATION FOR ETHICAL REVIEW OF RESEARCH INVOLVING HUMAN PARTICIPANTS

This application should be submitted alongside copies of any supporting documentation which will be handed to participants, including a participant information sheet, consent form, self-completion survey or questionnaire.

Where a form is submitted and sections are incomplete, the form will not be considered by TREC and will be returned to the applicant for completion.

For further guidance please contact Paru Jeram (academicquality@tavi-port.nhs.uk)

SECTION A: PROJECT DETAILS

Project title	What can be learned from focus group interviews with child psychotherapists who have been pregnant during their clinical work?		
Proposed project start date	May 2021	**Anticipated project end date**	December 2022

SECTION B: APPLICANT DETAILS

Name of Researcher	Tamara Hussain
Email address	tamaraleahhussain@gmail.com
Contact telephone number	0781 552 1268

SECTION C: CONFLICTS OF INTEREST

Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above their normal salary package or the costs of undertaking the research? **NO** If **YES**, please detail below:
n/a
Is there any further possibility for conflict of interest? NO If **YES**, please detail below:
n/a

FOR ALL APPLICANTS

'Is your research being commissioned by and or carried out on behalf of a body external to the trust? (for example; commissioned by a local authority, school, care home, other NHS Trust or other organisation). *Please note that 'external' is defined as an organisation which is external to the Tavistock and Portman NHS Foundation Trust (Trust)	**NO**
If **YES**, please supply details below:	
Has external* ethics approval been sought for this research? **(i.e. submission via Integrated Research Application System (IRAS) to the Health Research Authority (HRA) or other external research ethics committee)** *Please note that 'external' is defined as an organisation/body which is external to the Tavistock and Portman Trust Research Ethics Committee (TREC) If **YES**, please supply details of the ethical approval bodies below **AND** include any letters of approval from the ethical approval bodies:	**NO**
If your research is being undertaken externally to the Trust, please provide details of the sponsor of your research? N/A	
Do you have local approval (this includes R&D approval)? If granted approval, I will submit this application to the research and development team of my employing trust.	**N**

SECTION D: SIGNATURES AND DECLARATIONS

APPLICANT DECLARATION

I confirm that:

- The information contained in this application is, to the best of my knowledge, correct and up to date.
- I have attempted to identify all risks related to the research.
- I acknowledge my obligations and commitment to upholding our University's Code of Practice for ethical research and observing the rights of the participants.
- I am aware that cases of proven misconduct, in line with our University's policies, may result in formal disciplinary proceedings and/or the cancellation of the proposed research.

Applicant (print name)	Tamara Hussain
Signed	
Date	14/6/21

FOR RESEARCH DEGREE STUDENT APPLICANTS ONLY

Name of Supervisor	Rajni Sharma
Qualification for which research is being undertaken	Professional Doctorate in Psychoanalytic child and adolescent psychotherapy

Supervisor –

- Does the student have the necessary skills to carry out the research?
  YES
- Is the participant information sheet, consent form and any other documentation appropriate?
  YES
- Are the procedures for recruitment of participants and obtaining informed consent suitable and sufficient?
  YES
- Where required, does the researcher have current Disclosure and Barring Service (DBS) clearance?
  YES

Signed	
Date	14th June 2021

COURSE LEAD/RESEARCH LEAD

- Does the proposed research as detailed herein have your support to proceed?
  YES

Signed	
Date	14.06.2021

SECTION E: DETAILS OF THE PROPOSED RESEARCH

- **Provide a brief description of the proposed research, including the requirements of participants. This must be in lay terms and free from technical or discipline specific terminology or jargon. If such terms are required, please ensure they are adequately explained (Do not exceed 500 words)**

This study seeks to learn about the experience of pregnancy for child psychotherapists (CPTs). Child psychotherapy is concerned with the internal world of children, and suggests that insights into their internal life can be understood through their behaviour and interactions, and within the development of their relationships with others. It is a field founded and dominated by women and as such, during the course of their careers many CPTs will become pregnant. However, there has not been a great deal of research that focuses on the experience of pregnancy for child psychotherapists. This is curious, considering that a child psychotherapists training places such great emphasis on the early experiences of life. There is a depth of attention given to the infantile aspects of a child's experience, yet it seems that there has been little published work that explores the impact of a therapist's pregnancy on her work with children. It is interesting to consider the ways in which a child psychotherapist's training, experience of psychoanalysis and understanding of the internal world is felt to have impacted her understanding and experience of her own pregnancy.

A child psychotherapist is interested in unconscious emotions, which are often overwhelmingly strong and hard to access verbally, but may be felt through interactions with others. A child psychotherapist's training seeks to understand the meaning of what transpires within the therapeutic relationship, and to find meaning in the 'transference' – a term that is used to describe what happens in this emotional exchange. It might be expected then, that becoming pregnant takes on a particular significance for child psychotherapists and this research is designed to explore how a woman's changing physical and emotional state might affect her clinical work.

The study seeks to learn about the range of experiences of pregnancy for CPTs, considering the impact of the pregnancy on their relational work with children.

Requirements of Participants

Twelve participants will be recruited using an advert publicised in the Association of Child Psychotherapy bulletin, which is circulated via email to child psychotherapists. Participants will be asked to take part in one of two or three focus groups, consisting of 4-6 members. Before the group, participants will be asked to sign a consent form that sets out the confidentiality agreement for the study. This makes is clear that their responses will be anonymised, and all information given will be securely stored by the researcher in accordance with General Data Protection Regulations 2018. Participants will be to confirm that they will not share the content of the discussion with others outside of the group. Each group will last up to ninety minutes and participants will be asked to reflect upon their thoughts and feelings about being pregnant whilst working as a child psychotherapist. This may encompass the therapists' personal emotional response to pregnancy, any challenges faced, the prospect of the break and return from maternity leave, and their thoughts about the ways in which their young patients responded to their pregnancies. Participants will be encouraged to reflect upon their ideas about how being a child psychotherapist may have impacted their pregnancy, given their interest in early development, clinical experience and academic studies. Transcripts of the responses will be analysed using Thematic Analysis (TA).

- **Provide a statement on the aims and significance of the proposed research, including potential impact to knowledge and understanding in the field (where appropriate, indicate the associated hypothesis which will be tested). This should be a clear justification of the proposed research, why it should proceed and a statement on any anticipated benefits to the community. (Do not exceed 700 words)**

Aims

The study aims to interview CPTs who have experienced pregnancies whilst working with children to learn about their experiences, and the impact of the pregnancy for both the therapists and their young patients. Participants will be invited to take part in focus groups, designed to encourage them to think with one another about their experiences of being a pregnant child psychotherapist.

Background

Child psychotherapists are interested in infantile needs, theorising that early experiences have implications for attachment style, personality, relationships, and behaviour. CPTs are fascinated by developments in prenatal life and beyond, and the training devotes two years to observing the earliest relationship between an infant and his mother (Bick,1964). Children referred for child psychotherapy have often suffered complex trauma that impacts their mental functioning and interpersonal relationships. CPTs consider the child's play, interactions and behaviour as communicative projections that give insight to their internal states of mind, and child psychotherapy supports the child to help difficulties in the external world feel tolerable. There is reparative hope, as the child begins to feel their difficulties could be understood by another mind. CPTs aim to take 'thoughtful neutrality' (Alvarez, 1985, page 101) enabling children's projections to be sensitively contained and explored. This process is described as transference, and therapists' emotional responses are understood as counter transference. A child psychotherapist usually works with a child over an extended period of time, often for many years, offering multiple therapeutic sessions each week, and the work can take on a unique intimacy and intensity.

Potential to impact child psychotherapy knowledge

This study is interested in what happens when a child psychotherapist becomes pregnant, and the implications for the transference relationship. A pregnancy could be considered an interruption to the intimacy of the work, an indication that the therapist inhabits a life outside the therapeutic dyad. A pregnancy may evoke powerful emotional responses (envy, rivalry and loss) and the CPT may experience preoccupation, guilt and anxiety. This study considers the meaning of a pregnancy, for the therapist and the child, and how the idea of a 'third', the unborn infant in the room, might influence the treatment. The study seeks to explore what child psychotherapists say about their experiences of pregnancy and the effect upon transference relationships.

Justification

Whilst there has been some research that considers the experiences of pregnant therapists after a 'complete silence' on the subject (Whyte, 2004, pg. 5), these papers mainly focus on adult psychotherapists. Lax (1969) suggested that counter transference responses intensify during the therapist's pregnancy, and discusses the therapists' vulnerability and the conflicts evoked for patients during this period of their treatment. Surprisingly few studies focus specifically on the experiences of CPTs working with children (Simonis-Gayed and Levin, 1994), and this study will have the opportunity to explore why this may be, and to consider how the experience of being

a pregnant psychotherapist may be different for those working with children. A recently published book chapter by Sharma (2019) details a child psychotherapists clinical research project, combining case studies from the authors own experience of her pregnancy, with six interviews of CPTs who had experiences of working whilst pregnant. This study proposes that 'there is considerable experience and knowledge in this area that has not been tapped into' (Sharma, 2019). It may be interesting to see how the findings from the proposed study support or differ from the themes identified in this study, initially conducted in 2012, nearly a decade ago.

Benefits to community

There have been very few published studies on this topic, and it is hoped that the findings from this research will offer more insight into the experience of pregnancy for CPTs, and will be helpful for other women who become pregnant during the course of their professional lifetime. Sharma (2019) hypothesizes that the process of interviews helped clinicians to develop insight into these issues. This indicates that there is a foundation upon which the proposed research could begin, and that there could be benefits for clinicians to participate in group interviews to explore the subject in further depth. Bienen (1990) suggests that further studies would support psychotherapists to fully explore and understand their countertransference responses, and to feel less isolated throughout their pregnancies.

- **Provide an outline of the methodology for the proposed research, including proposed method of data collection, tasks assigned to participants of the research and the proposed method and duration of data analysis. If the proposed research makes use of pre-established and generally accepted techniques, please make this clear. (Do not exceed 500 words)**

Methodology

This study will conduct thematic analysis of two or three focus groups with child psychotherapists who have experienced pregnancy whilst offering psychoanalytic child psychotherapy with children. Small group discussion is a model familiar to child psychotherapists, and it is hoped that offering a relatively intimate space with small numbers of participants will allow for a rich and reflective conversation, and that each member will have adequate opportunity to contribute to the discussion. The qualitative method Thematic Analysis (TA) will be used to code and analyse group interview data, and extract themes from the material. TA was selected due to its straightforward nature whilst enabling the richness of data to be analysed through a rigorous coding process (Braun and Clarke 2006).

Focus groups have been chosen as the qualitative approach for this study in attempt to allow participants to consider their individual experience within the context of a group of others who may have had similar experiences. Focus groups are a novel way to investigate this topic, as previous studies have focused on case studies or individual interviews. Pregnant psychotherapists have found groups to be a useful source of support, helping them to make sense of their experiences and to understand their patients' projections (Steiner, 2004). Focus groups provide an opportunity to facilitate a guided discussion on a specific topic, wherein participants are able to candidly build on one another's responses (Leungand Savithiri,2009). Given the lack of published literature on this topic, it is hoped that through providing an interactive space, a dialogue might emerge between participants that will create depth to the discussion, and allow themes to be identified in the data analysis. Child psychotherapists are familiar with the shared space provided by group discussion, as these reflective spaces are a core component for training within profession, offering space to explore unconscious and conscious dynamics in their clinical work (Rustin, 2008). It is hoped that participants will feel comfortable using the group space for shared thinking on the topic, and will already have a great deal of experience in participating in meaningful group discussions. Participants will also have expertise in sharing confidential clinical information, and be skilled in disguising identifying details of their patients, but confidentiality will be reiterated and any identifying details discussed will be anonymised. The researcher will also keep detailed notes of the focus groups, in additional to the audio-visual recordings, in attempt to record some of the unique features of each group, and the nature of the discussion that unfolds.

The material from the focus groups will be transcribed and coded used Thematic Analysis (TA). This method is considered particularly suited for psychotherapy research as it allows for flexibility in incorporating the researcher's theoretical stance, (McLeod 2011) and this allows for the inclusion of shared clinical concepts to be employed. TA has been selected for this study as it allows for the consideration of psychoanalytic ideas, such as the intersubjective experience between therapist and patient, which underpin the work of CPTs, and participants can be confidently expected to have a shared understanding of the meaning of the concepts, such as the

transference dynamics, that are of interest to this study. It is hoped that the use of TA will allow close attention to be paid to the participants narration, and that themes may be drawn from individual experiences, and that concepts linking themes may be identified across the groups.

Data Collection

Due to the current COVID-19 pandemic, focus groups will take place via secure video conferencing software, such as Microsoft teams or Zoom. At the time of this research proposal, many child psychotherapists are working from home and the interviewer will clarify that a suitable confidential space will be used by all participants for the duration of the group interviews. In some cases, this may be the interviewees place of work, and it may be necessary to arrange for permission to book a meeting room for the interview to take place with managers in the employing trust. Participants will be made aware that each group will be audio and video recorded to enable transcription and data analysis. The interviewer will outline the confidential nature of each group, requesting that the discussion is not shared with others, and will remind participants that their data will be safely stored and anonymised. It will be made clear to all participants that confidentiality is of upmost importance, and that the research will make every effort to ensure that all participants understand the sensitive nature of the subject enquiry.

Participants will be given an information sheet prior to the interview that clearly sets out the areas of interest for the research enquiry. They will also be requested to fill in a brief pre-interview survey, to distinguish details of each participant (e.g.; qualified/trainee CPT, number of pregnancies, etc). The groups will be semi-structured, and include a loose interview schedule that accounts for the need for prompts, clarification if a response appears to be unclear, and redirection to the focus of the study in the case of any tangential replies that begin to deviate away from the study's enquiry. A provisional time frame of up to ninety minutes will be allotted for each group, and participants will be given an opportunity to contact the researcher to request a further interview if they feel this is required. It is hoped that focus groups will take place in the summer- autumn term of 2021, so that data analysis can begin in the spring of 2022.

SECTION F: PARTICIPANT DETAILS

- **Provide an explanation detailing how you will identify, approach and recruit the participants for the proposed research, including clarification on sample size and location. Please provide justification for the exclusion/inclusion criteria for this study (i.e. who will be allowed to / not allowed to participate) and explain briefly, in lay terms, why this criteria is in place. (Do not exceed 500 words)**

Sample

A sample of twelve child psychotherapists will be recruited and interviewed for the study, and written consent will be requested, confirming that they agree to take part in focus groups. No personal identifying information will be included in the transcription of the data. Participants will be randomly assigned to one of the groups offered, but this may be impacted by practical considerations, such as the day or time they are able to attend, given their clinical commitments.

Inclusion criteria for the study will be that all clinicians who take part are registered with the Association of Child Psychotherapists, and were offering child psychotherapy treatment during the period of their pregnancy. It is hoped that the sample will be culturally and ethnically diverse and represent the range of clinicians that practice as child psychotherapists. Demographic information will not be a factor in recruitment, but it is expected that each individual's background and history will enrich the findings of the study. Participants will be asked to fill in a brief pre-interview survey, that outlines the circumstances of their pregnancy; including details about any unique characteristics of their pregnancy, and clarifying their role as a trainee or qualified child psychotherapist. An upper limit on the length of time that may have passed since the child psychotherapist's pregnancy has not been set, as although their memories of the specific details of their work may influence responses, it is felt that their reflections and contributions to the study will still be useful and interesting. The length of time since the child's birth and the participants interview may be an interesting aspect of the discussion and possibly give an indication of the significance and complexity of the experience, if the participant relates memories that remain lively and vivid in their mind.

Exclusion criteria will include child psychotherapists who were not currently working with children at the time of their pregnancy, those who did not meet the inclusion criteria specified above, and those who withdraw their participation consent up to the point of data analysis.

Recruitment

I have made contact with a number of child psychotherapists who have been pregnant either during their training, or after qualifying, to discuss their potential participation in the study. These initial enquiries provisionally indicated that there are a number of suitable candidates who would be willing to be anonymously interviewed. A few of these individuals have offered to put me in touch with other child psychotherapist who might be interested in taking part in a focus group, which suggests that there may be a 'snowball' trajectory in recruitment, as participants suggests colleagues who might also be interested in taking part.

Other recruitment methods will include: emails to Tavistock and Portman child psychotherapists and trainee child psychotherapists, emails to child psychotherapists working in local CAMHS teams, a flyer in the trainee common room at the Tavistock clinic and at the British Psychotherapy Foundation, an advert in the Association of Child Psychotherapists newsletter bulletin, direct contact via face-to-face introductions and if necessary, at local team meetings. This recruitment process will include providing potential participants with a written explanation clarifying the aims of the study, explaining that the study aims to offer CPTS an opportunity to reflect upon their experience of pregnancy through participating in academic research.

- **Will the participants be from any of the following groups?*(Tick as appropriate)***

Students or staff of the Trust or the University. ✓

Adults (over the age of 18 years with mental capacity to give consent to participate in the research). ✓

Children or legal minors (anyone under the age of 16 years)[1]

Adults who are unconscious, severely ill or have a terminal illness.

Adults who may lose mental capacity to consent during the course of the research.

Adults in emergency situations.

Adults[2] with mental illness - particularly those detained under the Mental Health Act (1983 & 2007).

Participants who may lack capacity to consent to participate in the research under the research requirements of the Mental Capacity Act (2005).

Prisoners, where ethical approval may be required from the National Offender Management Service (NOMS).

Young Offenders, where ethical approval may be required from the National Offender Management Service (NOMS).

Healthy volunteers (in high risk intervention studies).

Participants who may be considered to have a pre-existing and potentially dependent[3] relationship with the investigator (e.g. those in care homes, students, colleagues, service-users, patients).

Other vulnerable groups (see Question 6).

Adults who are in custody, custodial care, or for whom a court has assumed responsibility.

Participants who are members of the Armed Forces.

[1]If the proposed research involves children or adults who meet the Police Act (1997) definition of vulnerability[3], any researchers who will have contact with participants must have current Disclosure and Barring Service (DBS) clearance.

[2] 'Adults with a learning or physical disability, a physical or mental illness, or a reduction in physical or mental capacity, and living in a care home or home for people with learning difficulties or receiving care in their own home, or receiving hospital or social care services.' (Police Act, 1997)

[3] Proposed research involving participants with whom the investigator or researcher(s) shares a dependent or unequal relationships (e.g. teacher/student, clinical therapist/service-user) may compromise the ability to give informed consent which is free from any form of pressure (real or implied) arising from this relationship. TREC recommends that, wherever practicable, investigators choose participants with whom they have no dependent relationship. Following due scrutiny, if the investigator is confident that the research involving participants in dependent relationships is vital and defensible, TREC will require additional information setting out the case and detailing how risks inherent in the dependent relationship will be managed. TREC will also need to be reassured that refusal to participate will not result in any discrimination or penalty

- **Will the study involve participants who are vulnerable? NO**

For the purposes of research, 'vulnerable' participants may be adults whose ability to protect their own interests are impaired or reduced in comparison to that of the broader population. Vulnerability may arise from the participant's personal characteristics (e.g. mental or physical impairment) or from their social environment, context and/or disadvantage (e.g. socio-economic mobility, educational attainment, resources, substance dependence, displacement or homelessness). Where prospective participants are at high risk of consenting under duress, or as a result of manipulation or coercion, they must also be considered as vulnerable.

Adults lacking mental capacity to consent to participate in research and children are automatically presumed to be vulnerable. Studies involving adults (over the age of 16) who lack mental capacity to consent in research must be submitted to a REC approved for that purpose. Please consult Health Research Authority (HRA) for guidance: https://www.hra.nhs.uk/

6.1. If YES, what special arrangements are in place to protect vulnerable participants' interests?

If **YES**, the research activity proposed will require a DBS check. *(NOTE: information concerning activities which require DBS checks can be found via https://www.gov.uk/government/publications/dbs-check-eligible-positions-guidance)*

N/A

- **Do you propose to make any form of payment or incentive available to participants of the research? NO**

  If **YES**, please provide details taking into account that any payment or incentive should be representative of reasonable remuneration for participation and may not be of a value that could be coercive or exerting undue influence on potential participants' decision to take part in the research. Wherever possible, remuneration in a monetary form should be avoided and substituted with vouchers, coupons or equivalent. Any payment made to research participants may have benefit or HMRC implications and participants should be alerted to this in the participant information sheet as they may wish to choose to decline payment.

n/a

- **What special arrangements are in place for eliciting informed consent from participants who may not adequately understand verbal explanations or written information provided in English; where participants have special communication needs; where participants have limited literacy; or where children are involved in the research? (Do not exceed 200 words)**

n/a

SECTION F: RISK ASSESSMENT AND RISK MANAGEMENT

- **Does the proposed research involve any of the following?** ***(Tick as appropriate)***

use of a questionnaire, self-completion survey or data-collection instrument (attach copy) ✓
use of emails or the internet as a means of data collection
use of written or computerised tests
interviews (attach interview questions) ✓
diaries (attach diary record form)
participant observation
participant observation (in a non-public place) without their knowledge / covert research
audio-recording interviewees or events ✓
video-recording interviewees or events ✓
access to personal and/or sensitive data (i.e. student, patient, client or service-user data) without the participant's informed consent for use of these data for research purposes
administration of any questions, tasks, investigations, procedures or stimuli which may be experienced by participants as physically or mentally painful, stressful or unpleasant during or after the research process
performance of any acts which might diminish the self-esteem of participants or cause them to experience discomfiture, regret or any other adverse emotional or psychological reaction
investigation of participants involved in illegal or illicit activities (e.g. use of illegal drugs)
procedures that involve the deception of participants
administration of any substance or agent
use of non-treatment of placebo control conditions
participation in a clinical trial
research undertaken at an off-campus location (risk assessment attached)
research overseas (copy of VCG overseas travel approval attached)

- **Does the proposed research involve any specific or anticipated risks (e.g. physical, psychological, social, legal or economic) to participants that are greater than those encountered in everyday life? NO**
  If **YES**, please describe below including details of precautionary measures.

n/a

- **Where the procedures involve potential hazards and/or discomfort or distress for participants, please state what previous experience the investigator or researcher(s) have had in conducting this type of research.**

n/a

- **Provide an explanation of any potential benefits to participants. Please ensure this is framed within the overall contribution of the proposed research to knowledge or practice. (Do not exceed 400 words)**
  NOTE: Where the proposed research involves students of our University, they should be assured that accepting the offer to participate or choosing to decline will have no impact on their assessments or learning experience. Similarly, it should be made clear to participants who are patients, service-users and/or receiving any form of treatment or medication that they are not invited to participate in the belief that participation in the research will result in some relief or improvement in their condition.

The strength of this study is that it seeks to address an apparent gap in the literature, exploring CPTs experiences of pregnancy, and the impact upon the relationship with the children they worked with. It is hoped that participants with value the opportunity to reflect and share their experiences of being pregnant whilst practicing as a child psychotherapist. If later published or disseminated, findings from the study may offer child psychotherapists insight into the complexity of experiences encountered during pregnancy.

- **Provide an outline of any measures you have in place in the event of adverse or unexpected outcomes and the potential impact this may have on participants involved in the proposed research. (Do not exceed 300 words)**

The researcher will ensure that all participants who take part in the study do so with full consent, have a clear understanding of the aims and objectives of the research and understand their right to withdraw their consent to participate up to the point of data analysis.

All data collected will be appropriately stored to ensure that confidentiality of the material is maintained. Interview transcripts will be anonymised, including any references to current or previous patients, and if plans are made for publication of the study, permission will be sought from the interviewees. Each participant will be given a pseudonym to ensure that their data cannot be identified by anyone other than the researcher.

It is likely that during the study, participants will reflect on their work with individual patients. It is customary practice for child psychotherapists to anonymise the names and detail of their cases when presenting their work, but as a further safeguard to protect patient confidentiality, any reference to patients will be further de-identified, using pseudonyms or initials.

- **Provide an outline of your debriefing, support and feedback protocol for participants involved in the proposed research. This should include, for example, where participants may feel the need to discuss thoughts or feelings brought about following their participation in the research. This may involve referral to an external support or counseling service, where participation in the research has caused specific issues for participants. Where medical aftercare may be necessary, this should include details of the treatment available to participants. Debriefing may involve the disclosure of further information on the aims of the research, the participant's performance and/or the results of the research. (Do not exceed 500 words)**

Consideration will be given to sensitive material that may be raised in the interviews. Reflecting upon their experiences of pregnancy may stir up a number of issues for participants relating to their experiences of difficulties surrounding pregnancy and birth (for example, infertility, miscarriage, stillbirth, loss, and birth trauma). Pregnancy can evoke a powerful emotional response for mothers, and this may be particularly poignant when she is working with children who have had extreme experiences of deprivation, abuse and trauma. Whilst trainee child psychotherapists are expected to be in analytic treatment throughout the period of the training, and have high levels of supervision, there may not always be similar high levels of support available for qualified CPTs. Therefore, the researcher will include post interview information that notes the sensitivity of the topic, signposts participants to appropriate support should this be needed. The information provided to participant will remind them that participation in the study is entirely voluntary and that they have a right to withdraw from the project without needing to give a reason. I would prefer to allow for spontaneous, natural responses to the interview questions which have not been planned in advance, but if required, a copy of the proposed interview questions can be emailed in advance of the interview.

FOR RESEARCH UNDERTAKEN AWAY FROM THE TRUST OR OUTSIDE THE UK

- **Does any part of your research take place in premises outside the Trust?**

  YES, Interviews will take virtually via video conferencing, so participants will be asked to ensure that they are in a confidential space before the focus groups take place.

- **Does the proposed research involve travel outside of the UK? NO**

  YES, I have consulted the Foreign and Commonwealth Office website for guidance/travel advice? http://www.fco.gov.uk/en/travel-and-living-abroad/

  YES, I am a non-UK national and I have sought travel advice/guidance from the Foreign Office (or equivalent body) of my country of origin

  YES, I have completed the overseas travel approval process and enclosed a copy of the document with this application

  For details on university study abroad policies, please contact academicquality@tavi-port.nhs.uk

IF YES:

- Is the research covered by the Trust's insurance and indemnity provision?

  YES

18. Please evidence how compliance with all local research ethics and research governance requirements have been assessed for the country(ies) in which the research is taking place.

NOTE:
For students conducting research where the Trust is the sponsor, the Dean of the Department of Education and Training (DET) has overall responsibility for risk assessment regarding their health and safety. If you are proposing to undertake research outside the UK, please ensure that permission from the Dean has been granted before the research commences (please attach written confirmation)

SECTION G: PARTICIPANT CONSENT AND WITHDRAWAL

- **Have you attached a copy of your participant information sheet (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials. YES**

If **NO**, please indicate what alternative arrangements are in place below:

- **Have you attached a copy of your participant consent form (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials.**
  YES

- **The following is a participant information sheet checklist covering the various points that should be included in this document.**

Clear identification of the Trust as the sponsor for the research, the project title, the Researcher or Principal Investigator and other researchers along with relevant contact details.
Details of what involvement in the proposed research will require (e.g., participation in interviews, completion of questionnaire, audio/video-recording of events), estimated time commitment and any risks involved.
A statement confirming that the research has received formal approval from TREC.
If the sample size is small, advice to participants that this may have implications for confidentiality / anonymity.
A clear statement that where participants are in a dependent relationship with any of the researchers that participation in the research will have no impact on assessment / treatment / service-use or support.
Assurance that involvement in the project is voluntary and that participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied.
Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations.
A statement that the data generated in the course of the research will be retained in accordance with the University's Data Protection Policy.
Advice that if participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)
Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

- **The following is a consent form checklist covering the various points that should be included in this document.**

Trust letterhead or logo.
Title of the project (with research degree projects this need not necessarily be the title of the thesis) and names of investigators.
Confirmation that the project is research.
Confirmation that involvement in the project is voluntary and that participants are free to withdraw at any time, or to withdraw any unprocessed data previously supplied.
Confirmation of particular requirements of participants, including for example whether interviews are to be audio-/video-recorded, whether anonymised quotes will be used in publications advice of legal limitations to data confidentiality.
If the sample size is small, confirmation that this may have implications for anonymity any other relevant information.
The proposed method of publication or dissemination of the research findings.
Details of any external contractors or partner institutions involved in the research.
Details of any funding bodies or research councils supporting the research.
Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

SECTION H: CONFIDENTIALITY AND ANONYMITY

- **Below is a checklist covering key points relating to the confidentiality and anonymity of participants. Please indicate where relevant to the proposed research.**

Participants will be completely anonymised and their identity will not be known by the investigator or researcher(s) (i.e. the participants are part of an anonymous randomised sample and return responses with no form of personal identification)?
The responses are anonymised or are an anonymised sample (i.e. a permanent process of coding has been carried out whereby direct and indirect identifiers have been removed from data and replaced by a code, with no record retained of how the code relates to the identifiers).
The samples and data are de-identified (i.e. direct and indirect identifiers have been removed and replaced by a code. The investigator or researchers are able to link the code to the original identifiers and isolate the participant to whom the sample or data relates).
Participants have the option of being identified in a publication that will arise from the research.
Participants will be pseudo-anonymised in a publication that will arise from the research. (I.e. the researcher will endeavour to remove or alter details that would identify the participant.)
The proposed research will make use of personal sensitive data.
Participants consent to be identified in the study and subsequent dissemination of research findings and/or publication.

- **Participants must be made aware that the confidentiality of the information they provide is subject to legal limitations in data confidentiality (i.e. the data may be subject to a subpoena, a freedom of information request or mandated reporting by some professions). This only applies to named or de-identified data. If your participants are named or de-identified, please confirm that you will specifically state these limitations.**

  YES

  If **NO**, please indicate why this is the case below:

NOTE: WHERE THE PROPOSED RESEARCH INVOLVES A SMALL SAMPLE OR FOCUS GROUP, PARTICIPANTS SHOULD BE ADVISED THAT THERE WILL BE DISTINCT LIMITATIONS IN THE LEVEL OF ANONYMITY THEY CAN BE AFFORDED.

SECTION I: DATA ACCESS, SECURITY AND MANAGEMENT

- **Will the Researcher/Principal Investigator be responsible for the security of all data collected in connection with the proposed research? YES**
  If **NO**, please indicate what alternative arrangements are in place below:

- **In line with the 5th principle of the Data Protection Act (1998), which states that personal data shall not be kept for longer than is necessary for that purpose or those purposes for which it was collected; please state how long data will be retained for.**

  3-5 years

  NOTE: Research Councils UK (RCUK) guidance currently states that data should normally be preserved and accessible for 10 years, but for projects of clinical or major social, environmental or heritage importance, for 20 years or longer. (http://www.rcuk.ac.uk/documents/reviews/grc/grcpoldraft.pdf)

- **Below is a checklist which relates to the management, storage and secure destruction of data for the purposes of the proposed research. Please indicate where relevant to your proposed arrangements.**

Research data, codes and all identifying information to be kept in separate locked filing cabinets.
Access to computer files to be available to research team by password only.
Access to computer files to be available to individuals outside the research team by password only (See **23.1**).
Research data will be encrypted and transferred electronically within the European Economic Area (EEA).
Research data will be encrypted and transferred electronically outside of the European Economic Area (EEA). (See **28**).

NOTE: Transfer of research data via third party commercial file sharing services, such as Google Docs and YouSendIt are not necessarily secure or permanent. These systems may also be located overseas and not covered by UK law. If the system is located outside the European Economic Area (EEA) or territories deemed to have sufficient standards of data protection, transfer may also breach the Data Protection Act (1998).

Use of personal addresses, postcodes, faxes, e-mails or telephone numbers.
Use of personal data in the form of audio or video recordings.
Primary data gathered on encrypted mobile devices (i.e. laptops). **NOTE:** This should be transferred to secure UEL servers at the first opportunity.
All electronic data will undergo secure disposal.

NOTE: For hard drives and magnetic storage devices (HDD or SSD), deleting files does not permanently erase the data on most systems, but only deletes the reference to the file. Files can be restored when deleted in this way. Research files must be overwritten to ensure they are completely irretrievable. Software is available for the secure erasing of files from hard drives which meet recognised standards to securely scramble sensitive data. Examples of this software are BC Wipe, Wipe File, DeleteOnClick and Eraser for Windows platforms. Mac users can use the standard 'secure empty trash' option; an alternative is Permanent eraser software.
All hardcopy data will undergo secure disposal.

NOTE: For shredding research data stored in hardcopy (i.e. paper), adopting DIN 3 ensures files are cut into 2mm strips or confetti like cross-cut particles of 4x40mm. The UK government requires a minimum standard of DIN 4 for its material, which ensures cross cut particles of at least 2x15mm.

- **Please provide details of individuals outside the research team who will be given password protected access to encrypted data for the proposed research.**

n/a

- **Please provide details on the regions and territories where research data will be electronically transferred that are external to the European Economic Area (EEA).**

n/a

29. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs? NO

If **YES** please provide details:

SECTION J: PUBLICATION AND DISSEMINATION OF RESEARCH FINDINGS

- **How will the results of the research be reported and disseminated?** ***(Select all that apply)***

Peer reviewed journal ✓
Non-peer reviewed journal
Peer reviewed books
Publication in media, social media or website (including Podcasts and online videos)
Conference presentation
Internal report ✓
Promotional report and materials
Reports compiled for or on behalf of external organisations Dissertation/Thesis ✓
Other publication
Written feedback to research participants
Presentation to participants or relevant community groups
Other (Please specify below)

SECTION K: OTHER ETHICAL ISSUES

- **Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of Tavistock Research Ethics Committee (TREC)?**

n/a

SECTION L: CHECKLIST FOR ATTACHED DOCUMENTS

- **Please check that the following documents are attached to your application.**

Letters of approval from any external ethical approval bodies (where relevant)
Recruitment advertisement ✓
Participant information sheets (including easy-read where relevant) ✓
Consent forms (including easy-read where relevant) ✓
Assent form for children (where relevant)
Evidence of any external approvals needed
Questionnaire
Interview Schedule or topic guide ✓
Risk Assessment (where applicable)
Overseas travel approval (where applicable)

- **Where it is not possible to attach the above materials, please provide an explanation below.**

Appendix 6: Response to recommendations for ethical approval

Pregnant child psychotherapist study
TREC Amendments
Date: 01/06/21
Researcher: Tamara Hussain
TREC ID:

Condition	Comments	Your response
Data Collections	A definitive and consistent data collection strategy is required across all participants. To ensure participant contributions are treated equitably, all participants should have the same opportunities to contribute, i.e. focus group and or individual interview.	The original application suggested applicants could be offered a one-to-one interview in addition to a focus group. To ensure consistency, the form has been amended to reflect that all participants will be invited to focus groups. Individual interviews will not be offered.
Vulnerability of Participants	Item has been ticked indicating that participants may have a pre-existing or potentially dependent relationship with the researcher. More information is needed about this to assess potential vulnerability of such participants.	This study seeks to interview child psychotherapists, which is relatively small profession. This means that it may possible that some participants may be known to me as students at the university, or employees of the trust. However, I will not be interviewing any direct colleagues, friends or family members, to ensure participants do not have a dependant relationship with me. I will not interview anyone who I supervise, or who manages or supervises me. Therefore, after reviewing the form, I have not ticked that the participants might be vulnerable due to a dependant relationship with the researcher. It may be possible that participants know, or have met, one another through their work in the field. I will reiterate the confidential nature of the task and clarify the boundaries of the discussion. Child psychotherapists are familiar with the nature of psychoanalytic dialogue with colleagues, as their training involves continuous participation in work discussion groups, that promote shared thinking space and high levels of discretion to promote patient and therapist confidentiality.
Review Title	Review title/objective of the study to ensure the former accurately represents the latter. Title may also contain a typographical error.	The title of the study has been reviewed and amended. The typographical error (a repeated word) has been omitted.
Typo/Grammatical Proof Reading	Ensure participant facing information is free from minor errors.	I have reviewed the public facing documents and amended any minor errors detected.
Signature	TREC form needs to be signed by relevant Course or Research Lead	The form has been sent to course leads and research leads for their signature and approval before submission.

Appendix 7 Ethical Approval

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699
Fax: 020 7447 3837

Tamara Hussain
By Email

30 June 2021

Dear Tamara,

Re: Trust Research Ethics Application

Title: What can be learned from focus group interviews with child psychotherapists who have been pregnant during their clinical work?

I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

Paru Jeram
Secretary to the Trust Research Degrees Subcommittee
T: 020 938 2699
E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor

Appendix 8: Participant consent form

The Tavistock and Portman
NHS Foundation Trust

Participant consent form

Study: What can be learned from focus group interviews with child psychotherapists who have been pregnant during their clinical work?

Researcher: Tamara Hussain, Child and Adolescent Psychotherapist in doctoral training

Thank you for your interest in taking part in my research study. I look forward to learning more about your experience of working as a child psychotherapist during your pregnancy. Please read through the statements below to confirm that you consent to participate in the study.

	Please tick
I have read and understood the information sheet for the study and confirm that I am happy to take part in a recorded focus group via video conferencing.	
I understand that my participation in the study is voluntary, and I am free to withdraw my participation up to two weeks after my interview without needing to provide a reason.	
I understand that the researcher will make every effort to maintain confidentiality and that any identifiable details from the group such as my name and my patients' names will be anonymised to protect our identities.	
I understand that due to the nature of the study there are limits to confidentiality and that there is a small possibility some aspects of my interview, such as quotes, may be recognisable to colleagues I work closely with, but all personal data and information about me will be held securely by the researcher and will not be published in the final study.	
I am aware that my interview will be recorded and transcribed, and that the information will be analysed as part of a doctoral research study. The results of this research will be part of a published thesis, and there is a possibility that in the future, findings from the study could be used in related journal articles or academic publications.	
I understand the confidential nature of the focus group and agree that I will not share any of the responses shared by other participants beyond the parameters of the controlled session.	

Participant's full name: (BLOCK CAPITALS) _____

Participant's signature: _____

Date: _____

Thank you for agreeing to contribute to this research study.

If you have any further questions, please do not hesitate to contact me at tamaraleahhussain@gmail.com

One copy to be given to the participant and one copy to be held by the researcher.

Appendix 9: Recruitment advert

What is it like to be a pregnant child psychotherapist?

My name is Tamara Hussain and I am interested in learning about the experiences of trainee and qualified child psychotherapists who have been pregnant during their clinical practice.

- Would you like to reflect on your experience of being pregnant whilst working as a child psychotherapist?

- Would you like to be involved in research that considers the impact of pregnancy for child psychotherapists?

- Would you be willing to take part in a focus group, to think about your experience with other child psychotherapists?

If you have answered 'yes' to all of the above then please contact me at tamaraleahhussain@gmail.com for more information about the study and to discuss any questions you might have.

Appendix 10: Participant information sheet

The Tavistock and Portman
NHS Foundation Trust

Participant Information Sheet

Thank you for your interest in this study. This information sheet will describe the nature of the research and what it will involve should you choose to participate.

Research question
What can be learned from focus group interviews with child psychotherapists who have been pregnant during their clinical work?

Background information
I am a child and adolescent psychotherapist in doctoral training conducting a research project. I hope to interview child psychotherapists who have been pregnant during their clinical work, and to hear their thoughts on how their pregnancies may have impacted their work and their relationships with their patients and professional colleagues. I will invite you to participate in a focus group via video conferencing (using secure software such as Microsoft Teams or Zoom), which will be recorded and later transcribed. The group interviews will be an opportunity to reflect upon your time in work during your pregnancy. The session will last approximately an hour.

Participation criteria
This study is for ACP registered child psychotherapists who have been pregnant whilst practicing child psychotherapy.

Confidentiality and data protection
The results of this study will be used in my research dissertation project and Doctorate qualification. It may also be used in future academic presentations, journal publications or conferences. I will record and transcribe your interview and keep identifiable information about you for a period of up to five years after the study has finished. After this time, all data will be destroyed. All electronic data from this study will be stored on a password protected computer that I have sole access to, and any paper copies will be kept in a locked filing cabinet. All recordings will be destroyed five years after the completion of the project.

As the data controller for this study, I will be responsible for storing the information from your interview securely in accordance with the General Data Protection Regulations 2018 (GDPR). I will be the only person who has access to your personal information and will only use these details to contact you. All other information you provide will be anonymised, and personal details such as your name will not be used in the final research paper. In very rare situations, it may be possible that quotes from your interview might be recognised by people who know you well. However, I will make every effort to disguise any details to prevent this from happening. I will also ask everyone who participates in the focus groups to sign a consent form that confirms they will not share any of the content of the discussion with others. Please contact me at any point if you have any concerns about this.

There are of course limitations to the confidentiality of the interview. If it becomes evident that you or someone else is at risk of harm, it may be necessary for myself or the sponsor for this study**,** The Tavistock and Portman NHS Foundation Trust, to contact the relevant statutory agencies.

For more information about the legal framework within which your information will be processed, you may wish to contact the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

Risks and Benefits
I hope that you will find this an interesting and useful opportunity to reflect on the unique experience of being pregnant whilst working as a child psychotherapist. It is hoped that it will provide a space for you to consider and reflect on your experience in a way that may be helpful for future work. I also hope you will find hearing the insights and reflections of other child psychotherapists valuable. The findings from this study may be useful in the future for other child psychotherapists. There are no direct risks to participating in the study but I am aware that this could be a sensitive topic that may stir up difficult emotions. If needed, details of a confidential service you can access will be provided.

Contact details:
I am the main contact for the study. If you have any questions about the project or would like to discuss this further, please do not hesitate to contact me: tamaraleahhussain@gmail.com

Alternatively, any concerns or further questions can be directed to my supervisor, Rajni Sharma: rajnisharma@nhs.net

If you have any concerns about the conduct of this research, the researcher, or any other aspect of the research project, please contact Simon Carrington, Head of Academic Governance and Quality Assurance: academicquality@tavi-port.nhs.uk

Disclaimer
This is a completely voluntary study, which you are not obliged to take part in, and are free to withdraw from up to two weeks after the focus group. After this time, the data will have been transcribed and analysed. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to provide a reason.

This research project has sought formal approval from the Tavistock and Portman Trust Research Ethics Committee.

If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact: Paru Jeram, the trust's Quality Assurance Officer pjeram@tavi-port.nhs.uk

Thank you for considering taking part in this study and for taking the time to read this information. If you are willing to take part in the research, please complete the consent form provided.

Appendix 11: Pre interview questionnaire

The Tavistock and Portman
NHS Foundation Trust

Pre focus group information

Thank you for agreeing to participate in my research project. I look forward to meeting with you and hearing your thoughts on the topic. Before attending the focus group, you may wish to reflect on your experience of working as a child psychotherapist during your pregnancy, and perhaps revisit some of your clinical notes from this time. Alternatively, you might prefer to attend the group without any preparation to see what thoughts and memories come to you spontaneously during the course of the discussion. This is entirely your choice.

It would however be useful to the study to have a little bit of general information about you and your pregnancy ahead of the focus session. I would therefore be very grateful if you could answer the questions below and return this form to me.

Were you undertaking training as a child psychotherapist during your pregnancy, or had you already qualified? (please circle)	Trainee CPT Qualified CPT
How long had you been working as a child and adolescent psychotherapist before you became pregnant?	
Was this your first pregnancy? If not, please specify using a number to indicate which pregnancy it was for you. i.e. '2' for your second pregnancy, '3' if it was your third and so on.	
Was there anything significant about this pregnancy that you feel might be useful to consider (for example, health complications, twin pregnancy, pregnancy following a loss, other challenges or aspects to the pregnancy that might feel particularly significant?)	
How soon after your pregnancy did you return to work?	
Upon your return, did you resume work with any of the patients you had seen during your pregnancy?	
Are there any specific themes related to the topic that you feel would be useful to discuss in the group?	

Thank you for taking the time to answer these questions. Please return the completed form to tamaraleahhussain@gmail.com

Appendix 12: Themes for discussion

The Tavistock and Portman
NHS Foundation Trust

Focus group information

Research question: What can be learned from focus group interviews with child psychotherapists who have been pregnant during their clinical work?

Indicative schedule:

- Introduction and welcome; set out time frame; reminder that session will be recorded and reiterate confidentiality.
- Begin with open-ended core interview question; allow participants to answer this as fully as they choose to.
- Depending on initial answers further questions may be asked to follow specific themes the participants raise or to seek more detail. Participants are free to 'pass' on any question that they prefer not to answer, or to expand upon their experience in as much depth as they choose.
- If any group member has not spoken much, they will be invited to contribute.
- A reminder will be given5-10 minutes before the discussion comes to an end.
- Participants will be asked if there is anything else they feel is relevant to the interview topic that has not been covered but they wish to include.
- Participants will be welcomed to contact the researcher with any further questions and thanked for their time.
- Participants will be sent post study information.

Core Interview question: I am interested in hearing about your experiences of being pregnant whilst working as child and adolescent psychotherapists. Could you tell me about your memories of that time? Please feel free to go into as much depth as you wish.

Themes and possible prompts

Personal experience

- Do you think your training as a child and adolescent psychotherapist impacted your pregnancy in any way? (For example, your understanding of prenatal life, the unconscious and personality development).
- Do you have any thoughts about how your unborn baby may have experienced your work in the consulting room?

Treatment

- How and when did you begin telling your patients about your pregnancy?

- Could you tell me about a patient who you felt was particularly affected by your pregnancy (this could be positively or negatively), perhaps ways in which you think your work with the child may have changed in response to your pregnancy?

Transference

- Do you have any thoughts about the way in which your pregnancy may have impacted upon the transference relationship with your patients?

Body states

- Do you have any thoughts related to how your changing body state may have affected your work (this may include your personal feelings or your patients' perceptions/interest in your body)

Responses to pregnancy

- What was your experience of colleagues and supervisor's responses to your pregnancy?
- Did you notice any differences in your work with parents?

Challenges

- Were there any risk factors that you needed to consider (for example, acting out, working with violent or aggressive patients whilst you were pregnant?)
- Do you think child and adolescent psychotherapists who become pregnant are given or have access to resources that support them to think about how pregnancy may impact their work (supervision, work discussion, journal articles, professional support etc?)? Is there anything that you might have found helpful?

Maternity Leave

- Could you tell me a little about maternity leave and your return to work, did you resume work with any of the patients you had seen whilst you were pregnant?

Appendix 13: Full list of codes

A beginning 14	An ending 50	Being a trainee 51	Being interested 20
Being pregnant 55	Being preoccupied 16	Being qualified 9	Belonging to the child psychotherapist 7
Characteristics of patient 34	Conception 5	In the room 11	Intrusion 14
Knowing - Not knowing 23	Lack of research 3	Loss 1	Making a connection 41
Personal professional conflict 36	Positive and negative 17	Reality 33	Related to a challenge 32
Related to analysis 20	Related to supervision 24	Related to the pandemic 14	Related to time 40
Response from patient 34	Responses from others 29	Returning from maternity leave 18	Separating 10
Something changed 33	Something complicated 10	Something explicit 32	Something hidden 51
Something important 13	Something painful 3	Something unusual 7	Something useful 16
Space to think 20	The baby 32	Therapist as mother 37	Therapist Patient dyad 38
Therapists body 41	Therapist's feelings 23	Trauma 9	Unconscious fantasy 39

Appendix 14: Codebook

Research Project

Codes\\Initial codes

Name	Description
Belonging to the child psychotherapist	
Being a trainee	
Being pregnant	
Being qualified	
Personal professional conflict	
The baby	
Therapist's feelings	
Knowing - Not knowing	
Reality	
Something explicit	
Something hidden	
Unconscious fantasy	
Related to time	
A beginning	
Conception	
An ending	
Loss	
Something changed	
Being pregnant	
Positive and negative	
Something important	

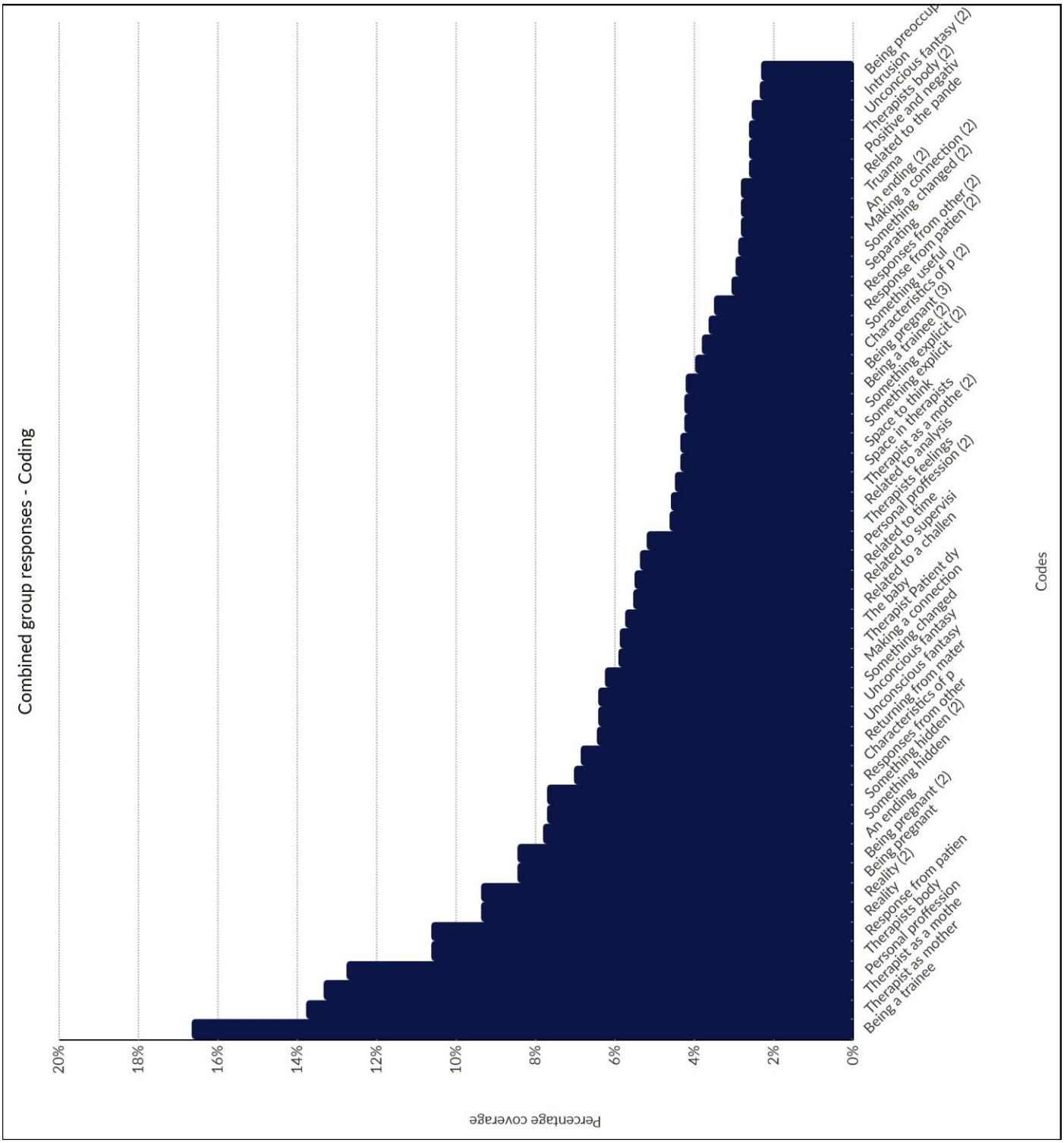
Name	Description
Something useful	
Related to the pandemic	
Responses	
Characteristics of patient	
Trauma	
Response from patient	
Characteristics of patient	
Trauma	
Responses from others	
Separating	
Returning from maternity leave	
Something unusual	
Space to think	
Being interested	
Being preoccupied	
Lack of research	
Making a connection	
Related to analysis	
Related to supervision	
Something complicated	
Related to a challenge	
Something painful	
Therapist Patient dyad	
In the room	
Intrusion	

Name	Description
Therapist as mother	
Therapists body	
Unconscious fantasy	

Codes\\Initial codes\\Therapist as a mother

Name	Description
Therapist as a mother	

Appendix 15: Code Frequency



Appendix 16: Final list of themes

Final List of themes

Themes	Belonging to the child psychotherapist	Knowing and Not knowing	Something Changed	Related to Time	Space to think	Therapist Patient Dyad
Codes	Being a trainee Being pregnant Being qualified Personal professional conflict The baby Therapists feelings	Reality Something explicit Something hidden Unconscious fantasy	Related to the pandemic Something changed Being pregnant Positive and negative Something important Something useful Responses Responses from Patient Characteristics of the patient Trauma Responses from others Separating Returning from maternity leave	A beginning Conception An ending Loss	Being interested Being preoccupied Lack of research Making a connection Related to analysis Related to supervision Something complicated Related to a challenge Something painful	In the room Intrusion Therapist as mother Therapists body Unconscious fantasy
Quotes	**Lina:** *I guess I think there's an idea during training that you're giving up your life to do your training, and people sort of, so many sacrifices for your patients, and I think that changes a little bit.*	**Aisha:** *"But even for the patient that real sense of knowing something about you...So, it was always there even when it wasn't always in my mind, there was that continued sense of knowledge whereas patients that I've started with since, you know, they might have fantasies about whether I'm a mum or not. But they don't know for definite. It's that idea of definite which can get in the way, that concreteness I think sometimes.".*	**Emily:** *I think for me I'm really dealing more with the post pregnancy now, a new mum trainee state of mind and it's really taking time for me to adjust and just make sense of the work which I am familiar with, because I have done three years of the training, but also I've changed: it's been a really wonderful experience to become a mum, I think it helped me to be a better clinician, and I'm just really thinking about whether that change in me is in the material present somewhere.*	**Mona:** *It felt like a really, a big moment that constantly trying to keep up with really, and you're on a time limit at that point, once you're pregnant, you know you've only got a certain amount of months left in therapeutic work with the children and young people that you're working with. So you know that there is an endpoint, they know that there is an endpoint and so there is a bit of a pressure I think to continue the therapeutic work while also continuing to help them think about what this might mean as well.*	**Kate:** *I felt anyway that the sickness was quite intrusive because you couldn't forget about it. It was there the whole time. And then I think as that got better it was sort of tiredness and not feeling as-thinking as clearly or maybe having as much space in your mind.*	**Aisha:** *And it so powerfully put in touch the absolutely crisis catastrophe of what the knowledge of my own very real pregnancy had upon her fantasies. And I think that's so-that's what sort of stayed with me, is how the fantasies can really be brought out in a helpful way but also could be really shattered.*

Belonging to the child psychotherapist					
Being a trainee	**Being pregnant**	**Being qualified**	**Personal professional conflict**	**The baby**	**Therapists feelings**
Lina: *I guess I think there's an idea during training that you're giving up your life to do your training, and people sort of, so many sacrifices for your patients, and I think that changes a little bit.* **Kate:** *I'm sure my fantasies sort of really feed into this but I felt like it wasn't spoken about at all. Sort of whether it was kind of allowed on the training. And so, it was felt a bit hush, hush, and I could understand they don't want to kind of encourage it, and it is disruptive and everything. But I sort of felt like it could be something really sort of not welcomed, and I wasn't sure about whether I was going to be supported so I think that for me was quite an anxious time. I did- my personal tutor who I was close to I sort of confided in her, and then sort of realised, but it was sort of a oh, it's okay to get pregnant on the training.* **Emily:** *I remember my analyst said that the trainees a long time ago, who were doing the training were given a choice between becoming a mum and becoming child psychotherapists in the past, that it used to be, it used to be a part of the process of interviews and even considering accepting potential trainees. So when I became pregnant I felt I am the super trainee, I managed in my real life to achieve to make myself happy becoming a mum and being a child psychotherapy trainee. So I think I was a little bit triumphant, and that air of triumphant feelings is still around undeniably; it's just maybe part of my personality.*	**Sophie:** *I think I was sort of sick up to about 18 weeks and that was really hard, and there would be times where I was turning my head and like gagging, like literally in the room and in my head I think I was very much in denial* **Mona:** *But you know, when these babies get bigger and they move around and your whole body feels like it's moving, you know sometimes I'd wonder whether patients can see that, like you know, can they see the baby kind of moving around in my body and what does that feel like, for them to see that? So I think probably, and your own you know, your own perceptions of your own body changing, that you've gone from pre pregnancy body where you weren't, where you didn't have another life growing inside you, and you weren't kind of undergoing all these hormonal changes that are huge actually, to then everything feels, well for me, everything felt quite sensitive really and quite significant. So, and people don't see it, people just you know, see the bump and are kind of, oh that's all it is; but it's your whole body really, it's not, not just in your uterus it's everywhere: you know, your breasts are bigger, you know my whole body was bigger, and yes it's, as pregnancy is, its all-encompassing I suppose.* **Sara:** *I think actually because people could see that's part of my body, so I was really aware of you know, my breasts that was growing, so I was trying to put like shirts to cover it up, to not show it. But I think I remember at the beginning, when I still didn't know that I was pregnant, I had an idea, but I wasn't so sure: I had a lot of nausea and I remember that, that was the feeling of feeling so sick in some sessions, when actually the material that they was bringing was making me feel so sick. I really didn't know how to behave with these feelings of you know, of really stomach ache and wanted to throw up in a session, and I think that's when I was aware of my body that was changing. Sometimes, when you really want to, to throw up like, you can't, you can't do it anything you know, if you have nausea, morning sickness that was happening, and I was really worried that this could come up during a session and that I needed to stop a session; but actually, it didn't happen.*	**Aisha:** *"Afterwards there was some real questions around that, so it was like we'll just have to go with it, and it was making that very difficult choice of it might mean I don't ever qualify"* **Mona:** *"Just thinking, it was a little bit less complicated maybe in some ways for me, because I didn't have to think about stepping away from the training school or analysis whilst I was on maternity leave. I went on maternity leave from my job when I work in the NHS and it's reasonable, they've got policies and procedures that are age old for people going on maternity leave, so in that respect I was very well supported by my manager and my supervisor and things like that".* **Mona:** *"And it felt a little bit I suppose yes, as a qualified child psychotherapist there is less supervision around isn't there, and I felt just a little bit like just struggling through it at one point and just trying to keep us all afloat really and all kind of steadying the ship when there's this kind of otherness in the room with us"*	**Aisha:** *So, I'm back to back every single day that I'm in and I can only do any clinical work or clinical write ups in the evenings once my little boy is in bed. But I've already experienced even just in these first eight months that if a crisis happens I have no reaction response time, and that's when I do have to cancel patients, and likewise I'm the first port of call if anything happens to my little boy at nursery, which he's a very active typical little boy and he's had accidents. And it's just the way it's been unfortunately but it's- I think it's been really difficult, but it's actually been really helpful for me to realise that there is life outside of the training.* **Kate:** *I feel it's kind of an ongoing negotiation in my mind I think, it's sort of new boundaries to establish and I think it's kind of other's expectations, which are all different. My own expectations of myself, and then limitations, and it sometimes feels like you can't give your all to either, which is a hard thing to kind of accept, and if you're going to sort of- if one's going to sort of not lose out but get less of you it's going to be work and I think that's hard to feel as well when you're faced with patients with such a level of deprivation and need. I think it's an ongoing sort of conflict. I'm not sure there's really a solution but just kind of- imagine it gets easier the more you're doing it.* **Victoria:** *But I think with psychotherapy there's something, I think, kind of analysis sort of brings it together: that there's your personal life and there's your professional life, and with psychotherapy it's kind of I don't know, I just feel like it's so much of both; like the training changes you as a person personally as well as professionally.*	**Lina:** *"I don't know that it changes for everybody because again some supervisors they sort of expect you to put your patients before anything, and just naturally your baby comes first".* **Aisha:** *"And actually, it was within those moments that I really for one of the first times properly felt my own baby kick, as if to say I am here. You can't forget about me".* **Mona:** *"I think there was a bit of a fantasy maybe when I was pregnant, that was almost like this would be another baby observation you know, I'd get all of that time just to sit and watch my baby, and I do watch my baby quite a lot but, but the, you have all of this knowledge and all of this understanding about children and about early development and then you've got it live in the room with you as well; but you are part of it, you are not detached from it".*	**Aisha:** *"I struggled with the feelings of guilt…sort of denial about my own limitations".* **Mona:** *"I think there's a lot of anxiety about whether we are causing damage to them by becoming pregnant, but on the other hand I also believe that it's a very, very hopeful thing for them to have a pregnant child psychotherapist: because in some ways, it can confirm that they haven't damaged us really, that we are able to carry on having our own happy separate lives and that we are able to, to have babies, that they haven't really ruined our internal resources and that you know, we have enough of resource to, to have another baby".*

Knowing and Not Knowing			
Reality	**Something explicit**	**Something hidden**	**Unconscious fantasy**
Victoria *I think there's something you know, women obviously have babies and that's how the population grows, and it's not you know, the children see it at nursery, they see it at school, they see it at home and to have a psychotherapist, you know, no psychotherapists that are pregnant that just seems kind of absurd and to be with a therapist that's pregnant and thinking about them, it's something so powerful, I think you know, there's so many positive things that could come out of that, that I feel that there's not enough written about that.* **Kate:** *I was just thinking about looked after children as we were saying, and something about a kind of sharp sort of reality kind of coming into the room.*	**Mona:** *The need to hold on to something concrete sometimes is great actually. You know, you just want to get hold of the facts or the reality or whatever it is to steady yourself.* **Lina:** *I think every time I presented I told my patients I'm pregnant this is, they say this is good news and not good news. So, really trying to give them a chance to say- everyone thinks I should celebrate, maybe it's not really welcome. it's not good news for our therapy. And they acknowledge that, but I don't think then it was ever easy for them to speak about the fact that I was leaving or pregnant, or another baby coming unless you really sort of put it to them. That's there and we can speak about it.*	**Kate:** *And then the baby starts kicking, that can happen in the middle of the session and the patient doesn't know but you know. So, there's something kind of unspoken there.* **Sophie:** *So, I suppose for me it was a slightly strange experience because I never explicitly told any of my patients that I was pregnant. Because I was coming to the end of my training, I was finishing with my patients anyway, that would have been happening. So, it was never explicitly said but obviously as time went on it was kind of explicitly there and I think there was a really sort of naïve part of me that imagined that some of them didn't know. So, for example, my under five training case, it was never kind of brought up or mentioned.* **Mona:** *So yes, I don't know whether the profession needs to catch up a little bit with, with that…there will be lots of other child psychotherapist out there that have had babies in this time but it does feel like it's, it's not it's not hugely talked about or, or there's some kind of almost martyrdom…*	**Aisha:** *And it so powerfully put in touch the absolutely crisis catastrophe of what the knowledge of my own very real pregnancy had upon her fantasies. And I think that's so- that's what sort of stayed with me, is how the fantasies can really be brought out in a helpful way but also could be really shattered.* **Mona:** *it's a tricky one isn't it, because it depends on who you're working with and what, -because some children and young people that you work with would absolutely be able to manage working with a fantasy and working with the unknown, and to be able to explore that within the context of their own internal world really.* **Mona:** *I suppose it's the fantasy isn't it as well? I wondered what their fantasy was and I wondered, I probably wasn't as brave as I could have been to then explore what their fantasy was about, kind of what I was going to say, and how kind of, how they took it really, and it felt a little bit I suppose yes, as a qualified child psychotherapist there is less supervision around isn't there, and I felt just a little bit like just struggling through it at one point and just trying to keep us all afloat really and all kind of steadying the ship when there's this kind of otherness in the room with us, and working with you know, as we all do really, working with children who've had really disrupted early lives you know, have very complex relationships with their parents and then you're, you're telling them that you're going to be a parent and that fantasy really of, what kind of mummy are you actually going to be, let alone the mummy that you are to them in the therapeutic situation as well.*

Something Changed					
Responses from others	**Responses from Patient**	**Trauma**	**Positive and negative**	**Characteristics of Patient**	**Something useful**
Lina: *Parents have been more angry actually than the children, they're more open about expressing their anger I think, what a disappointment.* **Aisha:** *I think the interesting thing was also responses from fellow professionals as well as patients. I was- some patients were quite accepting or almost understanding on the surface level at the very least of what was going on, when planned endings were involved anyway. But it was the professional network that maybe were struggling, and even my supervisor really- I have a very close sort of relationship with my supervisor for good and bad, and I think it was a very difficult process for them to acknowledge the pregnancy* **Emily:** *I left my trainee group so I think it was really more of a projected envy: I just, not only I was happy but also I was so worried. I think I was worried that I caused damage to my trainee group by making all these sort of wonderful changes in my life, getting married and being pregnant.*	**Aisha:** *I think one of the most powerful experiences I've been put in terms of the transference in the room with her was I was forced to choose as a pretend play mum between her dying on the couch, and there was also a dying new born next to me. And I had to choose which the paramedics went to first. And it so powerfully put in touch the absolutely crisis catastrophe of what the knowledge of my own very real pregnancy had upon her fantasies There was a real fear from him of what had he done to me in his mind really. And within that there was the aggression. There was lots of talk of abortion, and miscarriages within the room, increasingly as my pregnancy became more obvious.* **Sophie:** *I mean I think one of the boys- I always felt was quite an intrusive patient anyway. I found it very hard, and he would say things like the lid of his box gave him x-ray vision and he could see my body, and see inside. So, it felt with him I kind of wanted to push him off and I didn't want him near my baby. With another one, with the very little one, it felt different. It felt that he recognised something about a mum, his mum was pregnant at the start of our work together, and he had a little brother born kind of during that work.*	**Lina: I** *want to say badly, you know, I had patients, for examples, parents who have lost their babies at the very end of the pregnancy, and lots of stories, just full of stories of how things can go wrong. And when you've seen these people as the therapist, I mean the world is full of things that go wrong but you really got into their lives, and you know the story of something that has gone wrong inside out, and how it's affected them. So, it becomes very vivid, how that birth had gone wrong and how they are still dealing with the consequences- you've given it so much thought, the traumas- I think that's our part, we take on so much trauma and then how do we process it, and then you're going through such a fragile time as pregnancy, as child birth can be, and it's hard to keep it up I guess. I think you just need to be disconnected at times and we're very connected.* **Sophie:** *I think there's something about being in the room with children who have been through horrendous things, and seeing their resilience, and thinking actually they've had a terrible start, and they're still here, and they're still able to function.*	**Aisha** *Something has been freed up in my own thinking, and it's made me a better clinician actually and more open within the work. So, I think it's- as hard as it's been and the sacrifices that have inevitably had to happen, like I had to give up the research doctorate which was such a large part of my identity in my training there actually has been something that's been allowed to be left in. So, it feels like there's both a give and a take in equal measure really.* **Emily:** *First then she was really able to show me how furious she was about it in some ways because it was all out there, it was maybe a little bit easy easier to be more open and explore*	**Lina:** I found a striking difference between how female patients and male patients react. So, the males are just like, yes, I mean they're much funnier in a way, but they put it aside. A sort of denial or they're much less connected to it. Less empathic, or they are in the position of the sibling or the child, but it's not something that concerns them really. You can get a feeling that it's more other. Some have been angry. Some have been matter of fact. I mean it's such a- I cannot summarise because each patient has come up with a particular thing really. So, whatever their pathology. I think yes there probably were kind of differences in how adolescents and younger children responded, and in terms of gender, but certainly I felt like there was aggressive underlying quite a lot of it. I do think, for example, with eating disorders, there's something about them feel quite disgusted about your body changing and all that. The time is limited, and I also never knew how much to talk about that. I mean obviously with a foster child the sort of feelings must be very, very live. You're going to have a baby and maybe the fact that you're going to abandon him, or he's going to be removed, but it's your baby. With adolescents I think the defences are much stronger in terms of babyhood and childhood being sort of very defended against. So, they're less interested.	**Kate:** *I think since having the baby I just always come and obviously help in analysis about good enough mothering, and I really just hold on to that and I have to remind myself of that. And so, I think in that respect what we know from our training and what can really help steady me as well, so it's- I think being pregnant- everything was more heightened as well, so it was more difficult to hold on to that then, and there was so much unknown.* **Victoria:** *I think they are really helpful words to think about it Mona, what you were saying about settling something and steadying something? That feels really helpful to me, because I think there's something that has been sort of working out in my mind but it kind of, can't kind of, that needs to be communicated, that it needs to be settled and things need to be stabilised.*
Related to the pandemic	**Something changed**	**Something Important**	**Being Pregnant**	**Separating**	**Returning from maternity leave**
Sara: *I just found out being pregnant when they announced lockdown. So I think, I think that's the theme that I suggested you know, having a baby during lockdown as well, how it can impact you know, being a child psychotherapist at the same time you know, all this uncertainty as a woman, being pregnant and you know, what was going around in the world at that time… I think the struggle that I had is that because lockdown and Covid was so new, when I found out I was pregnant*	**Emily:** I *think for me I'm really dealing more with the post pregnancy now, a new mum trainee state of mind and it's really taking time for me to adjust and just make sense of the work which I am familiar with, because I have done three years of the training, but also I've changed: it's been a really wonderful experience to become a mum, I think it helped me to be a better clinician, and I'm just really thinking about whether that change in me is in the material present somewhere.*	**Mona:** *Everything feels, well for me, everything felt quite sensitive really and quite significant…But also that it felt really important to make sure that you know, you were giving enough, thinking enough, really being a good enough mother, as Winnicott might say.*	As above	**Victoria:** *I think that, that would be very strange kind of seeing him again but also could be, could be very powerful in, you know I've still been thinking about him, and I think he probably would start school in that time or be starting school and yes, that to kind of think about those changes for him you know, he kind of lost his mum when he was taken into care and then he's now back with his mum. I don't know if it would be kind of like a repetition of losing me and then me coming back, so it would be interesting to see.*	**Sara:**. *Now I'm worrying on coming back, and you know how that's going to affect being a mum and being a child psychotherapist, and how you know being with patients and the same time now I feel that my mind is really occupied with my baby, and I feel that I don't have space: like I'm hearing you and I'm thinking, I don't have space for patients in my mind at the moment at all, and I really you know, I really hope that when I will be back at work I will have that time and space to think about them again.*

Related to Time			
A beginning	**Conception**	**An ending**	**Loss**
Aisha: *The girl who'd I actually started to see at the point of me realising my own pregnancy, so the conception of the work as well as my own child.*	**Victoria:** *Becoming pregnant is an evidence of having an active sexual life and I think a lot, I think for me, the guilt was around yeah, the triumph and guilt was to do with the fact that everyone can see I'm a heterosexual woman who is leading an active sexual life, it's undeniable. Pregnancy is not just the baby comes from, we know how babies are made and small children and little children and toddlers know how babies are made as well; so I think that's probably really the baseline of it all.*	**Sophie:** *I was really aware that I had an ending. I was finishing my training. I was saying goodbye to all my patients. And I kept sort of saying I'm only crying at my endings because I'm pregnant. And I think it wasn't that.* **Mona:** *So you know that there is an endpoint, they know that there is an endpoint and so there is a bit of a pressure I think to continue the therapeutic work while also continuing to help them think about what this might mean as well.* **Aisha:** *We're all either qualified or child psychotherapists that have returned back following our maternity leave whereas actually I'm still quite friendly with somebody who was a trainee who felt pregnant in her first year, and due to not continuing analysis during her maternity leave there wasn't the space available. And for one reason or another she wasn't able to continue on with the training. And it feels quite important to acknowledge that, you know, those instances, although they're not massively common they do happen where there has to be that real decision made that maybe the choice for a family dependent obviously on timings is that you don't carry on with the training. So, it just felt important to acknowledge that because obviously we're sort of success stories as it were in that we have been able to return and have the option of doing that, but it's not always possible.*	**Victoria:** *From the moment I found out I was pregnant I was just worrying all the time, was this going to stay or was I going to lose it, and there had been so much loss around me; I've lost a few significant people in my life in the past year and it's been really hard, and you know my mum, my sister, both had kind of miscarriages and so I just kind of, it didn't really feel real and I couldn't really feel like this is really going to happen, you know, that there's a life sort of coming rather than all this death that's kind of been around.*

Space to think		
Being interested	**Being preoccupied**	**Lack of research**
Aisha: *In terms of why I've been drawn to the study, both sort of get a deeper understanding sort of in my own mind about the experiences that I've had, good and bad. As pregnancy is anyway. But also, just because there isn't a lot of research out there and I think it's something really interesting, and really important given the work we do to give some thought to the pressures that there are out there, particularly as a trainee, and the impact it can have on your training.* **Sophie:** *I think for me this feels really interesting because I think it did have an impact on my work. And particularly for me in terms of I was ending but also had a beginning around, and I suppose I'm sort of curious about other people's experiences. To hear more about that as well.*	**Aisha:** *I think that was so poignant a thing of wanting to give your full mindful attention to a patient that really needs it but being constantly, and sometimes unhelpfully, reminded of the position that you're in for yourself as well.* **Lina:** *How it's impacted; I guess you can't be that present anymore.*	**Kate:** *When I was looking for things to read about this topic when I was pregnant I couldn't find very much, so I'm also kind of, you know, I think it would be really helpful if there was more research done in this area as well.*
Making a connection	**Related to analysis**	**Related to supervision**
Kate: *I suppose it's partly just to kind of link up with others that have been in the same position and sort of share experiences, and hear others, and that sense of community as well.*	**Lina:** *Analysts, it's not unusual for people to finish their analysis as they're having a baby and you wonder is that the right time because they're going to be busy anyway because they had a baby at the end of training, and that coincides with the time they would have finished analysis anyway. Or even analysts feel somehow okay, off you go, you have your babies, you're going to busy with them. You don't need this analysis anymore.* **Emily:** *But yes, having had the analysis and having had my infantile part contained by someone else in my adult age definitely helped me to be a better parent which is something I try to do in my adult life, to be a better parent.*	**Sara:** *So, I spoke with the supervisor and we decided to use that space to talk about how I was feeling, and being pregnant and so I think it was really, really helpful.* **Sophie:** *I think my supervisor probably is someone who didn't feel that when she had a child the way that she has described that to me, that she was much more kind of still work was the thing. And she's struggled a bit. We've had to have a bit of a think about it.*
Something complicated	**Related to a challenge**	**Something painful**
Sophie: *I was thinking of genders and whether I noticed any difference in kind of response to my sort of changing body, and the baby, and I think probably reflecting on it there probably was more aggression from male patient, but I think a lot of the male patients that I had were looked after children or in kinship care, and it felt like that made it even more complicated in a sense because here I was as a mum who was looking after my baby.* *I was thinking also there was a- someone who I worked with who was in the process of transitioning, so kind of accessing the gender identity services, and had been born male but was now living as a female, and I think that was complicated as well. There were lots of thoughts about kind of disgust at pregnant bodies, and women who gave up their lives to have children. So, kind of more of that verbal attack I suppose on me rather than something more violent.*	**Kate:** *I think my experience of being pregnant, working as a trainee child psychotherapist sort of brought- it brought up lots of things that sort of felt new and challenging.* **Aisha:** *Because all of the sacrifices that I made to make the training my life meant that I don't have any family close by, and neither does my husband, so it's just the two of us. My commute to analysis is extremely long and my commute from analysis to work is extremely long. So, my day at work is now- because I've gone part time to make sure I do carve out some time with my family, is actually that due to just all the situations I've got a lot of training still to do and complete in my final year. So, I'm back to back every single day that I'm in and I can only do any clinical work or clinical write ups in the evenings once my little boy is in bed.*	**Aisha:** *The response I had, although was really positive from my personal tutor, but jokey comments were made by other tutors: oh, jumping on the bandwagon are we. And actually, for who'd really struggled to get pregnant although it was meant in a jokey way and they immediately apologised after they had said it, it was quite painful and quite hurtful actually*

Therapist Patient Dyad				
In the room	**Intrusion**	**Therapist as mother**	**Therapists body**	**Unconscious fantasy**
Mona: *Working with young people and how it fills the room in all sorts of different ways I think had kind of drawn me to it really* *Aisha: One particular thing that I really remember being quite poignant for me was actually speaking to him about how in the room it was, you know, I was there to think about him and his struggles, because he was feeling really difficult to be able to speak to some of these things when there was clearly a third in the room.*	**Mona:** *I guess in some ways that, potentially feeling a little bit intrusive you know, you don't just get to have an ordinary pregnancy and you know just have it for, not for yourself but not you know, you are working in the transference and wondering what that means for the, for the child in the room as well.* *He was being pushed out by this baby, and that's a real fact for him as well, that he's being pushed out by this baby, because our sessions have to come to an end because I'm going to go off and have a child, and you know, almost grasping that in a more concrete way was actually quite helpful for him*	**Kate:** *I think since having the baby I just always come and obviously help in analysis about good enough mothering, and I really just hold on to that and I have to remind myself of that.* **Mona:** *What kind of mummy are you actually going to be, let alone the mummy that you are to them in the therapeutic situation as well. I think there was a bit of a fantasy maybe when I was pregnant, that was almost like this would be another baby observation you know, I'd get all of that time just to sit and watch my baby, and I do watch my baby quite a lot but, but the, you have all of this knowledge and all of this understanding about children and about early development and then you've got it live in the room with you as well; but you are part of it, you are not detached from it. This time you know, you are in the thick of it and feeling all of those things that perhaps you've read about at one point, and it's not a confidence maybe, but it gives you a something, -well it gave me something I think, about becoming a parent* **Sophie:** *I'm going to do with my little girl is try my very best, and be there to support. And I think there probably some internal pressure of kind of you're a child psychotherapist so you should know what to do. And of course, it doesn't work like that. I think generally I sort of think there's something about just taking in something good, and I think that's what I've aimed to provide for her. And so, I've tried to hold on to that really more than anything, but I think you could easily become quite persecutory towards yourself and think about everything you do has an impact, and I know there were moments were patient are like shouting at you. You can feel a bit of adrenalin or a feeling, and I'm thinking of evidence about kind of domestic violence, or a question. What could be taken in by my little girl. So, it does have an impact, the knowledge I think, yes.*	**Sophie:** *There was a- someone who I worked with who was in the process of transitioning, so kind of accessing the gender identity services, and had been born male but was now living as a female, and I think that was complicated as well. There were lots of thoughts about kind of disgust at pregnant bodies, and women who gave up their lives to have children.* **Mona:** *I think, I think I was certainly much more aware of my body: I was very uncomfortable for the last kind of three months as well and I think that trying to move in a therapy room without giving away too much that you're actually… really quite painful it's quite hard really you know, and that just adds another dynamic to it doesn't it and whether some of that kind of caring came out a bit more? But there was a, -it's a bit of a, but I felt that the last sort of after Christmas kind of thing so from kind of six, six and a half months onwards, it was almost like for some people I was working with, my body changed every week, and it was commented on almost like, "Wow" or, "You're definitely pregnant now." or you know, comments along those kind of lines almost like it could have been denied before but now actually it really can't be, it can't be denied, and you know as you go further through your pregnancy as well, I mean you start feeling the baby move. I think Sara as you said, about you know, you could touch your bump because you were online but the temptation to touch yourself, your baby when he's moving, but not do that because you're in a therapy session is, yes it's a bit of a split isn't there a little bi, of the what should be kind of intrinsic and natural is the, you're trying to keep your neutral stance I guess. So yes, the body mind, obviously there is a huge connection, but then is there a disconnect as well?*	**Aisha:** *And it so powerfully put in touch the absolutely crisis catastrophe of what the knowledge of my own very real pregnancy had upon her fantasies. And I think that's so- that's what sort of stayed with me, is how the fantasies can really be brought out in a helpful way but also could be really shattered.* **Mona:** *It's a tricky one isn't it, because it depends on who you're working with and what, -because some children and young people that you work with would absolutely be able to manage working with a fantasy and working with the unknown, and to be able to explore that within the context of their own internal world really.* **Mona:** *I suppose it's the fantasy isn't it as well? I wondered what their fantasy was and I wondered, I probably wasn't as brave as I could have been to then explore what their fantasy was about, kind of what I was going to say, and how kind of, how they took it really, and it felt a little bit I suppose yes, as a qualified child psychotherapist there is less supervision around isn't there, and I felt just a little bit like just struggling through it at one point and just trying to keep us all afloat really and all kind of steadying the ship when there's this kind of otherness in the room with us, and working with you know, as we all do really, working with children who've had really disrupted early lives you know, have very complex relationships with their parents and then you're, you're telling them that you're going to be a parent and that fantasy really of, what kind of mummy are you actually going to be, let alone the mummy that you are to them in the therapeutic situation as well.*