"An emotional sensitivity now that I didn't have before".

The therapist's experience of new motherhood: An IPA study

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Table of Contents

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Abstract

Aims: Women who are therapists potentially face a landscape of changes during their transition to motherhood. This study aims to explore therapists' lived experience of returning to therapeutic practice after having their first baby, particularly in terms of whether therapists notice any changes to their experience of client work as new mothers.

Method: This qualitative phenomenological research was conducted based on semi-structured interviews with six participants (all practicing therapists with a child under two), whose accounts were analysed using Interpretative Phenomenological Analysis (IPA).

Results: Analysis revealed three group experiential themes. The first highlighted how therapists seemed to be working with a view of their baby in therapy. The second dealt with how the participants navigated their emotional sensitivity in sessions and the associated issues and client groups that they could no longer work with, as well as their attempts to find their own emotional safety. The third explored how therapists integrated their mother and therapist selves by redefining their boundaries, switching between the roles, their felt sense of growth, and continued dedication to being therapists.

Discussion: This study's findings suggest that the therapists' transition to motherhood involves many complex dynamics with important implications for both therapists themselves and the therapeutic relationship. The findings highlight new-mother therapists' need for support and supervision upon their return to work. The study advocates for further research to explore how motherhood affects the therapist.

Definition of terms

Perinatal: The period from pregnancy up to a year after giving birth

Postnatal: The post-natal period is the first 6-8 weeks after birth

Postpartum: The period immediately after childbirth

Therapist: A person trained in delivering psychological therapy including Clinical/Counselling Psychologists, Counsellors, CBT therapists and Mental Health Wellbeing Practitioners

New-mother therapists: Constructed term to describe therapists who themselves have had their first baby within the last two years

Client: A person who seeks psychological therapy with a therapist

Introduction

Emotional responses to motherhood are typically conceptualised as pathological, with the medical model dominating academic, professional, and lay understandings in Western society. Even many qualitative studies that claim to give voice to women still ascribe to constructed labels such as 'post-natal depression' (e.g., Puckering et al., 2010). The present study adopts a feminist perspective and theorises women's emotional experiences and any distress arising during early motherhood as understandable responses. Contributory factors include the associated loss, including their former sense of a separated, autonomous, and individuated self (Oakley, 1980). Something that mothers are tasked to grieve and come to terms with (Nicholson, 1990). In fact, difficulties arise when women are unable to experience, express and validate their feelings within supportive, accepting, and non-judgemental interpersonal relationships and cultural contexts (Mauthner, 1999). This needs improvement within Western individualistic culture, so mothers avoid an inferior status from the medicalisation of childbirth, poor provision of funded childcare, and the likely loss of occupational status and identity. That is investing in communities and providing support that new mother's value. This topic is undoubtedly complex and whilst counselling psychology cannot deny the reality of a medical model, it can promote wellbeing through community engagement and challenge entrenched narratives and stigma.

Existing ideologies detract from women's tenacity after enduring one of the most physical exertions of the human body, with the intensity of pregnancy akin to running a 40-week marathon (Thurber et al., 2019). Motherhood can evoke complex emotions including resentment, fear of failure and guilt (Coates, Ayers and de Visser, 2014), often coinciding with joy, devotion, and a distinctive love that produces internal conflict (Stone, 2020). Relationship history and trauma have potential to awaken via the medical procedures, bodily changes, and relational symbolism, meaning mothers can face unprecedented and multifaceted changes within their broader transition to motherhood. That is not to deny mothers of a happy and relatively unproblematic motherhood (Mauthner, 1999).

Mother's employment trajectories differ sharply from those of fathers with far fewer women following a full-time career after maternity leave (University of Essex, Institute for Social and Economic Research, 2019). The motherhood penalty has been publicised recently by Claudia Godwin's Nobel Prize in October 2023, whose work reveals the birth

of a first child explains the bulk of the gender pay gap. More women participate in work outside of the home than ever before (Office for National Statistics, 2020, as cited in Ridout, 2020) and evidence suggests a trend where women are either prioritising careers by choosing to have children later in life (Harper & Botero-Meneses, 2022) or are forced to limit childbearing preferences due to the associated costs (Pregnant Then Screwed, 2022). In turn, women seem to be facing increasing demands to reach the top of their career game whilst trying to experience motherhood on their terms. Working mothers reportedly feel healthier and happier than those who stay at home during their children's infancy and pre-school years (Buehler & O'Brien, 2011). This can come at a cost with associated work-life conflicts and exhaustion (Ravindranath et al. 2021), combined with the emotional wrench of missing their child (Lyness et al. 1999). Tennis star Serena Williams, commonly considered the epitome of a working-mother, candidly shared how she "never wanted to have to choose between tennis and a family. I don't think it's fair" whilst announcing her retirement (Williams, 2022, para. 3). The present study merges motherhood with the therapist personal perspective to gain an insight into another subjective facet of life as a new mother. Therapists have their own transition to make, like any mother, albeit their return to therapeutic practice has potential to rouse specific relational and professional issues. This is especially relevant given the comparisons that have been made between therapy and mothering (Van Deurzen-Smith, 1996). Much research has pointed to therapists as instrumental in the process of therapy (Aponte, 2022), yet fewer studies have addressed the relationship between therapists' personal experiences and the quality of their therapeutic work, including those of new-mother therapists (Waldman, 2003). In the present study it is hoped that by exploring new-mothers' experiences we can begin unpacking what bearing, if any, new-motherhood has on them in the therapeutic space. This thesis will explore an alternative to psychiatric nosology and motherhood ideologies rooted in patriarchy by adopting a feminist, trauma-informed and non-pathological lens. The more specific contribution of this project is the contrast it delineates between the ideal of maternal love and the 'untroubled' therapist propagated by traditional discourses, and the reality of co-existing maternal and therapeutic relationships, as evidenced in the narratives of new-mother therapists

Chapter 1: Literature Review

1.1 Matrescence

"Becoming a mother leaves no woman as it found her. It unravels her and rebuilds her. It cracks her open, taker her to her edges. It's both beautiful and brutal; often at the same time" Nikki McCahon

Motherhood is marked with ordinariness and 605,479 births in England and Wales in a single year (Office for National Statistics, 2023), yet its meaning, emotion and impact are stark. The birth of a child is a top "positive" antecedent of crying in adults (Vingerhoets & Bylsma, 2015) symbolising the immediacy in emotional connection for people.

The topic of motherhood is having a moment (Westervelt, 2018) with the revival of matrescence, a term coined by medical anthropologist Dana Raphael (1975) and more recently extended by Dr Aurelie Athan's work. Matrescence understands the bio-psycho-social-political-spiritual spheres involved in the transition to motherhood as akin to the developmental push during adolescence (Athan, 2019). It places the mother at the heart as she treks through pre-conception, pregnancy and birth, surrogacy, or adoption, to the postnatal period and beyond. Athan defines the process of motherhood as something individual, unbounded, and transitional as new mothers continue their journeys and future childbearing intentions. One area of transition for women is of course a bodily one, where women undertake substantial physiological processes. This is observable in brain structure, whereby the volume of grey matter (GM) reduced in mothers for at least 2 years post-pregnancy (Hoekzema et al. 2017). GM plays a significant role in all aspects of human life including control of daily functions of movement, memory, and emotions (Mercadante & Tadi, 2023). Furthermore, Hoekzema et al. (2017) found volume changes during pregnancy corresponded to measures of attachment after birth, suggesting some sort of adaptive process for mothers in preparation to respond to their infant's needs. Although neuroplasticity is known to be a lifelong capacity of the brain (Power & Schlaggar, 2016), Heokzema et al.'s (2017) study indicates the magnitude and permanency of potential changes for women during new motherhood.

A study that evaluated women's physical recovery from childbirth found that whilst some musculoskeletal injuries resolved, other muscle tears did not substantially change at 8 months postpartum (Miller et al. 2015). The sorts of injuries measured in the study were identified from special fluid-sensitive sequences in magnetic resonance imaging (MRI), which is usually recommended in cases of sport-related injury (DelGrande et al. 2014 as

cited in Miller et al. 2015) and not readily accessible for new mothers. This means the long-lasting injuries sustained during labour and delivery may go undetected, despite being comparable to the sport-related injuries this specialist technology usually serves. Such is likely to impact women's sense making of their post-partum bodies and recovery. Mothers have also been found to suffer a prolonged lack of sleep after having a baby (Richter et al., 2019) potentially leading to adverse consequences, with sleep associated with brain function and systemic physiology (Medic, Wille, Hemels, 2017). Diminished sleep occurred particularly during the first three months but did not fully recover until their child reached age six (Richter et al., 2019). Furthermore, Richter et al. found reduced sleep was worse after a first child, in comparison to subsequent children and occurred largely irrelevant of other circumstances such as household income and parental age, suggesting that sleep deprivation is inevitable for most mothers and harder to adjust to the first time.

Other research has suggested that stressful experiences are associated with altered brain responses to infant cues (Pilyoung, 2021). The study scoped the literature for brain adaptations arising from a complex array of stressful experiences. These included childhood adversity, poverty, violence, racism, and stress in the context of childbirth and parenting, such as preterm birth, difficult birth experiences and infant temperament. The findings suggest that mothering capacity may partly rely on changes in brain responses that life experiences also influence. That is, the mother does not arrive at motherhood 'new' but rather as the sum of her experiences that impose and intersect at levels of body and mind.

1.1.2 A psychological revolution that alters our relationship to almost everyone.

Motherhood is undoubtedly a complex journey involving an interplay of historic and current phenomena, lending itself well to consider mothers as embedded in a complex web of wider and more intimate social relations (Gilligan, 1982). That is, "the networks of schemas that undergo reworking are the mother's self as a woman, mother, wife, career-person, friend, daughter, granddaughter; her role in society; her place in her family of origin; her legal status; herself as the person with cardinal responsibility for the life and growth of someone else, as the possessor of a different body [. . .] and so on, in short, almost every aspect of her life" (Stern, 1998, p. 24). From the start of pregnancy, a continuity of biological, psychological, intrapsychic, interpersonal and intergenerational

processes occurs. The mother's internal landscape comprises of herself as the adult woman, the child she has been, the parental figures she has had and her imagined child. There are symbiotic elements (being a mother, mother-child unit) and aspects of identification-separation (producing a child, imagining a child other than oneself). Becoming a mother can therefore be a process of deep transformation re-activating attachment histories and childhood memories to form a representation of the self as a mother. A Polish study found complex psychological processes in the transition to motherhood, with the relationships of different maternal attachment styles; self-image as a mother, and the image of one's mother as a mother during and after pregnancy as influential in the processes of bonding with the baby (Zdolska-Wawrzkiewicz et al., 2020). Following childbirth, a woman moves beyond being a child of her mother, to the mother of her own child. In turn, redefining the relationship and image of her mother as a mother. It has been described how mother and baby can find each other impervious (Jones, 2017), as the mother attempts to protect herself from a baby she experiences as persecutory. There is in essence a two-way infantile process, the newly born baby and the revived baby, or small child, in the mother. Whilst it is important to note that attachment wounds can influence parenting and previous trauma increases the likelihood that a woman will experience a trauma stress response after birth (Slade, 2006), they do not determine the outcome. Awareness, self-reflection, and support can help mothers develop secure future attachment relationships with their children. One study that interviewed women found their pregnancy initiated a desire to heal past trauma prior to the birth of their child and to be a 'good' mother (Berman et al., 2014). The study reported women's efforts to contain trauma and their commitment to strategies, which included blocking it out, blurring, reframing, and confronting the memories. For many women in the study, motherhood sparked impetus for positive change, and they described hope for the future. Embarking upon the journey of motherhood is therefore, perhaps, a time that women may need and exhibit readiness for self-development and/or therapy.

Maternal ambivalence is a term used to convey the dynamic fluctuations and co-existence of love and hate towards one's child. Although attempts have been made to normalise the internal conflict (Parker, 1995) it still often remains unspeakable (Almond, 2010), marginalised, and typically constructed in the context of pathology (Takševa, 2017; Adams, 2011). Feminist scholars have attempted to unmask the idealisation and

denigration of mothers by recognising ambivalence as a constitution of both psychological and social factors, emerging from contradictions at a subjective level and via social structures. Almond (2010), for example, advocated for the endorsement of maternal ambivalence, during an era when women feel they should be able to do it all. A study involving Bosnian rape survivors revealed harrowing accounts of mothers who learnt to embrace their ambivalence as an inevitable part of their love for their children. Their subjection to pregnancy from rape helped explain their ambivalence (Takševa, 2017). These women's accounts are distressing to read and it is sobering to comprehend the extremity of circumstances that afford mothers with a tolerance of their ambivalence. Nonetheless, the message embedded within the findings of this study is an optimistic one, which characterises ambivalence as a healthy component of any relationship and one necessary to mothering. It highlights the complex nature of mother love and that even in the most horrific circumstances women can benefit and thrive when ambivalence is visible and thus a potential source of empowerment. Furthermore, it launches an encouraging prophecy of the enormity mothers could achieve in healthier circumstances and if society welcomed their struggle.

Entering motherhood is associated with an increase in emotional sensitivity (Korukcu, 2020). The study collected qualitative data by interviewing women between four and five months after childbirth, which revealed reduced tolerance as they expressed being unable to withstand hearing about children suffering or being abused. Mothers' increased sensitivity is likely of value to their baby, as infants whose mothers were highly sensitive to their internal states at 10 months had a better understanding of mind and emotion by age four (Ereky-Stevens, 2008). Other studies have found mothers possess stronger empathy responses than non-mothers regardless of whether the target of empathy is a child or adult (Plank et al., 2021). New mothers also report higher empathic concern and understanding for other new mothers than that of childless women (Hodges et al., 2010). Similarly, in medical services, one study found GPs who were mothers acknowledged that their own motherhood experiences influenced their treatment decisions for pregnant women and reported a strong desire for women to have an improved quality of life and positive experience (McCauley & Casson, 2013). This suggests across different contexts mothers relate to one another and possess an increased empathy for suffering. Hodges et al. (2010) also explored empathy from recipients' perspectives and found they too felt significantly better understood by the new mothers, suggesting motherhood may

influence overall affective social understanding. A great deal of research into empathy examines women's neural responses to stimuli or targets (Bak et al., 2021; Zhang et al., 2020 & Plank et al., 2021), again simplifying motherhood to a purely adaptive mechanism that neglects the complex array of social, emotional, and cognitive processes that are also likely to influence changes in empathy. Furthermore, there is little understanding as to how women experience and make sense of their new empathy. In addition to an apparent adaptive response, mothers appear to hone their soothing skills with experience (Kurth et al., 2014). This research found that mothers' ability to mitigate their own stress from hearing their baby cry evolved over time and for first time mothers their understanding and expectations of crying differed to mothers of more than one child. This suggests that there is a lot to be gained by experience and whilst some adaptive processes may be at play, this does not encapsulate what is gained from experience, particularly for those mothers transitioning for the first time.

A longitudinal study explored multiple aspects of relationship functioning during the transition to parenthood, including relationship satisfaction and self-reported communication, problem intensity, and relationship dedication and confidence (Doss, Rhoades, Stanley & Markman, 2009). The study targeted both immediate and more gradual changes and found parenthood initiated negative and persistent effects on most areas of relationship functioning. However, the study presented quantitative summaries of relationship directionality and offered little context to how and why these changes take hold. Furthermore, the researchers set the parameters of relationship functioning, preventing the appearance of more complex ideas. Nevertheless, this study supports the notion that relational trades occur after becoming parents. Almost half of women report a lack of interest in sexual activity after having a baby (O'Malley et al., 2018) and O'Connell (2018) explores her experience thoroughly in an article, which is also an excerpt from her book, and highlights her conflict with imagining intimacy with her husband whilst living a life so inextricably entwined with her baby. She depicts her grapple with willing her desires to be different and the doubt this brought about herself and her relationship. Her narrative profoundly portrays the relational layers to this issue too, as she realised, she had not effectively communicated her lack of sex drive to her husband, who equally had not asked about her sexual wellbeing. Such accounts stand as a reminder of the baby's impact on mothers' capacity to connect with others on multiple

levels and beyond the physical changes, as well as the two-way nature of connectedness in relationships as parents.

1.1.3 What is the problem with motherhood?

According to Heidegger (1962), humans propel into the conditions of human experience such as mortality, existence in the world, relations to others and embodiment (Cohn, 2002). Simultaneously, humans arrive into the circumstances that represent their individual life circumstances (i.e. culture, gender, social and historical contexts). Given the volume, complexity and depth of changes that infringe on women's physiological, psychological, and social experiences it's perhaps not surprising that the early post-natal period is considered 'high risk' to experience mental health difficulties (National Institute for Health and Care Excellence (NICE, 2016). Furthermore, the first 1000 days are critical for the infant (House of Commons Health and Social Care Committee, 2019). In recent years, perinatal mental health has become a significant focus of interest in the UK. Since 2016, new specialist mental health services have rolled out in England (NHS England, 2018) and whilst services increase awareness of the strain of mothering and appears to prioritise new mothers, specialist teams are typically underpinned by biomedical frameworks that diagnose instead of listening to experiences. These include the medical regulation and control of the pregnant body, that is approached with risk awareness (Johanson, Newburn & Macfarlane, 2002) that likely continues post-partum with women tending to think about risk differently to healthcare professionals (Lee et al., 2019). Ultimately, women navigating this momentous transition and struggling with the fallout of traumatic births and pregnancies (where they are commonly subjected to procedures without consent, sleep deprivation, and domestic abuse) are further traumatised by the claim they are mentally ill when they seek support. Five types of 'good' mothers and corresponding normative expectations identified from a scoping review include the present mother who is attentive to the child, the future-orientated mother who secures the child's successful development, working mother who integrates employment into mothering, public mother who is in control and the happy mother who is contented with her role. Mothers who fear being 'bad' struggle to articulate the complexities of their problems and believe that health professions will focus on the wellbeing of their babies over their own (Mayor, 2017). Up to a third of women view their births as traumatic (Slade, 2006) and despite the evidence for effectiveness of psychological therapies, GPs

are much more likely to prescribe medication (Khan, 2015) even though the majority admit they would not take it themselves (Mendel et al., 2010). A 'pills or therapy' culture has developed where women are led to believe the cure is within one or both, and if that does not work it's because they're not working hard enough or just need more. Yet neither of these approaches will work for many new mothers because there is no quick fix to effortlessly adapt or find the magnitude of what mothering entails enjoyable. Indeed, there is evidence to suggest women tend to face gradual shifts towards feeling like a mother (Miller, 2005). A recent study of eighty-three people found using anti-pathologising, supportive and trauma informed approaches to people feeling depressed were successful (Kostic et al., 2024). The participants were supported adequately and for long enough that their depths of their depression passed and 64.5% felt better three months later despite accessing no medication or psychotherapy. Although the study did not focus on mothers nor explore postnatal experiences specifically, the authors argued people with depression usually had a set of problems that were bothering them (rather than a chemical in balance in their brain) and on that basis we can understand new mothers who struggle as experiencing an (understandable) response to the stress they are under. These findings acknowledge the benefit of watchful waiting, advice, shared decision making, validating feelings and good support. They also highlight the power of non-medicalised interventions of which there are many options for mothers to draw upon such as hobbies, writing, reading, talking, singing, exercise, connecting with nature, meditation, or expression through art. That is, completely bypassing the systems in overdrive when post-natal depression is mentioned with their risk adverse practice, assessments, and so-called 'safeguarding'.

Dominant cultural ideologies of motherhood abate the nature of a mother's love, where women are expected to bear and raise children at the detriment to all other aspects of their lives to be deemed a 'good' mother (Park, Banchefsky & Reynolds, 2015). Femininity is then broadly defined in essential terms as associated with beliefs that women possess instincts that position them as selfless nurturers. The maternal instinct discourse assumes women's biological capacity equates to their possession of maternal instinctive abilities to carry and care for her child and regardless of any other factors and her own experience of being mothered. A mother's love is represented as effortlessly selfless, unconditional and a source of endless joy. Such assumptions are unfounded when most mothers report some type of concern related to becoming and adjusting to their mother role (Copeland &

Harbaugh, 2019). Yet it remains the case that these discourses inform society's expectations and social practices that assign and confine women as predominantly mothers over their other roles. Motherhood is something women are repeatedly told from infancy that they are made for (Beauvoir, 1908-1986, as cited in Bain 2015), which ignores the social nature and understandable reasons why motherhood can be problematic (Oakley, 1981; Nicolson, 1986). The cultural construction of the ideal mother detracts attention from social accountability and distorts the role of partners and fathers, family, friends, and community empowerment.

Pregnancy and early motherhood positions women within a vulnerable group in society mainly due to the perception that some social and psychological factors are detrimental to the foetus, infant, and child. Statistics give merit to concerns that show women are more at risk of domestic abuse during pregnancy and after birth (Callaghan, Morrison & Abdullatif, 2018). Although notably it is the abuser, not the mother, who poses a risk to the mother and baby. Positioning women as vulnerable has some potential benefits in them accessing timely support, with NICE guidance (2014) recommending fast tracking of perinatal mothers in NHS services. However, an assumption of global vulnerability rather than something context-dependent, dynamic, and situational has potential to continue the oppression of woman and mothers. Rather than acknowledging and celebrating all a woman has endured to have a baby, they become the secondary beneficiaries to the vulnerability imposed upon them, which is motivated by society's central intention to promote the baby's wellbeing and in turn dampens the value of women. Furthermore, women's position as primary carer identifies them as responsible for their child's development and when psychological or behavioural problems do develop during childhood, the blame lies with the mother, who also assume their own responsibility (Elliot et al., 2015), pregnant women are frequently denied a voice and excluded from research participation (Wild, 2012). Historically, motherhood has been objectified and starved of female subjectivity through bastions of male power such as religion, art, medicine, and psychoanalysis. Gender role stereotypes and misogyny are thought to contribute to public perceptions of mothers. For example, women who became pregnant from sexual assault in the UK were frequently blamed and there lacked a distinct perception of them as victims of a serious crime (Taylor & Shrive, 2021). Furthermore, the same study noted expectations persisted that women would be dedicated mothers even in such oppressive circumstances. Considerable judgment of women or girls occurred

whether they terminated or kept a pregnancy from rape. Yet women who chose not to be mothers are no less free from scrutiny (Turnball, Graham & Taket, 2017) revealing a dichotomy for woman's choices, including those about their own bodies that draws criticism and discrimination. In turn a no-win narrative exists within the very society that mothers yearn for more support from (Holopainen and Hakulinen, 2019). Even mothers themselves are restricted by normative diagnostic labels, for example, a study exploring mothers' accounts found they applied language such as depression, anxiety, and panic attacks to their distress (McLeish & Redshaw, 2017) and mothers who internalise representations of a 'good mother' have been shown to struggle most (Wall, 2010). Overall, patriarchal strategies infuse medical discourses and fantasises motherhood as natural, idyllic, and desirable. Historically we have lacked the language and theoretical paradigms to pursue the psychology and subjectivism of mothers.

Studies that prioritise mothers' perspectives and go some way in unpacking systemic explanations of distress have found those who did not experience practical and emotional support in their relationships linked a lack of support to their difficult feelings (Enlander, Simonds & Hanna, 2022) and increased feelings of stress (Hennekam, Syed, Ali & Dumazart, 2019). Enlander, Simons & Hanna (2022) also found relationships to be capable of reinforcing harmful social norms around motherhood, for example women reported anxiety around other mothers about whether they were doing everything right. Their fear of getting it wrong reinforced expectations around what it means to be good mother. This was not dissimilar to Mauthner's (1995) research almost thirty years prior that found mothers who experienced distress often felt isolated from other mothers. On the other hand, Enlander et al. (2022) found relationships also had potential to offer a space to debunk norms and create wider discourses about what it means to be a mother. Support groups were considered a "lifeline" by the mothers of this study and allowed them to tell their story. Further momentum is gathered in a study giving voice to disadvantaged expectant and new mothers (the majority of whom were woman of colour) that found one-to-one peer support positively affected emotional well-being (McLeish & Redshaw, 2017). The women included in this study had histories of prolific trauma including forced migration, rape, children removed from their care and the death of a child or partner. There were also significant on-going stressors including unemployment, poverty, homelessness, chronic ill health, domestic abuse, children with additional needs and unstable immigration status. Many women expressed their sense of isolation and difficult

relationships with health professionals. Women described their impression of midwives' rigid agenda of physical checks with little remit to support their emotional needs. Some mothers also talked of feeling watched and judged around their mental health by professionals rather than supported. The findings were unhelpfully conceptualised by the authors as an unwillingness to engage, portraying mothers as defiant and to blame. Nonetheless, the mothers in this study expressed several benefits of peer support, including the emotional release of being able to talk openly as well as opportunities to build confidence, feel empowered, valued, and reduce stress. This suggests it is the quality of the relationship and scope of the support available that influences how mothers perceive its benefit. It cannot be assumed that any contact with a health professional is emotionally supportive, especially when priorities around physical health are demonstrated. The connected nature of motherhood is complex, because "even though it is mainly an individual experience, it requires the collaboration and warmth of other women; mothers, sisters, cousins, colleagues, that is, women who represent both her current reality and the reference to the past" (Bydlowski, 2000 p.20 as cited in Ferrara Mori, 2015).

Matrescence engenders a position of acknowledging complexity and incorporates intersecting maternal factors such as quality of support, cultural context, personal history, trauma, adversity, loss, and experiences of feeling 'othered' (such as issues related to race, class, and sexuality). Understanding mothers' experiences within a broader context calls for a movement to widen our search for solutions, by concentrating on social support and pushing for collective efforts to dispel narratives and systemic responses. For example, a study found family therapy beneficial for mothers experiencing low mood (Cluxton-Keller & Bruce, 2018). Whilst a randomised control trial currently being conducted in China hopes to create an interaction intervention programme between new mothers' families and communities to help with low mood (Guo et al. 2023), it descends from the disempowering view that woman stay at home after childbirth and therefore need additional support systems sourcing for them, instead of demonstrating broader thinking. This highlights the journey ahead in eradicating such views embedded across cultures. One study that offers an exceptional perspective striving to normalise feelings and adjustment to new motherhood found women viewed their distress as being down to several factors sitting on a continuum of severity (Copeland & Harbaugh, 2019). The study found women's perceptions of stress related to emotional concerns with being a new

mother and managing social and environmental changes. It's particularly striking in this study how social support and relationships became a determining factor of mothers' mental health. Although circumstances and resources may not have necessarily changed drastically post-birth for many women (for example living away from family), the arrival of a baby altered their need for secure support systems and consequently became a source of disconnect and worry. The mothers recruited for this study were all of low-incomes and the majority single, which may have accentuated their sense of isolation and means to overcome it. Given that women's circumstances may not always be easily solvable, it is important to look to a wider community approach, including what messages are instilled about women's coping and distress. Motherhood may not be what women expect (Mauthner 1999; Oakley, 1979) and a recognition of despair is lacking in our cultural conversations about childbearing and motherhood with a stigma around sharing difficulties (Modak et al., 2023). Community care is especially important during early motherhood and the research is consistently showing the ways in which mothers need each other, their families and wider community. Matrescence speaks to a community movement, whether mothers are part of reciprocal support systems such as peer mentoring, volunteers, neighbourhood groups, support groups, community-based organisations, community mental health programs, communal homes, donating or advocating. Furthermore, evidence confirms the benefits of cooperative parenting (Sear, 2021), yet mothers as main caregivers within the nuclear family is still idealised in many Western societies, such as a UK. There is a need for healthcare to adopt a systemic approach moving away from locating the problem and onus within mothers to find a way to cope alone or with individual (and often medicalised) 'treatment' from a professional.

1.2 Doing it all is not a badge of honour

There are more women employed now than ever before (Office for National Statistics, ONS, 2020) yet women are three times more likely to work part-time than men (The Government Equalities Office, 2019). Despite evidence to suggest a trend where women are prioritising careers by choosing to have children later in life (Harper & Botero-Meneses, 2022), rising abortions and declining birth rates reveal the financial burden of childcare (Pregnant Then Screwed, 2022) with the UK having the third most expensive childcare system in the world (The Organisation for Economic Co-operation and Development, 2023). Furthermore, in another report, Pregnant Then Screwed (2023)

found a staggering three out of four mothers who pay for childcare say it no longer makes financial sense for them to work, painting a much bleaker picture than the one concealed by the misconstrued figures of women's emerging empowerment. There is movement developing to recognise caring work over public life and paid employment. Kate Libin, the co-founder and CEO of HeyMama, leans into the similarities between work and motherhood, "it teaches us to multitask more effectively, negotiate more creatively, communicate more clearly, perform more efficiently, and perhaps above all, manage more empathetically" (Libin 2020, as cited in Malacoff, 2020). Recognising motherhood in this way, not only validates its demands but also celebrates mothers as an asset to the workplace. Similarly, Lauren Smith Brody (2018) who is founder of The Fifth Trimester, a consultancy group that helps business support and retain parents in the US, argues that mothers are more efficient and profitable in leadership roles. However, the dominant presence of groups of men and valued forms of masculinities allows the gender leadership problem to persist (Ryan & Dickson, 2016). Extracurricular activities impel perceptions of employee desirability and preference, hence expressions of masculine sport and war metaphors saturating work and leadership discourses (McCabe & Knights, 2015). Whilst the motherhood penalty means mothers are perceived as less attractive for employment and promotion compared to non-parents (or fathers) and evidenced by the motherhood wage penalty where mothers earn almost half of their projected salaries without children in the first six years after giving birth (Vagni & Breen, 2021).

The transition to motherhood, in the case of working women, arrives with layers of combining or separating their mothering and professional selves. A study on social roles found that women's focus turns inwards during pregnancy and away from the public world of work (Smith, 1999) and those who value their careers and professional identity perceive the arrival of their baby as more problematic (Hennekam at al. 2019). Harkness et al. (2019) found women's employment status prior to birth is the most important factor influencing the probability of returning to work full-time. Women who worked in the public sector were more likely to return to work and these women were better able to maintain the same occupational grade after childbirth, but with lower chances of career progression. Sixty-nine per cent of families in the same study had a sole male earner or male breadwinner.

Hays' (1996) concept of 'intensive mothering' refers to an ideology where the 'proper' approach to raising children, as perceived by women, means unwavering dedication and

commitment to their children. Mothering methods are self-sacrificing, labour-intensive, and costly with children viewed as entitled to this investment. Mothers, who perform intensive mothering regard themselves as the core caregiver, centre themselves on their child's needs and their child rearing is unrivalled in its value. Ennis (2014) suggests one internal payoff to subscribing to such arduous demands may be the subsequent relief from the guilt of being a 'bad' mother. Child-absorbed mothers who work risk experiencing difficult feelings related to their failure to confirm to the intensive mothering ideal (Warner, 2005). For example, guilt and anxiety about leaving their child in the care of others (Gatrell, 2005). Hays (1996) acknowledged how this style of mothering limits women's opportunities and development in their careers due to the constraints of dedicating themselves to their children. One study examined the extent full-time working mothers of infants endorsed intensive mothering beliefs and found that mothers tended to reject claims around being home-based as primary caregivers (Walls et al., 2014). They instead adopted aspects that were still attainable within the context of employment, such as believing mothers are naturally nurturing. This suggests contemporary employed mothers may align their beliefs around good mothering to incorporate paid employment as another valid contribution i.e. mothers as economic co-providers. In other words, people construct accounts to explain their behaviour, even if these are not the sole motives for their actions and knowing they will be criticised (Scott & Lyman, 1986). These findings stress how working mothers do not necessarily place any less emphasis on the importance of mothering, but rather they have chosen, or are forced, to recognise the ways employment supports their pursuit as a way of coping with societal expectations. Nevertheless, moral gender ideologies maintain the link between women's workforce participation and selfishness (Damaske, 2013), so the 'no win' scenario prevails.

Furthermore, there is still likely a sacrifice for working mothers, whose stories reveal the little time they have for their own needs after channelling time outside of work for their children (Gatrell, 2005). Mothers in the study reported going to great lengths to accommodate their work and simultaneously attend to the detailed features of their children's lives. This left less time to invest in their relationship with their partner, which brought changes to romantic relationships as partners slipped in women's list of priorities. Furthermore, the birth of the first child proved the most difficult to adjust to in comparison to subsequent children. It therefore seems that women must sacrifice

something in their lives regardless of what they prioritise, and this is particularly challenging when navigating it for the first time.

Although mothers of young children are increasingly combining parenting and employment, there is little agreement on whether employment is helpful or damaging to new mothers' well-being, particularly when most research is child focused. Such studies have found the best arrangement for children's socioemotional development is when mothers work, partly because mothers are less likely to be depressed (McMunn et al., 2012). Mothers have also described work as a way of coping with depression and regaining a sense of control in their lives following a period of feeling trapped at home with their baby (Gatrell, 2005). Another study drawing on data from the American National Institute of Child and Human Development study of early childcare, found that mothers of babies and pre-schoolers who are employed part-time enjoy better health, are less likely to be depressed or conflicted about their work-life balance and more sensitive to their children (Buehler & O'Brien, 2011). Other studies have found working mothers to be eighteen percent more stressed than women with no children (Chandola et al., 2018). Mothers perform "cognitive acrobatics" to manage the reconciliation between work and living up to the good mother mandate (Johnston & Swanson, 2007, p. 447). Furthermore, women have found work compounded pressures longer-term (Gatrell, 2005). However, this does not necessarily discredit the benefit of work for mothers who invariably have different practicalities to juggle, some of which may exist regardless of whether they work.

According to latest Health and Safety Executive statistics, women experience a twenty-five per cent higher rate of work-related stress compared to men, with working mothers forty per cent more stressed than those without children (Spill, n.d.). The Priory psychiatrist, Dr Judith Mohring (n.d.), discusses in a blog how women have taken on more responsibilities at work whilst retaining their roles at home. She argues the number of women experiencing work-related stress is fifty per cent higher than for men of the same age and is thought to be down to, in part, women's commitment to traditional roles in the home as well as simultaneously achieving great careers. Although empowering to read about the enormity of what women and mothers successfully shoulder, it is surmounting evidence that a patriarchal society still exists. Furthermore, it begs the question of what women, as human beings, must sacrifice to achieve these unrelenting standards. Studies that concentrate on women's experiences of returning to work found a

perceived identity conflict between being a mother and employee reduced wellbeing (Zagefka et al., 2021). Furthermore, balancing work and family life in the early phases of returning to work is comparable to weathering a storm (Spiteri & Xuereb, 2012). One survey found one in three women find it difficult to return to work after maternity leave (Morris, 2008, as cited in Brand & Barreiro-Lucas, 2014). Their responses revealed fears about returning to work commonly related to childcare, separation issues, their ability to be a 'good' mother and fear of adversely affecting their child's development. Thirty-four percent of the women asked branded their adjustment to work difficult because they missed their child. This suggests there is both practical and emotional burdens of returning to work. Mothers tend to defend employment in novel ways to blend work with childcare responsibilities, for example, extolling the value of employment for themselves and their children (Christopher, 2012). Unlike fathers, society assumes women are 'bad' mothers if they work particularly if they enjoy successful careers (Okimoto & Heilman, 2012) and some experience discrimination in the workplace (Harris & Estevez, 2017).

Despite certain pressures, there is research to suggest there are no detrimental outcomes on the baby if the mother works (Hazan et al., 2015; Del Boca at al., 2016). According to studies, secure attachment only risks being compromised in cases where an infant is left in non-maternal care for more than sixty hours a week (Hazan et al., 2015), building a narrative for women to work, but not too much. A Harvard study (McGinn et al., 2019) that included data from the UK; found women who combine work with mothering provide a strong role model for daughters. They go on to enjoy better careers, higher pay, and more equal relationships. Whilst the study failed to show mothers' employment status having any influence on her sons' employment outcomes, they did end up spending more time caring for family members. This suggests mothers having careers goes some way to change the traditional trajectory, with the future dads of working mothers being more involved in their children's care. Whilst this is hopeful, it is also problematic to situate the issue as women's responsibility to change.

Having it all is advocated as a feasible reality by Vanderkam (2017), who accentuates the importance of time management and requirement to fit important pieces of life together like tiles in a mosaic. One of Vanderkam's specific strategies promotes malleable working hours split across day times and evenings to coincide with family schedules. She argues that our culture's gloomy fixation on the challenges obscures the wider experience of working parenthood where women obtain much fulfilment. This is akin to the

Kaleidoscope career model (Mainero & Sullivan, 2006), which describes the fluidity of women's career decisions from a relational lens. This model proposes women shift the pattern of their careers by rotating aspects of their lives to arrange roles and relationships around their current values. For example, women may begin their careers inspired but years later opt out when drawn towards a family balance and are motivated by authenticity, balance, and challenge throughout their careers. The guilt-ridden and exhausted underpaid working mothers, however, may find such depictions fallacious when comparing themselves to the women included in Vanderkam's (2017) book, who earn six-figure salaries. Lucy Powell (Powell, 2013, as cited in Watt, 2013), Manchester's first female Labour MP, also set out to champion working mothers, "we are all too often still having to choose between career and motherhood and being plagued by guilt whichever path we take. There remains a penetrable glass ceiling for working mums". Yet guilt can offer an advent of possibility for first-time mothers whereby their new responsibility (LeBeau, 2017) offers a unique opportunity to reformulate the self in relation to another (Baraitser, 2009). LeBeau (2017) found first-time mothers wanted to be the best they could by attending to their babies, but also wanted to meet their own needs. The mothers of this study found the call of their career, as one example, emerged as more than an obligation. Instead, they saw it as an opportunity to separate from their baby and achieve time for themselves, but often posed an internal struggle. Perhaps reframing guilt could empower mothers to welcome its discomfort, rather than another dysfunctional emotional experience associated with failing.

The subliminal message weaved throughout much of the literature is that combining motherhood and work becomes something mothers are getting wrong unless it is enjoyable and undemanding. Therefore, presenting a life free of angst as not only desirable, but also possible. From a counselling psychology perspective, it would be helpful to move away from such notions and maintain a curious position that allows for individual perspectives.

1.3 Therapists are human

Therapy is an impalpable term used to describe the interactive and relational process between therapist and client, grounded within a collection of divergent theoretical frameworks. According to American Psychological Association (APA, 2012, para. 3), therapists "help people of all ages live happier, healthier and more productive lives",

"apply research-based techniques to help people develop more effective habits" and describe therapy as "a collaborative treatment based on the relationship" (between client and therapist). That is, therapy is a "relational process where both therapist and client co-constitute and actively participate in the therapeutic encounter" (Judd & Wilson, 2005, p. 438). Nonetheless, therapists are no less affected by social-cultural ideas and life events, "there is no therapist and no person immune to the inherent tragedies of existence" (Yalom, 2002, p.8). The therapeutic relationship is one of the best predictors of success in therapy (Horvath & Symonds, 1991), however, few studies tell us about the relationship between therapists' personal experiences and the quality of their therapeutic work. The results of one such study does suggest clients are sensitive to their therapist's personal experience of distress (Nissen-Lie et al., 2017).

Therapists considered highly effective are those who possess well-developed interpersonal qualities that are rooted in their beliefs, attitudes, and skills, yet honed through lived experience, rather than taught (Bennett-Levy, 2006). 'Personal practice' has shown to strengthen interpersonal skills (Bennett-Levy, 2019), which is the process of reflection and incorporates three elements: personal self-reflection, therapist self-reflection and the reflective bridge in-between. That is, it is possible to enhance conceptual and technical skills when therapists can reflect on the meaning of their experience for their therapy work. Furthermore, 'personal practice' is associated with reports of reduced distress, increased self-acceptance and better self-care, seeming to benefit both therapist and client.

Workers in the human health and social work sector have the highest rate of work-related stress, depression, or anxiety (Health and Safety Executive, 2023). Psychological professionals are essential in their growing contribution to health services in the government's NHS workforce plan (BPS, 2023). Yet the paradox of a psychological workforce supporting service users and colleagues work within the same NHS system whereby staff sickness commonly relates to mental health is striking. The wellbeing of psychological therapists more specifically has been publicised in recent years and findings from a survey by the BPS, in conjunction with The New Savoy Partnership, revealed seventy percent find their jobs stressful. This especially related to feelings of isolation and lacking opportunities to talk about the emotional impact of the work on their wellbeing (Rao, 2017). Eighty percent of the respondents were female and the two dominant areas for desired change were supportive and facilitative structures and a compassionate work

culture. The survey led to the launch of Psychological Professionals Wellbeing and Resilience Charter in 2016, which promotes practitioners engaging in reflective discussions and a shared onus with employers to make the necessary adjustments to create a caring culture in the workplace. Burnout is estimated to account for thirty-seven per cent of all work-related cases of ill health, costing the NHS £2.4 billion a year from data which pre-dates the pandemic (Agha, 2018). Others had already reported a rising trend in NHS mental-health staff feeling unwell due to work-related stress with poor work-life balance resulting in staff deciding to leave their NHS posts (Johnson et al., 2017). Since then, the BPS has called the chancellor's recent Autumn Statement a missed opportunity to prioritise NHS staff mental health and wellbeing (BPS, 2023).

Vicarious traumatisation is the notion of the emotional impact of engaging with another person in an empathic relationship and a survey of over two hundred therapists in the UK found seventy per cent of therapists were at high risk (Sodeke-Gregson et al., 2013). A meta-ethnographic review (McNeillie & Rose, 2020) found working with trauma has a profound impact on therapists as traumatic material infiltrated their personal lives. Therapists acquired an altered outlook on life as well as the emotional, physiological, cognitive, and behavioural impact, which seemed to parallel the client's experience of trauma responses. Another study found exposure to traumatic material did not affect vicarious traumatisation or burnout and rather work-related stressors predicted distress (Devilly et al., 2009). Notably, this study only included quantitative data and not in-depth accounts of experiences, instead drawing conclusions from reductive measures. In addition, sixty-eight per cent of participants invited to take part declined to do so. Thus, the finding that exposure to traumatic material does not distress discounts the possibility that a proportion of those who did not come forward are traumatised workers not wanting, or unable, to partake in the sensitive subject matter. Although the study collected demographic information on whether participants were parents, the data was not included so it is unknown whether this had any bearing on findings.

Staff well-being is the biggest predictor of patient experience and staff performance (Elman & Forrest, 2007; Boorman, 2009; Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). It is widely understood in counselling psychology how "the therapist's own attachment behaviours may be activated from time to time, even if we are functioning fully in our role as professional caregivers" (Nelson, 2017, p. 48). Pope and Vasquez (2011, p. 65) state that therapists have an ethical responsibility "that requires continuous

awareness to prevent compromised performance especially during difficult or challenging periods". New mother therapists are resuming another emotionally demanding role, and therapist burnout has been known to occur when distress is left unchecked (Baker 2003; Westwood et al., 2017). BPS guidelines on 'Fitness to Practice' (BPS, 2017) emphasises the need for therapists to be aware of their psychological position before returning to practice, which is important because personal and professional domains impact and influence one other (Pipes et al., 2005). Whilst motherhood is not an issue to solve, the effects are enduring and the detail of being 'fit' is nuanced and messy. For example, the benefit of self-care in counteracting problems such chronic sleep deprivation is likely modest. Therefore, interpretations of guidelines should be with care and not in pursuit of striving for a blank slate, nor an 'us and them' mentality. For example, mental health professionals have described their personal experiences of mental health difficulties among their family members leading to feelings of incompetence (Hinshaw, 2008). As Counselling Psychologists, modelling appropriate open and reflective discussions with supervisors and colleagues can pave the way to explore individual narratives and hold reflective and compassionate spaces. More specific guidance from the BPS may also aid therapists' recognition of how personal experiences influences wishes, feelings and treatment of clients.

Bram (1995) recorded how during difficult personal circumstances, the therapist's desire to return to work may defend against their own vulnerability and be motivated by their yearning to feel competent and maintain an identity. An article in The Guardian published four therapist's reasons for seeking therapy themselves, one of which, unsurprisingly, related to their need to process personal life events (Hackman, 2017). One therapist interviewed for the article was Dr Leslie Prusnofsky, a psychiatrist and psychoanalyst, who discussed the specific obstacles when a therapist comes for therapy, including additional walls to break through and their knowledge and use of jargon having potential to hide their real problems. Another survey echoed similar findings with personal growth and distress being the two most frequently cited reasons for therapists having therapy (Daw & Joseph, 2007) with positive outcomes reported by more than 90% of therapists (Bike et al., 2009). However, there may be merit in pursuing in-depth explorations into the unique layers that may unfold for therapists in their own therapy, studies that report such ordinary phenomenon and still segregate it from other client findings, position therapists as untouched and different to their clients. Nonetheless, personal therapy may currently

be the main channel for therapists to explore their journeys to motherhood, including how it affects their therapeutic work, with many therapists opting for therapy to aid their professional development (Daw & Joseph, 2007). Although therapy with therapists should not inherently mean anything different (Hackman, 2017), the specifics and meaning for therapists are worth teasing out, particularly for personal issues that may encroach on their therapeutic work. One study, which interviewed psychoanalysts, brought to light their work's disposition to elicit triggers and stimulate personal issues (Wiseman & Shefler, 2001). One psychoanalyst included in the study described how her own therapy had been a tool to familiarise with all parts of the self, including "weak points, points of pain, or points of vulnerability" to accept them and not jeopardise client work. Another participant identified self-as-therapist and analysant-self as interchangeable. This characterises, at minimum, a two-way link between the therapist and their personal and professional selves, with the space occupied likely infringing on one another. In addition, supervision has shown to increase therapists' awareness of their personal issues (Juménez Andújar, 2002 as cited in Wheeler & Richards, 2007). Therapist wellbeing and functioning improves when supervision involves a positive alliance (Livni et al., 2012) as well as group and individual supervision providing differing forms of interaction (Akhurst & Kelly, 2006), both factors which invariably depend, in part, on the service or setting and supervisor. Wiseman & Shefler's (2001) study also probed at whether therapists would sacrifice supervision or personal therapy, and one psychotherapist described how they prioritised their own therapy during periods of personal instability. Another psychotherapist in the same study identified a parallel process, where supervisee experiences were often material for therapy. Arguably, psychoanalysts may be more inclined to study their own process compared to those orientated to other approaches, with it regarded as one of the main tools for their professional and personal development (Strupp, 1955). It would be interesting to explore whether the same processes occur across modalities, especially given the literature's focus on trainees. Some therapists may therefore utilise personal therapy above supervision even for issues arising within their professional therapeutic work, especially if the supervision is not conducive to an individual's personal and professional development.

Issues of maternal ambivalence is a popular reason for mothers to seek therapy, "conflicts concerning motherhood, often expressed as the tension between independence and dependence, between self-assertion and self-abnegation, and

between love and hate", according to Parker (1995, p. 10-11). Parker (1995) noted therapists' own sense of maternal ambivalence, relating to their own mothers and children, as well as in response to their clients. Carne (2019) reflects upon therapists' potential anxiety working with distressed mothers and issues of attuning to their emotion and pace. This may bring heightened or new issues for therapists who are simultaneously navigating her own construction of being a good-enough mother. Issues of mothering in the therapeutic arena appear dense and suggests value in therapists acquiring a capacity to lean towards their own maternal positioning.

Therapists may be particularly struck by dominant ideologies, especially if admitting their internal experience risks them being seen as both an inadequate mother and therapist, given many therapists continue to see themselves as 'experts' in the psychology of humans (Basescue, 1996). Evidently, the literature presents a skewed picture whereby client issues and experiences are preferred over the therapists own (Van Deurzen & Arnold-Baker, 2005). The myth that mental health professionals are 'fixed', trauma-free and objective people who know more about their client's life than they do is problematic. The professionalisation of services causes an elitism that can position therapists in a power dynamic where they are unable present their authentically imperfect selves in therapy. Whilst it's argued therapist self-disclosure should be relative (Patterson, 1985) it seems especially pertinent within the subject of mothering given the importance of providing social support and the ways the transition to motherhood will be revealed in therapy i.e. the therapist's pregnancy and maternity leave. Ultimately, therapists are also mothers and exposed to the same motherhood constellation as their clients.

The literature outlined suggests how movement in significant relationships has potential to unsettle anyone, but for therapists, also has potential to interfere with their framework for forming therapeutic relationships. Therapists have disclosed marital-couple distress as the top reason for seeking therapy, according to a survey (Bike et al., 2009). Given the revolution to relationships that occurs after having a baby, including the reported relationship strain, it is important therapists consider their own process as they simultaneously attend to professional and relational work. Distressed new mother are typical cases for counselling psychologists whilst they themselves may experience similar difficulties relating to motherhood or mothering. The relational aspects are also potentially exasperated for the therapist as a "wounded healer" (Jung, 1961).

Furthermore, the fact that a great deal of joy and happiness is also associated with motherhood could mean its impact on therapy as a 'crisis', is unique.

During other identity transitions such as bereavement, therapists have expressed their grief as encompassing both short-term negative effects (Antonas, 2002) and offering a resource to draw upon when working with clients' issues of grief (Dunphy & Schniering, 2009). In an article for The Guardian, Thomas (2019) acknowledges therapists' lives "…crumbling and as fragmented as those of their clients" (p. 16) and uses an example of a therapist's maternal grief interacting with their client's search for a maternal figure in therapy. Thomas pinpoints that when therapists identify too heavily with their client there is potential for therapeutic work to muddy. This is because the boundaries that offer containment and a plot for the client to project their feelings has merged with the therapist's own 'stuff'. Thomas argues the therapist needs to be as empty or blank as possible for transference and countertransference to operate effectively. However, Kegerreis (2023) disagrees and poses countertransference as a complex interrelationship unavoidably shaped by therapists' own stories. Furthermore, a self-reported wisdom derives from experiencing more of the human condition (Adams, 2014). Ultimately, therapists are also human beings who have lives outside the therapy room, and it is refreshing to consider these implications in a non-punitive and curious way.

1.4 New-mother therapists

Guy (1987, as cited in Adams, 2014) argues the significance of parenthood for therapists: "*Parenthood is an important developmental stage encountered by most psychotherapists. Its profound impact on the personal life of the therapist cannot help but have an effect on his or her practice of psychotherapy at one time or another*" (p. 23). Most studies that explore therapists' experience of motherhood are anecdotal accounts with few offering an insight into how other therapists understand their therapeutic encounters as new mothers. Anecdotal accounts reveal how mother-therapists notice shifts in transference, problems of separation and abandonment and expanding boundaries upon their return to therapeutic work (Waldman, 2003). Benedict-Montgomery (2016) described her own experience of becoming a mother-therapist, as she "frequently encountered therapeutic issues related to mothering", was "tender and vulnerable" in sessions and "more tearful and emotionally responsive" than before (p. 49). Basescu's (1996, p. 102) chapter encapsulates juxtaposition, "moments of role conflict, confusion and clash, are par for the

course, everyday occurrences for the therapist who is also a parent". She portrays the tensions of motherhood, and combined with therapy, learns the power of humans' inherent psychic resources as well as vulnerabilities when relating to others. She enunciates the requirement to, at times, "get out the way" and equally express love and connectedness with her clients and children (p. 114). Basescu (1996) discusses instances of feeling pre-occupied, fearful of short-changing her clients as well as bearing guilt for abandoning her children to uphold her professional identity. In clinical work, she articulates concerns for a parent-centric bias driving her interest, her attraction to the maternal role, and rising envy of other mothers. She draws special attention to the early months of returning to therapeutic practice when guilt, anxiety and preoccupation with her child were intense. She also recounts the strength required to tolerate feelings that could be both overwhelming and wholesome and pinpoints the on-going ways therapy and motherhood interact more widely, in both helpful and agonising ways. For example, heeding client's stories about childhood and their experience of parenting or feeling moved when seminars or discussions detail events that occurred at a similar age to one of her own children. These are all powerful illustrations that reiterate the significance and interplay between motherhood and therapy.

Whilst anecdotal accounts hold persuasive impact (de Wit et al., 2008) and shine an intimate light on how therapists may navigate their own lived experience in therapy, there are limitations. For example, relying entirely on personal testimony surrenders breadth and depth from looking at multiple accounts and valuing the similarities and disparity across cases. Most existing literature situates within a psychoanalytical terrain, concentrating on issues such as transference and countertransference. Yet this topic's relevance extends to all women and mothers, shaped by their own experiences and attachment histories regardless of therapeutic orientation.

Smith's (2018) thesis contributes to the field with a narrative study on becoming a new parent while working as mental health clinician. Participants spoke of experiencing fatigue, intense emotions, increased empathy and frequently feeling triggered in their client work. Some participants also reported lowered empathy in cases with clients who were perpetrators and adult abusers. Her inquiry encapsulated a broader timeframe than the current study, with clinicians being parents of children up to age five at the time of data collection. Lyndon's (2014) thesis attributes the challenges and internal conflict to the cultural idealisation of motherhood, which is pertinent for therapist-mothers who

occupy a maternal role for clients and their own children. This means mother-therapists may be particularly susceptible to the struggle to be good enough for both (Lyndon, 2014). Another thesis explored mother-therapists experiences of therapeutic work with mothers whose child had died (Godfrey-Djundja 2019). Mother therapists in this study found they identified with clients and the similarities between their children, which made the work challenging at times. They also reported how being a mother aided their ability to attune to and empathise with clients, whilst supervision and self-care became important when working with this client group. Interestingly, the relevance of early motherhood may be apparent to trainees who frequently conduct studies.

One similar study to this one explored the lived experience of music therapists and found therapists relayed a range of impactful features on their work (Dindoyal, 2018). Therapists provided intense accounts around the pressures of motherhood, often feeling guilty about whoever they were 'letting down'. The required emotional availability of therapists revealed challenges for the mothers trying to integrate both roles when their attention may switch from the client to their child. All mother-therapists recruited in the study reported a more urgent sense of empathy for clients and these directly related to the parallels of their own experiences. One participant described how she had developed a better appreciation of the difficulties that families face since becoming a mother. Subsequently, all participants also agreed that there was a need for firmer emotional boundaries. However, therapists also shared how they adopted a more fluid working agreement, i.e., where clients were informed regarding reasons for absence to reflect their therapist identity.

Theory on mothering is pertinent in ways that are two-fold for therapists. For example, Winnicott's (1971) hallmark of the good-enough mother involves attuning, giving voice and responding to their baby, creating a holding environment and facilitates the baby's development towards a more autonomous position. For therapists, something similar may apply to their mothering and therapeutic pursuit. Therapists themselves have likened their own personal therapy to having a 'good mother' in their therapist (Wiseman & Shefler, 2001). Therapists set similar parameters for clients to engage in the self-exploration that often takes place in therapy (Kenny, 2014). Numerous authors write about parental love, for example, for Bowlby (1988, p. 140) "the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world". Similarly, the relationship between the therapist's arousal and a

client's affect in therapy resembles caregivers soothing a crying infant (Nelson, 2017). One therapist described her own experience; "we are doing the same thing at home and at work: we are involving our self, immersing ourselves in the growth and development of other human beings" (Basescu, 1996, p. 102). Basescu also points out that while family and work roles integrate in complex ways, there are of course important differences that may clash. For example, the development tasks we face, the wide array of interactive modalities we incorporate with our children, and the boundaries of our responsibility for the other. Differences are apparent, as Macnab (1995) relays experiencing a more chaotic relationship with her children than clients, whilst Van Niel (1993) reports feeling less consumed by the dependency of clients. Moore (2008), a trainee art therapist, discusses her struggle in separating motherly feelings and frequently finding herself caught up in the countertransference. Overall, the theory and literature point to therapists navigating essentially two simultaneous pursuits of mothering, whilst being acutely aware of the important differences.

After diving deeper into the literature, it was surprising to find that few papers examine the experience of therapists through the lens of motherhood. The journey through pregnancy is preferred, probably because there are more observable physical changes that explicitly impose and affect both the therapist and client (Fenster et al., 1986). Although new-motherhood means the baby is no longer tangibly in the therapeutic space, mother-therapists have opposed this denotes the end of the intrusion (Basescu, 1996). Whilst considering their return to work, therapists' preceding therapeutic encounters are likely to have been whilst pregnant, so working with clients again after giving birth has potential to reawaken or extend these experiences. This combined with the break taken during maternity leave means a significant passage of time since therapists last connected with their former pre-motherhood therapist identity. Motherhood has potential to rouse new issues for the therapist, for example, mothers have already undergone the self-disclosure their pregnancy, observable within the therapy room. However, their later self-disclosures related to being a mother themselves or their mothering experiences would be at their discretion. Ruddle and Dilks (2015) offer a reminder of the complexities of therapist self-disclosure and point out there being few studies exploring the experience, particularly on the relationship between gender and self-disclosure (Barbeau, 2018). There is essentially not a concrete answer as to whether self-disclosure is helpful for clients, as it is a complicated and multifaceted intervention (Pinto-Coelho, Hill &

Kivlighan, 2016). However, it is worth exploring in the context of motherhood, given new mothers' particular desire for alliance by feeling understood and not judged (Small et al., 2011)

There remains a scarcity of studies that invite new mother therapists to share their stories, and this project hopes to reach broader narratives from multiple perspectives, which cannot be captured from one case study alone.

This literature review has highlighted the potential distinctiveness of becoming a mother for the first time. Whether it's associated with a harder time adjusting (i.e. Richter et al., 2019) or the specific work required to integrate self as a mother for the first time (Javadifar et al., 2016), the complexity and range of motherhood experiences directs studies to probe junctures. What's more, 'new motherhood syndrome' is a term coined to reflect the complex matrix of emotions experienced after having a baby, whilst separating this transition from the challenges faced later in parenthood (Gordon-Walker & Naughton, 2018). The term considers that regardless of whether a mother re-evaluates life, experiences turmoil or feels complete; her new life inevitably has impact, and this moment in time within motherhood is of particular interest in the present study.

1.5 Feminism and new motherhood

Motherhood and reproduction should have been central to the feminist discourse about women's rights since its onset. Whilst second wave movements did focus on women's reproductive rights whilst attempting to forage a public appreciation of motherhood, most have shied away. Liberal and radical-libertarian feminism denigrates motherhood as a bastion of women's oppression and denotes that emancipation is only achievable by denouncing motherhood. Radical feminist Shulamith Firestone (2015) articulated this plainly in her argument that women would never be free of patriarchy until they no longer hold the encumbrance of reproduction. Yet, promoting a dichotomy where woman either succumb to society's flaws and release themselves from reproduction or chose it over equality, potentially subjugates women further. These, perhaps, are disappointing claims that digress from feminist philosophy aimed at resisting the oppression of women (Mason, 2018). Furthermore, it is debatable whether rejecting reproduction would truly solve the problem of patriarchy, let alone represent what women want. Womanists, for example, have tended to move away from assuming motherhood limits women's

capabilities and instead argues that it can serve as an enhancement that challenges white patriarchal structures. Furthermore, self-defined black motherhood identity, rooted in historic memory of forced sterilisation, forges new definitions of empowerment and agency (Abdullah, 2012).

Therefore, motherhood has very much remained the unfinished business of feminism (Westervelt, 2018) and one of the issues to split movements. Historically, the feminist approach disempowers mothers, as Westervelt (2018) points out the topic appears in fewer than 3% of literature on modern gender theory despite eighty per cent of women becoming mothers in their lifetime. This reflects the complicated relationship that exists between feminism and motherhood, with an evident disconnect between the marginal representation of motherhood and the reality of most women. Despite other significant advances made for women's rights and the general improved valuing of women, mothers have not seen an equivalent movement, particularly in their paid employment. Over the last decade, mothers have called to feminism; however, those who perceive it as an encounter against essentialism often dismiss and ignore them. Some feminist theorists overlook the fact that ideas and expectations around motherhood affect all women whether they have children or not. With women without children frequently asked to explain their choices and often bear the largely unseen burden of covering maternity leave or quietly expected to compensate for the shortfall. The academic explorations of this topic therefore really prove inadequate given the complexities of integrating motherhood into all women's identities.

The birth of a mother-centred mode of feminism, 'matricentric feminism' (O'Reilly, 2019), finally arrived and offers a feminist theory that proposes maternity matters more than gender and segregates motherhood as a distinct category within feminism. This aligns with the present study's assumption that mothering matters and is at the core of the lives of women who are mothers. Furthermore, matricentric feminism serves this study's recognition of the specific social, economic, political, cultural, and psychological problems women face, embedded within their roles and identities as mothers. Mothering should be considered important work that is valued by society whilst the responsibility for mothering not resting solely on a mother's duty. O'Reilly (2019) argues that mothering and motherhood should not confused, with women's personal experiences defining mothering and the institution ensuring women remain under male control claims motherhood. In fact, a mothering freed from motherhood may offer a source of

empowerment and site of social change. The present study hopes to contribute to the important aim of motherhood studies, that is, to convey the voice of the mother, exploring dimensions of becoming and being a mother from the perspective and subjectivity of mothers themselves. That is, the belief that the topic of mothers, mothering and motherhood deserve thoughtful and continued scholarly inquiry that should sit within feminism to do it justice.

1.6 The role of Counselling Psychology

This topic is particularly pertinent to Counselling Psychology; a discipline committed to endorsing the value of subjective and intersubjective factors in the therapy process. Husserl (2012) coined the idea that our ability to empathise with others is proportional to the degree that we are ourselves are in touch with our own feelings and pain. Inter-subjectivity and its evolution and impact on therapist and client co-creates the therapeutic space (Cooper, 2004). Given the therapeutic alliance is one of the best predictors of therapeutic outcome (Ardito & Rabellino, 2011), it is pertinent to understand the therapeutic relationship as a reciprocal relational experience. This study sees the motherhood transition as normative and hopes to explore how this extends to therapists returning to a therapeutic space for the first as mothers.

The role of mothers and meaning of the maternal is active within theories of counselling psychology. Furthermore, some of counselling psychologists' main competencies rely on self-reflection and awareness. Although counselling psychology conceptually considers the therapeutic relationship as pivotal in the outcome of therapy, most studies occupy the client's perspective (Easterbrook & Meehan, 2017), with less having been explored on the therapist's side. Understanding the therapist's inter-subjectivity in more depth is important when therapists are also always negotiating a personal world and its narratives. One recent study that does tackle this phenomenon found therapists referred to awareness and wellness as two key themes in their "use of self" and some explicitly noted the inner world of the therapist interacting with the inner world of the client (Sleater & Scheiner, 2020). However, the paper includes little researcher reflexivity. This study hopes to encourage therapists to reflect on personal issues and how, if at all, they enter therapeutic work. Specifically, to encourage therapists to regularly re-evaluate their practice in the context of their personal lives. In the present study, the maternal perspective and mother-therapist's involvement is privileged.

1.7 Reflexive exploration

My interest in this area of study began after having my first child in 2016. Like many mothers of young children, my own subjective experience of motherhood informs my outlook on life. Whilst attempting to embrace my own maternal ambivalence, I uncovered a new fragility and appreciation for the human condition. Upon return to therapeutic practice, I noticed myself charged with a new emotional responsiveness, particularly stirred when met with clients who were survivors of early childhood trauma, new mothers themselves or those bringing live child-safeguarding concerns. My experience of the parallels between the roles of mother and therapist were polarised. At times, I felt my role allowed for nurturing, protection, and compassion, resonating with how I see myself as a mother. However, just as often I felt conflicted when confronted with the reality of my offer of therapeutic support to another meant depriving my own child of the very mother-infant interaction constantly referred to in the field as so crucial for healthy child development. For me, the emotional upheaval of returning to therapeutic work was just as powerful, albeit in a different way, as becoming a mother. This sparked my curiosity about whether other mother-therapists had similar or different experiences to me, and how these distinctly separate roles may overlap or collide.

1.8 Research aims

The proposed research study aims to capture rich and detailed accounts of therapists':

1. Initial experiences of returning to therapeutic practice as a mother (within 12 months of their return to work).
2. Notable changes, if any, to their experience of being a therapist in therapy and its associated relationships.

In addition, by investigating multiple cases this study seeks to gain a breadth and depth of information about the phenomena that is unobtainable within a single case. The study contributes to feminist studies through its critique of traditional ideologies of motherhood. Furthermore, it offers a trauma-informed approach, to correlate so-called 'mental health issues' with human trauma, distress, and oppression. Motherhood is rooted in potential trauma by its history in misogynistic narratives, the ordeal of childbirth and the adjustment to a new life-changing event and role. This study focuses on

the rights, well-being, journey and experiences of the mother, whilst considering the potential for variable and dynamic trauma. This acknowledges that the therapists included in this study are equally susceptible to trauma and distress themselves, in addition to the vicarious trauma from repeated exposure to distressing content and work environments. A central theme underpinning this research is to break down the facade of the 'good' mother and therapist, positioning such narratives as harmful and allowing therapists to consider their own trauma and coping mechanisms.

This study contributes to the field of counselling psychology and matrescence by placing the mother at the centre of the work. There are multiple levels that are systemic (ensuring female therapists' careers can remain intact after having a child) and personal (encouraging reflexivity). Essentially, the more therapists have use of platforms to evaluate their practice in the context of their personal lives, the more they will be able to integrate new and former identities and feel secure in their dual roles (Benedict-Montgomery, 2016). It is equally important to normalise women who feel trapped by motherhood and regret having children and we need non-judgemental spaces that allow all types of mothering experiences to arise. Essentially, how can this be offered to clients of therapists do not provide the same space for themselves.

Chapter 2: Methodology

2.1 Theoretical Principles

This project adopted an IPA approach to qualitative and experiential research. Concepts and debates from three key areas of philosophy of knowledge informs IPA: phenomenology, hermeneutics and idiography. Phenomenology is about the study of experience and concerned with the ways in which people experience their lived world. It is something personal to each of us but situated within a much wider context including our relationships to the world and others, rather than in isolation. IPA sees phenomenology as connected to hermeneutics (Smith et al. 2022), which is the theory of interpretation. That is, the researcher must partake in detective work to illuminate and understand the phenomenon. IPA acknowledges that the participant's world cannot be accessed directly, as the researcher can only make sense of the participant's experience via their own interpretation, referred to as a 'double hermeneutic': the researcher is trying to make sense of the participant trying to make sense of their world (Smith et al., 2009). During this process, the researcher aims to facilitate the participant's account and intends to represent their experiences in a way that remains 'true' to them. It equally involves viewing the data through a critical lens and asking questions to reveal meaning and the 'how' underpinning 'what' is being said. Finally, ideography is concerned with particulars, the sense of detail and depth of analysis. IPA is committed to the perspectives of how people understand experiential phenomena in a particular context.

IPA lends itself well to the field of psychology research and particularly counselling and psychotherapy research. The epistemological underpinnings as well as the position of the IPA researcher resembles a therapist being in a therapeutic encounter with a client. The focus on the person, their lived experience, and the meaning they assign to their experiences renders IPA suitable to explore phenomenon at a deeper level. IPA is brought closer to psychotherapy by the researcher entering the participants' world (walking in their shoes) with empathy whilst also holding a questioning stance and standing apart from the participant to see things from a different perspective. Good IPA should incorporate both positions of empathy and interrogative questioning (Smith et al., 2009). IPA is a method that provides a framework through which we can learn from and therapists' experience can inform our practice, professional development and encourage wider systemic support.

Epistemology refers to what researchers infer about what constitutes legitimate 'knowledge' and tackles the question of what is possible to know (Braun & Clarke, 2013). The study's epistemological stance is critical realism (Harper & Thompson, 2012), embodying the view that an independent world exists separate from our own perceptions, and that making sense of individual experience grants access to understanding phenomenon. Critical realism describes an intermediate position between positivism and social constructionism (Braun & Clarke, 2013). The social constructionist position assumes that participants' understandings of their therapeutic encounters during early motherhood develop through their own interpretation then understood within the context of their lived worlds (Willig, 2013). Ontology refers to the establishment of reality regarding our existence (Willig, 2001). A critical realist stance suggests that a reality does exist, which is independent of human perception (McEvoy & Richards, 2003) but simultaneously adopts a critical stance towards 'factual truth' and accepts that observations are fallible due to their nature of being shaped by our conceptual frameworks. By adopting a critical realist viewpoint, it is not reality itself that is socially constructed, but rather the theories about that reality and the methods utilised to investigate it (Pilgrim & Bentall, 1998). A critical realist stance complements counselling psychology's pursuit in understanding and respecting people's subjective accounts (BPS, 2021).

The present study aimed to understand how participants had subjectively experienced and made sense of their shared phenomenon of building therapeutic relationships from their new position as mothers. Therefore, analysis will be conducted from a critical realist ontology, within a broadly contextualist framework. That is, the research will embrace the participants' experiences of reality, not the reality itself. Our experiences and interpretations of the world are partial, imperfect, and open to multiple meanings (Braun & Clarke, 2013). From this position, we can unpick issues that are not initially transparent to us. Therefore, by revealing elements of the intransitive dimension, opportunities emerge to appreciate how becoming a mother affects therapeutic practice for different therapists. Accepting that participants give the best account of their experience, as they are able, from their perspective. Access to 'experience' is both partial and complex (Smith, 1996). That is, both participant and researcher co-construct the portrayed participant's account.

2.2 Research Design and Project Development

This study employed a qualitative approach for its compatibility with the study's aims of exploring individual experiences and meaning making (Braun & Clarke, 2013). A quantitative approach did not suit this study's appreciation of in-depth accounts, which required the analysis of words and not reducible to numbers. Furthermore, there are few quantitative measures available, one being The Psychologist and Counsellor Self-Efficacy Scale (PCES; Watt et al., 2018), which captures the therapists' self-reported confidence in different competences and doesn't target the occurrence of any change in these areas following life transitions, so would need to be administered before and after having a baby. With a scarcity of psychological research in this area, it would have been restrictive to take the position of the objective (unbiased) scientist with a throughput of reports and measures. A qualitative approach gives opportunity to hear voices and understand patterns of meaning, providing a richer understanding of a virtually unexplored topic. Essentially, qualitative research has the means to depict the complexity, messiness and contradiction that characterises the real world of motherhood, especially in an under-explored topic.

In the early stages of this project, Interpretative Phenomenological Analysis (IPA; Smith et al., 2009) and Thematic Analysis (TA; Braun & Clarke, 2006) were considered, due to the overlap in what they can deliver. In other words, there is potential for great similarity in the 'output' from these two pattern-based methodologies and as Braun and Clarke (2021) point out with the "hallowed method" (p. 37), researchers often imagine one analytical approach existing that is ideally suited to a particular research project. For this study, there was a process of comparing the similarities and differences between IPA and TA to ascertain which across-case approach would be better suited. IPA complemented this study's focus on examining human lived experience and TA being apt to centre on the analysis of patterns of meaning across the cases. Nonetheless, the fundamentals of this study are phenomenological, focusing on 'individual' as they stand within their world of things and relationships. This research wanted to explore personal perspectives in depth before moving to claims that are more general and so characterises the ideographic focus found within IPA. IPA is well suited to the experience led focus of this study and its appreciation for persons-in-context (i.e., motherhood).

The procedural recommendations for generating in-depth data, by using small, homogenous purposive samples and semi-structured interviews lends itself well to the

population whose personal experiences are being studied (e.g. Smith et al., 2009; Smith & Osborn, 2007; Spiers & Riley, 2019). The topic under investigation ensured a homogeneous sample as all participants needed to be first-time mothers to a child under two and working as a psychological therapist. Controversially, trained clinical psychologists are reported by the British Psychology Society (BPS) as predominantly white, female (BPS, 2016) and likely to be middle-class (Friedman & Laurison, 2019), meaning the current study would likely recruit an undiversified sample. Another distinctive feature of IPA is its commitment to a detailed interpretative account of the cases which can realistically only be fulfilled with a small sample, therefore sacrificing breadth for depth. This complemented the similar characteristics of participants that was required for this study, to tap into the experiences of the participants in a particular moment in time. IPA is a useful methodology in exploring subjects that are complex and emotionally laden (Smith & Osborn, 2015). Motherhood is a prime exemplar of such a phenomenon; involving multiple fundamental changes that are difficult to articulate (Mayor, 2017). The aims remain true to phenomenology and positions motherhood as an 'ordinary' everyday experience that becomes 'an experience' of importance as the mother reflects on the significance of what has happened. That is, with an embodied, cognitive, affective, and existential focus. This is less the case in TA, unaligned to one theoretical position and able to adopt a more flexible approach across various data sets. IPA's requirement for rich data lends itself well to the in-depth and thorough account of therapists' experiences, in a non-directive way and with a focus on identity (Smith et al., 2009). Overall, it then makes sense to use IPA over TA, due to its constituency with the epistemological position of the research question for this study.

2.3 Recruitment and Data Collection

2.3.1 Recruitment

Recruiting online and utilising social media provided a way of reaching the target population and enabled a more geographically diverse population to participate (Gelinas et al., 2017). The study employed a purposive sampling method by posting a research advert (Appendix B) on the Parenting and Clinical Psychology Facebook group. It also involved snowball sampling, whereby participants shared the research advert with others who might be able to take part. The researcher knew four participants in a professional capacity; however, recruitment to the study was via the protocols outlined. Recruitment

of six participants reached the depth required in IPA, the two participants unknown to the researcher made contact via social media.

The inclusion criteria for this study were first-time mothers who were qualified or trainee psychological therapists currently offering therapy as part of their role after maternity leave. They needed to have returned to work within the last twelve months and their child be under the age of two at the time of the interview, to capture woman's experiences as they were happening. It was, however, not practical to interview therapists any earlier in motherhood due to maternity leave often lasting up to twelve months. Although it was not a requirement, all participants who took part were biological mothers after a natural conception.

2.3.2 Data collection via face-to-face and online interviews

A key aim of this study was to gather rich data directly from participants, resulting in a singular method of data collection through semi-structured interviews. In IPA semi-structured interviews are the exemplary means of data generation adopting a phenomenological approach to interviews that seek to elicit "detailed stories, thoughts and feelings" (Smith et al., 2009, p.57) related to a particular life event. A semi-structured interview schedule (Appendix C) was created following engagement with the current body of qualitative literature available. Despite the schedule, participants were considered the expert, with the researcher following their lead and using the schedule as a prompt. The first phase of questions aimed to provide participants with an opportunity to reconnect with their experience of pregnancy, birth, and initial period with their new-born baby. The hope was that this would orientate participants to their transition, by inviting them to 'set the scene'. It also provided context and a broader narrative of participants' experiences of their transition so links could be made. Questions followed on in a chronological order and focused on participants' experience of their subsequent maternity leave, relationships, and ultimately their return to work. At the end of the interview participants were also invited to share anything they considered important that hadn't been covered by the questions asked. All participants produced powerful accounts that illustrated their unique narrative and often participants covered some of the questions within their narrative without having to be asked directly. The researcher disclosed 'insider' status on the research advert, in the hope it would build rapport and enable participants to be open and feel understood (Millward, 2006). This can potentially

enhance the interview process, as has occurred within the therapeutic relationship and treatment outcomes (Hodges et al., 2010). However, because personal disclosure of shared experience can also have the undesired effect by creating competitive or comparative dynamics (for example, wanting to be perceived as a 'good mother' and/or competent therapist), this was not elaborated on during interview.

No notes were taken during interviews to preserve full interviewer engagement in the participant interaction, but field notes were made immediately after as well as in-depth entries in a reflective journal. Interview duration was between forty-five and seventy minutes. It was an important ethical consideration to give the choice of venue to participants for in person interviews to conjure feelings of safety and autonomy. The one interview conducted face-to-face took place at the participant's private practice.

The importance of interviewing skills is emphasised by Smith (2011) who argues that the researcher's competence is key in collecting high quality data. It is a privileged position to hear and share people's stories and researchers have a duty to create safe environments for participants (Silverio et al., 2022). The interview schedule for this study consisted of seven questions and some additional prompts (see Appendix D). Participants were reminded verbally at the start of the interview that they only need share details they felt comfortable to and could pass any questions. This felt especially important to reiterate when some participants were known to the researcher and given that some questions, for example, regarding childbirth may bring up trauma. Several participants noted at the end of the interview how cathartic a process it had been. The first interview, which was the only one conducted face-to-face was intended to be a pilot interview, however, this interview generated in-depth data and so the decision was made to include this in the study.

One interview took place face-to-face and the remaining five were conducted online via Zoom. Using an online platform enabled the researcher to reach participants who met the eligibility criteria from further afield. Additionally, it meant interviews could still go ahead during the global pandemic COVID-19 and offered a flexible option for new working mothers with a young child. Telephone interviews were not offered to avoid losing non-verbal information (Block & Erskine, 2012) especially when maintaining the anonymity of participants from the interviewer was not necessary.

2.4 Participants

Participation for the interviews in this study were invited from psychological therapists who had returned to work within the last twelve months after having their first baby. Given the small sample size needed to reach the depth required of IPA, a total of six participants were recruited.

2.4.1 Participant demographics

A total of six participants engaged in a single interview (Face to face n = 1, Zoom n = 5).

Table 1 - Participant demographics

Participant (pseudo-name)	Age	Ethnicity	Age of baby	Marital status	Qualification	Setting
Maddy	35	White other	5 months	Married	Counselling Psychologist	Private practice
Penelope	32	Indian	18 months	Married	Clinical Psychologist	Child and Adolescent Mental Health (CAMHS) NHS
Michelle	41	White German	23 months	Married	Clinical Psychologist	Psycho-sexual NHS
Zara	35	White British	7 months	Married	Trainee Counselling Psychologist	University & placement(s)
Jessica	33	Mixed – white British & black Caribbean	20 months	Married	Clinical Psychologist	Early Intervention for psychosis (EI) NHS
Lauren	35	White British	18 months	Married	Clinical Psychologist	Intensive Service and Mental Health Liaison NHS

All participants were female aged between 32 and 41 with none identifying as having a disability. All women were in a heterosexual relationship.

2.4.2 COVID-19 impact

Most data (n = 5) were collected during the COVID-19 pandemic and subsequent lockdown between March and September 2020. Fortunately, participants' familiarisation with using online platforms at this time meant having professional and personal

discussions online was not unusual. Conducting interviews online also mitigated against common geographical and temporal barriers to participant uptake.

2.5 Ethical Considerations

Ethical approval for this study was granted from the University of the West of England, Faculty Research Ethics Committee (FREC REF No: HAS.19.10.037) before commencing data collection. The study adhered to the principles of the British Psychology Society's (BPS) Code of Ethics and Conduct (BPS, 2006) and Health & Care Professions Council's standards of proficiency (HCPC, 2023) to ensure sound ethical conduct. A participant information sheet (see Appendix D) and written consent form (Appendix E) were provided so that the participants were made aware of the procedure regarding how the data would be used; namely anonymity and exclusion of identifying details. Written and verbal information stated participation was entirely voluntary, and participants could terminate the interview at any time without explanation. Also, information on sources of support were provided on the participant debrief information (Appendix F), which was given to participants at the end of the interview. The limits around withdrawing from the research were also explained, with participants encouraged to contact the researcher within one week of their interview if they decided to withdraw their data.

There are several ethical considerations for the present study. Firstly, confidentiality is more problematic when participants are members of a relatively small community, and if multiple therapists chose to participate from one service, then it is possible that they may be able to identify each other's material. To combat this, I intend to achieve the highest level of anonymity possible without surrendering the meaning of any data and have been explicit about confidentiality's limitations on the participant information sheet. Secondly, because data collection is from those who work in the field the study is situated in, there is an increased likelihood that participants will seek out and read the write-up, so it is especially important to stay faithful to the data. To remain transparent, careful consideration has been given to the information provided to participants. Reflexivity is also incorporated to acknowledge such issues and the researcher's interpretative position. Four participants were known to the researcher as an insider-acquaintance in a professional capacity, however, there were no active dual relationships at the time of interviews. Nevertheless, this required careful consideration to ensure ethical conduct. Whilst a prior relationship with participants may be a useful resource to build rapport and

help researchers achieve an emotionally rich relationship, it may equally pose potential risks that require researcher self-care (Owton & Allen-Collinson, 2014). Additionally, studies have found participants frequently shift between their different positions within their institutional, professional and personal worlds during acquaintance interviews (Roiha & Iikkanen, 2022). Special attention must therefore be paid to anonymise the participants and not disclose any divulging background information. There is also an increased need for researcher reflexivity (Garton & Copland, 2010), as the researcher will be privy to contextual information that an outsider interview would not.

2.5.1 Data Protection

In line with General Data Protection Regulation and the Data Protection Act (GDPR 2018), any identifiable information was anonymised prior to analysis. This included the use of pseudonyms. The supervisory team and any external examiners (if requested) will have access to anonymised transcripts only. Data will be destroyed after the final award is conferred. A General Data Protection Regulation (GDPR) privacy notice is included with the participant information provided (Appendix G).

2.6 Analytical procedure

IPA is a widely used approach in counselling and psychotherapy research and comprises well-developed methodological guidance (McLeod, 2011). Smith et al.'s (2022) seven steps formed a guide, with the consideration that it is not intended to provide a prescriptive account nor single 'method' for working with the data.

Table 2 – IPA process based on the steps outlined by Smith et al. (2022)

Step	Process
Step 1 – Starting with the first case: reading and re-reading	Immersing oneself in the data – reading and re-reading the first interview transcripts
Step 2 – Exploratory noting	Noting initial impressions or insights within the transcripts, examining semantic content and language use
Step 3 – Constructing experiential statements	Consolidating and crystallising thoughts, articulating the most important features of the exploratory notes

Step 4 – Searching for connections across experiential statements	Mapping out how experiential statements fit together, by cutting out each statement and placing them on a large surface before experimenting with interconnections
Step 5 – Naming the personal experiential themes (PETS) and consolidating and organising them in a table	Creating a title to describe the characteristics of each cluster of statements to create PETs then present these in a table
Step 6 – Continuing the individual analysis of other cases	Repeating steps 1-5 with the other five transcripts
Step 7 - Working with personal experiential themes to develop group experiential themes across cases	Look for patterns of similarity and difference across the PETs – highlighting shared and unique features

The transcript format included three columns; the first being for emergent themes, the script itself sits in the second with the third for exploratory comments. Any initial particularly interesting exerts or related entities from the interview were colour coded in the original transcript column. Please see Appendix H for a sample of an annotated transcript.

The commentary was detailed and allowed for exploration of interpretations of what the participant had said. Experiential statements were then drawn, based on the interpretations arisen within the exploratory comments. All transcripts were processed through each step before progressing to the next, which varies from the outline above (i.e. omission of step 6); a preference of the researcher by enabling immersion in each step. Once all the experiential themes were generated, connections were sought across each transcript. This involved cutting out each statement and randomly distributing them on a large surface so different connections could be explored. See appendices H and I for examples of the initial scattering and final clustering of experiential statements respectively. Once a structure captured all the most interesting and important aspects relevant to the research aims, any leftover statements were discarded. A title was given to each cluster of experiential statements to describe its main attributes, and these were organised in a table of Personal Experiential Themes (PETs) for each participant. It became increasingly challenging as I progressed through the analysis to not be influenced by experiential themes from other participants. I found listening to the audio recordings again at this stage helped me to connect with that participant's individual story.

The final part of the analysis involved reviewing each table of personal experiential themes and using printed tables for each participant, which were then cut up to start

identifying idiosyncratic differences, similarities, connections and familiar patterns among all participants to form a set of Group Experiential Themes (GETs). This was not to gather a 'group norm' or 'average' but rather an attempt to highlight the shared and unique features of experience. Some group themes emerged quickly and were apparent from the outset. Others required deeper consideration and a more creative approach. Overall, I chose group experiential themes that I felt best addressed the research aims, contributed with meaningful ways of looking at the topic and felt most compelling after engaging with the participants and the data. One of the biggest challenges was condensing the data because everything participants shared felt important. Before reaching my final group experiential themes I ensured the process up until then had been efficient as possible by going back to earlier cases again and I reconsidered the personal experiential themes whilst keeping in mind themes that had developed since.

As I started to write up my results, I continued to revise themes, their titles and moved quotes to see where they worked best. Various revisions of the findings were made as I gathered feedback from my supervisors, and I took breaks from the analysis to help me revisit the data with a fresh perspective. Overall, the entire process involved much movement back and forth, mess, experimentation and considerable time before reaching the ultimate formation.

Chapter 3: Reflexivity

A fundamental component of IPA is the researcher's interpretative position. It is therefore an essential requirement that these positions are critically reflected upon and acknowledge by the researcher throughout the analytic process, as these too can provide further lines of enquiry and enhance the data analysis (Braun & Clarke, 2013). This process is also relevant to the profession of counselling psychology, which emphasises the development of reflexivity in understanding. Therefore, this section aims to make explicit the researcher's role in the production and analysis of data in this project.

3.1 Researcher positioning

In interpretivist research the person conducting the research takes a central role in interpretation and my position, as another human being, affects the nature of the interpretations that I make. Inspiration for this project originated from my own experience returning to therapeutic practice after becoming a mum for the first time. I was already aware of my general increased emotional sensitivity, but was struck by how different, emotionally, it was to relate to clients and hear clients' stories in therapy. I was interested professionally if other therapists experience changes within their transition too, and what sense could be made of it among a wider pool of therapists. I am aware that this research may partly be a bid to make sense and process my own experience of motherhood, but with the assumption that it would be relevant for other therapists too. The changes I noticed seemed important in terms of both professional development and the therapeutic relationship, but also supervisory relationships and support. Supporting colleagues and teams being another personal passion.

Throughout this research I have acknowledged my personal motivation and connection to the research project and attempted to utilise this awareness as a tool to ensure I remain open to hearing others' experiences of being mothers and therapists. I did not hope nor expect to find participants' experiences like my own and entered this project from a place of curiosity. Considering the subject matter through not only a therapist lens, but more broadly as a new-mother and human being whilst engaging in the wider reading has also helped me embrace the nuance, complexity, and messiness of mothers' stories. No two accounts of new motherhood will be the same, despite a dominant discourse that characterises the new-mother transition as a biological and 'natural' one (Miller, 2007). I

also participated in supervision and personal therapy throughout this project where I examined my own feelings and responses, shedding further light on my own process during my interpretative role.

I was also aware that my experience of notable change may have positioned me towards evaluating others experience through a similar perspective. I deliberately asked neutral questions that did not infer an occurrence of change and instead hoped to provide participants with an open forum to describe their experience, as it was for them. It is also important to note that I am deemed an 'insider' on multiple levels, being a (relatively) new-mother female therapist and my first child being under the age of two when the project started. This evolved as time went on and my child grew, and I eventually conceived and had my second baby. It is also important to highlight that I am a white, cis-gender woman and my own family structure involves being one of two un-married parents in a heterosexual relationship living with their biological children. This will mean I have a particular experience of the world that will have impacted the data and analysis generated (Heidegger, 1962; Braun & Clarke, 2013).

3.2 The research process

Researching this topic has been personally challenging. Initially, finding participants who met the eligibility criteria was difficult, and the initial search for Counselling Psychologists alone was aborted. Instead, the criteria expanded to include other therapists of varying backgrounds (subjected to a holding a reputable qualification) as well as trainees and hence recruiting participants known to the researcher. This was in part, likely a result of the persisting specificity of the participants sought as well as the practicalities involved with being a new mother back at work.

Unforeseen personal circumstances arose and stifled engagement with the subject matter. Whilst trying to conceive my second baby I suffered two miscarriages within the period of data collection and transcription. At this stage of the project there was a requirement to involve myself with other new mothers who had recently had a baby, two of whom were currently pregnant again and hearing participants' stories of pregnancy, and on occasions, loss too. This was a lot, and in fact too much to engage with, at a time of going through something so pertinent. It is something that's gradually become easier as I reconnected with the project again after having my second child. The process

involved having to face the difficultly and one that I did not chose, and instead, try to find a way to position myself within in it rather than continuing to lose myself in the world, what Heidegger called 'falling' (Heidegger, 1996, as cited in Willig, 2009). Keeping a reflective journal was even more important at this point and helped me to process my own responses, thoughts, and emotions during my immersion in such emotive data upon my return. Undoubtedly my own experience will have impacted my interpretations, but writing helped me to see what my meaning was and what belonged to participants. Writing about my experience also served as a reminder that while I could not change my circumstances, I could relate to them in different ways.

Chapter 4: Analysis

Table 3: *Summary of Group Experiential Themes and Subthemes*

Group experiential theme	Subthemes
4.1 Seeing the baby in therapy	4.1.1 It is not my baby, but that is my baby. They are all *our* babies.
	4.1.2 If we do not stand up for children, then we don't stand for much
4.2 I used to…but now I can't	4.2.1 Highly sensitive
	4.2.2. Seeking emotional safety
4.3 Integrating self as mother and therapist	4.3.1 Redefining boundaries
	4.3.2 It is insurmountable
	4.3.3 Growth and development
	4.3.4 Being a therapist is something special

4.1 Seeing the baby in therapy

An important feature of the participants' descriptions of their return to therapy was their particular emphasis on 'seeing' their babies. Participants found that being a mother meant they often experienced working with clinical cases that resonated deeply with their feelings towards their own babies. Some expressed a preoccupation with not only *their* babies, but babies and children more broadly. In fact, for some, their concern extended to the reminisced child, now superseded by their adult self (i.e., the client's inner child or childhood memory). All but one participant described emotional sensitivities due to being a mother and the 'holding' of their baby that, at some point, within their professional role has been overwhelming or difficult to bear.

4.1.1 It's not my baby, but that's my baby. They are all *our* babies

Two participants described the disturbing nature of attending to issues related to child abuse in therapy as mothers. For example, Michelle said:

> *It's somehow harder when you're a parent and like I think about my relationship I have with my son and I think oh gosh what sort of lack of support and resilience etc. they have to have themselves to be able to do those sorts of things to children you know? (p. 28)*

Michelle referred to her bond with her baby and the difficulty this caused her as a therapist in being able to comprehend how perpetrators abuse children. She vented her

confusion and disbelief and felt inhibited from understanding this type of human behaviour. It bothered Michelle, not only because of the distress the topic caused her, but because her inability to formulate the behaviour conflicted with her professional competency. This posed wider questions as her prior beliefs about human behaviour and motives crumbled. Michelle's emotional attachment with her baby heightened how attuned she felt to other children, and this meant she effortlessly imagined the harm caused by abuse. Therefore, an amplified emotional response affected the typical course therapy. When describing a conversation after seeing a news story during maternity leave, Penelope echoed a similar realisation:

> *How could anyone do that to a baby and I just really struggled to get my head round it even though I'd worked with abused and neglected children for however many years I think that was the first time it ever kind of hit home that I've had that newborn in my arms, I've had that baby smiling up at me and how could anyone do that to their child? (p. 30)*

Again, something became entirely incomprehensible about someone harming a baby, which unsettled and worried Penelope. She specifically noted her baby's efforts to connect (by smiling), which signalled a reciprocal relationship between them. She metaphorically held her smiling baby whilst processing information related to abuse, which left her emotionally charged, despite frequent exposure to these ordinary issues of the past. Penelope's experiences of mothering afforded her with a recognition of babies as individuals who cannot be dehumanised. She subsequently adopted an awareness of the infant's perspective, which situated abuse as implausible. However, neither Penelope nor Michelle attempted to deny the prevalence of abuse in response but expressed their sensitivity to this issue. Lauren conveyed a similar mutuality:

> *I've got a little person here you have very much a visual of what a one-year-old is like or whatever though he's not there yet what he might like at four or whatever and that fierce protective instinct (p. 16)*

Lauren cherished her image of her young son, and she was aware of his presence when she heard about child abuse. It was as if combining her familiarity with her own baby and protective instinct equipped her with a responsive gauge for infant safety and wellbeing. This seemed to be the by-product of the interplay between mind, body and brain. Jessica also illustrated her empathy:

It comes to child abuse those are the things that really I just feel like there's just this huge element of me that screams that shouldn't have happened, that should not have happened to you, you should not have been treated that way (p. 28)

Jessica's repetition encapsulated an instinctive drive to treasure babies and children, and she described how an integral part of her is outraged when she hears something so awful. Penelope also described a sense of righteous anger:

So feeling really angry on behalf of some people or feeling really upset for people when they tell me their stories umm that sense of justice I think gets me quite a lot about when kids come in and they've just had a really rubbish hand dealt to them but they've not got people looking out for them that really kind of gets to me (p. 28)

Here, Penelope expressed her anger in response to injustice, on behalf of her clients. She pointed out her horror when children lacked protective others, as she considered this a core task of mothering. She described the emotional impact of having to face the experiences of children in therapy and simultaneously realised the pervasiveness of violence against children and therefore the risk to her own child. She considered children as another oppressed group.

4.1.2 If we don't stand up for children, then we don't stand for much

Penelope articulated how her value and identity as a psychologist (and as a human being) is rooted in activism and ability to safeguard children:

Since I've come back to work I think those feelings come up straight away when there's any kind of hint of risk or when there's any kind of alarm bell that goes off it's not a quiet thing anymore it kind of dings away and I've got to ask the questions to make sure is this young person safe and what do I need to find out, what information do I need to get umm and just doing that really proactively rather than thinking oh well it might be okay and they'll tell me more when their ready. I think now it's just a case of I can't cope with if I was someone who held up that process (p. 30)

Penelope described an instinctive pursuit to protect children. She was armed with a pro-active stance governed by her worry and concern, as she explained how safeguarding

children moved to the forefront of her mind. Similarly, Jessica spoke about being "vigilant". Whilst she described home visits to service users, Lauren expressed benefitting from a similar faculty:

> *Now if I go round to someone's house and there's an 18-month-old that is seeming that sort of disconnected, self-dependent, I'd be, it would ring more alarm bells and I think. I'm much more, I worry a bit more about safeguarding now, umm so there's, I pay more attention to it (p. 21)*

The infant or child took precedence within Lauren's account. Even though she talked about visits to adult clients, her attention fixed on any associated children in the home, and she appeared to view adult's distress primarily through the child's eyes. Lauren went on to explain how it was not only shocking cases she noticed:

> *I think I'm more sensitive to it like you know they might not be sexually abusing them or beating them or something, but you know the impact on those children to have a mother that's sobbing (p. 20)*

Lauren articulated how attuned she had become to children's needs and identified nuanced signals for potential suffering:

> *I never needed to connect with the abuse of the victims necessarily, I just had to connect with the person and what they'd been through but now I can't help but connect it because I've got a little person here (p. 16)*

Here, Lauren talked about being propelled into her acquired new empathy for victims of abuse and explicitly associated this with her son. Furthermore, Jessica communicated her effort to separate or 'push out' her motherhood (and baby) from therapy. For example:

> *I try very hard to kind of create that brick wall between the thought of that happening to that person and how that must have felt and what experience they had versus you know the idea of that ever happening to my son (p. 29)*

Jessica used the metaphor of a brick wall to reflect her fierce endeavour to keep her son out of mind and as if she was exasperated from it. Becoming a mother had distracted her empathy away from the client's story and towards the fantasy of it happening to her own child. Both Jessica and Lauren shared a similar visual of their child as a 'third' person in therapy. So, from these mothers, we heard their distress when they could not help but imagine what they heard in therapy happening to their own babies. They described

gaining an embodied sense of a baby's vulnerability and sourced a special attention to protect them, even if they were not directly working with the (present-day) child in therapy.

Zara, on the other hand, shared something different. She was the only participant still training, and although described how she slipped into a more maternal role with clients, was instead afforded a new emotional freedom:

> *I'm just being there with them and yeah I think I feel a lot more, it sounds awful to say it, but I feel more complete and whole and grounded now I've had him' (p. 15)*

Rather than the indignation other participants expressed, Zara portrayed a calmer and grounding occurrence. She explained this being after so long of really wanting a baby and feeling incomplete. It seemed the process of finally becoming a mother allowed her to come into her own. She acknowledged how her baby (and the client) became her focus:

> *You're caring for another human who becomes the centre of everything, that probably has fed into how I approach clients (p. 16)*

Zara talked about her life revolving around her baby and given the immensity, extended to her therapeutic approach too. This seemed to manifest in her becoming "more present for them emotionally, but I'm not responding to them in an emotional way". It is possible that Zara's shift in being more present for clients also coincided with her progression through training and acquired competence. Furthermore, she may have worked with different client groups or presentations to the qualified participants, so may have had less exposure to triggering issues, such as child abuse. Nonetheless, Zara described something distinct from the other participants, that she no longer saw herself as emotionally fragile:

> *I've always struggled with over-empathising so if a client gets emotional I may get a bit teary and umm sort taking stuff on from clients (p. 19)*

Here, Zara recalled her emotionality in sessions prior to motherhood and used the terms "struggled" and "over-empathising" to signal her perception of this as detrimental. This is at contrast with the emergence of a new capacity as a mother, as she noticed herself "being more relational to just be alongside someone in the room". Maddy also described something similar:

Before I went on maternity leave I felt I was either mothering clients to some extent or I was their sibling in one way or another. Whereas now I feel more rational than any other time of my training (p. 11)

Maddy had created a healthier distance between herself and her clients. This is in the context of her description of clients as "my world" before the arrival of her baby.

4.2 I used to…but now I can't

Several participants expressed a new fragility to their wellbeing that was intrinsically linked to becoming a mother and the concomitant development of a special attachment with their own baby. Therapists expressed various strategies they had adopted to protect themselves from the potential trauma of combining motherhood with therapy. This was often conceptualised as a new concern that was typically not apparent before motherhood and was accompanied by an additional motive to take care of themselves to fulfil mothering.

4.2.1 Highly sensitive

Most participants reported an increased empathic engagement with clients. Whilst describing her first clinical experiences as a mum with cancer patients (an area she'd previously considered a specialism), Michelle remembered her struggle:

I had to deal with some parents who were going to die umm soon about how to tell their small children and that coming back straight from mat leave was just awful (p. 29)

It's as if her therapeutic involvement with the children meant Michelle was also subjected to something horrific and akin to the heartbreak of the parents (her clients). Michelle then described the lasting effect:

I still think about that and still think about her children and you know I guess you always, I think when you work in this field have certain families or people who just stay with you for whatever reason, but I think it was more extreme and more related of becoming a mum (p. 30)

Michelle described this as not just a 'typical' therapist experience, but one that pushed her to her limit as a new mother. There's an aura of vicarious trauma from an experience

which “felt emotionally so tough, like I would take those things home and really you know not, not be able to put them to rest so easily”. Michelle went on to express the emotional toll this work had on her wellbeing:

> *Things like trauma, birth trauma in particular, neglect in childhood in particular, you know, there are certain things now that definitely trigger my buttons more than they were beforehand (p. 26)*

Here, Michelle stated that the commencement of this emotional sensitivity is as a new mother, and reflected upon how this is different to before. It seemed important to her to refer to the specific issues that elicited this response too, and address that it’s not just a generic emotionality. Her use of the trauma-associated term “trigger”, particularly as a therapist, may again suggest some vicarious traumatisation. Interestingly, Jessica described her experience using the same word:

> *I would never be triggered so easily you know people say in the early stages of pregnancy you start crying at an advert, I feel as though that’s kind of stayed with me really ever since I got pregnant, that I get very tearful or emotional or things really trigger me very easily (p. 28)*

Both accounts conjured a sense of the therapists’ emotional sensitivity as new mothers. Jessica pointed to her vulnerability when she referred to it being, for her, an extension of the widely recognised emotional changes in pregnancy. She recognised her vulnerability throughout her interview:

> *There’s definitely been times over the last you know 6 months or so where I’ve had to really check in with myself (p. 28)*

Jessica realised a need to look out for problems occurring within herself upon her return to work. Lauren described an awareness of her emotional capacity outside of therapy:

> *It’s pretty easy to set me off and I and I definitely lost tolerance for watching, do you know it’s really weird umm I thought about this the other day, I just can’t watch anything scary anymore umm and it just feels more about like emotional arousal* (p. 19)

The intensity and ignition of emotion led Lauren to feel full and unwilling to expose herself to avoidable emotive (in this case scary) material. As she delved further into the aspect of emotional arousal, Michelle considered its effectiveness:

> *I sort of feel like in some situations it might make you a better therapist because it means that I have an emotional sensitivity now that I didn't have before but in other situations it might hinder it potentially (p. 33)*

Here, her empathy was delineated as a distinct change, but was less straightforward to assess its usefulness and comprised both advantages and disadvantages. It appeared participants observed their own vulnerabilities as therapists and those of their baby during their initial return to work.

4.2.2 Finding emotional safety

Motherhood meant therapeutic work became a challenge for some participants who shared a realisation that they needed to psychologically protect themselves in therapy. This materialised in several different ways; some therapists noticed changes in the issues and clients they felt comfortable to work with as new mothers. One participant, Cynthia, recognised a link between their own wellbeing and mothering:

> *There is something about keeping myself safe because the baby will pick up on my emotional state (p. 11)*

It seemed she feared losing connection with her baby if she submerged herself in the client's material too deeply and is another reoccurring, yet more implicit, prioritisation of the baby within therapy. Jessica spoke more about the dilemma she faced in balancing the tension between empathising with clients and protecting her own wellbeing and relationship with her son:

> *A constant battle of this kind of like allowing myself to immerse myself in this person's experience to really try and put myself in their shoes to understand their story and the filter they have on the world versus not allowing that, to implicate you know, me, my emotions towards my son (p. 29)*

Since motherhood, therapy had the power to affect her own wellbeing and was linked to the quality of relationship with her baby. These therapists expressed how they were trying to find a new equilibrium between their responsibility to clients and their maternal role.

The emergence of a different capacity for therapists seemed to be a direct result of the increased empathic engagement already described. For example, Maddy distanced herself from perinatal issues with clients:

> *I used to specialise in working with people with pregnancy related issues and I can't . . . I feel that I cannot deal with stillborn issues or miscarriages and things like that (p. 18)*

Maddy expressed feeling unable to support people with pregnancy-related issues as a new mother herself, despite this an area she previously considered a specialism. She avoided these issues, which became clear when she talked about reviewing her website and she "decided to take it off". This signalled the emotion that surrounded these issues. Lauren described a change that she addressed in supervision:

> *I'd always been able to separate those two things like there's the perpetrator and there's the victim and my work is with the perpetrator, so I've been able to do that and I wasn't able to do that anymore (p. 18)*

Lauren communicated how her therapy process changed due to being unable to separate perpetrators from their victims any longer. She acknowledged "struggling with empathising" and felt unable to fulfil her role with this client group like before. Maddy also articulated another similar experience of working with a client who could not see their child:

> *How difficult that is for me and I can't be empathic about that, I cannot be there for the client really because it's too close at the moment (p. 16)*

Maddy echoed the inconceivability other participants expressed, but her description depicts more of her own process, rather than the child centred approach others shared. This could be a manifestation of her training background and being the only qualified Counselling Psychologist of the group. She described how she felt unavailable to this client because their issues intruded upon her relationship with her own baby. Both Lauren and Maddy conveyed an unwillingness to return to their previous work too, with an implied commitment to avoid. Lauren was clear how she "wasn't able to do that anymore" and Maddy similarly said "I can't". Perhaps attributed to the intensity of emotion experienced when the welfare of babies and children are in question. Both participants seemed accepting of their limits and did not attempt to problem-solve nor

expressed a desire to revert during their interviews. Michelle also expressed her avoidance:

> *In terms of the severity of the mental health aspect of things is not as severe as what I've encountered before so it's quite sort of light touch in the you know in terms of psychological aspects and that makes it a lot easier for me to deal with because when I worked in IAPT we saw so much quite severe trauma (p. 27)*

Michelle had opted to work in a less demanding psycho-sexual service, which appeared to be a deliberate attempt to avoid the trauma she was exposed to whilst working in an Increasing Access to Psychological Therapies (IAPT) service. She knew this setting would be "more difficult to deal with emotionally now". These therapists seemed to be acutely aware of their adapted emotional capacity and were highly attuned to their individual sensitivities, often before they even arose. There seemed to be a visceral feeling that participants experienced in the therapy room that some participants were more responsive to as new mothers. Certain dynamics in therapy threatened participants' emotional safety, especially when their baby accompanied them during the therapy process. These therapists were unwilling to jeopardise their emotional safety as it seemed something they had previously established and perceived as essential to both their therapeutic work and mothering.

For Maddy, her adapted capacity seemed two-fold and defined by a sense of losing something loved:

> *They were my world, my work, my training was my universe. So, I guess it's not now (p. 10)*

Maddy declared the importance clients held in her life and how her work transcended everything else. She seemed to lack certainty or acceptance ("*I guess"*) that it no longer held the same significance after having a baby. Whilst this differed to what other participants described, it was a dilemma to solve for Maddy. It involved an adjustment to how much space and priority clients could occupy within motherhood and managing her dedication to both. This was a new capacity to work within as she discovered how much she could give to clients, as one part of her world, instead of its entirety. These four participants shared an expression of needing to feel emotionally safe in their therapeutic work as new mothers. Lauren characterised this change as permanent ("I don't think it will change"), whereas Cyntha imagined returning to things when her baby is older.

Overall, all participants expressed 'seeing' their baby in the therapy, albeit in a few different ways. Some were so attuned to their own babies they couldn't help but imagine them being subjected to the abuse they heard from clients. They described an instinctive global concern with the wellbeing of babies and associated safeguarding issues, which seemed to be talked about in terms of both the distress it caused participants as well as the therapeutic value. Other participants noted more about themselves and their own baby and described a lack of empathy or an inner sense of peace. Additionally, some participants revealed their pursuit to find emotional safety in therapy with a need to shield themselves from sources of distress that the baby's presence can bring.

4.3 Integrating self as mother and therapist

Most participants reflected on the enormity of being both a therapist and mother. A common way this was managed was by participants redefining their personal and professional boundaries. Secondly, participants articulated a sense that their therapeutic practice had grown and developed, helped along by their increased empathic engagement and connection with others.

4.3.1 Redefining boundaries

Penelope discussed how she executed a work-life balance:

> *I've been a lot more rigid with that than I thought I would do so umm it's been kind of phone off at 5 o'clock and not looking at it again and not checking my emails over the weekend, umm, that is just family time umm when I'm at work I'm trying really hard not to umm keep checking my phone to see if there's pictures or updates from the nursery or umm whoever is looking after him on that day (p. 24)*

She expresses her surprise at how firm she became with her boundaries, it seemed she found it easier to unplug from work than to miss out on updates on her son. Maddy discussed her firmer approach too:

> *So it is boundaried by time, because it's only certain times and days I see clients, it's boundaried by my oh I'm not sure lack of empathy but my keeping safe and I'm showing around my belly because that's how I felt when I was pregnant to keep*

people at a distance from my belly. And it is still there despite the baby's not in anymore (p. 12)

Boundaries for Maddy was multi-faceted and derived from a sustained need to protect herself and her baby during pregnancy. Again, there was an emphasis on condensing work time. Lauren echoed a similar notion:

I have been more boundaried in what I offer because I'm more realistic about what I can offer people. I've always wanted to help and maybe over-offered things and umm I've had to be more confident . . . but acknowledging that it's not perfect and umm so probably holding those boundaries I can do a little bit better because I'll have to for my own, to fit my life (p. 16)

A stepping up occurred where Lauren saw herself as sensible, confident, and assertive, which she favoured despite seeing no alternative. There was a sense of fitting work around motherhood, which was the opposite to how she described work as a priority prior. Penelope also discussed her development of assertiveness:

I think I was probably someone who did put other people's needs ahead of my own and I would have dropped stuff at the drop of a hat if someone needed me whereas now I'd probably think well can I really do that for that person cos I've got a little person at home who needs me (p. 14)

There were previous opportunities for selflessness, but this was now occupied by motherhood. Jessica also talked about developing realistic expectations:

As awful as it sounds I do as good enough as I can at work with the head capacity that I have, that I need to leave work at 4 o'clock in order to pick him up from childcare at four thirty, you know if I haven't got things done by then I haven't got them done by then, there's nothing I can do about it (p. 22)

Jessica expressed ambivalence and associated shame with what was a "big shift". It seemed like a tough adjustment and was perhaps hindered by the re-emergence of an old narrative, as she strived to be "the very best of a Psychologist". Zara also expressed how her baby invaded her work:

Before that clinical work just ran through my life and it's like oh I haven't done my notes for that I'll go do that now, umm, whereas now I sort of have this sort of

quite set time when I can be there for clinical work and also do my notes and things (p. 22)

Here, Zara highlighted a divergence in the organisation of her work and home life since becoming a mother. She lost the freedom of them being one in the same to a time-limited arrangement. Zara accentuated feeling flawed, with her lack or "space for things":

If I haven't thought of something within that time like oh I need to report that to safeguarding then it, it probably won't happen (p. 22)

Zara felt restricted by the implementation of boundaries, and she resigned herself to having insufficient time to complete necessary tasks. Zara's account was the exception, as although responses varied, most participants gave a positive evaluation. Lauren described her growth in confidence, Penelope acknowledged the family time it provided and despite Jessica's resistance, was "good enough". Maddy's view appeared more neutral in comparison. She raised her need for space from clients and the protection boundaries provided. Zara, however, found herself losing sight of things and she shared an example when she missed a safeguarding concern:

One incident was definitely impacted by me being a mum and trying to fit stuff in and it didn't get, yeah didn't get d umm picked up in the time that I had (p. 22)

Zara used third person to explain how "*it didn't get . . . picked up in time"*, and seemed to explain this in terms of circumstances at work rather than her fault per se. This differed from other participants' earlier descriptions of alertness around safeguarding issues. For Jessica, boundaries brought clarity:

On training there's so many grey areas of work and home life you just you have to work incredibly hard to get things done and that doesn't matter if it's ten o'clock at night, five o'clock in the afternoon, two o'clock, you just do it don't you because you've got the time to do it whereas when you've got a child I definitely do, do some work he goes to bed but I also very much value my down time so I tend to not to allow myself not to go back onto my computer as much as I can (p. 22)

Jessica's work infringed on all areas of her life prior to qualifying and motherhood, whilst she values her breaks now. Penelope acknowledged a similar change:

I would be probably staying late at work three or four days a week before, working full time and now I know that's not feasible for me umm it doesn't even come into my mind that I would stay late (p. 14)

There was a shift in priorities upon the arrival of Penelope's baby. Michelle also discussed how important self-care became:

You have to be sort of more boundaried or careful around things affect you (p. 27)

Michelle referred to an internal fulfilment of boundaries as part of her pursuit to tread carefully around her involvement in emotional cases. She alluded to an emotional hesitation to keep herself safe, like what Maddy portrayed and above the practical implications described by other participants.

Overall, boundaries transformed for all six participants and there was a shared essential movement in becoming unyielding as mothers. Boundaries provided an important function for most participants in navigating their relationships with clients and often supported their practical and emotional needs. Yet the complex nature of client work meant they were also seen as restrictive, particularly for the less experienced therapists. In general, participants described themselves as relatively passive in their tightening of boundaries, as if it were a natural progression they found themselves endorsing. Furthermore, most mothers welcomed this and saw it as a necessary crusade in their management of being in both roles. There was a sense of that therapy evolved into something therapists 'do' now, marked by their attempts to condense the role within their working hours. Whereas mothering was experienced as someone to 'be' and participants wanted to escape the burden of therapy work.

4.3.2 It's insurmountable

Participants reflected on the predicament being both and it transpired that it felt insurmountable to do both simultaneously. Subsequently, there tended to be a re-organisation of self-concept as another way the mothers expressed transferring between the two different parts of themselves. Lauren discussed her journey finding room for both:

Suddenly I've got this split where I still feel really passionately about that, but I feel really passionate about motherhood (p. 13)

Lauren described the occurrence of a split, where after a period of being completely dedicated to her career, she halved and segregated herself (rather than integrated) to embrace motherhood too. Penelope shared a similar notion:

> *Using my brain in a different way or kind of taping into a different part of myself, but it made me think I'm really ready to go back now and that it was I wasn't expecting it (p. 17)*

Similarly, Penelope distinguished her return to work as a separate part and distinct from motherhood. She shared that she did not expect to connect with this part again until she was back in the work environment and presumably dormant until then. Maddy also described two distinct modes:

> *I can almost wake up into the mode of Counselling Psychologist or going to work, when I will keep my phone on in between clients and check it but when I'm in the sessions I rarely think about what's going on at home (p. 12)*

Again, there was a psychological partition marked by preparedness for one mode or the other. Michelle's experience was uncannily similar:

> *I honestly just switch into work mode and that's it and I sort of forget and it's quite nice sometimes (laughs) cos it feels like ahh now I'm someone different and I just do this (p. 32)*

Michelle went further to say she felt a different person and the joy that came with being able to pause the burden of motherhood. She alluded that her role at work was comparatively uncomplicated and forged a breather from other responsibilities. It appeared this group of therapists developed specific strategies to handle being both a therapist and mother. Jessica described a similar notion:

> *I'm a mum at home and I'm a psychologist at work. And then if people ask me I'm a mum, but I'm a Psychologist at work and then if people ask me I'm a mum, but I'm a Psychologist at work, I guess, I keep them even though I'm yeah, I keep it very separate in my mind (p. 24)*

Jessica hid her mother identity at work, which seemed to be a deliberate decision, and she portrayed the distinction she made between the two roles. Participants phased out an unoccupied identity and moved between their two roles rather than allow one to

permeate the other. Furthermore, Penelope acknowledged her ordeal when worlds collided:

> *I wasn't necessarily prepared for how hard that would be leaving him crying with someone I didn't even know and then having to go and like shift my mind to being at work and concentrating on other families and other children and like having to think completely differently and switch off from that (p. 19)*

Again, she engaged in a different style of thinking, or mode, and had a need to disconnect from her baby at work. This psychological shift was necessary for her to be present with other families at work, but she clarified that she had suffered and stressed the overwhelm of being both. Penelope also recalled times she felt caught in the middle:

> *It was a weird conflict between do I answer this as a mum, do I answer this as a psychologist and what right do I even have to tell you because I don't even know what I'm doing in my life (p. 20)*

Penelope's response to her client's question clearly differs depending on 'who' she was, like took turns wearing different hats. She conveyed how having own baby threw into question everything she thought she knew, "it's not quite as neat as the books say", so when she offered interventions for young children, it was less straightforward as a mother. Lauren recalled her struggle to blend both parts:

> *I needed to work and I wanted to work as well so it was like how did I, I had this conflict about how did I mesh the two (p. 12)*

Lauren acknowledged the distinct territories of mother and therapist pulled her in opposing directions. Maddy articulated the preparation before sessions:

> *I didn't have to think about it, whereas now I come to the session five minutes earlier and I sit down and think okay I'm there for the client (p. 11)*

Maddy realised the transition into therapist mode required her to permit herself time to shift. Participants evidently decided it was necessary to transfer between roles and for the most part this seemed relatively smooth. The transition represented another method pioneered by this group of therapists to cope with their offer to clients and their baby.

The common issue raised among participants concerned a mother versus therapist dilemma that encapsulated two conflicted demands on their time and energy. Many participants expressed a drop in the number of hours they were willing to invest in

therapeutic work as new mothers. On the surface, this was not surprising but revolutionary to these participants who described prior narratives occupied by their identity centred around being a therapist.

4.3.3 Growth and development

For Zara and Penelope, above all else, motherhood supplemented their therapeutic practice, albeit in distinct ways. Zara described:

> *It was actually more of a sure shift for me in terms of identity in terms of where I'm at now (p. 24)*

Zara found herself progress in being "more confident", "more real" and "available" to clients. Prior to this, she scrutinised her therapeutic interventions*:*

> *Watching myself being like oh no you need to do this now uhh you haven't done enough* (p. 19)

Since becoming a mother, she expressed a shift:

> *Being a mum definitely has made that more accessible for me to being more relational to just be alongside someone in the room (p. 25)*

Motherhood generated a new relational capacity from being less self-focused and therefore present in her relationships. Human connection was important to her, by "just being with them as a person"'. Penelope expressed something similar:

> *I think it's given me real insights where maybe before I was just kind of talking the talk umm I think now I can kind of say things or suggest things and do that with a bit more depth that I couldn't before (p. 22)*

Motherhood provided Penelope with more substance to her work, she no longer felt constrained by theoretical knowledge and instead, delved further into concepts and issues, which empowered her as a therapist. She went on to provide an example:

> *Before I might have just said well do this, this, this and this and try this, this and this and the conversation this morning was really different it was more about ohh I can see what that would be difficult and hard for you as parents and umm have you thought about this and would it be helpful if I shared my experience of what I've tried this with my son? (p. 22)*

Motherhood nurtured a new ability to empathise with other parents, which provided opportunities to work more collaboratively, as opposed to being directive or authoritarian. In other words, she gained a new insight of what it was to be a mother and therefore supporting other parents was more complex and emotional than she could have comprehended before. Michelle echoed a similar notion:

> *I think I maybe understand more about how difficult it can be you like you know like people always say the struggle is real (p. 34)*

Michelle spoke about how hard motherhood could be and used the popular phrase "*the struggle is real"*, which demonstrated her enrolment within the parent community and she described an awareness of this earlier in her interview:

> *You don't realise there's a whole other world out there of parents and that you've entered an entirely different world when you've become a parent, it's like a big shift (p. 24)*

The "club" of parents Michelle had instinctively joined whereby a "weird knowing smile" is exchanged also extended to her therapeutic relationships, which benefitted from the same cohesion. An undeniable and inescapable connection existed with fellow parents, which aided her understanding of this client group and life stage in both personal and professional domains.

On this matter, Jessica's account stood out and revealed an awareness of herself vulnerable and sensitive:

> *Maybe it feels too early on in motherhood for me, maybe too early on in my career to really know what to do once I've opened that door and let out those emotions how do I then shut the door and contain them again (p. 30)*

Jessica instead broached the hindrance in being able to seek a satisfactory level of support for her emotionality. She muddled through ("I kind of work through it myself"), mostly by supressing her emotions. She identified several contributing factors, including supervision ("I don't feel like she really gives me that opportunity so I don't bring it"), the pandemic ("there's less to dissolve that*"*) as well as her own reluctance at this early stage of her career and motherhood. Overall, she did not express contentment with the arrangement, and she admitted leaning on her husband for the first time ("I do bring it home a little bit more"). Perhaps she implied her needs were not met by supervision and

this would partly explain why she hasn't observed some of the benefits facilitated by a similar emotional awakening as the other participants.

4.3.4 Being a therapist is something special

Participants consistently conveyed their love for their babies who were ultimately their priority, however, there remained something special to each of them in being a therapist. For most participants this had already been established in their prior lives without children. For Maddy especially, it became apparent how important preserving this aspect of herself was. One reason being, it was like having an alter ego:

> *I become this Counselling Psychologist and I guess that's why I needed to come back quite early (p. 8)*

She yearned for this character whilst on maternity leave and it compelled her to return to work quickly. Her role as a therapist built her self-esteem by being "a person that can do things" and escape being one of the many "*woman become mothers and only mothers like they are nothing* else". As well the pride associated with her role, it also crucially provided respite from an even harder job:

> *I needed to keep sane and have a break (p. 8)*

She found being a therapist fulfilling on several levels and its significance in her life has followed on after being at the core of what she was "doing, living, breathing". Lauren acknowledged a similar investment in her career:

> *It has been really thirteen years of Clinical Psychology being my focus (p. 13)*

Lauren easily quantified her investment, she was conscious of what she had dedicated to her career, and she wanted to retain that, despite the evident additional load. Work was more than an income; it resembled similar attributes to motherhood. She described being faced with two competing roles to divide herself between, but her career survived the movement to motherhood. Penelope communicated a similar occurrence, and she expressed being surprised by her continued commitment to work:

> *I would have said I'd love to be a full-time mum and now I know that I definitely couldn't do that (p. 17)*

There was something distinctive her work provides that cannot be met by mothering alone. She also said:

There was definitely a need to remember myself in it as well because there are probably times where I get really lost in being a mum (p. 14)

Work provided an opportunity to find herself again and nurture her own identity. She questioned "who is it right for" and seemed to resign herself to know, fundamentally, it is for her. Again, the benefits outweighed the challenges of being a mother-therapist. Michelle also articulated a sense of surprise at how her professional identity has regenerated:

I'm really happy with what I'm doing and that's surprised me in terms of my professional identity, having said that now being able to be back at work and working at a good level and feeling like I'm doing good work and contributing has been really important to me and I wouldn't not want to do it (p. 26)

Michelle felt content working again and acknowledged that she would not want anything to change. Jessica returned to work during the pandemic, which brought opportunities:

It felt like I was really contributing (p. 26)

There was something about her experience that stood out to her. She believed she did a good job, which felt satisfying and perhaps unlike her typical therapy experiences. Jessica described "completely different work" and the reward from being able to "really think I made a difference". She could be "at home with my child and that's where I want to be anyway" as "the ideal way of working". So, she saw her return as a positive experience. Her attention remained on her baby thought and she did not conceptualise an on-going dedication to her profession in the same way other participants did. She suggested an obligation to "balance both equally", however, this seems more in the context of her trying to compartmentalise her therapeutic work.

For Zara, her return happened earlier than she expected due to the pandemic and still training. She understood her work as an investment albeit with a different intention:

I accept that in the long-term it's so we have the freedom for me to, to work more umm like once I'm qualified I'll have the freedom to work more part-time so I can be with him so it's a kind of long-term goal, investing in a, a life in the long-term that I hope is better for him (p. 15)

Her investment in work aligned with her goal to attain financial security in the future to benefit her son, by ultimately working less. This supported her narrative around being

selfless and the importance of being a therapist existed within a complex interplay of competing goals for Zara. She attempted to detach from being a therapist to prioritise her son:

> *To actually umm converse with them in a therapeutic way it just does not it is not the same thing and I think umm yeah I don't think it's healthy from my personal experience so, how I, how I will do that going forwards I don't know but it is in my mind how to be a mum and to separate out the two (p. 27)*

From personal experience Zara knew the damage caused by attempting to provide your child with therapy, so she intended to avoid this by removing the therapist outside of work:

> *That is very much in my mind to actually not be the therapist or Psychologist with him (p. 12)*

She expressed her intentions clearly and held the view that therapy clashes with mothering and preferred to "*let them be and to find their own way"*. Zara also articulated a transition to feeling a better therapist overall, something she valued about her work:

> *I'm a lot more confident in myself with my client work umm (pause) I feel a lot more grounded (p. 15)*

This progress, after previously "taking stuff on from clients" demonstrated that her commitment remained entrenched in her mothering as opposed to the divide of passions expressed by some other participants. Nonetheless, she enjoyed her strengthened sense of self motherhood had afforded, both professionally and personally.

4.4 Summary

The explorations of this study put forward the ways in which participants experienced returning to therapeutic practice as new mothers. Their babies appeared in therapeutic work often and as a result, participants tended to feel more emotional, driven to protect and forced to find ways to cope themselves. Therapists described how they built walls in their therapeutic practice to attempt to keep triggers out of mind and avoid undertaking work that would be too distressing. Participants experienced the enormity of being a new mother therapist and refined their boundaries and transferred between roles to manage this. Participants' accounts gave the impression that motherhood was prioritised,

however, their careers as therapists retained a special significance for many of the participants.

4.5 Reflections

As already discussed, it is important to be aware of one's own biases and assumptions when undertaking qualitative research (Morrow, 2005), especially as an 'insider'. Whilst conducting the interviews I acknowledged the experiences I brought with me whilst engaging with participants. I was conscious of my position as a fellow therapist and mother but recognised that I was not interacting with participants within that capacity. Participants were aware of my status as a trainee counselling psychologist from my research advert and it felt as if this highlighted the implicit boundaries to focus our discussion despite there being other common ground. Whilst listening to the interviews themselves I was aware of my own reactions and responses to participants' experiences and felt able to separate these, so my questions and responses related to participants' accounts and the research aims, not my own hidden agenda. I came from a position of wanting to celebrate women's accounts and I believe mothers will have different experiences. So, I approached the interviews hoping to embrace each participant's unique account that would differ from each other and my own. This subsequently meant I was forced to pause my collection and analysis of data, as navigating my own pregnancy losses whilst exploring other new mothers' experiences was too distressing. Even when I felt ready to return to my research, data analysis was an emotionally demanding phase of this research. Whilst listening to the interview recordings and re-reading the transcripts, I was reminded of my own difficult experiences in conceiving my second baby and some participants shared their own experiences of loss. It was as if a parallel process unravelled and the emotional sensitivities some participants described resembled my own emotional responsiveness to hearing and engaging with others' accounts of pregnancy and new motherhood. My therapy skills and understanding of my own response meant I felt I was still able to engage in the analysis and stay true to the data without being swayed, however, it was at times a personally gruelling process that I certainly hadn't expected when I embarked on this study. I believe this has influenced my interpretations, particularly the incorporation of a trauma-informed approach to the study and emphasis on the support available. I have simultaneously reminded myself, however, that just because I see the potential trauma motherhood and being a therapist can bring, it is

equally possible that women have experiences that are straightforward, and it would be problematic to assume trauma applies to all mothers. This was certainly the case with one participant, who whilst she did endure a difficult journey to motherhood described a calmness that arrived with her baby. I have been aware of not projecting my own sensitivities on to my participants even when I hear their accounts of challenges and have tried to the best of my ability to allow their experience to be portrayed within my analysis

Chapter 5: Discussion

5.1 An overview of what it means to be a therapist and new mother

The findings of this study reflect the experiences of six therapists working with clients in the first two years after having their first baby. While each participant had their own unique story, the group held its own narrative too. The transition to motherhood has already been written about as a profoundly transformative experience for women (Smith, 1999) and this seemed no different for the participants of this study, who all expressed changes to their therapeutic experiences. The interviews of Penelope, Zara, Maddy, Lauren, Michelle and Jessica provided detailed insights into their return to therapeutic practice as new mothers, and the ways it felt different in a number of both pronounced and subtle ways. This included participants new priorities and emotional responsiveness in sessions, with many participants reporting an increased sensitivity, but also a calmness and increased self-assurance for one participant. The participants who experienced a heightened emotional response to clients' stories, usually when working with issues related to childhood trauma, noticed themselves more acutely aware of clients' risks, vulnerability, and safeguarding. This seemed related to empathy for their own babies, forming criteria they applied to others. Furthermore, it seemed less about parental judgement and more child-centred, with a focus on their whole wellbeing. Emphasis on child safety and increased emotional sensitivity in sessions led several participants to make concerted efforts to keep their baby out of mind, in attempt to cope with the burden of being in a state of high alert. There was an undercurrent of some participants being traumatised by their emotional responsiveness to distressing material. Often their interest in keeping themselves emotionally safe as a therapist was partly about enabling them to have enough emotional resources left to be the mother that they also needed to be. Furthermore, the level of emotional safety correlated to therapists' view of their congruence, where it became difficult to integrate their mother and therapist identities during distress. This was evident for those who expressed a reduced tolerance and willingness to explore upsetting material and avoided certain client groups (i.e., perpetrators of abuse) that produced significant discomfort in them when essentially entering in the same therapeutic 'space' as their baby.

Many participants acknowledged the magnitude of holding both roles simultaneously, particularly within such an early stage of motherhood. Most found they had tightened boundaries and split the mother and therapist parts of themselves, both psychologically

and logistically, to make it manageable. Nonetheless, consistent with the countless conflicting experiences of motherhood (Stone, 2020), many participants maintained that their work and identity as a therapist was special and worth the adversity it came with.

The themes will now be reviewed in the context of this study's aims, using existing literature and the selective introduction of alternative literature, as supported by Smith et al (2009), given that IPA studies often open new considerations. This discussion will focus on what it means to be a therapist as a new mother by focusing on the transformation described by the participants of this study. This included a psychological movement where all babies and children become shared among the group of mothers. It's as if by knowing what it took to bring a child into the world crafts a wider sense of themselves as a mother and connectedness to all children. In therapy, this meant an amalgamation of the therapist's baby and her clients. The relational impact will also be considered in the context of the therapist's wellbeing and support.

5.2 The client and baby become one

There is something distinct about the way therapists hold their baby in mind that is intrinsically linked to the type of work they undertake, with all participants relaying the significance and space babies and children now occupy in their therapeutic work. For most therapists included in this study there were times where the baby and client became one. The therapeutic relationship has been connected to positive outcomes by a wealth of evidence (Norcross & Lambert, 2018). That is, what happens between client and therapist goes beyond mere talking and has been likened to the developmental strides between mother and baby.

This was evident in therapists' new apprehension for safeguarding and associated emotional impact of hearing accounts of childhood trauma or suffering. Many commented on the dissimilarity between how they remember reacting to these issues before becoming a mother. There were several ways babies and children 'appeared' in therapy for the participants of this study, for example, as a child client, the child(ren) of adult clients and via the childhood memories (or inner child) of a present-day adult client. Working with multiple forms of the child in therapy seemed to generate an emotional responsiveness in therapists that often connected to their feelings and relationship with their own baby and as if they became one with certain clients. The inferred specialness of

the bond with their baby is supported by other qualitative studies that have found mothers declare their love for their babies is incomparable to any other kind of love and affection they've ever experienced (Javadifar et al., 2016). Furthermore, no obvious differentiation was made by therapists between the intensity of their emotional responses and their actual proximity to 'the child' i.e., current, recent, or historic stories. It appeared to be the imagined suffering and impact on the baby or child which generated this response among new mother therapists, rather than any significance to how 'close' it occurred to the present therapy. This suggests that for therapists who had this response, their distress was less related to the child's current risk of harm and more about their empathy for the suffering of the child, regardless of when it occurred.

Several participants expressed their anger in response to the injustice of adverse childhood experiences. Anger is a well-established topic in feminism and is considered a rationale response to oppression and act of insubordination, whilst having the potential to divide women from one another (Woodward, 1996). Anger is affiliated with power and children's increased exposure to violence and limited equality has recognised them as an oppressed group (Barth & Olsen, 2020). Whilst this has potential to group women and children, feminists have argued this erases the experiences of children and conceals a further power imbalance (Miccio, 2021). Nonetheless, the shared vulnerability of new mothers and children could explain participants' fresh desire to utilise the power they possess as therapists to protect others. Furthermore, although participants in this study did not discuss the gender of their clients' accounts, it's possible that participants were exposed to issues related to female perpetrated child abuse as a product of the powerlessness of women in society (Dougherty, 1993).

One way the female participants of this study channelled their anger was by safeguarding children, which is considered "one of the most important activities anyone can undertake" (Owen & Hughes, 2009, p. 10) and for most of these therapists becoming someone's mother was a moment that sparked a new realisation and protectiveness of babies and children, emerging as a central and tender concern in therapy. Interestingly, the transformation seemed automatic and unavoidable for those participants, as if driven by some instinctive response. These findings cultivate a curiosity as to what bearing motherhood, if any, has on therapists' perceived confidence to safeguard children. For many of these therapists, the process of becoming a mother initiated an emotionally receptive and alert approach to safeguarding. Having children illuminates therapists'

understanding of child development processes and irrespective of their previous training (Adams, 2013). As mothers, most participants of this study felt equipped with a highly responsive alarm, constantly signalling potential threats to them in sessions and this was frequently conceptualised as an asset to their practice. For example, Penelope describes "just doing that really proactively rather than thinking oh well it might be okay*",* construing her previous reactive approach as despondent, and one which motherhood has transformed to holding higher energy and hopefulness. Similarly, Adams's (2013) research offered an in-depth exploration to disperse the myth of the untroubled therapist, by considering a range of personal issues that can impact them as human beings. When reflecting on parenthood, one mother shared how discussing events in therapy that happened at a similar age to one of her children *was "distracting, excruciating, and anxiety provoking as I think about my own child's vulnerability"* (p. 25). This was remarkably like Lauren's account: "I've got a little person here you have very much a visual of what a one-year-old is like*"* and connects it to her *"*fierce protective instinct".

Feeling protective is pertinent to therapists, who whilst embarking on this individual and dynamic process with their own baby, simultaneously do have a duty of care to safeguard children and build protective relationships with clients in their role as a therapist. The accounts derived from this study suggests the bond between mother and baby contributes to the therapist's need to protect her clients and the extent they are impacted by what they hear. This is quite different to Waldman (2003), who accentuates the various layers of separation between therapist and baby in their client work and initiates a frequent 'wrong place at the wrong time' predicament. For example, she describes the guilt mother therapists feel towards their baby when with clients and vice versa, suggesting a more rotational style of relating than was found in this study.

For participants who described an increased alertness to safeguarding issues, this seemed to happen in response to their emotional arousal and awareness of the impact of trauma on a child. This is like studies that have found a parallel process between a woman's understanding of her baby's helplessness and the needs of others (i.e., Smith, 1999). Plus, women's shift in becoming more considerate towards children and experiencing increased compassion (Javadifar et al., 2016). First time motherhood is distinct, and mothers have displayed higher levels of worry that related to increased observed and self-reported overprotective parenting (Kalomiris & Kiel, 2016). Again, this is likely to be

two-fold for new-mother therapists, who whilst have a current heightened awareness of a baby's dependency also hold an understanding of the impact of early trauma and abuse has on people via their therapeutic experiences and theoretical knowledge. That is not to imply the participants who did not experience a heightened emotional process do not have a strong bond with their baby, but rather for those who did, it seemed to have everything to do with their baby.

A thesis by Brown (2018) explored therapists' experiences of working with safeguarding issues. The findings highlighted the complexities of safeguarding, including the relational and emotional responses that arise. It found therapists' own personal history influenced their responses, for example, their childhood experiences of receiving protection themselves altered their present desire to protect children. Brown shared her own account of being more "emotionally disturbed" (p. 71) by child abuse stories as a parent, which motivated her interest in reflecting upon any relevance becoming a parent had for her participants. Whilst some did acknowledge their heightened repulsion, most claimed to have not considered how being a parent may have influenced their responses and decision making. However, like the participants in this study, Brown herself describes how the subject matter became more emotive and distressing after having her own children and that dealing with child protection has forced her to imagine the possibility of her own child being subjected to abuse. Safeguarding is undoubtedly a complex issue for therapists with motherhood having potential to alter therapists' approach to it.

Relational models tell us that becoming a mother can draw out a woman's own wounded inner child (Babetin, 2020) and may explain some of the differences found between participants. A therapists' drive to protect her baby (and others) could therefore be seen as an attempt to repair and heal her own trauma from times she felt unprotected herself (Buchbinder, 2004). Although the present study cannot draw conclusions about participants' therapeutic experiences and their personal histories per se, Jessica did share her reflections on missing something from her own parents "I wish it's something that maybe my parents had for me because I do think that simply normalising anxiety for me as a teenager would have been huge". Psychodynamic literature tells us the inner child is present throughout the lifespan (Sjöblom et al. 2016) and Webster (2021) describes the concept of the 'personal mother wound' as:

"*A set of internalised limiting beliefs and patterns that originates from the early dynamics with our mothers that causes problems in many areas of our adult lives, impacting how we see ourselves, one another and our potential*" (para. 6).

In a blog post (Theis, 2023), one mother shares her healed shame from mothering her children's emotions in the way she wishes hers had been as a child. Overall, some therapists are telling us they cannot help but join up issues in therapy relating to a child with their own, which bestows a new capacity and perceived competence to recognise and respond to children's hardship. Furthermore, new mothers may be simultaneously and subconsciously reparenting some of their own childhood wounds. Nonetheless, as a therapist, their opportunity to heal whilst working with clients may be far less than the influence they have upon their own baby. Furthermore, their drive to protect, either way, often comes at a cost with heightened emotions for the therapist.

5.3 The interconnected continuum of motherhood

A movement occurred for the therapists of this study towards a more relational self, as the connection between others became a central concern. Cynthia described joining a 'club' when she realised parents turn towards each other with a "knowing smile". Whereas Jess deliberately concealed motherhood at work, only sharing this part of her with colleagues when it was necessary. The value of support systems for new mothers is well-known (D Sousa Machado et al., 2020) although those with the greatest need for support may be least able to maintain supportive connections (Harknett & Sten Hartnett, 2011). Smith's (1999) study revealed women's movement between a more public and personal world during their transition to motherhood. The current study also supports the notion that women's focus widens again as they return to work with their circle expanding to include fellow parents, clients, and colleagues. Yet there seems be something equally more intimate in the quality of some of these relationships, with participants' connectedness to client's childhood wellbeing resembling that to their own families.

In therapy, Lauren shares how her approach felt more pragmatic before, in that her ability to see offenders as people separate from their behaviour meant it felt comparatively objective and straightforward. Motherhood has then produced a heightened awareness of others leading to an intolerance for those who have abused.

Existing literature acknowledges the difficulty for therapists working with offenders (Farrenkopf, 1992). The study found half of therapists experienced an emotional hardening, anger, confrontation, and female therapists in particular reported feeling vulnerable. Nonetheless, therapists' responses were reported to be a result of client traits such as avoidance of responsibility and self-centredness. This differs from the women in this study who shared their responses as occurring from knowing they were working with an abuser rather than related to their persona. Furthermore, the literature has mixed results regarding gender differences as more recently Baum (2018) found males had a higher rate of vicarious traumatisation.

Parental ability to understand their child's mental states is associated with their child's attachment security (Camoirano, 2017). The participants of this study seemed particularly attuned to factors that could impact their (and other) baby's wellbeing. At times, this came at a cost to their own emotional process when exposed to the harm their clients had been subjected to, which could equate to as if it were their own child. Likewise, a thesis that found trainees working in child and adolescent services experienced intense emotion from being a parent that at times became overwhelming and difficult to bear (George, 2010). Trainees consequently described having to refrain from their instinct of wanting to mother or protect the children they worked with. The current findings illustrate a similar process, but also revealed that therapists don't have to be working directly with the child to be affected. According to Holmes & Slade (2018), Bowlby saw the way mothers and their infants relate to each other as the basis of the development of a secure base for the infant and resembles the unfolding of the therapeutic relationship between therapist and client. Thus, "the good therapist becomes a temporary attachment figure, assuming the functions of a nurturing mother" (Dermendzhiyska, 2020). The mothers in this study seemed to describe an embodied realisation of babies and children's vulnerability and dependency upon attachment, that generated increased empathy for the child of abuse, even when working with present-day adults. Therapists' mirroring of good caregiving early in life is galvanised by motherhood for the participants of this study, as they subconsciously tune into the unresolved emotions and internal states of the client. Waldman (2003) explains how the client's feelings toward the therapist are reminiscent of those toward other care givers in their lives and thus inevitable that the client becomes more childlike in therapy and re-enacts any internal conflicts. Therefore, a collision of 'both' mothers occurs and intensifies the therapeutic

relationship for the therapist, due to the simultaneous attachment formed with her own baby. Although therapists have some prior experience of metaphorically offering an emotional container for the client's growth, literally growing a baby inside her own body has potential to take attachment, connection, and boundaries to new heights. New mother therapists then have the task of deciphering where one person starts and the other ends, which is multi-faceted for the therapists of this study who see their baby, client, and selves in the therapy space. Previous studies suggest more of a switch in the therapists' attention, with them reporting preoccupation with their own children and difficulty at times in staying with the client in the room (Adams, 2014). Although this is akin to Waldman's discussion of therapists' alternating their attention between their client and baby, it does draw out how their child can psychologically and literally interrupt and intrude on the therapy space, particularly when there are pressing concerns. Furthermore, as well as drawing closer to childlike clients, participants did seek to separate themselves and expressed a clear need to divide their roles. This insinuates that a mother's need for space co-exists with that of support and connectedness to others.

Overall, mothers' emotional sensitivity has been shown to play an important role in their child's development (Ereky-Stevens, 2008) and restoring attachment through therapy may have many potential gains for clients (Dermendzhiyska, 2020). On the other hand, it seems to have potential to build a somewhat emotional burden for the therapist, who is likely enacting a similar dance with multiple clients. Paradoxically this symbolises Winnicott's (1971) good enough mother, who can be both wholly dedicated and humanely unreliable to her child. Nonetheless, it should be acknowledged that these female therapists seem to find themselves in another one-way caring culture (Guy, 2000) with no expectation of receiving any care in return (Skovholt et al. 2001) and akin to the burnout of motherhood (Motherly, 2021).

5.4 Therapist wellbeing and self-care

The complexity of life for new-mother therapists is quite distinct. They are susceptible to a multitude of oppressive patriarchal, medicalised, and organisational structures within their personal and professional lives, whilst interacting with their own and clients' trauma. That is, not only do they navigate the world as women, but now as new mothers showered with existing dominant discourses, and soon after, the motherhood penalty upon return to work. Participants appeared to reject their assigned gender roles, seeing

themselves as more than mere bodies gestating wombs and producing milk and valuing their mind and careers. However, instead of liberating women to act as they please, an uncomfortable dichotomy exists whereby feminism promotes a culture that prefers women to act like men (Helmick, 2022). It seems impossible for women to reject misogyny whilst enjoying a traditional mothering role. Unlike people without children, higher endorsements of gender equity attitudes have not shown to improve the psychological wellbeing of parents (Delgado-Herrera et al., 2024), likely explained by the heightened social pressure and entrenched societal normal regarding parenting and childcare. Furthermore, mothers who pursue employment and face pressure to meet the ideal of a perfect mother suffer from higher levels of stress and anxiety. This may offer one explanation as to why many participants expressed the unsurmountable task in trying to accomplish both their mother and therapist role. Such is acknowledged in descriptions of the intensity of motherhood where it is seen as the most valuable role a woman can undertake. At the same time, it imposes unattainable standards including the socially unseen double workload involving paid employment and mothering (Hays, 1996).

New mother therapists enter a new realm of humanity as they care for clients and their baby within a new relational and emotional terrain (Adams, 2013). The new mothers in this study discussed their unique dilemma in being both a mother and therapist, due to the volume of each role feeling insurmountable. Women typically positioned themselves as less important than their infants with the emphasis frequently resting on how important children are. Although considering therapists as a group perhaps more capable of good parenting given their knowledge of theory, the vulnerabilities of the children of renowned Psychologists have also been written about in Cohen's (2016) book, following the death of his own son. Although this study did not focus on therapists' parenting experiences, Zara referred to her own experience of being the child of a therapist "that is very much in my mind to actually not be the therapist or Psychologist with him" as she tells us how she tries to remove the therapist from her mothering. Similarly, most participants seemed to resist integrating their therapist and mother identities, instead preferring to separate them as much as possible. Participants awareness of babies needs appeared to be a welcomed additional skill for those who described feeling more equipped, but equally fought at times, by those who expressed their efforts to keep their baby out of therapy. Participants frequently admitted how difficult this was resembling

another study that interviewed music therapists and found mothers adjusted their work life balance and described splitting themselves (Dindoyal, 2018).

The literature on the impact of therapists' grief, another personal experience that impacts therapeutic practice, similarly reveals both beneficial and negative effects. For example, increases in empathy and greater reciprocity have been reported and characterise an enhancement in practice (Antonas, 2002). Similarly, Adams (2014) noted how therapists are often still able to work while coping with grief. On the other hand, therapists may unconsciously seek to replace their loved one through client work (Givelbar & Simon, 1981), which reveals another life event where the client and someone close to the therapist can become one.

This raises the issues of self-care; The British Association of Counselling and Psychotherapy (2018) describe self-care as:

"…an ongoing process of caring for yourself; making a conscious effort to do things that maintain, improve and repair your mental, emotional, physical and spiritual wellness. It's about having awareness of your own being, identifying needs … Protecting and preserving yourself in the face of challenging work, self-care is also important when dealing with the troubles that arise from our personal life e.g., bereavement, illness, family difficulties, financial stresses etc".

In a study that explored how therapists engage in self-care during personal distress, self-care was frequently something that participants described as transitional, with an emphasis on self, relationships, and physical activity. Being open and honest in personal and professional relationships stood out as important to participants in the same study, supporting the significance of relationships to therapists' wellbeing and points to the 'village' we know mothers need (Berry, 2022). Furthermore, all participants reported taking their personal distress to supervision for self-support, lowering caseloads when needed and maintaining self-efficacy (Baker & Gabriel, 2021). This is supported by the British Association for Counselling and Psychotherapy, who state the responsibility of therapists to "be open and honest in supervision about anything affecting your practice" (BACP, n.d.). However, this may not be as straightforward as it sounds. Although two participants in the present study mentioned supervision, they both said they hadn't taken issues arising from new motherhood to supervision yet. This appeared to be for different reasons, for Jessica, it was her fear of divulging, whereas Lauren related her willingness to discuss motherhood to the orientation of supervision and felt there was more permission

to explore this during pregnancy with a psychodynamic supervisor. This wouldn't be the first-time therapists have faced dilemmas addressing issues in supervision, for example, therapists have feared stigmatisation and possible loss of professional standing amidst sharing their personal stories (Sawyer, 2011). Furthermore, Sawyer describes her supervisor's approach as centred on understanding how the personal world plays out in the therapy's transference, insinuating a permission or even obligatory contribution from the supervisee to concentrate on these issues in supervision. This corroborates Lauren's point and her sense of what is expected of her in different supervision models. Individual supervision has been identified as safer than groups in promoting therapists' personal growth (Jiménez Anújar, 2002, as cited in Wheeler & Richards, 2007). The format, orientation and quality of supervision clearly needs to be considered and reviewed to allow new mothers returning to therapeutic practice to utilise supervision effectively as a space for self-care. Furthermore, matching the supervisor with supervisee may be appropriate, with studies illustrating mothers' experiences of feeling better understood by other mothers (Dennis & Chung-Lee, 2006). Although it's also worth noting that the differences in findings between this and Baker and Gabriel's (2021) study may be explained by the on-going and current impact of motherhood on participants at the time of interview. Baker and Gabriel's target population were counsellors who felt affected by significant experiences or events that generated distress as defined by themselves. However, they could not currently be experiencing the event or distress to take part, so the ongoing range of emotions as part of motherhood would not have met the inclusion criteria for this study. This is an overly simplistic approach to distress, and by associating it with a singular event that ends whilst inferring distress occurs because of something external, overlooks the complexity and nuance of human emotion. Furthermore, it's difficult to know what range of emotional experiences therapists include in their characterisation of distress.

Although these range of findings support the view that personal aspects of the therapist are significant to their clinical work, they need further consideration and exploration for therapists during training and beyond. Despite the significance of the therapist as a human, the findings challenge the idea that it's nonsensical to separate out the personal from the professional (Gillmer & Marckus, 2003) and Kottler and Parr's (2000) perceived difficulty identifying where the personal and professional begin and end. Most participants in this study expressed a strong preference to separate out their mother and

therapist selves and talked about this distinction as appearing obvious to them. Fenster et al. (1986) stated the conflict between being a good mother and professional is "unresolvable and the feelings of perpetual conflicts provides a backdrop for understanding the therapist mother" (p. 116). The participants of this study revealed a need to adapt their thinking and implementation of boundaries in response to the changes (or distress) derived from motherhood. Their firmer boundaries often involved the pragmatics of client work, such as the time spent writing notes and the limits of when and how many sessions they could offer, creating a clearer working day more closely aligned to their contracted hours. Although this was conceptualised as something important and necessary to address by all participants, it also stands as a reminder that the mother role is rarely questioned in existing literature, and it is consistently the mother (and all participants in this study) who must adapt her work tasks to look after children (Pew Research Centre, 2015). Under this assumption, it's possible that these participants' adaptation of boundaries is essentially a career interruption that they are defending. Nevertheless, mothers' voices revealed the relational aspects in sessions involved more of a fight to disentangle, with several participants sharing their process of securing boundaries to aid them in making this distinction. Such is supported by Reeves (2018), who advocates for therapists constructing clear boundaries between their work and non-work lives to avoid compassion fatigue.

This fosters a curiosity for how current 'fitness to practice' standards are constructed and understood. Improvement to the current structure has already been suggested by a study which found HCPC's investigation process had significant effects on professional's wellbeing (Maben et al., 2021). According to HCPC, a professional's practice could be impaired due to their mental health and complaints related to the therapist's fitness to practice include therapist's not taking sufficient care of their own health needs. Participants' experience of whether motherhood helped or hindered their practice in this study, is best thought about as dynamic. It supports the idea that complexities exist when therapists undergo a significant life event, therefore a nuanced and individual approach is required to understand how this may, or may not, translate to their competence. In Baker & Gabriel's (2021) study, none of the participants stopped seeing clients during their own period of personal distress and although most preferred to lower their caseload, some working in private practice admitted to taking on more clients than they felt able or comfortable to work with during that time. This is perhaps not surprising given that if you

are self-employed, you don't get paid if you don't work. This highlights the complexity involved in decision-making around how or whether to remain in practice. Overall, Baker & Gabriel argue that the key deciding factor in whether to continue working or not, rests on the degree of trauma experienced.

The concept of fitness to practice whilst crucial, has potential to perpetuate dominant discourses around the good mother. This concurring with the associated joy of new motherhood, could make it even more difficult for some therapists to share and reflect upon clinical experiences that they feel may portray a vulnerability or incompetence (Baker & Gabriel, 2021). Some participants in this study were very transparent about their perceived inability to work with certain issues now. It's unclear to what extent this is encapsulated within HCPC's (2023) standard to "practise safely and effectively within their scope of practice" (p. 6) seeing as most participants seemingly saw theirs differently before and after motherhood. Although these standards welcome personal judgement, the concept of capacity may be more transient and interpersonal than these standards capture in its uncomplicated and linear structure. The organisational setting may further impact the extent practitioners believe they can practice neatly within their scope, with NHS culture associated with limited control and therapists' feelings of deficiency (Scevoli, 2020). Nevertheless, GPs have also acknowledged how their own motherhood influences their treatment of patients (McCauley & Casson, 2013), suggesting the potential extensive impact upon professionals and calls for the development of further specific guidance from BPS on the impact of motherhood, or at least personal experiences, on practice.

The therapists in this study described feeling sensitised both in and outside of sessions, supporting the idea that mothers experience an increased emotional sensitivity (Korukcu, 2020). Several participants used language such as "easy to set me off" and "triggered", the latter typically associated with a trauma response in therapy. Participants seemed able to avoid triggers outside of therapy, for example, Lauren said "I just can't watch anything scary anymore". Whereas emotional arousal seemed rife in the therapy room. Both motherhood and therapy work can be seen as trauma. Therefore, it makes sense to consider participants' subsequent empathy (increase & decrease) changes as a trauma response, especially given the terminology used that alluded to trauma. If participants feel traumatised, empathy changes may develop as a coping mechanism. Maddy was the only participant to report a reduction in empathy towards clients, which became

apparent during pregnancy. Lacking empathy could be the result of exhaustion and overwhelm when processing such a huge transformation and probably some element of personal distress. Lacking empathy may therefore be an unconscious or conscious decision to stop caring for others to protect from further burnout or harm and preserve resources for the baby. Increased empathy may partly occur in relation to the shared experience that some described (i.e., they now have lived experience and insight into the process of motherhood themselves). A broader shift in worldview, for some people, seemed transformational and elicited higher empathy for others and a greater understanding of human suffering. Taylor & Shrive (2023) argue that any changes in empathy resulting from trauma should be considered in context and on an individual basis i.e., not based on any assumption that an increase or decrease is inherently good or bad. Or that experiencing an increase suggests someone is coping better than when levels have decreased. They also point out that whilst higher empathy is generally considered positive, it may also lead to quicker burnout, vicarious trauma, exhaustion and overwhelm from trying to support other people whilst in a state of distress themselves. Although personal therapy has been found to increase empathic capacity and ability to tune into the client's experience among a group of psychoanalysts (Wiseman & Shefler, 2001), it comes at a financial cost which can be a barrier for therapists in utilising it as a source of self-care (Baker & Gabriel 2021).

There is undoubtedly complexity to distress and emotions; whole-person responses involving behavioural facets, muscular movement, subjective experience, and salient bodily sensations. Silvestre and Vandenberghe (2008) argue emotions can contribute to wellbeing depending on the way they influence our engagement with the world around us and therefore a therapist's feelings can enhance treatment. Alternatively, the strong emotional responses within some of the therapists may reveal the topics they are trying to avoid in their daily lives. These therapists are now mothers, and an imperative part of their existence is protecting their baby. So, the participants who expressed a new unwillingness to work with offenders or comprehend the actions of those who harm a child, cannot then allow client problems that are in too deeper conflict with what they're trying to fulfil in their own lives. This also offers one possible explanation as to why Lauren discusses being able to work within a forensic setting before motherhood, due to her prior dominant cognitive process of disconnecting the person from the crime.

Nonetheless, there are clear individual differences. Zara describes a sense of calmness and inner peace, operating quite differently from the other participants. Such findings are a stark reminder that whilst there may be a lot to say about the distress and trauma of motherhood that many share and therapists are particularly interested in, individuals will experience and respond to motherhood as individuals. There is also likely to be a complex interplay of factors based on professional and personal experiences that influence a woman's transition to motherhood as a therapist. Zara formulates her positive experience of motherhood as deriving from a difficult period of longing to become a mother. So, finally having a baby brought a growth in her sense of self, contentment, and reduction in strong emotional responses in therapy. Research by Adams (2014) acknowledges therapists' personal sorrow whilst longing for motherhood, as well as her own feelings of inadequacy in sessions as a childless therapist when working with pregnant clients. The therapists involved who had prolonged or intense periods of therapeutic practice before or without motherhood noticed their distress or sense of threat was prominent in the absence of motherhood, and a moment when therapists may feel they have to justify their non-mother self. Kahn (2000, as cited in Adams, 2014) argues in these cases a non-defensive approach is required, by the therapist, to maintain a healthy working alliance.

A study that focused on mothers' transition in an organisational context found that women who felt they could share their experiences openly, either because they perceived their team as supportive or it comprised of other mothers, helped women feel approved in both their role at work and as mothers (Millward, 2006). This not only highlights the benefit women may derive from supportive spaces, but also the array of other non-therapy processes therapists will simultaneously be navigating upon their return to work. Millward identified women's pursuit of restoring their sense of belonging, reintegrating themselves within their work setting and re-establishing a viable employee identity. The study found women experienced return dilemmas, and many questioned themselves as valid mothers. This is akin to the reality for the therapists in the present study, who often had to make adaptations to their prior therapist identities to cope with juggling both roles. This is like Fenster et al. (1986)'s anticipated loss and dual role integration stages of new mother therapists' return to work. These stages are depicted by the therapist's feared loss of connectedness to her baby as well as less overinvolvement in the therapy child. Lydon (2014) acknowledges the on-going struggle to separate out and shift

discretely between roles in a thesis that explores how therapists navigate between maternal and professional desires. Lyndon attributes this to the maternal role therapists are assigned with both clients and their own children within the cultural idealisation of mothers. Therapists' acknowledgement and acceptance of the mutual interdependence of their roles is advocated by the same study, where mothers may then reach a sense of consolidation rather than having to split.

In a profession where burnout is already high (Westwood et al., 2017) and many leaving NHS posts due to a poor work-life balance (Johnson et al. 2017), it's crucial that leaders, who are often practicing clinicians themselves, are aware of issues new-mother therapists may face and reflect upon the extent compassion is demonstrated within all levels of the organisation. Like the value of peer support and social connection found in studies (George, 2010), new mother therapists may benefit from specific supportive spaces and peers at work, particularly given the difficult nature of therapy and the apparent presence of the baby. New mothers' increased empathy and emotional sensitivity may prove too much in some cases or settings and this should be considered of course by therapists themselves, but also by their supervisor's. This could include an exploration of their perceived emotional capacity in a moment in time, that is free of judgement and implied competence. New mother therapists should consider personal therapy as an additional tool for self-care and opportunity to explore their emotional processes at depth, however, it is equally valid that this may not be feasible or necessary for all.

Nonetheless, the intention of this study is not to impose further vulnerability upon women and mothers. Therefore, although an awareness of the issues at hand shares the load of responsibility, the needs of each woman and mother should be considered individually. Findings equally demonstrate that new-mother therapists frequently consider themselves to be more credible in their professional role due to the occupancy of their motherhood. Many participants felt they had gained something in motherhood through their new insights and better understanding of the human condition. This may impact the relationships that new mother therapists form with clients who are also parents. The client may perceive the therapist as knowledgeable or someone who can empathise more readily following either the therapist's disclosure, or the client's assumption, of their parental self. Such positioning has potential to give rise to beneficial and adverse implications for practice, and when combined with the associated

development in safeguarding, does locate motherhood as a potential tool and asset in therapy.

Baker & Gabriel's (2021) interviews revealed that none of the therapists recruited had covered self-care as a topic whilst training, despite all eventually recognising their need to implement self-care to continue working during times of personal distress. One participant in that study who was a mother stated that she was only able to take time to practice self-care now her children were older, implying the additional time restraints that are likely to exist for mothers of young children. Given the intensity of emotion and trauma at work may be exacerbated by new motherhood, providing therapists with opportunities for self-care within working hours may go some way to help restore the impact their therapy work has on them. This lends itself to a compassionate approach permitting the common humanity therapists experience as new mothers to be attended to, where "one is emotionally supportive toward both the self and others when hardship or human imperfection is confronted" (Yarnell & Neff, 2012). Compassion for self and others and nontherapeutic mentorship has been considered helpful responses to both burnout and disaffection and change at work (Devenish-Meares, 2015). Whereas therapists who provide compassion to others without practising self-compassion are more likely to burnout (Gilbert & Choden 2015). Furthermore, early motherhood has been shown to involve practical and emotional barriers to self-compassion (Felton, 2021), so even therapists who had developed these skills prior to having their first baby, may find this different or more difficult now. Ongoing self-reflection and the integrity of mothers' internal truth enables them to overcome challenges and difficult emotions (Akerjordet & Severinsson, 2010) so such spaces should be facilitated by supervisors and managers, who equally need to be informed about the transformation therapists may encounter.

5.5 Limitations and future research

In this study, my status as a mother was of significance and my own autobiographical narrative informed the interest and reasons for choosing this research topic. As a mother-therapist conducting a study with other mother-therapists about mother-therapists, there was the risk of identifying myself in the accounts of participants, which posed a threat to rigour at all stages of the research process. My disclosure of being an 'insider' seemed to produce a sense of over-intimacy at points and the resonance of the stories

caused some discomfort when I was forced to remember my own emotional sensitivity and distress within my new-mother therapeutic encounters. It may have been that explicitly not disclosing my identities would have achieved certain functions, especially given the emotive nature of the project. Moreover, the significance of being an insider may be more important to the researcher than to participants themselves (Holt & Frost, 2014). Dominant discourses of good motherhood My maternal status meant the need to perform or resist 'good motherhood' was always in the vicinity. For example, commenting on one participant's crying baby and welcoming her to pause the interview to attend to him enabled this participant to keep their performance of good motherhood intact. However, open and neutral questions asked during interview regarding how participants navigated their return to work had potential to invite a range of positive or negative experiences, therefore resisting the notion of good motherhood. My different identities as a woman, mother, feminist and researcher affected the ability I had to produce powerful change whilst negotiating the dominant discourses of motherhood myself.

Motherhood is a complex phenomenon, and this study inadvertently assigns motherhood to a binary where woman either are or are not. In the spirit of maternal subjectivity, the study could have embraced the messiness of motherhood better by acknowledging there being no beginning, middle or end and instead consider as a spectrum. As there are likely a complex interplay of factors that contribute to the timing woman begin seeing themselves as mothers. Many studies, including this one, recruit mothers who have undergone pregnancy and childbirth. However, maternity should be viewed as a sociocultural composition rather than one that's purely biological. Whilst this study hopes to provide a starting point, it is necessary to include other ways women become mothers such as surrogacy, adoption or fostering, co-parenting and being the non-birth mother within a lesbian couple, in future discussions of maternal transition. Two participants also disclosed suffering prior pregnancy loss, which is something that each woman will decide whether they retain a mother identity from. Mother therapists who conceived through IVF for example, may have had motherhood on their mind for longer than those who experience an unplanned pregnancy. Embracing a more varied motherhood trajectory may have also assisted recruitment, which proved difficult, hence having to reach out beyond Counselling Psychologists. The sample may therefore have also been less homogeneous than first thought and mothers may have been at more varied stages of their transition to motherhood than the time frame suggested. Two

participants were known to be pregnant again at the time of interview, which also may have impacted their positioning to first-time motherhood for the purposes of this study. Equally, some participants may still not identify as a mother at all or not in the linear manner concurring with the progression of pregnancy and childbirth. Other social factors, such as already being a stepparent, or occupying another mothering role, may impact this sense-making process too. Therefore, this study is problematic in its simplification and assumption that there is one pertinent transition route. However, given the scarcity of research in this area, it needed to start somewhere.

A critique to the approach to sampling includes the occurrence of self-selection, meaning participants all had experiences that they wished to share within the context of this research. This may have meant a narrower range of experiences were explored and the therapists who did participate are likely to be those who held a sense of satisfaction and some notable changes in their therapeutic practice since motherhood. Those who found the transition unremarkable, or perhaps too painful or shameful to discuss, may have been less likely to put themselves forward to be interviewed on the topic.

Whilst this study intentionally focused on the experiences of new mothers who were within the perinatal period, it only scratches the surface of what impact motherhood has on therapists and its findings warrant further exploration. Future studies need to continue placing the mother at the centre of the work and should address if and how changes in practice evolve over time and whether going on to have further children impacts the therapist. Moreover, future research could explore whether experiences of being a therapist transfer to their mothering experiences, and if so, how. Another thesis found trainee therapists also experienced anxiety relating specifically to the vulnerability of their own children (George, 2010). Future research could identify whether the emotional sensitivity found in the present study impacts therapists' attachment style with their baby. Also, understanding if and to what extent clients experience the therapist's transition would be worth exploring to develop our understanding of the phenomenon.

Furthermore, it would be worth exploring how the experience might vary cross culturally. Taking into consideration the whole-body experience of motherhood, an "embodied relational" approach to future research may help fulfil what language can only indirectly identify and could offer new insights by applying bodily awareness and contemplative and creative dimensions (Damsgaard et al., 2022). For example, methodologies that incorporate mindful activities or other creative approaches such as self-system pictures or

mask making. This might be advantageous for participants who are therapists and may approach a typical interview with a professional and controlled style, especially for the participant whose interview took place at their place of work. In the present study, participants were aware the interviewer was a trainee, whereas all but one of the participants were qualified psychologists, so may have perceived the interviewer as a less experienced colleague and adapted their responses accordingly. The ideal scenario might have been to ensure participants were in a neutral, confidential, and comfortable place for them to feel fully at ease to discuss all their thoughts and feelings in depth. However, given that participants were new mums who had recently returned to work, it would not have been reasonable to stipulate a particular location for interview, so participants chose what environment felt best for them. Recommendations could, however, have been made within the participant information sheet.

Two of the six participants were at home with their babies at the time of the online interview. Although both participants had childcare arrangements in place, it is still possible that participants were at least partially distracted by the needs of their baby or less likely to discuss certain subjects whilst at home with family. Nonetheless, no reticence to talk was detected and participants seemed to offer a full and frank account of their experiences.

5.6 Implications for the practice of counselling psychologists

Considering the findings from this qualitative investigation, several cornerstones of counselling psychologists' practice are highlighted. The importance of therapists reflecting on their own process and emotional experiences after becoming mothers is evident. There is often an emotional component of mothering that psychologists need to be aware of and attend to in relationship to countertransference and on a relational level. With increased awareness, it is possible for reflective and normalised conversations on this topic to occur more widely within supervision. Furthermore, explorations of any changes to therapeutic practice and relational process due to motherhood can become commonplace. At the same time, individual women's subjectivity and needs within the workplace are respected. Considerations can be made to the wide spectrum of maternal and therapist experiences and presentations of discomfort, which therapists can also instil into client work.

Given the significance of the role that stigma plays in postpartum distress (Edwards & Timmons, 2005), psychologists need to consider any barriers they experience themselves in seeking support for their emotional sensitivities. As a profession we need to do more with the goal of eliminating perinatal mental health stigma by reducing the use of terms such as 'postnatal depression' that indicate an individualised disorder. This study calls for psychologists to limit the 'them and us' mentality with clients and instead model open conversations that resist shame and oppression of mothers. Revealing the significant range of experiences people can face provides the freedom and acceptance to absorb how all-encompassing motherhood can be. As counselling psychologists develop their understanding of how personal experiences of the therapist may affect them in practice, they become better equipped to support their clients, colleagues and harness their own vulnerabilities. Prospective new mother therapists especially, may find it helpful to know about some of the issues therapists experience in advance. This could lead to higher awareness, self-compassion and an increased likelihood that support is sought sooner in both their personal and professional lives. It may also enable therapists to explore the impact promptly in supervision and personal therapy, if necessary. It is important managers, supervisors and trainers are aware of the complexities around how therapy work may *feel* different for therapists upon their return. Educating supervisors on the transformative process of new motherhood for therapists equips them with the curiosity to explore this with supervisees in meetings. This coincides with the importance of supervisor training becoming more widely recognised and accepted (Borders, 2010). However, studies that have identified core areas for supervisor training have still not recognised the ways therapists' personal lives affect their practice as an important topic (i.e. Watkins, 2012). The findings also suggest that it would be beneficial for supervisors to tailor supervision to reflect on client groups and individual cases in terms of the extent therapists feel secure working with them. This is especially important given the uncertainty of therapeutic work and therapists cannot predict what clients will bring nor what might arise during the space even following attempts to avoid certain presenting issues. Tailored supervision may support therapists in their own process, where they are empowered to talk openly about their emotion, boundaries and vulnerability. Rather than being seen as problematic, this may provide therapists with an opportunity to consider in greater depth how they are engaging with clients. They may be motivated to reflect on their attempts to separate the personal or professional as well as identify parts of them

that feel sensitive and strengthened and how this may shape the way therapeutic work unfolds.

New motherhood deeply affects a therapist's personal and professional life. The relative paucity of research in this area presents a further difficulty for therapists attempting to cope with major changes in their life. In highlighting the complexity of therapeutic processes for therapists navigating new motherhood, this study constitutes an invitation for training institutions to facilitate an open dialogue in relation to the merging of therapists' personal and professional lives. Celebrating humanity in its many facets may contribute to a shift towards seeing people, including therapists, as susceptible to the human condition and de-stigmatising the wounded healer in education (Martin, 2011).

Emphasising the personal and emotional impact may help to reduce assumptions that the main issues to navigate around maternity are practical ones, especially given that managers may prioritise strategic planning. Availability of studies such as this one support those in leadership roles in developing an awareness of issues for their staff, regardless of their current knowledge, experience or understanding. This is also relevant to initiatives to improve NHS staff retention (NHS Wales Workforce, 2018).

Counselling psychology favours the subjective and intersubjective experiences of the other, so psychologists are well placed to advocate for mothers and women-centred care that supports women and mothers to take agency rather than assigned prescriptive experiences. Furthermore, counselling psychologists can defend the position that the emotional experiences of motherhood are understandable and nonpathological, whilst considering the women's unique circumstances, values, beliefs, and relationships.

Chapter 6 Conclusion

In this research, participant accounts unveiled the highly complex yet instinctual nature of new motherhood upon therapists' therapeutic encounters soon after their return to work. Most participants reported working hard to safeguard the children they meet in therapy, but this combined with hearing distressing stories involving children came at an emotional cost. All therapists described needing to tighten their boundaries and felt compelled to separate their mother and therapist identities as much as possible. Despite having more to think about than ever before, new-mother therapists need to maintain and draw upon their self-awareness to identify what and how to respond to experiences they have upon return to work. Managers and supervisors equally have a responsibility to recognise that it should not fall all upon the shoulders of mothers to navigate these changes (that impact work experiences) independently. The workplace within society needs to do its part, changing the narrative away from thinking they are helping mothers with their assigned 'role' and instead creating a collective mothering village. After all, flexible and family-friendly workplaces are a crucial step towards equity (Neely & Reed, 2023). Curious and supportive conversations should be offered to reflect each therapists' unique experience of returning to therapeutic practice and what their needs for professional support might be. The overarching goal here, is to place the woman, mother, and therapist at the centre and depart from existing structures that predominantly only consider mothers' wellbeing to promote them fulfilling either their baby or client's needs. An emphasis which neglects and diminishes the maternal transition.

Motherhood really appears less of a distinct role but rather a mode of being. The working self is a component of the conceptual framework termed Self Memory System (SMS; Conway & Pleydell-Pearce, 2000) where memory is seen as the storage system of the self and motivated by a set of active goals. Autobiographical knowledge compels what the self is, has been, and can be. The changes women experienced were not only geared towards their own child and their role of caring for them, but also incorporated their acquired emotional connection and sense of responsibility for the safety of all children. This impacted their therapeutic relationships with clients, who often present with issues related to children or childhood. It can then be said this study provides some of the detail to help flesh out how motherhood has potential to awaken powerful and unique issues for therapists. Nonetheless, this study only really offers a brief look at one moment in

time for new mother therapists and makes a plea for future research to investigate therapists' motherhood experiences.

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Appendices

Appendix A

Journal Article - "An emotional sensitivity now that I didn't have before" The therapist's experience of new motherhood: An IPA study

Introduction

Guy (1987, as cited in Adams, 2013) argues the significance of parenthood for therapists: "*Parenthood is an important developmental stage encountered by most psychotherapists. Its profound impact on the personal life of the therapist cannot help but have an effect on his or her practice of psychotherapy at one time or another*" (p. 23). Many existing studies are anecdotal and new mother-therapists seem to notice shifts in transference, problems of separation and abandonment and expanding boundaries upon their return to therapeutic work (Waldman, 2003). Benedict-Montgomery (2016) described her own experience of "frequently encountered therapeutic issues related to mothering", was "tender and vulnerable" in sessions and "more tearful and emotionally responsive" than before (p. 49). Basescu's (1996, p. 102) chapter encapsulates juxtaposition, "moments of role conflict, confusion and clash, are par for the course, everyday occurrences for the therapist who is also a parent". She portrays the tensions of motherhood, and combined with therapy, learns the power of humans' inherent psychic resources as well as vulnerabilities when relating to others. She enunciates the requirement to, at times, "get out the way" and equally express love and connectedness with her clients and children (p. 114). Basescu discusses instances of feeling pre-occupied, fearful of short-changing her clients as well as bearing guilt for abandoning her children to uphold her professional identity. In clinical work, she articulates concerns for a 'parent-centric' bias driving her interest, her attraction to the maternal role, and arising envy of other mothers and draws special attention to the early months of returning to therapeutic practice when guilt, anxiety and preoccupation with her child were intense. She also recounts the strength required to tolerate feelings that could be both overwhelming and wholesome and pinpoints the on-going ways therapy and motherhood interact more widely, in both helpful and agonising ways. For example, heeding client's stories about childhood and their experience of parenting or feeling moved when seminars or discussions detail events that occurred at a similar age to one of her own children. These are all powerful illustrations that reiterate the significance and interplay between motherhood and therapy.

Whilst anecdotal accounts hold persuasive impact (de Wit et al., 2008), relying entirely on personal testimony surrenders breadth and depth from looking at multiple peoples lived experience. Smith's (2018) thesis contributes to the field with a narrative study on becoming a new parent while working as mental health clinician. Participants spoke of experiencing fatigue, intense emotions, increased empathy and frequently feeling triggered in their client work. Some participants also reported lowered empathy in cases with clients who were perpetrators and adult abusers.

A study that explored the lived experience of music therapists and found therapists relayed a range of impactful features on their work (Dindoyal, 2018). Therapists provided intense accounts around the pressures of motherhood, often feeling guilty about whoever they were 'letting down'. The required emotional availability of therapists revealed challenges for the mothers trying to integrate both roles when their attention may switch from the client to their child. All mother-therapists reported a more urgent sense of empathy for clients and these directly related to the parallels of their own experiences. One participant described how she had developed a better appreciation of the difficulties that families face since becoming a mother. Subsequently, all participants also agreed that there was a need for firmer emotional boundaries.

Theory on mothering is pertinent in ways that are two-fold for mother therapists. For example, Winnicott's (1971) hallmark of the 'good-enough' mother involves attuning, giving voice and responding to their baby, creating a 'holding environment' and facilitates the baby's development towards a more autonomous position. For therapists, something similar may be applied to not only their identity as mothers, but also their therapeutic pursuit. For Bowlby (1988, p. 140) "the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world". Similarly, the relationship between the therapist's arousal and a client's affect in therapy has been likened to when caregivers soothe and regulate a crying infant (Nelson, 2017). Basescu points out that while family and work roles integrate in complex ways, there are of course important differences, which may conflict. For example, the development tasks we face, the wide array of interactive modalities we incorporate with our children, and the boundaries of our responsibility for the other. Differences have also been noted by Macnab (1995), who relays experiencing a more chaotic relationship with her children than clients, whilst Van Niel (1993) reports being less consumed by dependency with clients. Moore (2008), a trainee art therapist, discusses her struggle in separating

'motherly' feelings and frequently finding herself 'caught up' in her countertransference. Overall, the theory and literature points to therapists navigating essentially two simultaneous pursuits of mothering, whilst being acutely aware of the important differences.

Therapists have their own transition to make, like any mother, albeit their return to therapeutic practice has potential to rouse layers of relational and professional encounters. This is relevant given the comparisons that have been made between therapy and mothering (Van Deurzen-Smith, 1996). Much research has pointed to therapists as instrumental in the process of therapy (Aponte, 2022), yet fewer studies have addressed the relationship between therapists' personal experiences and the quality of their therapeutic work, including those of new-mother therapists (Waldman, 2003). In the present study it is hoped that by exploring new-mothers' experiences we can begin unpacking what bearing, if any, new-motherhood has on them in the therapeutic space. This study will explore an alternative to psychiatric nosology and motherhood ideologies rooted in patriarchy by adopting a feminist, trauma-informed and non-pathological lens. The more specific contribution of this project is the contrast it delineates between the ideal of maternal love and the 'untroubled' therapist propagated by traditional discourses, and the reality of co-existing maternal and therapeutic relationships, as evidenced in the narratives of new-mother therapists.

Methodology

Participants

Participation for the interviews in this study were invited from psychological therapists who had returned to clinical work within the last twelve months after having their first baby. The general aim was to find a small group of women who were comparable in terms of these factors. All women were in heterosexual relationships.

Table 1 - *Participant demographics*

Participant (pseudo-name)	Age	Ethnicity	Age of baby	Marital status	Qualification	Setting
Maddy	35	White other	5 months	Married	Counselling Psychologist	Private practice
Penelope	32	Indian	18 months	Married	Clinical Psychologist	Child and Adolescent

						Mental Health (CAMHS) NHS
Michelle	41	White German	23 months	Married	Clinical Psychologist	Psycho-sexual NHS
Zara	35	White British	7 months	Married	Trainee Counselling Psychologist	University & placement(s)
Jessica	33	Mixed – white British & black Caribbean	20 months	Married	Clinical Psychologist	Early Intervention for psychosis (EI) NHS
Lauren	35	White British	18 months	Married	Clinical Psychologist	Intensive Service and Mental Health Liaison NHS

The names of the women and members of their families have been changed to protect confidentiality. Each woman was provided with an information sheet and gave written consent before taking part. Participants were told they could withdraw at any time during the interview.

Data collection

The research was advertised on social media and participants were recruited via purposeful sampling. Although four of the participants were known to the researcher in a professional capacity, they were recruited to the study via the protocols outlined. A key aim of this study was to gather rich data directly from participants, resulting a singular method of data collection through one-to-one semi-structured interviews conducted in person or remotely. The interview was intended as an exploration of the therapist's personal experience of returning to therapeutic work as a mother. An interview schedule was used to facilitate the interview process, but the questions were deliberately open, intended mainly as cues for the women to then talk freely and tell their own story. Interviews were recorded on a Dictaphone and transcribed verbatim. The sample size (n = 6) is appropriate for idiographic research utilising IPA (Pietkiewicz & Smith, 2014).

Ethics

Ethical approval was received from the University of the West of England. Informed consent was obtained from all participants via a signed consent form. To uphold

confidentiality participants were provided with a pseudo name and identifiable details were removed from interview transcripts.

Analysis

The transcripts were subjected to interpretative phenomenological analysis (Smith et al., 2022). IPA is an idiographic approach concerned with exploring individuals lived experiences and the meanings they attribute to those experiences (Smith & Eatough, 2007). Smith et al.'s (2022) seven steps formed a guide, with the consideration that the steps are not intended to provide a prescriptive account nor single method for working with the data. Interview transcripts were read multiple times to allow the researcher to immerse themselves in the data (Smith & Osborn, 2003). Exploratory notes were made where initial impressions or insights were noted, and semantic content and language use was examined. After a period of consolidating and crystallising thoughts, the most important features formed experiential statements. A title was given to each cluster of experiential statements to describe its main attributes, and these were organised in a table of Personal Experiential Themes (PETs) for each participant. The final part of the analysis involved searching for patterns of similarity and difference across the PETs to form a set of Group Experiential Themes (GETs).

Results

Results revealed three GETs and their respective subthemes, outlined in Table 2.

Table 2: *Summary of Group Experiential Themes and Subthemes*

Group experiential theme	Subthemes
1. Seeing the baby in therapy	1.1 It's not my baby, but that's my baby. They are all *our* babies.
	1.2 If we don't stand up for children, then we don't stand for much
2. I used to…but now I can't	2.1 Highly sensitive
	2.2. Seeking emotional safety
3. Integrating self as mother and therapist	3.1 Redefining boundaries
	3.2 It's insurmountable
	3.3 Growth and development
	3.4 Being a therapist is something special

Seeing the baby in therapy

It's not my baby, but that's my baby. They are all *our* babies

Two of the participants noted their disbelief when hearing about child abuse that links to becoming a mother. For example, Michelle said:

> *It's somehow harder when you're a parent . . ., what sort of lack of support and resilience etc they have to have themselves to be able to do those sorts of things to children (p. 28)*

Here, Michelle points to the bond she has with her son and the difficulty this causes her as a therapist in being able to comprehend how people abuse children. There is a sense of incredulity in her words that inhibits her formulation. Penelope echoed a similar realisation:

> *How could anyone do that to a baby . . ., I think that was the first time it ever kind of hit home? (p. 30)*

Something has become incomprehensible and hits home for Penelope. It is as if she acquires recognition of the child's perspective for the first time as a mother. Lauren conveys a similar mutuality:

> *I've got a little person here you have very much a visual of what a one-year-old is like (p. 16)*

Lauren cherishes her visual of her young son and she is attuned to him too when hearing about child abuse. It is as if combining her familiarity with her own baby and strong protective instinct equips her with an inherent gauge for safeguarding *all* children.

If we don't stand up for children, then we don't stand for much

Penelope expresses how she perceives her value as a psychologist and a person being rooted in activism and her ability to safeguard children:

> *feelings come up straight away when there's any kind of hint of risk or when there's any kind of alarm bell that goes off (p. 30)*

Here, Penelope describes an instinct to protect children. She talks about how loud she hears warning signs and safeguarding children is now automatically at forefront of her attention. Lauren describes something very similar:

it would ring more alarm bells and I think . . ., I worry a bit more about safeguarding now (p. 21)

The child takes precedence within Lauren's account. She goes on to explain how she notices more than only apparent abuse:

I'm more sensitive to it like . . ., you know the impact on those children to have a mother that's sobbing (p. 20)

Whereas for Jessica, the intensity of feelings lead her to want to push the image of her baby away from therapy work. For example:

I try very hard to kind of create that brick wall between the thought of that happening to that person . . ., versus you know the idea of that ever happening to my son (p. 29)

Jessica seems to share a similar connection between what she hears about abuse and her own baby, but attempts to separate the two, presumably to reduce the distress caused by imagining her own son coming to harm.

Zara, on the other hand, feels afforded a new emotional freedom:

I feel more complete and whole and grounded now I've had him (p. 15)

Instead of an activated threat system other participants articulate, Zara portrays an increase in a calming and grounding experience. Zara describes overcoming seeing herself as emotionally fragile:

I've always struggled with over-empathising so if a client gets emotional, I may get a bit teary and umm sort taking stuff on from clients (p. 19)

Here Zara recalls getting emotional in sessions before having a baby and uses the terms of perceives this as detrimental. What has emerged since becoming a mother is:

being more relational to just be alongside someone in the room (p. 19).

Zara's focus has shifted to relate to the client so is less caught up in their story. Maddy describes her own shift:

I was either mothering clients to some extent or I was their sibling in one way or another. Whereas now I feel more rational than any other time of my training (p. 11)

By becoming a mother, Maddy has created a healthier distance from her clients. This is in the context of her describing them as "my world" before the arrival of her baby.

I used to…but now I can't

Highly sensitive

Whilst describing her first clinical experiences with cancer patients as a mum, Michelle remembers her struggle:

> *I had to deal with some parents who were going to die umm soon about how to tell their small children . . ., was just awful (p. 29)*

It is as if her involvement with these patients' small children meant Michelle was subjected to something "awful" herself and speaks to the heartbreak the parents (her clients) suffered. There's an aura of vicarious trauma in her description:

> "*emotionally so tough, like I would take those things home and really you know not, not be able to put them to rest so easily*".

Here, Michelle uses the trauma-associated term "*trigger"*, and particularly making this reference as a psychologist, may suggest her own traumatisation. Interestingly, Jessica describes her experience using the same word:

> *I get very tearful or emotional or things really trigger me very easily (p. 28)*

Jessica refers to her emotional sensitivity a bit like a bomb that is easily set off. Delving further into the aspect of emotional arousal, Michelle considers its effectiveness:

> *it might make you a better therapist because it means that I have an emotional sensitivity now that I didn't have before but in other situations it might hinder it potentially (p. 33)*

Here, her empathy is delineated as a distinct change, but is not straightforward to assess its usefulness and comprises both advantages and disadvantages. It would appear participants observe both their baby's and their own vulnerability as therapists during their initial return to work.

Finding emotional safety

One participant recognises a link between their own wellbeing and mothering, as Cynthia mentions:

> *There is something about keeping myself safe because the baby will pick up on my emotional state (p. 11)*

It's seems there's fear of losing connection with her baby if she submerges herself in the client's material too deeply. Jessica says more about the dilemma she faces in balancing out the tension between empathising with clients and protecting her own wellbeing and relationship with her son:

> *A constant battle of this kind of like allowing myself to immerse myself in this person's experience . . ., versus not allowing that, to implicate you know, me, my emotions towards my son (p. 29)*

Now, perhaps more than ever, therapy has the power to impact her own wellbeing, which is linked to the quality of relationship with her baby. An emergence of a new capacity for therapists seems a direct result of their higher sensitivity. Lauren describes a similar transformation that she addressed in supervision:

> *I'd always been able to separate those two things like there's the perpetrator and there's the victim and my work is with the perpetrator, so I've been able to do that and I wasn't able to do that anymore (p. 18)*

Lauren communicates how her therapy process has changed due to being unable to separate perpetrators from their victims now. She feels unable to fulfil her role with this client group how she did before. Maddy also articulates another similar experience of working with a client who cannot see their child:

> *How difficult that is for me and I can't be empathic about that, I cannot be there for the client really because it's too close at the moment (p. 16)*

Here, Maddy echoes the inconceivability the other mothers have also identified, but her description draws out more on her own process, rather than the child centred approach others share. Both participants seem accepting of their emotional capacity and do not attempt to problem-solve or express a desire to revert.

Integrating self as mother and therapist

Redefining boundaries

Penelope discusses her facilitation of a work-life balance:

> *I've been a lot more rigid with that than I thought I would (p. 24)*

She expresses her surprise at how firm she's become with her boundaries. Maddy discusses her firmer approach too:

> *So it is boundaried by time, because it's only certain times and days I see clients (p. 12)*

Again, boundaries for Maddie involves an emphasis on condensing work time. Lauren echoes a similar notion:

> *I have been more boundaried in what I offer because I'm more realistic about what I can offer people. (p. 16)*

There is a sense of Maddie fitting work around her life as a mother now. Zara accentuates feeling flawed by lacking "*space for things"* whilst recalling an incident:

> *If I haven't thought of something within that time like, oh, I need to report that to safeguarding then it, it probably won't happen (p. 22)*

For Zara the implementation of boundaries is restrictive, and she resigns herself to having insufficient time to complete necessary tasks. Michelle also discusses how important allocated time for self-care has become:

> *You have to be sort of more boundaried or careful around things affect you (p. 27)*

Michelle refers to an internal fulfilment of boundaries as part of treading carefully around her involvement in emotional cases. She alludes to an emotional hesitation to keep herself safe. Boundaries provide an important function for most participants in navigating their relationships with clients, often supporting their practical and emotional needs.

It's insurmountable

Participants reflected on the predicament being both roles and overall, it seemed insurmountable to do this simultaneously. Lauren discusses her route towards finding room for both:

> *Suddenly I've got this split where I still feel really passionately about that, but I feel really passionate about motherhood (p. 13)*

Lauren describes a split, as if after all this time of dedicating herself to her career, she now needs to segregate herself, rather than integrate, in order to embrace both passions. Penelope shares a similar notion:

> *Using my brain in a different way or kind of taping into a different part of myself, but it made me think I'm really ready to go back now and that it was I wasn't expecting it (p. 17)*

Similarly, Penelope distinguishes her return to work involving a separate part of herself and therapy being distinct from mothering. Maddy also describes two distinct modes:

> *I can almost wake up into the mode of Counselling Psychologist or going to work . . ., I rarely think about what's going on at home (p. 12)*

Again, there is a psychological partition marked by preparedness for one mode or the other. This group of therapists have compartmentalised their different identities to cope with being both.

Growth and development

For Zara and Penelope in particular, above all else motherhood supplements their therapeutic practice, albeit in distinctive ways. Zara finds herself moving forward in being "more confident", "more real" and "available" to clients. Prior to this Zara discusses putting herself under surveillance, getting caught in ensuring the technique or process *was* right:

> *watching myself being like oh no you need to do this now, uhh, you haven't done enough*'.

Since becoming a mum, Zara expresses a shift:

> *Being a mum definitely has made that more accessible for me to being more relational to just be alongside someone in the room (p. 25)*

Motherhood generates a new relational capacity by Zara becoming less self-focused and therefore present in her relationships. Human connection becomes important to her, by being with clients as people. Penelope expressed something similar:

> *do that with a bit more depth that I couldn't before (p. 22)*

Motherhood has provided Penelope with more substance to her work, she no longer feels constrained by theoretical knowledge and instead, can delve further into concepts and issues, empowering her in being a better therapist.

Being a therapist is something special

Despite participants consistently conveying their love for their babies who ultimately are their priority, there remains something special to each of them in being a therapist, for many bolstered in their prior lives without children. For Maddy especially, it's apparent how important preserving this aspect of herself was. One reason being, for her, it's like having an alter ego:

> *I become this counselling psychologist and I guess that's why I needed to come back quite early (p. 8)*

She yearned for this identity whilst on maternity leave and it compelled her to return to work quickly. Her role as a psychologist sees her self-esteem build by being *"a person that can do things"* and resisting oppression "woman become mothers and only mothers like they are nothing else".

A similar notion is expressed by Lauren who acknowledges her investment in her career:

> *It has been really thirteen years of Clinical Psychology being my focus (p. 13)*

Lauren can quantify her investment impromptu; she knows what she's put into her career and a sense of not wanting to let that go. Here, there is something distinct her work provides that is not met by mothering alone.

Discussion

This study contributes to knowledge around how the inner world of therapists effects their experience of offering therapy. Participants shared having new priorities and emotional responsiveness in sessions, with the majority reporting an increased sensitivity, but also a calmness and increased self-assurance for one participant. The participants who experienced a heightened emotional response to clients' stories, usually when working with issues related to childhood trauma, noticed themselves more acutely aware of clients' risks, vulnerability, and safeguarding. This seemed related to empathy for their own babies, forming criteria they applied to others. Furthermore, it seemed less about

parental judgement and more child-centred, with a focus on their whole wellbeing. Emphasis on child safety and increased emotional sensitivity in sessions led several participants to make concerted efforts to keep their baby out of mind, in attempt to cope with the burden of being in a state of high alert. There was an undercurrent of some participants being traumatised by their emotional responsiveness to distressing material. Often their interest in keeping themselves emotionally safe as a therapist was partly about enabling them to have enough emotional resources left to be the mother that they also needed to be. Furthermore, the level of emotional safety correlated to therapists' view of their congruence, where it became difficult to integrate their mother and therapist identities during distress. This was evident for those who expressed a reduced tolerance and willingness to explore upsetting material and avoided certain client groups (i.e., perpetrators) that produced significant discomfort in them when essentially entering in the same therapeutic 'space' as their baby.

There is something distinct about the way therapists hold their babies in mind that is intrinsically linked to the type of work they undertake, with all participants relaying the significance and space babies and children now occupy in their therapeutic work. For many therapists there were times where the baby and client became one. Some therapists expressed a new apprehension for safeguarding and the associated emotional impact of hearing accounts of childhood trauma and/or suffering. There were several ways babies and children 'appeared' in therapy for the participants of this study, for example, child clients, the child(ren) of adult clients and via the childhood memories (or inner child) of a present-day adult client. Working with multiple forms of the child in therapy seemed to generate an emotional responsiveness in therapists that often connected to their feelings and relationship with their own baby and as if they became one with certain clients. The inferred specialness of the bond with their baby is supported by other qualitative studies that have found mothers declare their love for their babies is incomparable to any other kind of love and affection they've ever experienced (Javadifar et al., 2016). Safeguarding children is "one of the most important activities anyone can undertake" (Owen & Hughes, 2009, p. 10) and for most of these therapists, becoming someone's mother was a moment that sparked a new realisation and protectiveness of babies and children, emerging as a central and tender concern in therapy. For most of these therapists, the process of becoming a mother initiated an emotionally receptive and alert approach to safeguarding. Having children illuminates therapists' understanding

of child development processes and irrespective of their previous training (Adams, 2013). As mothers, most participants of this study felt equipped with a highly responsive alarm, constantly signalling potential threats to them in sessions and this was frequently conceptualised as an asset to their practice. This was like Adams's (2013) research, which offered an in-depth exploration to disperse the myth of the untroubled therapist, by considering a range of personal issues that can affect them as human beings. When reflecting on parenthood, one mother shared how discussing events in therapy that happened at a similar age to one of her children was "*distracting, excruciating, and anxiety provoking as I think about my own child's vulnerability*" (p. 25).

The therapists in this study described feeling sensitised both in and outside of sessions, supporting the idea that mothers experience an increased emotional sensitivity (Korukcu, 2020). Several participants used language such as "easy to set me off" and "triggered", the latter typically associated with a trauma response in therapy. Participants seemed able to avoid triggers outside of therapy, for example, Lauren said "I just can't watch anything scary anymore". Whereas emotional arousal seemed rife in the therapy room. Both motherhood and therapy work can be seen as trauma. Therefore, it makes sense to consider participants' subsequent empathy (increase & decrease) changes as a trauma response, especially given the terminology used that alluded to trauma. If participants feel traumatised, empathy changes may develop as a coping mechanism. Maddie was the only participant to report a reduction in empathy towards clients, which became apparent during pregnancy. Lacking empathy could be the result of exhaustion and overwhelm when processing such a huge transformation and probably some element of personal distress. Lacking empathy may therefore be an unconscious or conscious decision to stop caring for others to protect self from further burnout or harm and preserve resources for the baby. Increased empathy may partly occur in relation to the shared experience that some described (i.e., they now have lived experience and insight into the process of motherhood themselves). A broader shift in worldview, for some people, seemed transformational and elicited higher empathy for others and a greater understanding of human suffering. Taylor & Shrive (2023) argue that any changes in empathy resulting from trauma should be considered in context and on an individual basis. That is, not based on any assumption that an increase or decrease is inherently good or bad. Or that experiencing an increase suggests someone is 'coping' better than when levels have decreased. They also point out that whilst higher empathy is generally

considered positive, it may also lead to quicker burnout, vicarious trauma, exhaustion and overwhelm from trying to support other people whilst in a state of distress themselves. Although personal therapy has been found to increase empathic capacity and ability to tune into the client's experience among a group of psychoanalysts (Wiseman & Shefler, 2001), it comes at a financial cost which can be a barrier for therapists in utilising it as a source of self-care (Baker & Gabriel 2021).

Given the whole-body experience of motherhood, incorporating an "embodied relational" approach to future research may help fulfil what language can only indirectly identify and would offer new insights by applying bodily awareness and contemplative and creative dimensions (Damsgaard et al., 2022). For example, methodologies that incorporate mindful activities or other creative approaches such as self-system pictures or mask making. This might be advantageous for participants who are therapists and may approach a typical interview with a professional and controlled style, especially for the participant whose interview took place at their place of work. In the present study, participants were aware the interviewer was a trainee, whereas all but one of the participants were qualified psychologists, so may have perceived the interviewer as a less experienced colleague and adapted their responses accordingly. The ideal scenario might have been to ensure participants were in a neutral, confidential, and comfortable place for them to feel fully at ease to discuss all their thoughts and feelings in depth. However, given that participants were new mums who had recently returned to work, it would not have been reasonable to stipulate a particular location for interview, so participants chose what environment felt best for them. Recommendations could, however, have been made within the participant information sheet.

Whilst this study intentionally focused on the experiences of new mothers who were within the perinatal period, it only scratches the surface of what impact motherhood has on therapists and its findings warrant further exploration. Future studies need to continue placing the mother at the centre of the work and should address if and how changes in practice evolve over time and whether going on to have further children impacts the therapist.

In this study, participant accounts unveiled the highly complex yet instinctual nature of new motherhood upon therapists' therapeutic encounters soon after their return to work. Most participants reported working hard to safeguard the children they meet in therapy, but this combined with hearing distressing stories involving children came at an

emotional cost. All therapists described needing to tighten their boundaries and felt compelled to separate their mother and therapist identities as much as possible. Motherhood really appears less of a 'role' but rather a new internal working model. The changes women experienced were not only geared towards their own child and 'taking on' the role of caring for them, but also incorporated their acquired emotional connection and sense of responsibility for the safety of all children. This heavily affected their therapeutic relationships with clients, who often present with issues related to children or childhood.

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Appendix B
Research Advert

Are you a Counselling Psychologist who has recently returned to work after maternity leave?

I am looking for Counselling Psychologists who have returned to therapeutic practice (NHS and/or private/third sector) within the last 12 months after having their first child.

I am a trainee Counselling Psychologist at the University of the West of England. For my doctoral study I am researching how new motherhood impacts the therapist. I gave birth to my first child 3 years ago and noticed momentous shifts in many areas of my life, and my feelings in the therapeutic space was one of these changes. I am interested to explore and unpick other therapists' experiences.

I am inviting people to join me for either a face-to-face or Zoom interview.

Contact Information:
If you would like to take part, or have any questions, please contact me:
Lucinda Stirton
Trainee Counselling Psychologist
lucinda2.stirton@live.uwe.ac.uk

Appendix C

Interview Schedule

1. Can you describe your transition to motherhood?
    - How long ago did you give birth?
    - Type of birth?
    - Planned/unplanned?

2. How did becoming a mother affect you emotionally?
    - Can you describe your feelings after having a baby?
    - How did you cope after having a baby?
    - Was it enjoyable/challenging?

3. How did becoming a mother affect your relationships with others?

4. Can you describe how you made sense of your transition to motherhood?
    - How did you think about yourself?
    - How did you experience life after having a baby?
    - How did this impact your self-image and perception of life?

5. Could you tell me about what returning to work as a Counselling Psychologist after maternity leave has been like for you, what your day to day experiences are.
    - Relating to colleagues
    - Priorities at work

6. Drawing on one or two examples, have you noticed your therapeutic practice/relationships have changed in any way since having a child? And if so, how?
    - How did you experience the therapeutic encounter with your client since having a baby?
    - Did you notice any changes in your emotional responsiveness to your clients? If so, any client(s)/groups in particular?
    - How was your way of working or your therapeutic style affected, if at all?
    - Did anything help or hinder your work with your clients in light of having a baby?
    - Were there any differences in the way you follow processes/policies/procedures?

7. As a result of this experience, what have you learnt (if anything) about yourself, your therapeutic work and the field of Psychology/Counselling?

8. Anything else?

Appendix D

Participant Information Sheet

The therapists' experience of new motherhood: An interpretative phenomenological analysis

Thank you for showing an interest in this research study. Before you decide to participate it is important you understand what the purpose of the research is and what it will involve, so please read the information below carefully.

Summary of research study
My name is Lucinda Stirton. I am a trainee Counselling Psychologist at the University of the West of England. For my doctoral study I am researching how new motherhood impacts Counselling Psychologists returning to work after having their first child. I am interested in this after becoming a mum myself. As a trainee Counselling Psychologist, I hope the study will help us better understand how having a baby impacts therapeutic practice and professional identity.

What will taking part involve?
This is a qualitative study which involves taking part in a one-to-one qualitative interview, which will last approximately 60 minutes. The aim is to explore in detail your experience of returning to therapeutic practice after having a first child, so it is possible it will take longer. If you know that you have a limited amount of time available for our interview, please let me know and I will ensure that we finish when you need to.
The interview will be audio-recorded onto a media file, securely stored and then destroyed once a verbatim transcript has been made. We will agree a place to meet that feels comfortable to you. Interviews can take place in person or over Skype.

The benefits of taking part
There are few studies of this nature. Your involvement will help us understand better the phenomenon of new motherhood in the life of the Counselling Psychologist and hence contribute to much needed research in this area. Taking part in this study invites you to reflect on your own experience and perhaps gain new perspectives and insights, which may also facilitate reflection for your own current practice.

What difficulties may arise from taking part?
Having a baby can be a challenging time. You may experience a re-emergence of emotions relating to your experience or you may be reminded of difficult events/experiences that you hadn't considered for some time. In order to prepare for any difficulties, I would recommend you discuss any concerns with trusted friends, family, colleagues or a supervisor to ensure you have the necessary support before you agree to participate.

Confidentiality
Every effort will be made to ensure that the information that you share will remain confidential and anonymous. All data produced from the interviews will have identifying information removed (pseudonyms will be used) and any documents with participant information will be stored securely and separately. The information that you provide will be used to explore the phenomenon of new

information removed (pseudonyms will be used) and any documents with participant information will be stored securely and separately. The information that you provide will be used to explore the phenomenon of new motherhood in the therapeutic encounter and it is possible that I will use anonymous quotations from your interview in my doctoral thesis, in presentations at conferences, in publications, or training resources. It is possible that other Counselling Psychologists who take part or read this project may know each other and potentially identify colleagues from the data.

Ethical approval

All proposals for research using human participants are reviewed by an ethics committee before they can proceed. The University of the West of England's faculty research ethics committee have reviewed and provided ethical consent for this study (FREC REF No: HAS.19.10.037).

Your rights

Your participation in this study is completely voluntary. If you decide to take part you may terminate the interview or audio-recording at any time, decline to answer any question and withdraw at any time during the interview without giving a reason. Please be informed that you may also read a copy of your interview transcript if you request to do so. I will ask that you complete a consent form on the day of the interview, and this will be accepted as your informed decision to participate. You are free withdraw your data up to one week after interview. After this the analysis will have taken place and merged with other interview data.

If you would like to participate in this study, please contact me using the details shown below. If you have any questions about participation or any other queries, please also get in touch. My supervisor, who is overseeing this project's contact details are also included on this page.

Contact details:

Researcher: Lucinda Stirton, trainee Counselling Psychologist, University of the West of England, lucinda2.stirton@live.uwe.ac.uk

Research Supervisor: Dr Tony Ward, Associate Professor, University of the West of England, tony.ward@uwe.ac.uk,

Appendix E

Participant Consent Form

The therapists' experience of new motherhood: An interpretative phenomenological analysis

I have understood the details of the research as explained to me by the researcher and confirm that I have consented to act as a participant.

I understand that my participation is entirely voluntary, all attempts will be made to ensure data collected during the research unidentifiable, and I have a right to withdraw from the project at any time without justification.

I also understand that the data I provide may be used for analysis and subsequent publication in an anonymous form and provide consent that this might occur.

I agree to being audio-recorded during this interview and that it will be securely stored until the research is completed, after which, the recording will be destroyed.

Print name of Participant: Participant's signature:

…….. ……..

Date:

Print name of Researcher: Researcher's signature:

…….. ……..

Date:

Appendix F

Participant Debrief

The therapists' experience of new motherhood: An interpretative phenomenological analysis

Thank you for taking part in this study.

The purpose of this research is to explore and make sense of therapists' lived experience of becoming a mother and how (if at all) this impacts the therapeutic encounter. Therefore, the aim of this study is to understand how transitioning to motherhood impacts the therapeutic process and how a therapists' personal and professional identity is shaped by this experience.

The information you have shared will be anonymised and all efforts will be made to make your contribution not identifiable.

In the event that you feel emotionally distressed following participation in this study I advise you to contact a personal therapist, support service or supportive other. There are a number of organisations that may be able to offer support if you feel this is necessary:

- Samaritans: 116 123
- NHS employee support service
- Your local IAPT service/GP

If you have any questions about this study, please feel free to contact me at: Lucinda2.stirton@live.uwe.ac.uk

Thank you again for your participation; without you this research would not be possible. Your involvement helps us explore the phenomenon of new-motherhood for Counselling Psychologists in terms of the therapeutic encounter and how such a transition is navigated.

Appendix G

GDPR Privacy Notice

The personal information collected for the Study will be processed by the University of the West of England in accordance with the General Data Protection Regulation as applied, enacted and amended in UK law. The data controller is the University of the West of England. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law. Your personal information will be used and processed as follows:

a) The data you provide will be collected by the University of the West of England for the purposes of academic research and shall be stored, used, analysed, disseminated and published for these purposes

b) No dissemination or publication of the data you provide shall identify you individually. Your data will be disseminated and published in aggregate form, combined with other study participants although non-aggregated de-identified demographic data relating to you as an individual may be included in such dissemination and publication

c) The data you provide will be stored securely by the University of the West of England on its secure servers and/or in a locked cabinet and shall be kept for a period of time until the project is completed. After this time, it will be permanently destroyed or deleted.

d) The data you provide will also be held by the survey provider (Qualtrics as a data processor). The University of the West of England has terms in place with this party require such data be held by it in a manner consistent with applicable legislation

In respect of your personal data held by us, you have the following qualified rights to:

i. access it

ii. receive it in a structured machine readable format

iii. rectify it if it is not accurate or complete

iv. erase it

v. restrict its processing

vi. withdrawing any consent provided or otherwise object to its processing

	from friends it just felt like at that point in time there was friends I needed more than others and I think that's okay. **Q14** Yeah, yeah. Umm is there any sort of inner narrative do you think you hold about like becoming a mother and a working mum as well? Hmmm (pause). Umm I think there's definitely something in there about doing the best in both, being the very best at both, at the same time, umm you know I don't, I definitely give everything to being a mum and I think prior to going back to work I had a narrative about the fact that I should still be the very best of a Psychologist I can be. And I think that's definitely shifted, I think I, as awful as it sounds I do as good enough as I can at work with the head capacity that I have, that I need to leave work at 4 o'clock in order to pick him up from childcare at 4:30, you know if I haven't got things done by then I haven't got them done by then there's nothing I can do about it because he still needs to get collected and that was a big shift that was a big change for me because prior to that I suppose on training there's so many grey areas of work and home life you just you have to work incredibly hard to get things done and that doesn't matter if it's ten o'clock at night, five o'clock in the afternoon, two o' clock, you just do it don't you because you've got the time to do it whereas when you've got a child I definitely do, do some work when he goes to bed but I also very much value my down time so I tend to not to allow myself not to go back onto my computer as much as I can, so yeah I think in those early stages there was a narrative of I should be doing the best, I should be the very best at what I'm doing and I think all my experiences that led up to me getting onto a doctorate have to be that way in many ways otherwise you don't do that path and then you have to kind of reset yourself when you get on it and be like oh I don't actually know anything	All of a sudden you feel okay – <u>reassurance from others meaning so much</u> Being the very best in both (work and mum) <u>- initially seems to be part of her 'old self' speaking up.</u> Then describes how *actually* (at the same time) her capacity at work has to yield around her baby now, who comes first. She can no longer give more than her contracted hours to work - the boundary between home and work is clearer now, previously there was more overlap There's nothing I can do about it, <u>her hands are tied</u>, she needs to pick her son up – <u>so being the best at work is not entirely derived from emotion, but also her responsibility and practical issues?</u> A big shift and a big change - training before children was all consuming and now there is much more of balance to be had working as a mum <u>Values down time but does have to stop herself from doing more work – a tussle between old self and new?</u>
Prioritises motherhood Acquiring realistic expectations of self Succumbed to being time-bound Differentiating between home and work Discovering self-care Sometimes it's hard not to do more work at home		

Her work/life balance has completely changed She's had to lower her expectations of herself to be feasible as a mother Detaches from her baby Conserving energy for both	I've pretended I did to get here and then I don't know anything so now I've got to learn it all umm but yeah I feel as though perhaps you know if you'd have asked me kind of two years ago how yeah my narrative for life it would be like I should be the best I can, and now it's very much like I've just got to be as good as I can when I can and it's okay if I'm not. **Q15** Yeah, yeah, okay. Umm would you say kind of say becoming a mum has affected your identity professionally or personally? I guess that might be similar to what you've just said about going from wanting to be the best to good enough, but anything else on identity that comes to mind? Yeah, umm (pause) weirdly enough I don't really feel as if I identify with being a mum at work I don't know whether or not it's because it's a new job like I moved to this area fairly recently a year ago moved into this job six months ago so and a lot of the people I work with aren't my age they're a lot older they're like ten years older perhaps, five or ten years older so when I have conversations at work as bad as it sounds I don't really feel as though I involve Zac* in those conversations or even consider him as part of those conversations. I feel as though work is work whereas I guess when I look back on other jobs that I've had which is maybe more reflective of assistant roles or PWP role where there's more people your own age group that my personal life is very much part of my work life you know what I was doing that evening or who I was seeing or it was all just part of the conversation whereas at the moment it does feel as though they're very separate entities even though they're probably more kind of encapsulated than ever because actually you have to balance both equally in terms of what I actually bring into work and bring into the therapeutic room both with the client or even	You don't get on the doctorate without the mindset of being the best Conned her way through being the best to get a place, then started her learning from scratch – didn't realise how much she didn't know until starting the course? Her outlook on life was different two years ago, motherhood has changed her Her story and experiences leading up to motherhood were 'I should be the best'. Now, as she navigates being a new working mum she wants to be as good as a can, but she also adds that it's okay if I'm not, as if she experienced days where she doesn't feel good at all. Similar to Winnicott's the good enough mother? The unpredictability of motherhood – the outcome is not always based on your input or in your control. The significance of work for her has changed from being a near top priority to it being another important aspect of her life, but fitting around a new identity as a mum Don't really feel as if I identify with being a mum at work – she's more separated from her colleagues at work than pre-qualifying Doesn't share as much about her personal life at work as she has in previous roles, feels different to her colleagues – doesn't think of her baby when chatting at work. As bad as it sounds – another source of guilt? This isn't what a mum 'should' say, you should want your baby in every part of life?

Preserve wellbeing Tries to forget Survival mode Self as a mother is hidden Coming back to work during lockdown and usual work wasn't happening	in my supervision I always find myself when someone says oh you know how you getting on how's Zac* if my supervisor asks me that I'm like oh yeah he's fine and I'm not sure I divulge if he wasn't fine unless it was affecting me being able to go to work I don't feel as though I involve it. Umm I don't know why that is as I said I think it's maybe because I'm new, I'm new to being a mum and working and I feel as though I want to keep them both separate umm also maybe it's the element of the work I'm doing, so a lot of the work I'm doing is trauma based umm there's a lot of abuse involved with that trauma and I think part of me just doesn't want to associate those two things, I don't want to associate my child and think about a child and think about abuse, all those things I don't want to link together so I think in my head I compartmentalise them. And I'm mum at home and I'm Psychologist at work and then if people ask me I'm a mum, but I'm a Psychologist at work, I guess, I keep them even though I'm yeah I keep it very separate in my mind and I'm not sure why that is yet but I think that's why. **Q16** Yeah okay. And what about umm your experience of returning to work how did you find that? Yeah so when I returned to work after my mat leave? Yeah? How did I find it, well, it was I mean it was April so obviously lockdown happened in March so it was all really up in the air the course didn't really know what was going to happen cos I basically wasn't living in London so when lockdown happened we decided to move out of London to live with Ben's* parents because I still had a month left of mat leave and we had no outdoor space so I just said we should just leave London you	Motherhood and work are separate but also more entwinned than ever – another paradox in motherhood. **Having** to hold both things **equally**, it wouldn't be manageable to bring everything as a mum to work and still hold enough space for clients. This sounds like a careful balance she's forced to reach and still early days, she hasn't been tested if Zac wasn't fine yet *Balance both equally is precise, as if there is not much wiggle room? So, like walking a tightrope, would it be easy to slip?* Is attentive to not bring the demands motherhood into work and the therapy room. Is she saying it's not possible to be there for the client if she allows the realm of herself as a mother to enter the room? How much energy and effort does this take? I want to keep them both separate – it would be too much to encompass the full realm of motherhood at work? An exchange from mother to Psychologist, can't be there for both simultaneously although she feels unsure about why It would be too upsetting to remember her own baby when hearing stories of abuse. She compartmentalises the two areas as a coping/defence mechanism so doesn't have to bear imagining the awfulness in the world happening to her child. Competing social identities (Crisp, 2011) She explains this as one of the reasons she views herself as a Psychologist first at work and keeps her mum identity distant/hidden

Appendix I

Extract of Personal Experiential Themes for Jessica

<u>Increased empathy</u>

Survival mode p24

'I don't want to associate my child and think about a child and think about abuse, all those things I don't want to link together so I think in my head I compartmentalise them'.

Keeping her baby out of mind p29

'I try very hard to kind of create that brick wall between the thought of that happening to that person . . . versus you know the idea of that ever happening to my son'.

Battling between therapy and mothering p29

'A constant battle of this kind of like allowing myself to immerse myself in this person's experience . . . versus not allowing that, to implicate you know, me, my emotions and then my emotions towards my son'.

Highly sensitised p29 & 30

'I do feel as I'm more emotional'.

'Definitely more emotional since I've been back'.

Bottles up vulnerability p30

'Maybe feels too early on in motherhood for me maybe and too early on in my career to really know what to do once I've opened that door and let out those emotions how do I then shut the door and contain them again?'

Easily triggered p 28

'I would never be triggered so easily you know people say in the early stages of pregnancy you start crying at an advert I feel as though that's kind of stayed with me really ever since I got pregnant that I get very tearful or very emotional or things really trigger me very easily'.

Guarding self p28

'I've had to really check in with myself'.

Child advocate p29

'This huge element of me that screams that shouldn't have happened'.