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"You've got children haven't you…?": Involuntary childlessness as a neglected aspect of therapist diversity in the professional context

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Abstract: In a previous article we detailed the findings of a qualitative research project into the lived experience of qualified involuntary childless therapists and showed how this connected to work with clients in the therapy room. The project also examined the experience of involuntary childless therapists in relation to the wider profession and counselling theory (areas which are missing from the existing literature). This current article presents these findings and discusses their implications. Five participants completed a semi-structured interview. Interpretative Phenomenological Analysis was used to analyse interview transcripts and draw out aspects of the lived experience of involuntary childless therapists. A variety of experience in the professional context was found. For some participants supervision was a safe space to discuss their childlessness and for others it was a place of alienation, anxiety and potential judgement. The participants tended to find themselves feeling on the edge of the therapy world and the issue of microaggressions around childlessness is discussed. In relation to a therapist developing their theoretical approach the participants' experiences demonstrate the need for reflexivity around how childlessness may impact the process. This article highlights the importance of parental status being recognised as a significant and often unacknowledged aspect of difference and diversity for therapists.

Keywords: Childlessness, qualitative research, diversity, supervision, counselling and psychotherapy.

As a married therapist moving from my late 30s to early 40s I (the first author, Martin) was progressing towards an age which symbolised the end of any potential possibility of me having my own children. Consequently, I began to grow in awareness of my desire to have children whilst remaining childlessness and its intersection with my therapy practice during a second training as a practitioner. Initially, I became more conscious of my childlessness in the training environment whilst observing another student progress through their journey of pregnancy and childrearing. I experienced sadness and loss as I began to acknowledge that this journey towards parenthood was one that I would probably never be part of my life. This growing awareness of my childlessness then moved to the therapy room. I began to notice how my own childlessness appeared in sessions with clients – I sometimes felt a client's critical judgment and experienced aspects of proactive countertransference (Clarkson, 2003). Additionally, I observed how I experienced my childlessness in the wider professional context (outside of client work) with other professionals being silent on the issue or when assumptions around parental status were being made. I began to realise that my childlessness was an unacknowledged (both by myself and others) source of

struggle with me experiencing aspects of alienation, anxiety, and frustration in the wider professional context. It is this subjective awareness which motivated me (an already a qualified therapist) to engage in wider research of the phenomenon as part of a further therapy training course.

Contexts of Therapist Childlessness

Therapists Childlessness

Childlessness is an aspect of physical and social diversity which normally unfolds during a person's 20s-40s rather than necessarily being present throughout life from birth. It is a reality for one-in-five women and one-quarter of men aged 42 years (Berrington, 2017). The membership figures of the British Association for Counselling and Psychotherapy (BACP) – the largest professional body for counsellors and psychotherapists in the United Kingdom (UK) in 2017 were approximately 45,000 with 69% of members being over 45yrs old and a gender ratio of 16% (Male) to 84% (Female) (BACP, personal communication, November 1, 2017). It would be reasonable to estimate that at least 5000 BACP counsellors and psychotherapists are childless in the UK. This estimate would encompass a variety of experiences of childlessness, from those who are voluntarily childless (i.e. have made a considered decision that they do not want to have children and experience happiness as the freedom they have) to those who are involuntarily childless (i.e. have a desire to have children but are unable to for a variety of reasons and consequently experience a complex subjective response encompassing emotions such as loss, shame, envy and depression). Although the numbers of therapists who are childless are potentially not insignificant, therapist childlessness is an under researched area of diversity in the counselling and psychotherapy literature. Most extant literature focuses on therapists' work with clients who face childlessness.

Only three published pieces of research (Adams, 2014; Leibowitz, 1996; Stokley & Sanders, 2019) explicitly explore therapists' experiences of their continuing involuntary childlessness in relation to therapeutic practice. All three concentrate on therapists' experience of their childlessness when in the room with clients and highlight issues such as countertransference, displacement of parental desires, self-disclosure and potential client judgement. None of the research considers wider therapist experience outside of the therapy room in broader professional contexts or the diversity implications. In the professional context, therapists may experience unconscious prejudice about whether they will be an adequate therapist for a particular client due to their childlessness. I have noticed (in an organisational context) that the majority of clients allocated to me tend to be those without children, or at the very least without younger children. Although anecdotal, this observation does raise important questions about potential unconscious bias in the profession.

In our previous article (Stokley & Sanders, 2019) we detailed a qualitative research project which explored the lived experience of involuntary childless therapists in relation to their adult therapy work using interpretative phenomenological analysis (Smith, Flowers & Larkin, 2009). The findings complement the previous literature through a careful listening to five therapists' voices about their lived experience of their involuntary childlessness in their therapy work. We reported five themes drawn from the participant interviews in relation to childless therapists' work when with clients: i. clients judging the therapist as being less competent compared to a therapist who is a parent; ii. the impact on the childless therapist's subjective sense of self when with clients; iii. how the emotional struggle of therapist childlessness appeared in the therapy room; iv. the metaphor of having a 'parental role' in the therapeutic relationship; and v. also issues around self-disclosure of therapist childlessness. These themes demonstrated a need for childless therapists to take a reflexive approach to their own childlessness emerging in their work with clients.

Additionally, the project also explored the participants' lived experience in the professional context and highlighted therapist childlessness as an important and often unacknowledged aspect of therapist diversity.

The aim of this article is to report the findings of the project regarding the issue of therapist diversity. In terms of ethical publication, reporting the findings of the project across two separate publications is justified, firstly, in respecting the full contribution of involuntary childless therapists whose voices have previously been almost silent in the literature; and secondly, in the fact that the this current article focuses on issues of therapist diversity hence there is little overlap with our previous publication (Happell, 2016).

Diversity and the Childless Therapist in a Professional Context

There is a large body of counselling and psychotherapy literature which explores the importance of aspects of clinical practice around client difference and diversity. The literature covers issues around the 'big seven' social categories of class, ethnicity, age, gender, sexuality, disability and religion or spirituality (Moodley & Murphy, 2010). In an introduction to a special edition of the journal Psychotherapy Theory, Research, Practice, Training exploring therapist diversity, Gelso (2010)

notes that an emphasis on client diversity is of significant importance. However, Gelso also observes that the diversity status of therapists themselves is often unacknowledged with us "seeming to forget that the therapist's diversity status is also a key element of the treatment process" (2010, p.143). In the same edition of this journal Nezu (2010) explores how his diversity status as an ethnic minority therapist impacts his work from both his point of view and the client's. In addition to the standard categories of difference and diversity, he highlights physical stature and interracial marriage as important areas for himself which have an effect upon a client. He writes that his diversity impacted his own perspectives and practice regarding theoretical orientation, formulation, and the therapeutic relationship. The awareness of how theoretical orientations of therapists could be influenced by their diversity status is an especially relevant question for those therapists who are childless. This is because all therapeutic modalities highlight the importance of child development in some form and in varying degrees for therapeutic practice. It is interesting to note that in the special edition of the journal mentioned above parental status and the issue of childlessness are not explicitly included in the discussion of the therapist's diversity status.

Intersectionality and Therapist Childlessness

Childlessness can be both an invisible or a visible area of diversity for therapists in that parental status can be openly disclosed or hidden. However, this does not exhaust the ways of thinking about childlessness as an issue of diversity. The literature indicates that the lived experience of childlessness is also shaped by gender and culture and therefore it is a psychosocial experience (e.g. Dyer, Abrahams, Hoffman & Van Der Spuy, 2002; Greil, McQuillan & Slauson-Blevins, 2011; Van Balen & Bos, 2009).

There are two main approaches to diversity that are recognised the in the literature: a difference orientated approach or an intersectional approach (Hanappi-Egger, 2012). The difference orientated approach to diversity imposes immutable categories on people thereby identifying the essential distinctions between groups. It tends to reify categories without recognising how difference can be socially constructed. In this approach 'difference' is thought to reside within people and this is brought to social interactions, rather than social interactions having a role in constructing difference. Generally, a difference orientated approach identifies one main area of diversity, such as gender or race, and focuses on this at the expense of other areas.

Alternatively, an intersectional approach identifies how diversity is a complex social phenomenon which includes multiple aspects of difference. In the intersectional approach socially constructed categories of difference (such as age, gender, race, sexuality etc.) are mutually interdependent and 'intersect' thereby impacting each other. It is therefore impossible to isolate one aspect of difference without considering the influence of other aspects of difference on it. Hill Collins and Bilge (2016, p.2) argue that with an intersectional approach "people's lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other". The intersectional approach allows a holistic approach to identity and diversity rather than reifying single aspects of identity. It promotes a complexifying of the nature of difference (Houshmand, Spanierman, & De Stefano 2017). This approach coheres well with the psychosocial nature of the phenomenon of involuntary childlessness, which recognises that the experience of childlessness is socially constructed and interacts with other aspects of difference such as culture, gender, age, sexuality, race, and so on. It allows for the fact that parental status is only one part of a person's whole social identity, with the diverse parts of social identity mutually interacting. An intersectional approach would therefore recognise the multilevel and complex nature of the phenomenon in relation to aspects of social identity, together with how the lived experience of childless therapists is impacted by socially constructed views in the professional context.

Difference and Discrimination

Proctor (2011) argues that language around difference and diversity is becoming depoliticised and issues of power, prejudice, inequality, and discrimination are being lost in the race to use language that celebrates each and every aspect of difference. Parental status and childlessness should not be just considered an issue of difference to be celebrated (it sometimes is termed 'childfree' to positively celebrate the opportunities of being without children) but it needs to be recognised that it is also can be a painful experience involving prejudice, stigmatisation and subtle devaluation of the person. This is not just a reality for the childless clients that therapists work with, but it is also a very real possible experience for therapists themselves. There is no immunity from this also occurring in professional interactions. Therapist behaviour around power and diversity towards clients is hugely significant in the therapeutic relationship. However, therapists themselves are also on the receiving end of power and discrimination which is potentially wielded by organisations and the social structures that make up the professional context of therapists' work. For example, Simon (2010) highlights that on some counselling or psychotherapy training courses

marginalised groups do not disclose parts of their identities because they do not feel comfortably part of the group. This would especially happen when aspects of difference are not recognised or are dismissed in the group. Marshall (2004) in the conclusion to her book on difference and discrimination in psychotherapy and counselling comments about the need to critique the ethos in counselling organisations and to challenge any prejudice there which may potentially manifest itself in the therapist's work. Our focus, therefore, is not on the power that the therapist potentially wields in the therapeutic relationship, but on the social/organisational structures which therapists are part of professionally, and how those structures can potentially reinforce experiences of stigma and marginalisation around childlessness.

Professional Ethics and Diversity

There is a general acknowledgement of the importance of an ethical commitment to equality and diversity in work with clients (BACP, 2018) but what appears less recognised is an awareness of the lived experience of the therapist's diversity status (including therapist childlessness) in wider professional relationships in the counselling and psychotherapy world. The parental status of the therapist could therefore be highlighted as an experience of diversity which often remains unvoiced for the therapist in their clinical practice and professional experience and is missing from the BACP ethical framework for practitioners.

Method

We have previously given full details of our qualitative research study (Stokley & Sanders, 2019) regarding the phenomenon of therapist involuntary childlessness, so it will just be summarised here. Interpretative phenomenological analysis (Smith, Flowers, & Larkin, 2009) was used to study the lived experience of childless therapists in relation to client work and wider professional issues. Selection criteria for participant inclusion in the study were: a qualified therapist, UK based, works with adult clients, would have liked to have children but have not been able to (for various reasons) and was able to give a rich description of their involuntary childlessness in relation to their therapy practice. An initial online survey acted as a pilot study to test an interview schedule and to also provide a platform for recruiting participants. Four involuntary childless female participants were recruited, and their experiences documented using audio recorded semi-structured interviews. Difficulty was experienced in recruiting male participants, therefore drawing on the ideas of heuristic research (Moustakas, 1990) where the researcher is involved as part of the research process I (Martin) completed a written self-interview (using the same interview schedule as other participants) so my own experiences of involuntary childlessness as a therapist became the male voice in the study. The semi-structured interviews explored experiences of therapist childlessness in the therapy room with clients, therapist experiences of their childlessness in supervision and wider professional relationships, and experiences around how therapist theoretical orientation may have been influenced by their involuntary childlessness. Transcribed interviews were analysed using the processes outlined by Smith, Flowers, and Larkin (2009) so that similarities and differences across participants could be identified. Three main (superordinate) themes and nine subthemes (subordinate) emerged from the data analysis, see Figure 1.

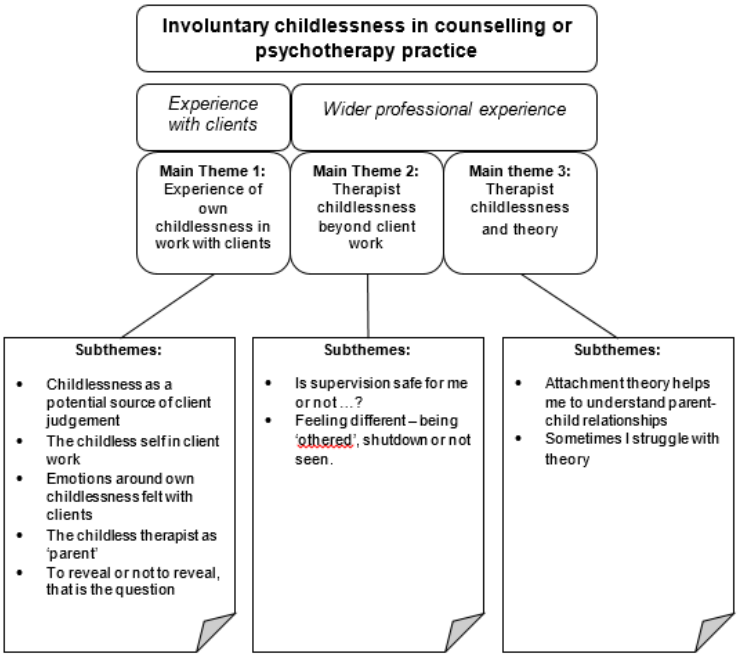

Figure 1: Main themes and subthemes

Participants

All five participants (four female and one male) were qualified between one and eleven years and worked integratively as therapists. They were aged between 34 and 55 years old and their stated reasons for their childlessness were: infertility, other health problems or undisclosed. Participants chose their own pseudonym which they would be referred to in the research to ensure anonymity.

Findings

In this paper we will enlarge on the findings of our project around the latter two themes detailed in Figure 1: 'therapist childlessness beyond client work' and 'therapist childlessness and theory'[1]. I (Martin) refer to my own self interview and experience in the first person.

Therapist Childlessness Beyond Client Work

Analysis of the interviews demonstrated that therapist involuntary childlessness is a critical issue to consider in the room with clients (Stokley & Sanders, 2019). The analysis also shows the importance of considering experiences in relation to the wider professional context. Two subthemes highlight this.

Subtheme 1: Is supervision safe for me or not …?

Feeling safe enough to be open about their childlessness in supervision was a significant issue for the participants. Participants describe a variety of experience around talking about their childlessness in supervision. This indicates the importance of an idiographic perspective in this subtheme. Some participants felt able to disclose all aspects of their childlessness in relation to their practice, whilst others felt less safe, which hindered authenticity in some areas.

Tarka was able to be congruent with her individual supervisor and process her emotions around childlessness because she did not "want that to go into the therapy room". She described feeling generally safe and being able to talk openly, although there were some aspects she held back:

> I know that I can say whatever I want to say, and I try to apart from the little niggly bits that I feel unsure about … I feel confident with him, I trust him, we have a good relationship (Tarka)

Tarka's supervisor helped her to understand and provided insights which she felt were missing due to her childlessness. Yet she experienced a fear that her supervisor may judge her as not being good enough due to her childlessness:

> I think that sometimes there might be things that I might avoid saying because I might think 'oh is he going to think that I'm OK'. Does he think that I'm going to be good enough, you know, maybe there might be certain things that I would avoid saying because of that (Tarka)

Sarah also found individual supervision a safe place where she could talk about the occasional deep distress she felt around her childlessness. She could do this without her supervisor trying to rescue her from the sometimes unending emotions of loss ("bottomless with grief"). Sarah linked this felt safety to the Winnicottian idea of 'being held' (Winnicott, 1965/2018) in her experience of involuntary childlessness as part of the supervision relationship. Her needs, desires, and emotions around wanting to have children were allowed to emerge in the holding environment. For Sarah being 'held' meant that the supervisor was a supportive reliable presence. He could be present with the variety of her emotions around her childlessness (such as irritation around people's unhelpful comments) as she processed them. Sarah's supervisor also aided a deeper level of processing:

> He might offer reflections or curiosities or challenge me on what I'm thinking but it always feels um… caring … or empathetic (Sarah)

For both Sarah and Alice having an individual supervisor with some personal experience of childlessness helped them to connect emotionally and enabled trust to develop. However, for Alice there was still a certain amount of raised anxiety around talking to her individual supervisor. She found she experienced supervisor-initiated conversation around childlessness difficult:

> I think that if, if she mentions these issues, I find uncomfortable it does bring things back for me a bit about my, again my feelings of failure (Alice)

There is a sense for Alice that individual supervisor-initiated conversation could be experienced as deeply shaming. It could trigger feelings which impacted on her sense of self as a childless person and were normally kept hidden away by Alice. In contrast, Alice appeared to feel safer in group supervision:

> I got to know them guys very well and my supervisor there so I wouldn't have had any hesitation in in raising it (Alice)

Alice attributed feeling safe in group supervision to the deep relationships and their sensitive and non-judgmental attitudes.

Rebecca intentionally was open with her individual supervisor about the health conditions which led to her childlessness:

> I went in there being very honest from the beginning, so even as I was searching for a supervisor… when I sent my initial email over … I said these are my health conditions

[1] Some readers will note a rewording of the subthemes in this article in comparison to the preliminary findings reported our previous article (Stokley & Sanders, 2019). The subthemes were reformulated in response to peer-review comments that the subthemes could capture the lived experience more closely. The substantial findings have not changed.

> just to let you know, is that going to be an issue and … so I went in there with that self-disclosure from the beginning (Rebecca)

She described always feeling supported and never judged. In contrast to Alice, when Rebecca's supervisor intentionally checked in about her childlessness and client work Rebecca found this a supportive experience. Yet, also in contrast with Alice, Rebecca found group supervision fundamentally less safe. Rebecca felt as if she was on the outside as a childless person gazing in and there was a sense of feeling alienated from the rest of the group. She found continual changes in group members destabilising as it meant "it was difficult to have that security with them because it all changed all over quickly again … somebody new in and out, in and out". Rebecca also questioned whether the group would be able to empathise with and accept her emotions as a childless therapist:

> There's an element of me that thinks that maybe they don't understand me because … because they have children and a lot of them have had children for a long time … and not understanding what it is like to feel like that thing is missing or to feel some of that frustration towards your client because you don't have a child and they're behaving in the way that they are or … that real strong emotional response to the client having the abortion. (Rebecca)

Rebecca appears to experience an internal split. The childless part of herself feels that other therapists will not be able to comprehend its emotional reactions to what is happening in the therapy room. This part of herself therefore tended to hide its countertransferences in group supervision to protect itself from judgement.

For myself, I focused on my experience in group supervision and described feeling alienated from and silenced by the group due to the assumptions around parenthood which were made:

> One turns to me and says "you must know about these things … you've got children haven't you …" but doesn't wait for response and the conversation continues. My detachment turns to feeling alienated, there is no acknowledgement in the room that a counsellor may not have children or be able to have children. (Martin)

Here, diversity around parental status was ignored, including by the group supervisor. An assumption of a parental norm was made, and I felt unseen, not given a voice, and frustrated that my experience as a childless male was being unacknowledged. Like Rebecca, I also experienced anxiety about judgement of my therapy practice due to my childlessness:

> Will I be judged by others because I struggle to understand a client or their situation because I don't have children? Will I be judged because I am wrestling with something which is a consequence of me not having children? (Martin)

In addition to trust being significant for feeling safe to talk about childlessness, I also noted that my own journey around childlessness impacted my openness in supervision:

> As it felt safer for me to explore my own feelings around my childlessness both in my own counselling, as part of this project and in the experiential group on my course so this in turn has made me be willing to take more risks in sharing my childlessness in supervision as well. (Martin)

The research impacted me as participant which enabled me to feel safer to talking about my own childlessness experience as part of supervision.

All the participants had varying experiences of talking about their childlessness in supervision. Some felt safe and experienced a sensitive handling of the issues, whilst others feared judgement. The supervision environment and not necessarily the mode of supervision (group, individual etc.) can potentially impact a childless therapist making the decision about whether to disclose or not. Particularly important are assumptions around parental status by supervisors or other group supervisees. However, it is important to additionally observe that for one participant their personal journey of childlessness affected their freedom to be authentic in supervision. Feeling safe in supervision to discuss therapist childlessness is likely to be linked to a complex interplay of the supervision environment and the therapist's own personal journey of childlessness.

Subtheme 2: Feeling different – being 'othered', shutdown or not seen

Apart from Rebecca, all participants referred to relationships with other therapists or organisations as significant in relation to the experience of their childlessness. The experiences seem to reinforce the participants' feelings of being different due to their childlessness. Tarka sometimes felt silenced around other therapists in discussions around children's and parents' behaviour:

> I don't know what that comes across as me being, maybe … I'm angry because I haven't had children myself, I don't really know, but it feels like I'm not allowed to say something. (Tarka)

She felt that sometimes she was silenced in relation to certain issues due to her childlessness. She indicates that she felt

anything she expressed could be interpreted (or assumed by others) as being rooted in own anger around being childless.

For Alice, her experience of her involuntary childlessness was a palpable experience as she related to other therapists in a professional environment. She described feeling the odd one out due to her childlessness. She also expressed how sometimes when therapists talk about their families, she found it hard to connect with them:

> Apart from one, all of my colleagues in the organization I work for are parents. So there is that sense of um being the odd one out [laughs] in that situation. Um, they've never voiced that and I don't feel it from them, erm, openly, but I think underneath it's probably within me. You know … they perhaps wondered why I haven't got a family. Or, again it's that connection you know when they talk about their families and I just can't get a feel for it, it goes over my head really. [laughs] (Alice)

Both being 'the odd one out' and being not able to 'get a feel for it' indicate the deep sense of being different that Alice experienced.

Sarah likewise sometimes experienced a sense that she was different from other therapists or was being 'othered' due to her childlessness:

> Maybe with colleagues, counselling colleagues, um, there again there's that expectation that er, I'm a woman of childbearing age, that I would have children and ...sometimes it feels like there can be a bit of kind of 'them and us'. That they're women that have got children and I'm a woman that hasn't got a child, um, so I can feel that sometimes … I suppose that I'm not part of that group, I don't belong to that group. Nothing's ever been said explicitly, er, yeah, nobody's ever made you know disparaging comments or said, "oh you wouldn't understand" or anything, it's just a, a sense. (Sarah)

It would be easy to explain away Sarah's, Tarka's and Alice's experiences as examples of projection of their own unconscious self-judgement of their childlessness. Yet, it is important to hear the depth of their experiences and question whether those experiences are based on the wider experience of societal responses to childlessness being played out in professional therapy relationships. It is this that could lead to the sense of alienation.

Sarah also experienced an uncaring attitude from an agency which left her feeling unseen and unacknowledged. In response to an agency's question, she had informed them that she would find it difficult to work with clients experiencing miscarriage, infertility, or issues around abortion. This was due to her raw emotional experience around her childlessness at the time. The agency, after agreeing not to give her these clients, proceeded to allocate her someone from this client group:

> That was distressing because I had asked them not to give me those kinds of clients and that hadn't been respected. So that, that was really hard to deal with. (Sarah)

Sarah was clearly frustrated that the agency placed her in this distressing situation and that they did not recognise the significance of her ongoing raw emotions as a childless therapist. There is a sense in which Sarah was not seen holistically as person, with the childless parts of herself being unacknowledged or being considered unimportant.

I highlighted that there seemed to be an assumption of a parental norm throughout the therapy world which also mirrors wider society:

> There is a natural assumption of parenthood and people having children … Even in counselling CPD workshops it has been my experience that childlessness is never mentioned, again the assumption is that people always have children. (Martin)

I felt that in the counselling world therapist childlessness was under recognised, which for me led to a sense of sadness around how such an important part of a counsellor's experience could be hidden away. I also experienced a sense of frustration that in a profession which values empathy, people could be so unempathetic regarding therapist childlessness. The experience of the childless other was not being recognised or seen.

For the all the study participants there seemed to be a sense that they were partly on the outside in the therapy world with their perspectives not always seen as valid or important due to their involuntary childlessness. Their psychosocial experience of involuntary childlessness is not always taken into account, not only in supervision but in the wider profession.

Therapist Childlessness and Theory

This smaller theme in the study findings highlights the mixed thoughts that participants had about the impact their diversity status as a childless therapist had on their understanding and experience of, and identification with, theory. Both Sarah and Rebecca felt childlessness had no impact on their understanding of theory. Sarah specifically felt she could draw on her own childhood experiences to help her understand

theory and having experienced being a parent was not necessary:

> I suppose it's because I can see it from my own experience… and .... I feel I can relate to it, empathetically …so for me it doesn't feel that it's important for me to have had a child to understand what attachment is like. (Sarah)

Subtheme 1: Attachment theory helps me to understand parent-child relationships

Two participants found attachment theory a source of help and a useful aid to understanding the missing experience of parenting. Sometimes with clients, Rebecca found herself wondering if she was naive about parenting. This led to self-doubt and therefore she tried to gain a theoretical understanding of parenthood to make up for her missing experience:

> I think maybe that's part of why I've done a lot of extensive CPD in parenting and attachment theory and things like that… so I can … maybe understand those parenting styles a bit more (Rebecca)

For Rebecca, this growing theoretical understanding of parenting and parent-child relationships reduced her self-doubt regarding her practice, but she still found herself questioning whether she fully understood the reality of parenting.

Tarka likewise drew on attachment theory to be able to understand the relational dynamics between a client and their child. This thereby enabled her to explain these parental dynamics to her clients:

> So I'm learning a lot more about that kind of stuff now and I can understand that enough to be able to relay that to clients when we're talking about what's going on with their children … when it comes to theory I can kind of try to use that to explain to parents what might be going on in relation to their relationship with their kids and stuff like that and even with them, so, so the knowledge of that sort of stuff is really useful. (Tarka)

For some participants, attachment theory therefore was a helpful resource to aid understanding of parent-child relationships which had not been personally experienced. Theories of child development provided a theoretical understanding of parent-child relational dynamics, thereby bringing understanding about missing parental experiences for the therapist and this consequently benefitted the client.

Subtheme 2: Sometimes I struggle with theory

In contrast, three participants identified theory as a source of struggle. Tarka and I related the struggle to understand theory linked to our childlessness. Tarka in response to being asked whether there were any aspects of theory she has struggled to understand because she did not have children commented:

> All the time … [laughs] … constantly. How does it fit, do you try, how do you make it fit as well? … Then you think oh, oh God, is that me again, you know and there are, when you learn something new, is that me again is that what it's like, is that what it is. (Tarka)

Tarka's words clearly communicate her frequent struggle to understand and grapple with theory. She perceives there is a link to her childlessness. She goes onto explain how she is on the continual search for answers, using theory to try to understand. Additionally, Tarka explained that she specifically sought other metaphors, such as her experience of keeping dogs, to help her understand parenting. Likewise, Tarka described her struggle with systemic family theories:

> And I look at the systemic family videos and I think 'look what's going on there between them there's a lot of hostility'. You know there's a lot of issues that they're trying to resolve and everything and yet these parents would give their life for their child … I can sort of look at that stuff and think what, what is that about? Why, why … so again it makes me feel that I am missing something. I'm missing some feelings. I'm missing some experiences. (Tarka)

This quotation shows the struggle of trying to grasp client parental experiences in the context of theory. Tarka perceives that her ability to understand what's going on from a theoretical point of view is intimately linked to her own childlessness. There is a sense of confusion and internal wrestling which Tarka demonstrates here.

For me, I highlighted how missing living examples of parenting and child development made theory more difficult to grasp:

> For me as a childless person the only understanding of child development I have is from books and the theory lectures on my course. I feel I have had to work a lot harder at understanding things like attachment theory or some of the psychodynamic models of child development because I only have written texts from which to learn. As I think about people who are parents or who have been parents, they have living examples which they can reflect on from their children and experience of parenthood. (Martin)

I perceive that I have 'deficit within' because I do not have some of the 'living examples' which help others to understand and bring to life that which is found in texts. I experience that I can be slower to grasp developmental theory with much more mental energy being required, when for others understanding may be easier and with less mental exertion.
I do recognise how I could use my own childhood to understand theory but feel something is missing:

> [I am] missing a tool in my toolbox. Therapists with children have a greater toolbox made up of their own childhood experiences and their experiences with their own children and both of these help them to understand theory. (Martin)

Like Tarka, I describe wrestling to understand and there is the feeling for both of us that at times we must put more work in to grasping theory because of our childlessness.

Sarah used her own childhood to understand theory, but Sarah's source of struggle with theory was different and related to knowledge of theory making her question whether she could be a social parent (through adoption or fostering):

> Every so often I think "oh maybe I'll adopt or maybe I'll do some fostering" and then I think "oh… I don't know if I can do it because I know about attachment issues and how is that going to show up and play out and all of that stuff". (Sarah)

Sarah felt like she now knows "too much to have children now" with theory raising her anxiety about her potential parenting abilities as a social parent. In addition, awareness of how previous parenting may influence any child who was fostered or adopted made the thought of becoming a social parent extremely more difficult. Sarah's wrestle with theory was different in that it was less about understanding theory and more about how her knowledge of developmental theories now impacted her confidence in her potential parenting abilities.

All participants struggled to identify with this main theme of 'therapist childlessness and theory' at some level which may indicate that this aspect of their childless experience is more at the edge of their awareness. There are, however, good indications in this research that theory is experienced in multiple ways (positively, negatively, and neutrally) in relation to childlessness for the participants.

Discussion

The findings of this study extend the previous research beyond the domain of the therapy room and explore the involuntary childless therapists' experience of their diversity in the wider professional context and in relation to theory. This gives a richer understanding of the potential lived experience of an involuntary childless therapist. Specifically, it seems as if there is a complex interplay of the childless therapist's diversity status with their professional relationships (in supervision, with organisational structures, and with other therapists) and theoretical orientation.

Childlessness and Supervision

A variety of experience around group and individual supervision was found. For participants, the key issue was around felt safety leading to authenticity and openness around talking about childlessness in supervision. Although this felt sense of safety can be linked to the therapist's personal journey of childlessness, the nature of the supervision environment was significant.

A 'parallel process' is the unconscious process whereby that which is being enacted between client and counsellor is also enacted between counsellor and supervisor with the counsellor playing the 'role' of the client and the supervisor playing the 'role' of counsellor (Watkins, 2017). The participants in our research do not describe this traditional form of parallel process, but they do indicate a potential form of parallel process where anticipated and real judgements of clients around childlessness (Stokley & Sanders, 2019) are unconsciously mirrored in the supervisor-supervisee relationship. The supervisor can enact the role of client towards the counsellor by making real or anticipated assumptions or judgements which are a mirror of what is being played out in the counselling room. This can potentially hinder exploration of aspects of the therapy work with the client as the supervisor replicates the same environment with the supervisee. It is important for supervisors to be aware of this dynamic at work as it can reinforce a childless therapist's felt stigma. Our research indicates the need for supervisors to be sensitive to the issue of therapist childlessness and potential ruptures of the supervision-alliance through mirroring relational dynamics present between client and counsellor around childlessness.

The participants' experiences do give some examples of supervisors who proactively help create a safe space which offers a holding and containing environment for the childless

therapist. This enables the childless therapist's lived experience to be sensitively worked with as an important aspect of therapist diversity in client work and with other professionals. The generation of this safe space by the supervisors appears to be more of a personal stance rather than because of explicit training. The current supervision literature on diversity encompasses a variety of issues around race, culture, gender, sexuality, and disability but surprisingly diversity around parental status is unacknowledged. Hawkins and Shohet (2012) in their seminal text on supervision include a chapter on diversity which focuses mainly on culture and race. Page and Wosket (2001) suggest a broad approach to diversity in supervision including wider issues than race and culture, but again parenthood and childlessness is missing.

The silence around therapist parental status in the supervision literature is surprising given that our research demonstrates this appears to be an important diversity issue, with the therapist to needing to explore their own thoughts and feelings around childlessness and the therapeutic process. The intersection of childlessness with other diversity characteristics (e.g. race or gender) which are already mentioned in the supervision literature is a potential area for future research. From a practice point of view it is important for supervisors to ask themselves what assumptions they make about the (un)importance of parental status and how they can provide a sensitive and safe space where these issues can be explored by therapists in response to their professional practice.

Dismissal of the Childless Therapist's Experience in the Professional Context

Participants sometimes felt on the outside (being 'othered') or different in the professional context, as if their voice and experience as a childless therapist was not valued (shutdown and unseen). A childless therapist can find that natalist narratives (which promote a bias towards the social value of parenthood) or parental experiences are assumed. Some of the participants' lived experience explored in this project could be explained through the psychological phenomenon of projection or transference where wider societal attitudes (which have been internalised as stigma) are unconsciously brought into relationships in the professional community. However, this is not the whole story as the participants certainly provide some evidence of experiencing negative or dismissing attitudes from other therapy professionals. The therapy world needs to become more aware of its assumptions of a parental norm and encompass a wider approach to the diversity of therapist backgrounds, thereby making greater space for the childless therapist's voice and experience.

Writing about cultural difference in teams of counsellors Grant (1999) comments "Staff teams are part of society and as such are not exempt from the prejudiced attitudes towards difference that can be seen in society" (p. 109). Grant's comments are relevant in that supervisors, staff teams and the wider profession are not beyond unconsciously rehearsing the prejudiced and stigmatising attitudes of wider society towards those who are childless, including childless therapists.

Sue et al. (2007) explore the concept of microaggressions from a racial perspective in relation to clinical practice but they also indicate the wider applicability of the concept beyond race. A microaggression can be defined as "brief, everyday exchanges that send denigrating messages" (Sue et al., 2007, p.273) and these messages can be conscious or unconscious. Three categories of microaggressions are normally delineated (Sue et al., 2007; Houshmand, Spanierman & De Stefano, 2017):

- microassaults – a blatant intentional attack indicating the inferiority of another;
- microinsults – often unconscious insensitive subtle insult which puts down another person and demeans their identity;
- microinvalidations – often unconscious exchanges which invalidate the feelings, thinking or lived experience of another.

Whilst the participants did not describe any experiences which could be identified with microassaults, it is clear both microinsults and microinvalidations were experienced in the professional context by involuntary childless therapists due to their parental status. Sarah's description of an agency who ignored her painful experience around childlessness and proceeded to allocate her a client which caused her distress can be thought of as an example of microinvalidation. The agency unconsciously dismissed the validity of the emotional depth of Sarah's lived experience around her childlessness at that moment in time. Likewise, for myself when a counsellor said, 'You have children don't you …' and never stopped to hear an answer a microinvalidating exchange took place. There was an assumption of a parental norm which dismissed the reality of my lived experience as a childless male therapist. Additionally, my observation that in continuing professional development courses or workshops a parental norm is generally assumed could also be considered a microinvalidation as the importance of the childless experience is invalidated through lack of consideration. Tarka's experience of not being able to contribute to conversations on parenting and feeling silenced could verge on the realms of a microinsult if this were verbalised or indicated non-verbally by the other therapists. Sarah's experience of being able to identify a sense of 'them and us' and feeling different when with counselling colleagues because she does not have

children could be linked to subtle non-verbalised microinsults which communicate that 'you are not part of our group'.

There is therefore good evidence indicating that for the involuntary childless therapist there are multiple microaggressions around childlessness. The professional context may be one where there are subtle devaluations or insults around the lived experience of childlessness which lead to a sense of being on the outside. This indicates the need for greater awareness of childlessness as a diversity issue in the professional therapy contexts.

Childlessness and the Development of the Therapist's Theoretical Approach in the Professional Context

Although it was not the experience of all those interviewed, there is evidence that some participants experienced a greater struggle to understand aspects of theory and incorporate certain theoretical ideas into their developing professional practice. For some there was a perceived greater struggle to connect with or understand theory due not having children. Theory is then seen at times as a source of confusion (due to childlessness) and therapists underwent a process of wrestling with it to enable them to incorporate it beneficially into their theoretical approach.

More positively, some participants intentionally sought out theoretical models of parenting, such as attachment theory, to make up for perceived deficits due to missing parental experiences. Theory here was viewed as beneficial in nature. For example, Rebecca undertook extra training around parental styles. For her theory was something which was positively received and could be beneficially incorporated to her developing professional identity with minimal struggle. Her struggle was less with understanding theory and more with her own knowledge of the lived experience of parent-child relationships, with theory providing insight into that.

We cannot dismiss the lived experience of Rebecca and Sarah who felt that their childlessness did not have any impact on their grasp of theory. Reflection on their own childhood or seeking further training to make up for missing experience was significant for them, but they specifically did not feel their understanding was hindered due to their childlessness. This suggests that it is not necessary to be a parent for the therapist to be fully equipped to understand theory or to practice competently.

What can be seen is the need to acknowledge the variety of experience around theory for childless therapists and how a therapist's diversity status can impact engagement with and incorporation of theory into professional practice. Anecdotal evidence (Halgin, 2006) suggests that life experiences influence a therapist's developing personal integration or core theoretical model. Wosket (1999, p.23) also comments the "ingredients of personal integration will be mediated by the practitioner's understanding of their own individual pathology and experience of their own healing process". Horton (2000) suggests that a therapist's personal integrative model will be influenced by their personal belief systems. Ultimately, it is not possible to objectively separate our belief systems from our journey through life and the life experiences we have had (including childlessness) as they will consciously or unconsciously inform our ways of seeing the world. The implication is that a therapist's integration of theoretical perspectives into their practice will include an element of subjectivity. The process of developing an integrative approach to therapy will be linked to a therapist's personal experience of difference and diversity. This means a therapist's developing theoretical stance in the wider professional context cannot necessarily be divorced from their experience of childlessness. It is suggestive that a more reflexive approach to the process of evolving a theoretical integration is needed which allows for a therapist to become more aware of how their parental status impacts their understanding, development and use of theory.

Whilst the participants were able to identify consciously how their childlessness impacted the development of their theoretical approach, it is important not to neglect the potential unconscious bias or unconscious impact that childlessness may introduce to a therapist's developing theoretical approach. Our research findings do not explicitly demonstrate this, but this does not mean that unconscious influence does not happen. A potential example from the literature can be found in Winnicott who, whilst becoming an expert on parenting and working with children in a therapeutic way, remained childless. Without autobiographical material which discusses his childlessness it is impossible to be certain what he thought and how he felt about it (Jacobs, 1995). Yet what is clear is that there seemed to be little place for fathers in Winnicott's writings (Jacobs, 1995; Phillips, 2007). We could certainly attribute Winnicott's lack of recognition of the role of father due to the time and social/psychoanalytical culture in which he lived (Jacobs,1995; Etchegoyen, 2001). However, it is possible that Winnicott's theories are also blind toward the father's role because he was childless and not a father himself. The lived experience of being childless, reinforced by the cultural and psychoanalytic contexts, could have led Winnicott to downplay the role of fathers in his therapeutic practice and theorising. One writer even suggests that Winnicott's fluid boundaries around the use of touch in his practice may have come from the "frustrated parental tendencies of a childless old man" (Kahr, 2006, p.13). This potentially implies that Winnicott's perspectives on child development and his technical approach to practice could have been unconsciously influenced by his experience of childlessness.

We are therefore suggesting that a reflexive approach is needed to enable therapists to identify how childlessness may impact their approach to theory and practice both consciously and unconsciously. Although childlessness may potentially be a factor in a therapist's development of their theoretical approach this in no way implies a lack of therapist competency (as the example of Winnicott's therapeutic success amply demonstrates).

Critical Evaluation

Reflexivity

Interpretative Phenomenological Analysis recognises the role of the research participant in giving meaning to their experience, as well as the researcher's role in interpreting, or making sense, of the participants' interpretation. This means that analysis of the phenomenon is a "double hermeneutic" (Shaw, 2010, p.179) process. Researcher reflexivity is therefore important as it allows the identification of, through their own self-awareness, how their subjectivity is present in the interpretative process and how the researcher's personal experiences and background potentially impacting on the research process and findings (Etherington, 2004; Willig, 2008). A reflexive approach to research involves acknowledging the place of the researcher in the process of constructing meaning rather than assuming the possibility of researcher objectivity (Finlay, 2003).

Both researchers in this project are childless therapists (for varying reasons), are from white Western backgrounds and both work as integrative therapists drawing on psychodynamic and humanistic concepts. The primary researcher (Martin) was responsible for data collection and analysis and was also a participant. To help maintain a reflexive self-awareness as a researcher and participant, a research journal was used to detail my own thoughts and feelings as part of the research journey, as well as indicating some of the relational dynamics between the researcher and participants.

Two areas of reflexivity appear significant. Firstly, as a researcher and participant it became clear that my own lived experienced of childlessness as a therapist had to be both acknowledged both in terms of its benefits and its detriments. Beneficially, my experience enabled me to be sensitive to my participants experiencing and it enabled rapport to be quickly developed with the participants. To avoid potential detriment effects, it was necessary to look beyond my experience to enable the hearing of the variety of participants' voices regarding the professional context on their own terms. Participants answers to the initial online survey questions, reflexive self-awareness during the audio recorded interviews and analysis of the consequent transcripts quickly highlighted areas of difference between my own experience and other people's experiences. I was surprised that some people were able to describe supervision as a safe space to discuss their childlessness as this had not necessarily been my experience. Likewise, my initial expectation (based on my own experience) was of only a negative impact of childlessness on the understanding of theory (especially around child development). I had to be cautious not to unconsciously lead the participants to reinforce my own experiences around childlessness as a researcher.

Secondly, during interviews I became aware of the tendency to oscillate between two polar opposites. At one end, the participants and myself struggled to remain close enough to the emotional experience of childlessness. The emotionally charged nature of the topic led both the participants and researcher to keep the experience of childlessness at arm's length. This meant at times, it was hard for the participants to express deeper levels of emotional and lived experience around childlessness. I reinforced this by my own defensive avoidance of drawing out participant's experience because it cohered with my own pain. At the other end of the pole, I over identified with a participant's story. I found myself getting caught up emotionally in the participant's story because of the resonances it had with my own. The impact of this oscillation on the research is that findings of the research in the professional context are not always as evocative and as rich as they could have been.

Throughout the research I had to try to set aside my own assumptions to be able to begin to hear the richness of participant lived experience in relation to theory during the interviews and transcript analysis. Given that it is ultimately impossible to retreat to objectivity, my subjectivity will have continued to influence the findings of this project around the professional context. My own experience of the professional context of therapy shaped the interview the semi-structured interview schedule and any additional questions I asked participants about their own experience of the professional context in interview. It also undoubtedly shaped my analysis of the data.

The insightful comments from the secondary researcher (Val) however helped me to see beyond my own subjectivity at points in the research process. In keeping a research journal, I noticed how my own physical sciences background led me to a nomothetic and universalising approach which is counter to the phenomenological and idiographic approach of Interpretative Phenomenological Analysis. This tendency again was highlighted during the peer review process where reviewers picked up on this nomothetic tendency in the data analysis and discussion section of an earlier draft of this article.

This led to a reformulation of the subthemes identified in the findings above.

It is quite possible another childless therapist may have drawn out insights about the professional context which I minimised or neglected due to not being able to see beyond my own subjective experience as a white Western male. Taking an intersectional perspective, my own experience of childlessness intersects with my gender, culture, and age (early 40s) in a specific way. Another researcher may have offered a differing analysis and approach to data collection due to the intersection of different aspects of diversity which make up their identity.

Strengths and Weaknesses of the Study

The strength of this research is that it enables us to hear the voices of five involuntary childless therapists in relation to the professional context and document them in the academic literature for the first time. Through the primary researcher openly acknowledging his own childlessness to the participants, trust during the data collection stage was fostered and enabled the participants to know that their own distinct experience would be heard.

This research is *relevant* (Finlay, 2011) in that it details therapist lived experience in relation to childlessness and thereby enables other therapists to more openly acknowledge similar or different experiences in the professional context which have been previously hidden. There is also relevance to the wider therapeutic community as this study highlights an aspect of therapist diversity which supervisors, training organisations, therapy providers, researchers and professional bodies have tended to ignore or minimise.

During the data analysis and writing up stages of the research the findings have *rigorously* (Finlay, 2011) been systematically rooted in the evidence found in the participants' transcripts. Participants were involved in the process of agreeing and correcting the accuracy of transcripts and the findings contained in the themes drawn from the data analysis. This helps to demonstrate the trustworthiness of the process undertaken to generate the findings.

Yet there are shortcomings in this study which limit the richness of the findings especially regarding the professional context. Firstly, in comparison to their experience in the therapy room (Stokley & Sanders, 2019) the participants found it more difficult to identify their experience as childless therapists in the professional context beyond work with clients. A larger number of participants in the study would have elicited a wider picture of lived experience. It also appears as if links between therapist childlessness and the professional context could be more implicit, being at the 'edge of awareness' (Preston, 2008) or being a form of an 'unthought known' (Bollas, 1987). Given that participants described a variety of different experiences further narrative research would be beneficial to gain a wider picture of childless therapists' subjective professional experience including phenomena which are more implicit in nature.

Secondly, this study has only explored the experience of involuntary childless therapists. There is an important question about whether voluntary childless (childfree) therapists have potentially the same professional lived experience of their childlessness as those who are involuntary childless. It would be natural to assume similarities due to the lack of acknowledgement of childlessness being an aspect of therapist diversity, however it is likely that there could be significant differences around the experience of professional encounters as the emotional experience of voluntary childless therapists will be different.

Finally, there are avenues for further research into the lived experience of childless therapists. The current student focused solely on therapists who work with adult clients and did not consider the experience of childless therapists who work in the context of child or adolescent therapy services. An important question is whether child or adolescent therapists experience the professional context in similar ways to those found in this study or whether their experience is more nuanced by their context. Additionally, it is important to note that the research was undertaken in a UK context. As we noted in our previous article (Stokley & Sanders, 2019), there is a cultural element to the lived experience of childlessness, and this is likely to be true for therapists professionally also. Further research in professional therapy contexts in other countries or cultures would be invaluable to investigate how culture impacts the experience of childless therapists in the professional context, thereby allowing a more complete intersectional analysis of the phenomenon.

Conclusion

This study highlights the need to recognise parental status and specifically therapist involuntary childlessness as an important aspect of diversity in the profession. The evidence from participants does not demonstrate significant explicit discrimination against involuntary childless therapists, but it does show an unacknowledged area of difference where therapists feel they are unheard, misunderstood, potentially marginalised or where there is a lack of sensitivity. It is the lack of awareness by the dominant parental majority where their experience is considered the norm (Lago & Smith, 2010) that

is potentially problematic. Our research reveals some of the frustration, anxiety, alienation, and isolation which childless therapists can experience in working relationships with other therapy professionals. However, in amongst some of the more negative examples highlighted by participants we do see demonstrated some good examples of supervisors working with childless therapists in a sensitive way which could be more widely emulated in the profession. An approach which emphasises being able to contain, hold and explore some of the more complex emotions childless therapists feel could provide the safe space for the childless therapist. Thereby enabling them to engage these issues in a meaningful and dynamic way which is beneficial to therapeutic work with clients and the diversity of the wider profession as a whole.

A key observation from the participants' stories is that there is no homogeneous lived experience for involuntary childless therapists in the professional context. For Tarka, Alice, Sarah, Rebecca, and Martin there are similarities of experience and there are also obvious differences. It is impossible to identify a unitary experience which applies to all. A phenomenological and idiographic approach which is aware of the uniqueness of individuals is necessary if we are to hear the voices of involuntary childless therapists regarding the professional context more clearly. Intersectionality helps to explain the variety of experience of the participants as being rooted in the interaction of therapist involuntary childlessness with other aspects of participant difference such as background, age, culture, and gender. This insight is invaluable as it recognises the complexity of lived experience around therapist childlessness in the professional context.

The profession would be enriched if it could begin to value the lived experiences of childless therapists as an aspect of diversity to a greater degree. Therapists, agencies, training organisations, supervisors and the psychotherapy literature all have a part to play in this regard.

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