A psychotherapeutic and counter-transferential pregnancy: imaginative spaces and articulations of the ghosts within pregnancy loss

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Thesis Declaration

I confirm that this thesis, presented to the University of Edinburgh for the degree of Doctor of Psychotherapy and Counselling, has:

1. been composed entirely by myself
2. been solely the result of my own work
3. not been submitted for any other degree or professional qualification

This Declaration is signed the 2nd day of August 2018, upon submission for examination.

Signed:

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Abstract

This thesis offers psychodynamic explorations of my experience working with clients who have had a pregnancy loss. I construct the concept of a counter-transferential pregnancy to explore how clients seem to need a different type of recognition within pregnancy loss. I review theories of social recognition of loss, including Doka's disenfranchised grief and Butler's grievability. Turning more specifically to research around pregnancy loss, I notice that while a focus tends be highlighting the significance of the loss, the way practitioners are impacted and make use of themselves within their work is usually excluded. Positioning myself therapeutically within my client work and research, I detail how using my counter-transference is a unique contribution to the existing literature on pregnancy loss. I conceptualise ghosts and narrative attempts around loss and wonder how I might listen to these using my counter-transference as well as through recognition, witnessing, relational and reflexive knowing, imagination, and empathy. Contending that writing as a method of inquiry is the most useful way to get at these forms of data, I outline how I engage with my therapeutic work with a fictionalised client within a composite case study.

Tracing the shape of the therapeutic process and relationship, I present phases of the work resembling stages of a pregnancy (loss): conception, gestation, and labour. Aligning myself with object relations theorists, I incorporate one main concept within each phase of my client work. Within the conception phase, Bion's work on containment helps me think into the edges of what it means to recognise, witness, and receive my client's intolerable sense of loss. Moving into the gestation phase, Bollas' unthought known offers a way to wonder about the unseen, unheard, and unthought of my client's early relational experiences and how these might relate to her experiences of pregnancy loss. The labour phase includes Ogden's and Benjamin's work on intersubjectivity and the 'third', where I continue to push into how the spaces within and between my client and myself allow for a (re)creation of and ongoing relationship with her lost son.

In each client chapter, I bring Butler's work on grievability into conversation with psychotherapeutic theories on how some therapists use themselves in attempts

to be alongside clients. I suggest that my client needs a different type of recognition, one that attends to the very present absence of her ghosts as well as my own experience of being with her. Noticing the transformational potential within the transference and counter-transference throughout our work – which often involves reluctance, struggle, and making use of my own losses – I argue that my client has a therapeutic experience that enables her grieving. Through analysis of theory as well as client work, I formulate the concept of a counter-transferential pregnancy, which incorporates my views as a therapist on imagining into losses in ways that are seldom done in current scholarship.

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Chapter 1 Introduction

1.1: The spaces within this research: how my inquiry took shape

My interest in pregnancy loss began while completing my initial training in counselling and psychotherapy. Working as a trainee counsellor within a specialist agency around pregnancy-related issues, my attention is drawn to and stirred by pregnancy loss. I find that clients have a sense that because their pregnancy is not viable, because their baby does not exist in the world 'out there', then their loss is also not viable or valid. But what about 'in here'? Clients often seem reluctant to use counselling as a space to bring themselves, their story, and their pain around their pregnancy loss. Moments of validating one's loss as significant seem sucked away as something guilty and silencing takes their place. A story comes to life, then dies. A story about death struggles to stay alive.

Doka's (1999) work on disenfranchised grief helps frame my understanding of what I notice within my clients: that grief often must remain private when individuals are not met with social support amidst their loss. The way in which clients often speak leads me to consider if they are asking: 'How can I call it grief if I can't call it loss? If I can't call it grief, then maybe it's not worth talking about'. Within this, I wonder what in clients' stories might be 'unspeakable'. My inquiry moved towards pregnancy loss as unrecognised and ungrievable. Yet implicit within this question are counsellors' experiences of attempting to bear witness to previously invalidated experiences. Noticing the complexities within narration – both the telling and listening – of pregnancy loss, my focus of inquiry shifted towards my struggle within listening to the nothingness that often consumed my clients. While I was hopeful that the process of counselling, the sharing and being received by another,

offered a place for grief to be enfranchised, I was left wondering how I might work within a space that felt very closed. I began to view my research as an opportunity to examine how, within the psychotherapeutic relationship, some therapists might work at the edges and with the tensions of narrating and listening to the disenfranchised grief of women who have lost a pregnancy.

I take the position that, while we cannot accurately capture our experience or story, we can offer narrative attempts into these. I argue that my embodied, sensate, and imaginal experiences 'speak into' and are a form of narrative attempt about what cannot be said within client stories. I reflect on how what is co-created within the therapeutic relationship resides in me and informs my work with clients around their pregnancy loss.

1.2: Outline of chapters

The second chapter, 'Overview of relevant research and reflections on my experience counselling women who have experienced a pregnancy loss', makes use of my noticings within my work to critically engage with available literature on pregnancy loss. While there is a plethora of research highlighting the significance and the need for validation, there is a persistent silence around pregnancy loss. I acknowledge socially dominant grieving rules, including Doka's concept of disenfranchised grief and Butler's work on grievability. I explore the stance that many researchers seem to take when approaching the subject of pregnancy loss, arguing for the need for further therapeutic research. Finally, I position myself theoretically as a therapist, laying a path for the psychodynamic object relations theory I use and how exploring my work counter-transferentially is a unique contribution to existing pregnancy loss literature.

The third chapter titled 'Ontology, Epistemology, Methodology, Design, and Ethics' explores my methodological decisions. I work with how I recognise, witness, and listen to ghosts and narrative attempts, suggesting the need to attend to data created within a therapeutic relationship, including counter-transference. I justify why writing as a method of inquiry into my work with clients is the best way of getting at these data. I explain the way I present my work as a case study and the potential risks within this work.

The fourth chapter is titled 'Conception: How do I listen into Helen's struggle to be recognised and received?'. I introduce my client, 'Helen', who comes to counselling to work with her loss of her unborn son. I give an overview of what I call the conception phase within our therapeutic work, noticing how I listen within the edges of womb-like spaces between us. I bring my thinking about our work into dialogue with Bion's work on containment, offering a chance to explore my attempts to contain my client and her loss. I make initial wonderings into my sense of Helen projecting into me, impregnating me, and how our counselling work may be a different type of pregnancy, a surrogacy perhaps. Finally, I use Butler's work on grievability in dialogue with what I notice in my work with Helen. This helps build my argument about the potential within some therapeutic work for a different type of recognition of loss.

In the fifth chapter, 'Gestation: How do I listen into Helen's early relational experiences?', I offer an overview of our therapeutic work within this more gestational phase. I again take a step back from the work, focusing on Bollas' concept of the unthought known which speaks to my struggle in listening within the edges of the unseen, unheard, and unthought of Helen's early relational experiences

and how these might relate to her experiences of pregnancy loss. Turning more explicitly to my counter-transference, I explore what is evoked in me through this therapeutic work and notice how Helen and her ghosts are increasingly using me as a womb. I propose the term 'counter-transferential pregnancy' to help me further describe our work. I end by revisiting grievability, where I deepen my argument about offering Helen a different type of recognition, extending it here to include intergenerational losses.

The sixth chapter, entitled 'Labour: How do I listen into Helen's (re)creation of and ongoing relationship with him?', is where I notice how Helen and I seem to shift to (re)creating him within her within this final phase of our work. Making use of Ogden's and Benjamin's work on intersubjectivity and the 'third', I further my ideas around my 'counter-transferential pregnancy', noticing how my surrogacy may facilitate a relationship with her lost son. I explore the intersubjective and swampy womb between Helen and myself and how we seem to use it to create and birth her son. I consider how attending to ghosts and present absences helps us push into the edges of narration and rethink grievability.

The seventh and final chapter, 'Conclusion: Grievability within the pregnancy of our therapeutic work', ends my work with Helen and provides a summary of my noticings and arguments. Throughout my work with Helen, I realise my primary therapeutic task is to offer her a different type of recognition, one that attends to her multiple losses as well as my own counter-transference experience of being with her, both of which involve the very present absence of ghosts. Finally, I acknowledge my personal and professional learning from undertaking this project.

Chapter 2 Overview of relevant research and reflections on my experience counselling women who have experienced a pregnancy loss

2.1: Introduction

In this chapter, I outline relevant research on pregnancy loss. I first name the significance of pregnancy loss as well as the need for validation. I then explore Butler and Doka's work on socially dominant grieving rules, noting the silence around pregnancy loss. Outlining who is researching pregnancy loss, I notice a lack of non-medicalised, experience-near studies. Considering research by health professionals and therapists, I see a marked absence of practitioners including their own experiences of working with pregnancy loss. Finally, making a case for the need for more therapeutic research that explores practitioners' responses to clients, I share my approach to therapeutic practice in order to situate myself within my research.

2.2: Significance of pregnancy loss and validation

While grief responses will not be present for all women, there is much literature that points towards pregnancy loss as a significant experience. For example, Mulvihill and Walsh (2014: 2296) state that after a pregnancy loss, women experience 'a wide range of feelings including shock, devastation, depression, self-blame, anger and searching for an explanation'. Affective responses to miscarriage include guilt, grief, and emptiness (Adolfsson et al, 2004). Much of the literature on pregnancy loss suggests that regardless of women's response, ranging from relief to devastation, their need is to have their experience validated (e.g. Corbet-Owen and Kruger, 2001).

An experience of pregnancy loss often contains multiple losses, for example the loss of the hoped-for future and self-concept as a parent (McCreight, 2008). Lloyd Jones (2015: 437) speaks of the complexity of loss for those experiencing miscarriage, 'especially for those who felt they had lost their chance to take up the role of mother'. Lang et al (2011: 190) report that many couples experiencing a perinatal loss find the ambiguity unsettling, leaving them with questions such as 'Do you see us as bereaved parents or as patients undergoing a medical procedure?'. One of Lovell's (1983a: 758) participants captures the potential significance and complexity of pregnancy loss as the 'terrible nothingness'.

Some studies focus on intense grief responses due to bonds existing between potential mother and unborn child (e.g. Uren and Wastell, 2002). Peppers (1989) reports grief responses to elective abortions as similar to involuntary perinatal losses such as miscarriage or stillbirth, suggesting there is an emotional attachment with the fetus. Nichols (1989: 122) states that regardless of a baby being 'normally formed, deformed, alive, or dead', parents usually wish to 'see, touch, hold, talk to, comfort, sing to, snuggle, explore, and protect their baby'. Much research suggests grief responses do not differ due to the type of or gestational stage of the loss (Peppers and Knapp, 1980; Lovell, 1983b; Malacrida, 1999). Early and late losses are both significant. As Lovell (1983a: 759) does, I challenge the notion of a 'hierarchy of sadness'. My experience working with clients is that the amount of time women carry their pregnancy seems less relevant to their grief than does the significance of the loss, including the hopes they have for their future and for the child.

2.3: Socially dominant grieving rules

Despite the frequency of about one in four women experiencing a pregnancy loss (Price, 2008), it remains a relatively silenced area within society. What seems especially defining and restricting of grief is when loss is not socially recognised as significant (Rowlands and Lee, 2010). In this section, I consider social rules around grieving, with mentions of society referring to the United Kingdom and the United States.

Butler (2009: 5) speaks of 'crafting a living being into a recognizable subject', taking into account our context and the external structures pressing upon and shaping us. We are produced by powers that pre-exist us and form us into subjects. Butler (2009: 23-24) states we 'cannot easily recognize life outside the frames in which it is given, and those frames not only structure how we come to know and identify life but constitute sustaining conditions for those very lives'. What is recognisable is due to frames, or social norms (Butler, 1997b). Social structures supply norms around what is to be included and excluded, significant or unimportant, heard or silenced, public or private. Butler (2006: 35) speaks of 'a limit to discourse that establishes the limits of human intelligibility', the limits of what can be thought.

Turning to social rules around grieving, Doka (1999: 37) outlines disenfranchised grief as resulting from how 'societies have sets of norms – in effect, "grieving rules" – that attempt to specify who, when, where, how, how long, and for whom people should grieve'. When norms determine a loss is not significant, this can lead to grief being disenfranchised (Doka, 2002). Norms of silence around pregnancy loss send messages about how people *should* be. I concur with Doka's

position, for in my practice I see clients often left with a sense that they are not allowed to grieve a pregnancy loss or that there is some timeline they must adhere to for getting through their grief. Disenfranchised grief can be experienced when one's grief is unrecognised by some others 'out there' in the social world. Some individuals are 'not accorded a "right to grieve"', including 'the ways a person grieves, the nature of the loss, or the nature of the relationship' (Doka, 2002: 5).

Butler (2009: 4) speaks of how subjects are formed through norms and how 'our very capacity to discern and name the "being" of the subject is dependent on norms that facilitate that recognition'. Butler (2009: 1) expounds on how operations of power dictate and frame who is recognised as a person: 'specific lives cannot be apprehended as injured or lost if they are not first apprehended as living. If certain lives do not qualify as lives or are, from the start, not conceivable as lives within certain epistemological frames, then these lives are never lived nor lost in the full sense'. While Butler (2009: 20) mentions the right to life debate, she does not enter into it here, and rather states that '[t]he question is not whether a given being is living or not, nor whether the being in question has the status of a "person"; it is, rather, whether the social conditions of persistence and flourishing are or are not possible'. Recognition is allocated according to intelligibility and also grievability, how there are some lives that are not perceived as grievable (Butler, 2009). Butler's focus here is on lives disregarded in times of war, yet her words speak beyond this, as she captures some of the ways the value of lives are assessed. Phrases such as 'lives that are not quite lives' and 'not everyone counts as a subject' (Butler, 2009: 31) can be applied to other losses not recognised as grievable by society.

In the intersection of Doka and Butler, there is much to be considered around clients' and counsellors' attempts to narrate and listen to grief. Madison (2005: 203) states that the bereaved may come to counselling

> because the people around them are no longer interested in discussing the deceased. On the other hand, some clients may seek counselling because they, unlike their friends and family, cannot talk about the deceased.
> And there are also instances when the social world does not recognize the legitimacy of the required discourse, so that the bereaved cannot locate and process the new roles and reality impinging upon them.

Stories of loss are complex and may leave one wondering how to respond. Rappaport (2000: 3) states that for those of us 'interested in social change, reading the community narratives of our own time differently, so that they *reveal and expose rather than hide* the terror, is a step toward helping to recast the narratives in ways that liberate'. While Butler would probably not agree with this message of liberation, as she would not see us as able to come out from under the power structures that create narrative discourses, she would likely agree with Rappaport's charge to expose and challenge norms. In Butler's (1997a) exposition of the limits of intelligibility, it is possible to see that movement can be made from being completely invisible and silent. Through performance, through speaking about loss and grievability, there can be potential for reworking norms of silence. Butler (2009: 34) states that 'responsiveness – and thus, ultimately, responsibility – is located in the affective responses to a sustaining and impinging world'.

Butler (2009: 53) suggests that 'normative frameworks establish in advance what kind of life will be a life worth living, what life will be a life worth preserving,

and what life will become worthy of being mourned'. Combining Butler's theories on recognition with theories of disenfranchised grief may shed more light on who counts as grievable. Much research focuses on who should *grieve* (e.g., Robson and Walter, 2013) rather than who should *be grieved*. My research thinks into Butler and Doka's theories, exploring how listening into the edges and tensions within grief narration may unsettle norms of silence and facilitate perception and recognition of the ungrieved.

Among the discourses that render subjects intelligible, responding to narrations of disenfranchised grief may serve to resist and resignify. Working between Butler and Doka offers a way to challenge 'the framework that silences the question of who counts as a "who"' (Butler, 2009: 163). Butler (2009) exposes grieving norms and incites resistance of norms, leaving a gap to be filled in how this could be applied to norms of silence around pregnancy loss.

2.4: Silence around pregnancy loss

Pregnancy loss is surrounded by norms of silence and has been socially constructed as insignificant. Doka (1999: 38) briefly mentions pregnancy loss as being largely unrecognised and dismissed by society, stating that it is often seen as insignificant or relatively minor, with many individuals wanting to 'minimise any sense of loss'. Lovell (1983b: 325) suggests that society's 'pressure on the bereaved to minimize the loss is even greater when the dead person is a neonate and even more so when the baby never lived outside the womb'. Lang et al (2011: 184) note that perinatal loss is generally socially 'viewed as a less traumatic or prolonged experience than the death of an older child or an adult' even though studies have shown how intense and long-

lasting this form of grief can be. Nichols (1989: 121) proposes that it is often difficult for friends to 'stand quietly alongside the grieving parents'. I witness this dismissal of pain in my work with clients who experience pregnancy-related loss and feel their normal supports, usually family and friends, do not want to or know how to speak of such pain. Tonkin (2012) wonders if her participants' struggle to speak arose from a lack of social recognition about the existence of something that never existed. Pregnancy loss, which is a hidden physical experience, remains hidden and silent for many women.

Grieving taboos, medicalisation, and messages around pregnancy loss communicate how we should grieve, what is best for us, what is too much, what is abnormal, or too loud. The rituals and supports that normally follow a death are often not socially considered as appropriate within perinatal loss (Malacrida, 1999: 504). Such practices contribute to a sense of one's loss as insignificant. A lack of recognition and empathy significantly impact a woman's grief around a loss of a pregnancy, for example around important dates such as birthdays and anniversaries, which are often then only acknowledged in private (Lang et al, 2011). I am struck by Lovell's (1983a: 758) research where some women received conflicting messages about how they 'should' grieve, for example a woman who, after losing her pregnancy, was told she should view the live babies before leaving the hospital yet when she did she was ushered out with the words 'You shouldn't be here'. Lovell (1983a: 757) addresses norms of medicalisation, noticing how bereaved mothers often look to health professionals as experts and how the reaction of medical professionals to miscarried or deformed babies can imply that 'such an object was unfit to be seen, unfit to be loved, unfit to live and not worthy of mourning'. This

ties in with Butler's theories of grievability, where women who lose pregnancies are often not treated as grieving mothers by society. The life and death of the child is denied, as well as the validity of the loss.

Some research suggests medical discourses construct pregnancy loss as a failure. Lovell (1983a: 757) notices that a woman who experiences a pregnancy loss 'disturbs the equilibrium and is a reminder of failure. Failures need to be hidden. Hospitals seem to have no physical or psychological space for such a person'. There is a hiding, a silence, a fear of death, loss, and pain. Martel (2013) uses Foucault's (1978, 2003) theories of biopower to examine how norms of silence around pregnancy loss stem from biomedical control, leaving grieving mothers shamed, fearful, and unable to mourn. Martel (2013: 338) acknowledges that the 'grief that pours out of the embodied experience of having part of one's body die is structured through shame, silence, and confusion in order to affectively mobilize fear, risk-aversion, and faith in (bio)medicalized reproductive technologies and techniques'. There is so little space for loss to be expressed and explored, so little validation of one's sense of how they need or want to grieve.

When a woman asks questions such as 'Am I still a mother?', the language used to answer shapes her understanding of her experience. For example, when someone's words express a diminished value of the loss or baby, this can lead to the loss experience being even more difficult for the parents (Jonas-Simpson and McMahon, 2005). Our socially constructed language of what constitutes existence falls short for many people's experience around pregnancy loss, leaving them without a way of talking about their losses. For example, there is no word in English to signify movement from 'parent' to 'parent of a deceased child' (Stroebe and

Schut, 1999: 214). This fits with Butler's (2006: 36) claim that what falls within a 'refusal of discourse' will be unspeakable.

If pregnancy loss is socially constructed as insignificant, is it also then unsayable, unnarratable? Hazen (2006: 244) posits that '[t]here is no shared, ordinary, daily language to express what happened and how [women] feel' about pregnancy loss. Hazen's (2003: 152) research witnesses how women's stories of pregnancy loss 'had about them a raw sense, with a struggle for words and confusion about chronology that mark a tale not often told about a subject that is often unspeakable'. Kluger-Bell (1998: 125) writes about 'unspeakable losses' and states that when not allowed to be 'public and important, the loss can become a private and nameless torment'. How do we narrate and listen to something that is 'unspeakable'? In my client work, it seems women who experience pregnancy loss are saying 'I can't talk about it in the world, but I also struggle to talk about it in the counselling room'. Tonkin's (2012: 12) work opened spaces for women to tell their unique grief reactions, noticing that 'there are few other available narratives to talk about a relationship with a child who exists in fantasy rather than in an embodied form, but is experienced as "real" in some way'. Women struggle to speak of their experience of pregnancy loss when it is not validated as significant and is expected to be kept silent. I also notice that as a counsellor I struggle to bear witness to experiences that have been invalidated by others.

Jonas-Simpson and McMahon (2005) suggest that others ask what the pregnancy loss or baby means to the parents. Whiteford and Gonzalez (1995: 35) highlight that women's silenced stories of infertility 'provide us with substantiation of alternative visions of reality; visions unlike the dominant medical story produced

and propagated by those in biomedicine'. Layne (1990: 70-71) suggests finding ways to 'protest the cultural denial of perinatal loss and seek to define a miscarriage or stillbirth as a legitimate source of grief'. Telling and listening to stories of reproductive loss and grief are acts of resistance against norms of silence.

2.5: Who is conducting research on pregnancy loss

Writing about pregnancy loss, including silence within pregnancy loss, arises predominantly from medical professionals where the focus tends to be placed on medical rather than affective experiences. The medicalisation of reproduction, pregnancy, and childbirth is evident in the literature on pregnancy loss, where much of the research comes from medical professionals and relies on quantitative approaches (e.g. Kong et al, 2010). Outcomes often suggest 'evidence-based healing interventions' (e.g. Capitulo, 2005: 389), including CBT and psychoeducation (e.g. Bennett et al, 2012). The focus is often 'grief resolution' (e.g. Kowalski, 1980), relying on models that distinguish between normal and pathological, appropriate and inappropriate grief responses. Similarly, perinatal bereavement research within the field of psychiatry often focuses on the 'psychological impact', with attempts to uncover predictors of impact through the use of questionnaires and scales (e.g. Uren and Wastell, 2002) or screening for symptoms such as anxiety (e.g. Brier, 2004).

Yet, I am struck by many health profession studies that address affective responses within pregnancy loss in a more qualitative and experience-near way. For example, midwives sensitively considering how to increase their empathic response to a family who has experienced pregnancy loss by using Seamus Heaney's touching poem 'Elegy for a still born child' (Patterson, Begley, and Nolan, 2016) and nurses

interviewing women around their lived experience of pregnancy loss (e.g. Van, 2012; Lang et al, 2011). Within nursing studies, Jonas-Simpson and McMahon (2005) attend to how the language around one's pregnancy loss should be coming from the parents rather than health professions. Nichols (1989), a hospital bereavement consultant, offers health care professionals ways to more sympathetically care for parents amidst perinatal loss. Harris (2004) suggests midwives encourage the telling of 'termination stories' just as they would 'birth stories'. Murphy and Merrell (2009) highlight the need for midwives and nurses to be aware of the transition or liminality inherent within miscarriage. Some studies explore the experience of women undergoing specific pregnancy loss, for example Jones, Baird, and Fenwick's (2017) midwifery focus on second trimester terminations around fetal abnormality. Simmons et al (2006) study women's experience of miscarriage in the UK, using both quantitative and qualitative data from questionnaires. Such health professionals are working closer to women's experience and these studies tend to include powerful quotes from participants. While reading this can be validating in itself, I am struck by the absence of the experience of the witness within these studies. I am left wondering how health practitioners might make use of themselves in a relational and intersubjective way within client interactions.

Much pregnancy loss literature takes a more sociological position with a focus on the ways that reproduction, including pregnancy loss and infertility, is constructed through dominant discourses (e.g. Letherby, 2002), or more specifically how it is medicalised (e.g. McCreight, 2004, 2008). Rather than having the loss medicalised, grieving parents need to have their emotional response acknowledged (McCreight, 2008). Studies within the broad areas of communication, culture, and

society critically explore the medicalisation of pregnancy loss (e.g. Martel, 2013) or the nuances amidst dominant discourses within women's online narratives around reproduction (e.g. Ratliff, 2009). Fisher, Hauck, and Fenwick (2006) point to the social construction of childbirth as hazardous and uncontrollable, thereby often seen as necessitating medical intervention and control, yet posit that birth is a social rather than a medical phenomenon. Hazen (2003, 2006) offers views on societal and workplace responses to pregnancy loss, exposing the medicalisation of and dominant discourses within reproduction and the need for the experience of the mother to be heard. Keane (2009: 166) compares biomedical models of personhood with more feminist and relational views where 'the status of a foetus depends on the social relations that surround it and either bring it into being as a person or not'. Within the field of anthropology, Layne (1997, 2003) disrupts the medicalisation of pregnancy, suggesting that women are often blamed for their pregnancy loss. Layne (2006) also explores the pregnancy loss support movement, critiquing the lack of awareness around contributing sociological issues such as domestic violence as well as wondering about the benefits of institutionalisation in promoting validation, research, and services.

Also adding to the conversation on the medicalisation of pregnancy loss, Lovell (1983b) addresses reactions of women experiencing a late miscarriage, stillbirth, or perinatal death. Yet her work focuses on the more medical experience of women and gives greater attention to offering suggestions for health professionals. In addition, her approach includes coming to 'work through' or 'fully accept' the loss, stating this helps with 'subsequent pregnancies and child-rearing' (Lovell,

1983b: 325). I see this as a perpetuation of society's wish for women to accept their loss, move on, get better, and get back to more productive roles.

Within the social work field, there is writing that sensitively explores women's need for validation around pregnancy loss (e.g. Mulvihill and Walsh, 2014). Price (2008) suggests that social workers offer 'empathetic words' and 'reflective self-awareness' to their clients. While much sociological research promotes thinking into ways reproduction and loss have been socially constructed, it often relies on interviews (e.g. Peppers and Knapp, 1980; Malacrida, 1999), leaving a lack of accounts of client work. Similarly, studies within the field of psychology often use interviews (e.g. Rowlands and Lee, 2010; Corbet-Owen and Kruger, 2001) or online surveys (e.g. Peel, 2010), resulting in a gap in knowledge of the clinician's experience of working with pregnancy loss.

Reviewing research on counselling women who have experienced a pregnancy loss, Randolph, Hruby, and Sharif (2015) find a dearth of literature outside of medicine, psychology, and social work and highlight a need for more research within the field of counselling. What literature does exist offers potentially useful suggestions about how counsellors might, for example encourage their clients to communicate the importance of their lost child to family and friends. Yet much of the work done by counsellors appears to fall within the medical model, for example Trepal, Semivan, and Caley-Bruce (2005: 164) state that counsellors need to 'determine what type and/or stage of grief' clients may be within. Other studies on pregnancy loss and counselling use questionnaires to investigate 'psychological adaptation' (e.g. Rowsell et al, 2001). Ost (1994), within the fields of education and counselling, interviews women about their experiences of pregnancy loss, exposing

ways they feel uncared for, often by medical professionals. Where there is research coming from practitioners' experience, it often comes back to the medical model and does not consider it relationally.

While Doka positions himself theoretically from a sociological perspective, his 2002 text on disenfranchised grief offers several chapters written by counsellors. However, while pregnancy loss is mentioned several times, it is excluded from the largest portion of the book, titled 'Illustrations of Practice'. This text does not provide clinical insight for practitioners working with pregnancy loss, highlighting a gap in literature on how counsellors might therapeutically engage with and respond to grief around pregnancy loss.

2.6: The need for therapeutic research around working with pregnancy loss

Where research does include health practitioners' and therapists' professional wisdom, the focus is usually on the experience of clients rather than the practitioner. Some counselling literature offers case studies of clients bringing their stories of pregnancy loss into counselling (e.g., Trepal, Semivan, and Caley-Bruce, 2005), yet they focus more on client narratives and when the therapist is mentioned, it relates to interventions used rather than emotional resonance and response. While Leon (1990: 81) suggests therapists' 'emotional responsiveness is vital in communicating awareness of the depth of this loss for the mother', there are no examples offered. Sparse literature exists on how counsellors work with women who have experienced a pregnancy loss within the context of a therapeutic relationship.

I find Kluger-Bell's (1998) work on working therapeutically with women's experience of pregnancy loss to be a lighthouse among a rather dark ocean of

potential stories. She shares case studies that explore various types of pregnancy loss and includes some vignettes of client/counsellor dialogue as well as some interview data from her work as a researcher. Kluger-Bell (1998) offers some of her therapeutic responses and makes insightful noticings about her work with this client group, including for example how she works with rituals and how she challenges clients to consider their losses as significant. She occasionally links her personal experience of pregnancy loss into her writing and also shares how her self-awareness, for example around political views, developed. However, she does not include reflexive exploration of her experience or process of working with clients.

Most researchers who have made use of Kluger-Bell's (1998) text convey parents' accounts of pregnancy loss gleaned from interviews, letters, and online memorials. One exception to this is Miller (1999) who offers short encounters between herself and her clients, with a chapter on pregnancy loss, and briefly captures something of her responses to their loss, for example her shock, her tears. Miller (1999) then turns to non-Western cultures to explore their customs around pregnancy loss, leaving behind her responses to clients.

Sives (2016: 51), a counsellor who conducted interviews of women who were involuntarily childless, offers accounts around 'the difficulty of negotiating the pain within the context of family and close friends'. While this may contribute to the understanding of women's disenfranchised grief, this study does not speak to therapists' experience working in this particular area. Lloyd Jones (2015: 434) captures some of the complexity of counselling women who lose a pregnancy as they are 'still intensely preoccupied, but without a live baby to focus on'. Lloyd Jones (2015) thinks theoretically into published narratives of women's accounts of

miscarriage and also considers what might be evoked from one of her client's childhood as a result of their therapeutic work around her miscarriage, yet I am left wondering about her use of self within the work. Tonkin (2012: 2), psychoanalytically explores interview data around childless women's stories, including the evocative notion of their 'relationship to a fantasy child', yet she does not extend her research into how she as a counsellor might engage with clients' fantasy children. What seems to be greatly lacking within the literature are accounts of therapists' use of self in experiencing clients' pregnancy loss.

A researcher and psychotherapist who makes use of self is Mahone (2015), who explores the embodied and imaginal dimensions of women's experience of miscarriage. She produces art in response to participant interviews and then dialogues with them about the art, with the view that this helps something new to emerge from lived experience. Mahone (2015: 28) says that the imaginal and dialogical engagement evokes contact with participants' psychic life, accessing the 'invisible' which includes 'implicit aspects (body feelings, gestures, images, dreams) that might hold some promise of a bridge between the ways of knowing rooted in the sensate and imaginal and some shared language'. Mahone relies on Gestalt theory on embodiment as well as Jungian and art therapy theory on active imagination and contemplation. While my research also accesses embodied and imaginal data, I instead use psychodynamic theory to help explore my responses to clients.

I find Quagliata's (2013) psychoanalytic explorations and observations of her clients' experiences of pregnancy, parenting, and perinatal loss insightful and applicable to my work yet lacking in practitioner reflectivity, presenting an invitation to push into observing the counter-transferential spaces within me. Cosgrove (2004:

118), makes recommendations for working with pregnancy loss, including attending to counter-transference; but her framing of counter-transference focuses on keeping the work clear of internalised ‘social myths’, for example around ‘maternal responsibility for pregnancy outcome’ rather than exploring the counter-transference within the context of an interpersonal relationship. Raphael-Leff (2000: 11) speaks of ‘[p]owerful countertransferential reactions’ arising within therapeutic work on perinatal issues, and while she offers some counter-transference in a case example on postnatal distress, she does not explore pregnancy loss counter-transferentially. I am building on the existing research on pregnancy loss by offering a sustained focus on my counter-transference and use of self within my therapeutic work.

More study is needed to better understand counsellors’ particular responses to pregnancy loss and what might be occurring in some therapeutic encounters. Rich’s (1999: 59) paper ‘When Your Client's Baby Dies’ acknowledges that listening to stories of pregnancy loss can ‘revive old losses’ within many therapists and names this as an opportunity for self-reflection. My research takes up something of Rich’s (1999) charge and explores my responses to a particular client and the ghosts that are stirred within us.

Case studies need not focus on clients, but perhaps rather the relationship between therapist and client or the reactions therapists have towards clients. Drawn to Prior’s (2012) theoretical thinking about his experience of an evocative therapeutic relationship, I began to realise how much potential lay within exploring my response to clients who were significantly impacting me. Following this realisation, an article by Zeavin (2012), offering her account of being in the presence of a client and her

new born, prompted me to attend more to my reactions to the presence of the unformed child, a ghost perhaps, in the room between my client and myself.

The layers of silence within these stories include how women historically and more broadly have often not had a voice, how pregnancy loss is often denied significance, and how counselling itself requires a certain amount of silence due to its confidential nature. I argue that this compounded silence further legitimises telling the stories that follow. Writing about pregnancy loss and counselling is unique and necessary. Sharing my subjective experience of counselling a woman after pregnancy loss has the potential to disrupt both the denial of a grief experience and the binding silence.

2.7: Positioning myself theoretically as a therapist

Neither in this project nor in my therapeutic work do I ascribe to the inappropriateness of grief responses or timelines for being within grief. I do not adhere to the need for scales, binaries, or solutions in one's grief experience. Rather, as Árnason (2001: 299) states, grief is a 'natural and ordinary process, yet individually variable and unique'. I also do not advocate for clients to have a cohesive narrative, but to attempt to narrate, to find words (Neimeyer, 1994; Linnell et al, 2008). Rogers (2006: 196) says that a client's 'speaking depends upon my hearing and, even more critically, how *she* hears me hearing her'. When we speak to someone, we are at least partially hearing ourselves through them. I make my own narrative attempts when I reflect, notice, wonder about clients and their stories. The seeming nothingness of speech moves towards a something within narrative attempts when I join in clients' repetitions and struggles.

Together we try to articulate and then decode some of the mysteriousness of experiences, thoughts, and emotion states. Or maybe more simply but more importantly we *notice* the mysteriousness, the ungraspable nature of loss. I allow spaces for silence, wordlessness, nothingness but also create spaces for something to come out of the silence, a waiting into what might be inarticulate or unthought (Bollas, 1987). I acknowledge the ordinary need for patience and acceptance in my offerings to clients, mirroring something of the maternal relationship (Winnicott, 1949). I wait, keeping opportunities open for exploration, and follow clients into their movement towards understanding.

One of the most important aspects of my therapeutic relationships is how I empathise with clients. I attempt to stay close to their experience, seeing it from their frame of reference 'as if' it were my own (Mearns, Thorne, and McLeod, 2013). Schmid (2002: 66) states that the other 'cannot be comprehended but can be empathized with'. Staying empathically attuned and engaged helps clients enter and move within our psychic interior. The therapist's body can provide a home for clients, where our experience helps us make sense of how they are taking up residence within us (Orbach, 1999; Carroll, 2005). As a therapist, I work between these ways of being, in the liminality between myself and clients, attending to what is stirred up within and between us.

I position myself as needing to find clients within me or possibly almost becoming the client at times (Bion, 1984), yet also needing to remain separate enough to think through my experience of being with them (Benjamin, 1990, 2005). I try to enter into my client's inner world yet also maintain a mind of my own. The unique way that perhaps many counsellors hold their clients in mind offers a

listening beyond ordinary everyday ways of being in our social world. Bollas (1987: 245) states that at times it may be more accurate to say that clients, rather than just talking to therapists about themselves, are 'talking to the self about the self, and utilizing the analyst as part of the mind'.

Central to how I work and central to this study is my therapeutic use of self. Wosket (1999: 24) proposes that making use of oneself is about drawing on our 'way of being' in a client-responsive way. Being in touch with and then offering back something of my own feelings and somatic responses is a way to make use of myself for the other. Basescu (1990: 162) names the value in using one's 'reactive emotional sensibilities for clues to understanding the less obvious aspects of what is being enacted' within clients. My intuitive and interpersonal experience, often referred to as transference and counter-transference, is valuable information within my therapeutic relationships. Freud's (1912) formulation of transference is that clients transfer psychic contents over to therapists. In my practice, I view counter-transference as the resonance of the client's transference within me. Heimann (1950: 81) states that the 'analyst's counter-transference is an instrument of research into the patient's unconscious'. Bollas (1987: 246) describes counter-transference as 'a psychological condition determined by our experience as the object of the patient's use within the transference'.

There are many ways to make use of my counter-transference, with the outcome often being to give clients an experience of themselves. This can include what I represent to clients or what is evoked in me by being with them. Cartwright (2010) says that much of the work of containing lies on the periphery of awareness and may be accessed through examining what resides within the therapist, the

processing of counter-transference states. At times, my counter-transference is related to something experienced outside of my relationship with my client that can be useful within our work. Other times, it may be an embodied and intuitive sense of client material. Counter-transference involves the creation of spaces to receive unconscious communication from clients (Bollas, 1987), that which may be attempting to come into articulation. Therapists' counter-transference 'remains somewhat undefined, unknowable' (Cartwright, 2010: 35) and resides within the edges of our unconscious and our work.

To facilitate working within the edges and unknowns, I turn to Melanie Klein's Object-Relations theory, which involves the way infants build a sense of self around how they relate to objects, or other people (Minsky, 1996). This early formation of self involves the struggle of 'hopes, fears and wishes experienced in bodily terms' where 'every inner movement is felt as an urge to connect with the object (the other) in desire or destructiveness' (Gomez, 1997: 34). In the transference, where past relationship patterns play out in the current relationship, clients show us something of their experience of their internal objects. Bollas (1987: 249-250) names the value of letting our clients affect us in such ways – even within the distress and deformation – in the transference, warning that being shut off to how our clients affect us 'forecloses the analysand's use of the transference to articulate more completely internal object relations and to recollect earlier states of childhood'. Therapists might help to reconstruct something of clients' preverbal worlds, simply through empathic attunement, lack of intrusions, and consistent presence (Bollas, 1987). Bollas (1987: 204) states that when therapists allow themselves to be stirred

and disturbed by clients, movement towards 'verbal representation of internal psychic states' is increased.

Projective identification within therapy is a particular experience of counter-transference, where aspects within oneself that are intolerable are projected into the therapist. Following Klein's work on projective identification, Segal (1992: 36) speaks of the active quality, the 'getting rid of something belonging to the self into someone else'. The infant attempts to project what is intolerable into the mother; the mother's capacity to take in the infant is then introjected by the infant (Britton, 1998). Winnicott (1949) uses the expression 'hate in the counter-transference', explaining that a mother/therapist cannot avoid and needs to feel hate for their baby/client. Attending to my hate, to the struggle within the counter-transference, helps me both withstand the hate my clients project into me and tell me much about clients' internal object worlds, their early relationships, their ghosts.

Therapists offer not passive receptivity but rather a struggling through uncertainty (Bion, 1970; Cartwright, 2013) that demonstrates to clients that their distress is received in its intensity yet that it is tolerable. I work with client material outside the counselling room, which can come in various forms including daydreaming, noticing thoughts and feelings in response to clients, and processing through writing or other forms. Bollas (1987: 10) notices that he finds himself 'engaged in thinking an idea struggling to have me think it'. Throughout my thinking and writing into my work with clients, I have the sense of them, and their ghosts, struggling to be thought of, held in mind, and known by me. Frosh (2013: 40-41) suggests that psychotherapy helps us listen to what ghosts have to say, stating that the 'present cannot exist on its own, as a separate point in time uninformed by

past and future: it is always transient, in process, so always saturated with the sounds and sights of memory and expectation'. The past is alive in the present and attending to ghosts and absent presences helps us hear into the silence within clients.

3.1: Introduction

In this chapter I ontologically explore the phenomena of ghosts and narrative attempts. I establish my epistemological position by examining how I listen among ghosts. I explain my methodology, including my rationale for writing as a method of inquiry and how this works on a more practical level as a case study of my therapeutic work. Finally, I discuss ethical considerations within my project.

3.2: The ontology of ghosts and narrative attempts

Within this study I explore the edges of narrative attempts within pregnancy loss. Among liminal spaces, ghosts seem to be hovering between the presence and absence of our narrative attempts. However, outlining ghosts as an entity is difficult. Derrida's (2006) hauntology precedes ontology as it does not insist that ghosts are real per say, but rather offers a challenge to engage with the possibility of the ghost. I conceptualise ghosts as a presence that affects us, whether we know it or not, rather than needing them to be imaginary or real, metaphor, or literal. Derrida (2006: 13) calls for us to be 'capable, beyond the opposition between presence and non-presence, actuality and inactuality, life and non-life, of thinking the possibility of the specter'.

Hauntology asks 'what is not a ghost?', implying that everything is a ghost (Davis, 2005). Ghosts are ubiquitous and are enfolded within our stories. Derrida and Stiegler (2013: 49) say that mourning and haunting are 'unleashed before death itself, out of the mere possibility of death'. There is something that may become absent yet still remains present. Following on from Derrida (2006), Bennett (2014:

4) states that hauntology is ‘an application of thought and not a thing in itself…eluding definition and stasis, and, alternatively, emphasizing open inquiry’. Hauntology is an ontological concept (St Pierre, 2014), yet whereas ontology alone is a conjuration (Derrida, 2006), perhaps hauntology takes us further into what is conjured, allowing us to hear from and imagine into what is conjured up. Ghosts reveal what is lost within ourselves (Britzman, 2000). ‘[T]he ghost remains that which gives one the most to think about – and to do’ (Derrida, 2006: 122). Barad (2017: 56) says that the void, absence, is ‘the yearning and the imagining of what might yet have been, and thus also the infinitely rich ground of imagining possibilities’.

While my research suggests that focus be given to the nothingness, absences, and imagination within working with ghosts, perhaps engaging with our ghosts then makes us more ‘real’. Hauntology appeals to an ontology that is not exorcised of ghosts (Barad, 2010). Ghosts complicate presence and reality, yet by taking us into absences, ghosts also make us more real in the present. We are constituted by our past, by what haunts us, or as Schwab (2010: 2) says, a crypt ‘buries a lost person or object or even a disavowed part of oneself or one’s history’. Perhaps we become more real as we decrypt ghostly presences. Barad (2017: 74) posits that hauntings ‘are not immaterial, and they are not mere recollections or reverberations of what was. Hauntings are an integral part of *existing* material conditions’. I am who I am because of my past, because of what was but also what almost was.

Frosh (2013: 166) says that ‘our sense of being haunted by the past is actually a shivering realisation of what is to come’, suggesting that when we acknowledge how ghosts impact us, we come closer to who we were, who we are, who we will

become. We 'need our ghosts if we are to be human subjects' (Frosh, 2013: 169); ontologically, maybe struggling to perceive the barely perceivable gives us more of a sense of being human. Engagement with our ghosts, in the 'interstices of the no longer and the not yet' (Lather, 2007: 124), possibly brings us closer to ourselves as humans. Hearing from our ghosts is a mourning, as Barad (2017: 86) describes it, an ongoing labour, where we are 'ontologically reconfiguring a past that never was'. The ghost demands we imagine into it, and in our response and dialogue with the ghost, we intersubjectively become.

Tamas (2016: 40) describes ghosts as 'lurking absences, the shadows of the not-quite-known or not-here-now, things that condense in gaps'. I view the nature of a ghost as a trace of that which once was, either tangibly or imaginary. Within the eluding and lurking, there is something worth inquiring into and attending to, as the ghost 'pushes us beyond the breech of understanding, feeling, and recognition' (Bennett, 2014: 7). Attending to the spaces within us and between us where ghosts seem to lurk and ask to be listened to acknowledges that ghosts are 'both unthinkable and the only thing worth thinking about' (Davis, 2005: 378). Wolfrey (2002: 3) says that 'to tell a story is always to invoke ghosts, to open a space through which something returns'. One of the key aspects of hauntology is the return of the ghost, the repeating, again and again (Derrida, 2006). Ghosts carry messages that may be relayed as amorphous tellings, as narrative attempts. Following Derrida (2006), Davis (2005: 379) says that the ghost holds a secret that 'is not unspeakable because it is taboo, but because it cannot not (yet) be articulated in the languages available to us. The ghost pushes at the boundaries of language and thought'. Ontologically, ghosts have much to say about what has previously been unnarratable.

Identities and selves are socially, relationally, and narratively constructed (Somers, 1994; Willis, 2012); realities are also constructed through narratives (Bruner, 1991). We construct stories both when we tell and when we listen, and within this research I see the stories of my client and her ghosts as constructed. Keane (2009: 153) explores personhood within pregnancy loss as 'constructed and negotiated, rather than inherent'. There is a constructed and 'productive opening of meaning rather than a determinate content to be uncovered' (Davis, 2005: 377) when working with ghosts. I explore imagination as an important aspect of narrative construction (Sarbin, 2004), with the ghosts demanding that we imagine into them. Atkinson and Coffey (2002: 810) assert that 'memory and experience are social actions in themselves. They are both enacted'. I view the stories offered in counselling, or any form of narration, as bearing a performative and imaginative nature. I recognise that 'over time, different memories, alternate ghosts, and differing versions of our selves can emerge to ultimately alter the stories we tell and the knowledges we create' (Doucet, 2008: 77).

Similar to Butler's (2001) claim on the impossibility of making an account of oneself, Hammersley (2003: 122) states that to 'conceptualise what we see or how we feel we must do so in a language that is a social product'. No account can represent reality (Hammersley, 2003). We are always influenced, shaped by the social frames surrounding us, and I acknowledge that my research account captures a thin slice of the complex picture within those frames. I am studying the way that narration and meaning are co-created in relationship, how language 'not only expresses personal meaning – language creates meaning' (Jonas-Simpson and McMahon, 2005: 124). Arguing that 'language cocreates human experience' (Jonas-

Simpson and McMahon, 2005: 126), I wonder about my experience of constructing narratives and meanings with clients. Language is a social practice that creates the world as we know and use it. We are born into language, 'spoken into being' (Richardson, 1997: 190), and spoken into knowing. The relational dialogue within some counselling relationships shapes the meaning ascribed to clients' experience of pregnancy loss. Yet with losses that are hidden, there may be a 'hidden language' (Rogers, 2006) as well. Getting close to the stories arising within a counselling relationship may reveal more about the attempt to narrate and make meaning after loss.

Clients' understanding of their loss and grief is shaped by external discourses and societal expectations, which often tell them their losses are unspeakable because they are not desirable to hear. The narratives and discourses available to us shape how we ascribe meanings within our lives (Richardson and St. Pierre, 2005), sometimes leaving us 'textually disfranchised' (Richardson, 1997: 58). Recognition of clients' losses is constructed by discourses; when clients come to counselling, they need another kind of recognition, one that attempts to counter the unspeakability, that joins the struggle to narrate. Cixous and Clément (1986: 6) state that 'every culture has an imaginary zone for what it excludes and it is that zone we must try to remember today'. I suggest some counselling offers the kind of recognition that opens spaces for different narratives, alternative discourses, what has been excluded within the ghostly.

Butler (2001: 26) posits that the 'norms by which I seek to make myself recognizable are not precisely mine', therefore so much is not narratable, not able to be given an account. Underlying, pre-existing forces are not within our control and

may cloud representation and narration. This is partly due to the notion that the telling of a narrative takes place partially in the transference and 'is riding a desire whose aims are not fully transparent to me' (Butler, 2001: 32). Within us and around us is life that is happening that we may not be able to see. Winnicott (1957: 153) points towards the unconscious, saying that '[i]n each adult observer there is the whole memory of his infancy and childhood, both the fantasy and the reality…Much is forgotten but nothing is lost'. We are inhabited by a world of feelings that reside within us.

I hold the position that the ways in which we narrate a story of our self are unstable and shifting in nature. Narrative construction involves a never-complete process. Our clients' stories may be seen as narrative attempts. Denzin (1990: 235) troubles the idea of making an account, referring to what he calls 'Derrida's Dilemma', where language does not permit pure representation, stating that '[i]n speech and writing the person's thoughts are always in a process of deferral, delay, and transformation, wherein nothing is ever simply present or absent'. Bondi (2013: 10) points to the gap between 'lived experience and representations of that experience'. There is a gap in what is experienced and what can be represented; the narration is not the experience itself. We cannot faithfully or fully represent ourselves, our stories, as '[a]ll seeing is partial and formative, even our own' (Tamas, 2009: 616). I see this instability and unknowability not as a constraint, but rather a possibility that opens and broadens the scope of my research, allowing spaces to imagine into what was lost.

Our stories are formed in collaboration with others; they exist because we form them in relationship and they are witnessed by another. The story comes not

solely from ‘out there’ nor ‘within’ but rather happens *between* us. Frank (1997: 22) states that the ‘truth of stories is not only what *was* experienced, but equally what *becomes* experience in the telling and its reception’. As we tell and receive stories, they form our narrative and our experience. Perhaps counsellors and clients form a shared language that facilitates the forming of a narrative.

3.3: Epistemology

If ghosts are liminal, amorphous, and often not narratable, then how do we come to recognise or ‘know’ them? In this section, I offer my epistemological approach which names how I evidence ghosts and narrative attempts, exploring recognition and witnessing as a form of listening into client stories. I wonder about working within an intersubjective and embodied relationship. Finally, I focus on data created within many therapeutic relationships, including what arises from imagination, empathy, and counter-transference.

3.3.1: Recognition and witnessing: listening to ghosts and narrative attempts

While much ‘evade[s] narrative formulations’ (Sclater, 2005: 165), attuned listening may help make clients’ stories of loss more recognisable or significant. Counselling is a place to potentially be recognised and received within narrative attempts. Oliver (2001: 106) states that ‘to recognize others requires acknowledging that their experiences are real even though they may be incomprehensible to us’. Similar to Winnicott’s (1971) theory of mirroring, described by Phillips (1988) as ‘real-making’, listening involves noticing and offering back one’s perception and recognition.

I also follow Oliver's (2001: 2) charge to move beyond recognition, towards witnessing which allows us to approach the unspeakable, to perceive 'the unseen in vision and the unspoken in speech'. As therapist and researcher, I listen beyond the words where I find 'shadow narratives' in clients' indirect communications (Makari and Shapiro, 1994). The notion of ghosts captures something of the vague but present stirrings within us. Ghosts evoke what is 'outside' of knowledge and 'excluded' from perception (Blanco and Peeren, 2013: 9). Gordon (2008: 194) acknowledges 'the always unsettled relationship between what we see and what we know'.

My project partially relies on visual recognition as well as auditory listening within the therapeutic relationship, and also attends to multi-sensory witnessing of the other and myself. Yet Agamben (1999: 34) names the need to acknowledge 'the impossibility of bearing witness' even as we attempt to witness another. Witnessing is an attempt to listen to the 'sound that arises from the lacuna, the non-language that one speaks when one is alone, the non-language to which language answers, to which language is born' (Agamben, 1999: 38). I feel into the non-language of pregnancy loss, engaging in what Speedy (2008: 32) calls 'multiple listening…within the gaps and cracks' of client stories. Finding a way to access 'the unsaid, the unsayable…or traces of forgotten, or unacknowledged, stories' (Speedy, 2008: 20) is part of the work I want to explore. In qualitative research the 'gap between personal experience and its narration can be troubling' (Bondi, 2013: 9), yet this gap remains, and researchers must find a way to work with it. I acknowledge this gap exists – I can never fully understand others or their experience within their social world – but I can 'feel into' a portion of it by letting myself get involved in the stories of others, by

experiencing and thinking about happens for me in relationship with my clients. I listen to myself within my client work as an example of reflective practitioner research (Bondi and Fewell, 2016). Reflexivity and witnessing offer ways to sense into what may be incomprehensible, indistinguishable, and unspeakable.

I 'mov[e] towards the spaces where untold stories lurk' (Speedy, 2008: 22). This includes how we search for, but often fail to find, words. I consider how the stunted and malformed parts are often missed in the stunted and malformed ways we speak of pregnancy loss. I am interested in how perhaps many counsellors work within and fumble at the edges of narration. Noticing, hearing the silence, and pushing into the edges involves the unknowable or possibly what Bollas (1987) calls the unthought known. Pitt and Britzman (2003: 758) notice how our pain 'resists meaning even as the affective force of the event can be felt'. Maybe I cannot make meaning out of the stories of my clients' losses, but I can explore how something that is often silenced or misrecognised can be worked with in the context of an empathic relationship. The act of witnessing allows for subjective truths and for new relationships between experience and narrative to emerge (Borck, 2011).

While psychotherapy often 'promises to see the unseen and to make the unintelligible tell' (Borck, 2011: 408), I argue that some aspects of our experience and stories are not knowable or tellable, even when there is an attentive witness. Generating knowledge from and about narration involves allowing understandings of which we may be consciously unaware to emerge. Within both counselling and researching, listening is an invitation to keep telling, forming an on-going conversation that pushes against the surrounding silence but not necessarily getting at the 'truth' of the matter.

3.3.2: Relational and reflexive knowing: intersubjectivity and embodiment

The elusiveness of ghosts may be approached through relational and reflexive ways of listening and responding. Blanco and Peeren (2013) work with Derrida's idea of hauntology, suggesting that allowing for the spectre or the ghost demands a response. I explore how my ability to offer a response (response-ability) is crucial to witnessing my client's loss (Oliver, 2001). I propose that my clients' ghosts, although eluding representation and knowing, partially get evoked or created through our therapeutic relationship. Neimeyer (2000: 552) suggests that meaning-making in grief therapy be viewed as 'a predominantly tacit, passionate process that unfolds in a social field'. Gordon (2008: 21) says that a 'different way of knowing and writing about the social world, an entirely different mode of production, still awaits our invention'. I call on theories of knowing, especially ones that emphasise attending to the internal world and that which may be unthought or ghostly. Allowing for ghosts and haunting has the potential to reveal something of our unconscious lives (Frosh, 2013). Using unconscious processes as data (Finlay and Evans, 2009) provides for an openness, an emerging of something unknown and possibly not knowable, at the edges perhaps.

Derrida (2006) acknowledges that looking for the ghost is not sufficient; we must speak to and allow oneself to hear from it. Attempts at relational exchanges with ghosts might help us hear in new ways. The act of 'telling new stories rather than faithfully reproducing existing ones' (Bondi, 2013: 10) within psychotherapeutic research seems more valuable than the limitation and impossibility of accurately representing. Pitt and Britzman (2003: 769) propose that 'research must be understood as provoking, not representing, knowledge'. Provoking new

stories may require, as Gordon (2008) suggests, an alternative epistemology, where knowledge can tolerate presence *and* absence.

I take a social constructivist view of knowledge, focusing on knowing as becoming and developing within a context, within relationship. Because humans interactively make meaning together, I view the researcher's experience as evidence, and I have made the decision to include it in my research. Finlay (2005: 272) advocates 'a research process that involves engaging, reflexively, with the participant's lived body, the researcher's own body, and the researcher's embodied intersubjective relationship with the participant'. As a therapist, being reflective, having a thinking space to process, is a valuable offering I make to clients. As a researcher, by critically reflecting on the relational encounter, I offer my embodied and theoretical views on working with pregnancy loss.

My reflexivity as a therapist, my bodily and emotional responses, are data. I know in ways that are rooted in embodiment (Conquergood, 2002), taking the view that intuitive body-based knowledge helps me listen to data within me, telling something of what might be excluded for clients. Frosh (2013), in his work on ghosts and psychotherapy, says we are inhabited by communications from others, including their ghosts, and to hear them we must give them a home. Data arising out of dreams, sensations, and emotional reactions (St. Pierre, 1997) reside within me. Data arise when practitioners and researchers are 'emotionally and bodily *engaged*' and 'in contact holistically, i.e. with the whole of themselves (own bodily sensations, emotions, thoughts and fantasies)' (Finlay and Evans, 2009: 109). I inquire into how I am in contact with and respond to myself and clients within therapeutic encounters. Finlay and Evans (2009: 29) promote qualitative relational-centred research, where

data are ‘seen to emerge out of the researcher-co-researcher relationship, co-created (at least in part) in the embodied dialogical encounter’. Embodiment speaks to the deeply intuitive nature of some counselling, the wisdom of the body that presents implicit and unconscious knowing (Fuchs, 2001; Canavan and Prior, 2016).

3.3.3: Creative data: imagination, empathy, and counter-transference

For intuitive, implicit, embodied understanding of the theory and clients we work with not to be lost in our research, we need to include impression, interpretation, and the imaginative as data, allowing our work to be both creative and relational. Speedy (2008: 31) states that practitioner-researchers, ‘spending as much day-to-day time as they do engaged in conversations about possibilities, hopes and dreams as yet barely imagined, are well positioned to bring these kinds of accounts more to the forefront of research studies’. To capture the impact of being in dialogue and relationship with the other, I interact with and influence client stories. Hinton (2007: 433) states that imaginatively articulating holes within understanding or narration within a ‘many-sided dialogical process best provides acquaintance with such a complex phenomenon’. I open up spaces to attend to and imagine into my intuitive and embodied sense of the work.

Accessing my embodied experience of clients honours the visceral nature of pregnancy loss. In addition, my psychodynamic theoretical assumptions attend to therapists’ embodied sense of the work. Some therapists might find it helpful to see it this way, however I recognise that not everyone will look at things in ways presented in this thesis. Paying attention to sensory experiences can offer insight into what is happening in the space between counsellor and client. I can imagine into

something, relationally and creatively, using my counter-transference, empathic resonance, and sensory knowledge as valuable information. Bollas (1987: 9) states that a client 'does not simply represent his internal world to the analyst in narrative' but rather 'uses the analyst as a transference object and this usage is further articulated through the analyst's countertransference'. Ontologically and epistemologically, empathy and counter-transference are interactive, intersubjective; it is impossible to disentangle what arises from the client and what comes from the counsellor. Empathy is not just an emotional knowing but a 'feeling with the Other', a 'process of imaginal self-transposition and mutual identification where self-understanding and Other-understanding is intertwined' (Finlay, 2005: 290-291). Not decipherable as being distinctly 'theirs' or 'mine', I enter a field – within the counselling room as well as my research – that clients and I create together. I attend to my empathy and counter-transference, seeing them as cues for what might be occurring within the therapeutic field. Wertz (2005: 168) says our 'intersubjective horizon of experience…allows access to the experience of others'. To know something of someone's reality, for example the particularity in how they experience loss, I can use my experience (of the other, myself, our relationship) to help me understand what might be going on for them. Finlay and Evans (2009: 23) state that 'relational researchers could be said to act as both witness (in seeking to represent participants' experience) and author (in the way interpretations are made)'. As a subjective witness and author, I do not need my client to confirm my imaginings in order to for me to consider them valuable sources of evidence of my sense of the relational field that we inhabit.

Winnicott's (1949) seminal concept of acknowledging hate in the counter-transference gives me more freedom to name what is difficult within my therapeutic work. Empathic and counter-transferential listening is hard work, where clients' feelings are projected into me, leaving me to experience them as if they were my own. This involves being actively engaged with my experience of clients and what arises within me around, for example, loss, motherhood, and failure. Counter-transferential movements are narrative attempts within our work. I try to notice, make some sense of, and use them between us in the field we create together.

Consistently, research shows that the qualities of the therapeutic relationship are much more potent than that of the therapeutic approach taken (Clarkson, 1995). Examining my counter-transference is a way in to valuing and understanding my position within the therapeutic relationship; as a counsellor, I am affected personally and subjectively by my client. Pivotal work by Heimann (1950) supports the view, now widely held within the psychodynamic tradition, that a psychotherapist's counter-transference is seen as providing a way into our client's inner world. Counter-transference is a subjective route into understanding the other's subjectivity. We are immersed in ours and others' subjectivity (e.g. Britton, 2004). Many researchers propose methods which work with subjective stories within counselling, including the researcher's subjectivity and use of self (e.g. Stickl, Wester, and Wachter Morris, 2018; West, 2001). Fauth (2006) names the centrality of the therapist's counter-transference in impacting the therapeutic work and therefore promotes it as a valid form of research within counselling and psychotherapy. Holmes (2014) outlines a move away from analytic neutrality towards an acknowledgement of subjectivity and use of counter-transference within

psychotherapy, which can also fuel reflexive processes in research as well as comprise data.

Inquiring into our counter-transference, our inner experiences, helps many therapists better understand how we intervene within our work (Jacobs, 1993). Hayes (2004) acknowledges the varying definitions of counter-transference and says that therapist and client co-create the counter-transference and as such it carries information about client dynamics. Counter-transference is data about what might be happening within our clients, or as Jacobs (1993: 7) names, the 'inner experiences of the analyst often provide a valuable pathway to understanding the inner experiences of the patient'. As Jacobs (1993: 14) also says, 'shards of memory and imagination that arise from within constitute meaningful and often illuminating responses to our patients' communications'. Samuels (1985: 58-59) works with the counter-transference experience of psychotherapists, shedding light on how 'two persons, in a certain kind of relationship, may constitute, or gain access to, or be linked by, that level of reality known as the *mundus imaginalis*', or the 'imaginal world'. I share an imaginal world with my client and listening to and internally investigating my own experience offers a potential way in to this inner and imaginal world.

I reflect on the meaning created in the 'embodied dialogical encounter' (Finlay and Evans, 2009: 29). The impact of clients' narratives of pregnancy loss on myself is the evidence I seek. Richardson and St. Pierre (2005: 967) contrast 'writing as a tracing of thought already thought, as a transparent reflection of the known and the real' versus 'writing to disrupt the known and real'. I imagine into conversations with the lost child (Watkins, 1986), I 'hear' from the lost child in whatever way they communicate to me. My reflections on client work are partial

and tentative (Finlay and Evans, 2009), where I engage with my counter-transference and sensate experiences to make wonderings about my experience of listening. Because I offer a personal account of my experience working with clients sharing their grief around pregnancy loss, where my observations, interpretations, and uncertainties count as data, I can come to understand this best by exploring and writing into data that reside within me.

3.4: Methodology: writing as a method of inquiry

My research touches on women's lived experience of disenfranchised grief. However, my social constructivist outlook on ghosts and narration indicate a methodology that, rather than presenting accurate accounts, allows for imagining into experiences of loss. Analysing my responses within listening is favoured over asking for someone to give me an account about loss. The former does not merely attempt to represent experience but can capture something of 'the ambiguity, ambivalence and richness of lived experience while touching the complexity of meanings in the social world' (Finlay and Evans, 2009: 2).

Initially, I thought my process of 'constructing data' would begin with my process notes, which contain descriptions of my client work, including my interpretations, imaginings, and embodied sense. These notes are typically written shortly after client sessions and can facilitate some therapists to express and process what the work brings up within them. My view was that as I looked for themes within my notes, I would create new layers of interpretation and reflection.

While I value my process notes as constituting a range of curiosities around being with clients, and I did review them to remind myself of salient words and

moments, mining my notes did not match my epistemological approach of data as constructed, arising and becoming rather than being excavated from something seemingly pre-existing. My process notes come out of what clients and I have already co-constructed; they are one representative of our relationship and work. Viewing my notes may partially *expose existing* themes; however, because I value the *emergence* of meaning, I also write into my experience, meaning I write about the counselling relationship as a form of inquiry (Richardson and St. Pierre, 2005), hoping other layers develop. Gubi and Swinton (2016) make a case for research that both arises from and informs counselling practice. Viewing both counselling and research as creative and transformative activities, I attempt to put words to some of the unspoken within my client work.

I seek to continue to produce understanding as I write about and into my experience of working with clients. Nothing is 'reducible to one single story' (Leader, 2009: 32); there are *many stories*, this is *a story*. I am not claiming to represent how it was for clients or even for myself; I am offering something of my knowings, how I can partially know. I write about and into the edges of our work, not about clients themselves. It is the subjectivity of the narration, not the narrator herself, that I research (Richardson and St. Pierre, 2005). Both my clients' narrations as well as my account of our work are narrative attempts. The process of writing constructs more data, as I dialogue with myself and my sense of clients within the liminal space of my therapeutic relationships. I suggest that all researchers have data that reside within them and that writing is a way to work with internal data.

My work with clients contains some conscious reflections, where something of their experience is tellable, or becomes tellable, but also creates spaces for the

unconscious, to tell what we can of it but also notice when something may be untellable. I am writing to see what comes, to give a voice to the unspoken, within clients and myself, to allow the unconscious to have space on the page. Speedy (2005: 64) says writing as inquiry allows for surprise and 'shapes our experience in different ways than we might have expected'. Reflexivity and interpretation take place both during and after my therapy and research encounters. Writing is generative: thought happens when we write, rather than writing what we think. I come to understand the research story I work with as I write it. This approach does not seek to extract pre-existing narratives, but rather illuminates the on-going and creative aspects of meaning. Reflecting on a story – versus telling a story – helps me enter the edges.

There is inherent tension in attending to these forms of data, for as St. Pierre (1997: 177) states, 'we must use the language we have inherited even as we put it under erasure'. Yet this loss seems to open a space; the insufficiency of words draws something from our unconscious. My study is an attempt to write into that unconscious space, where I inquire into what occurs between clients and myself. As I write, I am not reporting but making unexpected connections, I am listening to the writing itself. Drifting towards spaces filled with shadow, spaces that seem to resist words and knowing, I write to tell a story that eludes full understanding and finality. Working with my clients and processing our work has a dreamlike quality. Valuing unconscious data seems to acknowledge unintelligibility or the barely intelligible within us. St. Pierre's (1997: 182) words about a dream seem fitting here: 'This story never begins but has always been, and I slip into it over and over again in

different places, and it is as if I too have always been there'. There is always already, in many peoples' personal and social worlds, a story of a lost baby.

Clients, and their ghosts, affect us deeply. I find processing and writing about client work offers a deeper level of reflective knowing. Writing as a method of inquiry allows us to learn something of the 'unknowable and unimaginable' (Richardson and St. Pierre, 2005: 963). Cixous (1991: 53), speaking of her need to write into herself, says '[w]hat slowly develops in me finds its surging inscription in a form I cannot control'. Writing as inquiry helps me access the not yet thought, allowing the unbridled within spaces to be reflected upon and meaning to emerge. Writing into my experience helps me push into unexpected spaces, taking me to edges and unknowns and offering the potential to not just notice a curiosity, as I might have if looking for 'themes', but to wonder about the edges of client work, about the things that cannot be said.

3.5: How methods worked in practice: case study, particularity, and theory

I do not seek a methodology that eliminates distortion of experience as I view a completely accurate account as impossible. Using case material involves the analytic process being 'digested, integrated, selected and meted out' by the analyst-writer (Bernstein, 2008: 436) and contains subjectivity, as there are multiple layers of interpretation. Colombo and Michels (2007: 647) propose that case reports 'are almost palpably shaking with developmental angst, and not only that of the patient'. Case material might include some therapists' often wobbly attempts at empathically understanding clients, imaginatively processing what comes up for us, and working with the interplay of theory.

Klumpner and Frank (1991) outline the importance of using detailed case material to both help therapists communicate their ideas more effectively and create opportunity for readers to engage with the ideas. The 'case' I work with, not fitting with traditional psychodynamic views about case studies focusing on clients' backgrounds, presenting issues, disclosures, and outcomes (Canavan and Prior, 2016), instead offers a view of my counter-transference experience working with a client who lost a pregnancy. While my research is 'experience-near' (Sandler and Sandler, 1994: 1001), instead of defining my client's experience, I seek to explore my experience of being with her. The 'case' is not the client, but rather my sense of our work and the relationship between myself and the client, including my counter-transference and attempts to narrate the experience of being an intimate recipient and listener to her narrative attempts. I am researching the practice, my practice, of working with pregnancy loss and disenfranchised grief.

Working with experience-near case material allows for particularity. Bondi and Fewell (2016: 41) promote the use of examples that share the 'lived experience of therapeutic practice' which 'notice and attend to specific and particular details, often things that might be overlooked but that, when approached with deep curiosity, have the potential to offer new and important insights'. Throughout, I ask: what is it like to sit with this particular client in this particular moment? Within a story, what is told, how it is told, and how it is heard and interpreted is different from one researcher to the next (Finlay and Evans, 2009). Folded into the potential limitations of narrating and witnessing, I see a strength in that our stories are told in particular ways that are created through dialogue and relationships. This approach honours the contextualised nature of therapy, the values of a particular client, and the nuances of

the relationship. As my inquiry aims to examine my experience of being with my client within her stories of pregnancy loss, I selected several clients who initially evoked within me a sense of disenfranchised grief 'out there' yet where more internal layers emerged as the therapeutic work developed. Instead of searching for causes, I search for happenings (Stake, 1995); my work seeks not to explain, but to describe; not to generalise, but to particularise.

When I consider how to best give an account of my client work, I want the stories to stand uninterrupted. In chapters four, five, and six, I move closer to the work by leading with a brief story of that phase of our work. Then I take a few steps back from the work by offering a more theoretically informed commentary on the story. However, I acknowledge that the story and the theory cannot be fully separated, as I am the one telling a particular story through a particular lens. I offer both the intuitive and analytic parts (Bondi and Fewell, 2016) of working with the telling of grief experiences in a therapeutic context.

Without claiming representational truth for my client, I use theory to illuminate my thinking around my client work. As argued by Rizq (2008: 51), qualitative researchers might position themselves as both capturing something of the subjectivity within the project as well as 'retaining the analytic independence necessary for a meaningful and creative contribution to the research literature'. I do not, and cannot, represent my clients' experience, but rather think into my experience of being with my clients and their narrative attempts.

While useful, theory has limitations, namely that it is typically male-generated and privilege-laden (Griffiths, 1995). My theoretical analysis is offered not as the truth of the story, but as one possible way to think with the story (Frank,

1997). Thinking with, and into, the story helps me reflect on how I am impacted by my client. Bondi and Fewell (2016: 20) promote research that displays an embodied understanding of theory and 'how theory is lived in therapeutic work and how it animates therapeutic relationships'. I use theory to help articulate something of my emotional and embodied experience of being with my clients.

Initially I felt the pull of out there/in here, the seeming social demand to remain silent within pregnancy loss. My focus was on trying to understand how disenfranchised grief was impacting the interruptions of client narratives. However, when the focus remained on social norms, I felt unable to write about my clients. Shifting my attention to data that reside within me, I felt opened up to consider other ways of listening and knowing within my therapeutic work, both in the room with all my clients and in my inquiry into this particular client group. My feelings of being mired in theory and unable to write began to fade as I released my need to understand and started to write about what it was like to be with my clients.

Rather than naming or discovering my lived experience, my research is about exploring experiences and meaning that reside within me and wait to be wondered about. In addition, rather than attempting to make an account of how I witnessed or validated my client's grief, I wonder about what might be happening beneath the account. Hayes (2004: 29) suggests that a therapist's 'postsession reflections on countertransference' are a data set. I do not simply name my counter-transference as it was within our work, but rather allow spaces to reflect on and explore how it is still active within me; I write the case study in the present tense in order to capture the live and active quality of the work. I write about lived experience, yet I am only able

to understand it when I write into it, allowing myself to imagine into the ghosts and the life within the transference/counter-transference.

My composite case study is created by first reviewing my process notes to help me write the client narrative, along with some of my initial responses to the work. Then I review how certain theorists fit my growing sense of my client work and bring them into conversation. Possibly most importantly, I put aside the theory – the books and articles, as well as the thinking part of me – as best I can for a time in order to engage with and hear from the ghosts. As I move through successive moments of self-reflection (Denzin, 2008), I often hit upon a layer or a feeling that needs to further be written into. Within this phase of my process of writing, as I notice layers that appear to be missing, for example my hate in the counter-transference or what was developing into a very real relationship with mine and my client's ghosts, I focus on writing into these aspects of myself and my client work. These missing layers become not themes, but holes I want to crawl into and explore within my research. The emptiness and silence within my work seem to demand that I write into my experience of working with pregnancy loss. Writing as inquiry allows me to enter spaces and edges within me, as I allow some of the ghosts to come in more audibly and explicitly.

Writing into my relationship with my client helps me explore and make sense of my use of self within our work, and the case study forms as I write it. The case study becomes a place I can continue to respond to and create meaning around my sense of my client, myself, our process, as well as theory. I watch meaning unfold as I write into our experiences and accounts, and using a case study provides me with a frame in which to structure my reflections and creations. While my process notes

help within this research process, I do not rely on them for themes; for example, the phases of our work – conception, gestation, and labour – emerge from within me, unfolding out of my writing as inquiry. My writing becomes my reflective space, as the spaces within me become more reflective. Writing helps me perceive the blur and intersubjectivity within our work, and my sense of my counter-transferential pregnancy takes form.

Writing as a method of inquiry is not about separately collecting data, analysing, and then 'writing up', but rather the writing happens throughout the process, the writing *is* the process. I write into my experience of being with and attempting to witness the unwitnessable, noticing the space within me reverberating with my clients and their stories. Writing into these experiences feels like a dwelling in and around spaces within me where I internalise clients. Sensations and fantasies seem to become both unlocked and created within me, growing and pouring out of me.

I acknowledge that the stories herein are unfinished, possibly ever-incomplete; they contain selected portions of client stories and are told through my interpretive lens. I may never have a shared understanding of my work with clients, but I want to better understand our shared work. I explore the nuances and tensions within narrating and listening to fragmented stories of pregnancy loss. I do not seek to explain grief or how stories of pregnancy loss might be silenced or ignored, but rather reflect on how it was for me as a counsellor. My aim is for my wonderings to provoke thought and contribute to knowledge, yet within the unknowability, as Stake (1995: 99) suggests, for readers to 'find the infinite void still lying just beyond'. The knowledge within my project may offer intelligibilities not often recognised by

frames of understanding employed in the social world. A society which so often limits narrations of loss would benefit from seeing the legitimacy of stories of shadows and 'empty' spaces.

3.6: Potential risks to clients and self

I have chosen not to obtain client consent to use case material, holding the view that it can take away from the work, or the perception of the work, that was done. Polden (1998) suggests that clients' awareness of their inclusion in our research may lead to contamination in the work and/or interference with the transference. Additionally, ensuring that consent is truly a full expression of one's permission may not be possible and can be greatly influenced by the power therapists hold (Mason, 2002; McLeod, 2010).

I create a fictionalised account, including a pseudonym, that reads as a case study of my work with one client yet pulls from work with multiple clients. Fictionalised here means that the stories are anonymised, where identifying detail is excluded or altered, as well as composite, where several clients are combined into one. This blurring and merging conceals my clients' identities and maintains confidentiality.

However, potential risks exist including the impact on current and future clients. While I do not feel the pull to actively extrapolate information from my clients – because my research has primarily arisen from what I notice within client work, and I am not attempting to prove something – this does not mean that client work remains free from impact by my research. I acknowledge that my research interests have to some degree likely influenced the way I worked with these clients.

When I consider in particular the ethics of using a client I was working with concurrently with writing my project, I am aware that processing the case material so intensely can affect our work. Yet I view this impact not as contamination but rather an opportunity for further learning and reflexivity.

Not gaining consent to use case material, I still consider the data to be co-created (Finlay and Evans, 2009; Bondi, 2013). Both researcher and participant are immersed in the setting to be studied. I cannot completely separate out my stuff from the client's stuff, and as I am examining the relationship, I actually would not want to separate it out even if I could. My responses and processes are not solely for my clients, yet neither are they for solely my benefit. I propose that we do not have complete or sole ownership of our stories. Viewing the stories from a social constructivist standpoint offers an entry into seeing these stories as coming from the broader social world. Atkinson and Coffey (2002: 812) suggest continued recognition that as researchers we are 'part of the social events and processes we observe *and* help to narrate'. Assessing our precise level of involvement in the research process or outcomes is futile; we are in them before we even start.

Considering the potential impact on past, current, or future clients who may become aware of my interest in pregnancy loss, I see how my research is a form of self-disclosure. I feel the need to continue to hold this in my awareness, explicitly taking this to supervision and possibly wondering with certain clients how this might impact them and the way they bring their story. Motherhood and loss are common within client stories however, and I do not want to become overly consumed with worries that my clients are selectively attending to these issues just because I have a more focused or historical interest in them. It feels more useful to attend to how any

self-disclosure, whether intentional or not, ‘can cut both ways’ (Basescu, 1990: 164) and offer the potential for exploration within my therapeutic work. Another ethical debate resides in the possibility that I may, in my concentrated attention on this project and on the topic of pregnancy loss in general, offer less of myself in my work with clients who fall outside the scope of my research. The risk of harm appears to be slight, mostly because I maintain a self-reflexive position in relation to all my client work.

My writing into my understanding about my embodied sense of client work takes the sole focus off clients, yet I must reflect on how *I* am impacted by my research. Because I am undertaking introspective writing around topics of loss, there may be risk of discomfort or distress to myself. There is potential for things to be evoked within me; this is very likely as writing as a form of inquiry often takes us to unexpected places. I address this by discussing the process of researching with a close colleague and friend to help identify possible effects upon me. Throughout this process, I discuss the potential professional and personal impacts with both my clinical and research supervisors, ensuring this is an ethical endeavour for both my clients and myself. As with other intense and highly personal aspects of my counselling training, the nature of my research is reflexive, which while potentially draining is also in and of itself a process of self-awareness and self-care.

One of the most distressing parts of this thesis has been the struggle in staying with the particularity – the retaining of enough client detail to capture something of the work we did – while also protecting confidentiality. I felt the need to wrap my client up, take her to a secluded space, and write with her, as if I needed her permission and closeness. I was able to release my fearful clutch as I began to see

the value in writing so that something new can emerge. I write in response to my client, myself, and to our way of being together. Through writing, I listen into our work: the shifts in our chairs, shifts in our process, eyes averted, breaths held, released.

Chapter 4 Conception: How do I listen into Helen's struggle to be recognised and received?

> Everybody knew what she was called, but nobody anywhere knew her name. Disremembered and unaccounted for, she cannot be lost because no one is looking for her, and even if they were, how can they call her if they don't know her name? (Morrison, 1987: 274)

4.1: Introduction

This chapter addresses material from the first twelve of the thirty-six sessions I have with Helen – who lost her pregnancy, lost *him*, at twenty-two weeks. I include my initial impressions of her as well as some of the tensions in making use of the therapeutic alliance we are beginning to form. I present the early phase of our counselling relationship, where she shows me her need, yet struggle, to be taken in. Throughout this chapter, I explore how she empathically resonates within me, which involves a delicate noticing of what had previously been unrecognised within her. The story of the beginning of our work is followed by my use of theory to think into what might have been occurring within and between Helen and myself.

4.2: Narrating the conception phase: attending to recognition, empathy, and internal spaces

Helen comes into the room, eyes bright, with a quickness in her step, hair neatly arranged, nothing out of place. On the outside, her life appears pleasant – she wears colourful clothing with images of flowers and sailboats, and she frequently checks our sessions against other commitments in her diary. Her bright exterior and

presentation shout ‘There’s nothing troubling here’. Yet when she speaks there is a quiver in her eyes, a longing, a ghostly emptiness. When I imagine her in the outside world, I see not a colourful, full life but rather her staring at the empty space where she wishes a picture of her son was placed. She hides the picture of her son; she hides his ashes.

Helen is a forty-two-year-old female. She is British and has lived in the UK for all of her life. Never married, she has been in a committed relationship with her male partner for nine years. When she became pregnant shortly after meeting her partner, she was pleased as she had always envisioned having a large family. This first pregnancy, and two others that followed, ended in miscarriages. The years within and following this time were filled with both hope and loss, both physical and emotional pain as she underwent multiple tests. When it was discovered that she had fibroids growing into her uterine wall, she had them removed with an invasive surgical procedure, becoming more hopeful that pregnancy would be possible. Doctors advised that if she wished to become pregnant she do so shortly after her surgery, the time when there is less risk of the reoccurrence of fibroids. She and her partner agreed, and she became pregnant with a little boy within four months of healing from the procedure. She described this pregnancy as a worried one, with risks that the internal scars might rupture as he grew inside of her.

She carried this pregnancy with growing hope – telling friends and family about him, buying the pieces that made him feel real: the snowsuit, the memory box – until week eighteen when after reviewing genetic abnormalities made clear by a scan, Helen was told her son would be born severely deformed and was advised to

have a medical termination. This was a very difficult decision for her and her partner. She had the termination at twenty-two weeks.

After spending the first year avoiding her loss and 'in denial', she started to experience more pain associated with grief, yet it often felt too difficult to approach. She began counselling with me two years after the termination. Within those two years, Helen's fibroids returned. Medically, another pregnancy is most likely not possible, due to the ongoing fibroids and the resulting likelihood of needing a hysterectomy. She experiences sharp pain and frequent bleeding and has numerous medical appointments and scans amidst our work.

In session one she says that having scans – and other painful reminders such as being invited to baby showers, seeing babies, and Mothering Day – invite her to reminisce about her loss yet leave her feeling alone within it. Helen's life seems filled with hollowness: the acquaintances who walk past her with their heads down, the Mother who does not respond, the friend who equates Helen's loss with trivial events in her own life. Feeling something of the hollowness, I offer: 'Perhaps you come across as controlled to others. Maybe they don't see how much this is impacting you'. She responds with her fear that her story might burden others, that 'No one wants to be around someone who's sad all the time'. Upon reflection, I realise that my response to her is almost blaming, and I need to give more attention to my attempts, my fumblings, to recognise just how much her loss goes unrecognised in the invisibility 'out there'.

Yet I feel held at a distance from her sadness. In session two, she checks that the door to the counselling room is closed, the first of several times within this phase

of our work, naming the fear that someone may be listening to what she is saying. I am struck by her fear of being listened to, yet I am right here listening to her.

She is concerned with others seeing her upset but also with their judgment that she is 'still upset'. She notices their apparent preference for her silence and perceives their words, such as 'It's over' and 'You should be feeling better by now', as communicating his insignificance. Most of our early sessions are extremely repetitive, focusing on how she imagines others 'out there' want her to get over losing him.

She is confused about why she is even coming to counselling, questioning in session three 'why talking about it once is not enough' – as she notices was often put forth within her upbringing. She seems to look to me for the answers, often asking 'How does this get better?' or telling me there is only one answer, saying 'I'm a messy bag of emotions. I want to be able to put it in a box with a lid!'

My attempt to communicate my understanding of the repetitive struggle of both approaching her loss and conforming to how others want her to be – 'This still hurts, and you can talk about him here' – seems to move her into a rather elliptical narration. She says in session five 'I want to speak about him, but the words feel stuck in my chest, like my breath was taken away.' I can only wonder, but maybe the unsaid is something like: 'I'm desperate for someone else to say he matters…I'm desperate to keep him alive'. Left with a sense of the lost son lingering between us, I offer 'You've been carrying this for so long on your own. I can carry it with you'.

When she struggles to narrate what it was like to lose him, I find myself often imagining her within her home, where she says she grieves alone, privately, unseen. I envision a mantelpiece, in the living room, where she longs to display a picture of

her little boy. This picture seems to represent the desire for her loss to be more public, to be acknowledged by others. I imagine her sitting on the couch in front of the mantelpiece, with its gaping hole, immobilised by pain and hollowness, creating her own picture of what he might have looked like. I long to convey to her that I can feel something of how much he was desired before he was conceived, how much he was thought about before he was 'knowable', how much he was imagined before he was viable.

In session six, she identifies how helpful it is when I offer simple validation such as 'You have been through a lot'. She wants others to acknowledge that too yet names they cannot 'take in' her loss. This often turns into almost begging me for answers: 'When will this get better?'

I scan her, I scan my experience of her, I scan my empathy, I try to help her scan her own experience. And among our work, as here in session six, I hear her say that scans are terrifying:

> 'I have a scan in a few weeks….I think it will remind me of the other scans I've had'.
>
> 'When you saw that something was wrong?'
>
> 'And also the one we had after the termination, to see if all the placenta was gone. It was hard to see the emptiness'.

Fearful of scans yet having to receive them frequently and not for the reasons she had hoped, she seems unable to let me scan her, to let me in. Perhaps she does not want me to see the emptiness within her.

In session seven, she names a consuming fear that 'speaking of death, of loss, makes it feel more likely to happen, as if I can speak it into being'. It is as if the

intolerable will cease to exist if it is not expressed, if it is held inside. When I ask about past experiences of dealing with loss, she says 'I normally try to hide, to get away. I just don't want others to see me upset'. When she adds 'I just want to believe there's a way out', her hands clutch and claw at the air in front of her. I imagine her in a big dirt pit, powerless to get out. Maybe she needs some time to be in the pit, with the emptiness, or maybe with him. Then I have the mental image of him right between us, his little fingers reaching out, trying to clutch, to grasp onto her. I hear him saying 'Mummy, you aren't looking at me!' He wants to be attended to, to be held. I offer: 'You seem to be grasping for something'. Almost instantly, she recalls her mother's directive that Helen, at the age of eight, not attend her aunt's funeral but rather stay home and make tea for everyone when they returned. I hear how cryptic and unbearable loss likely is for Helen.

I have a growing sense that she erects boundaries to prevent others from 'getting in', from dwelling within her. When a family member says 'You would have been a great mum to him' and when a friend picks up his urn, she names that they've crossed a line. When I start to recognise him more within the counselling space, she puts up a boundary, telling me that speaking his name in session eight is too much, I have gone too far. It is almost as if she needs others to feel something of the deadness that she feels. As she leaves session eight, she says 'You should have a cup of tea'.

Helen seems to worry she will be too much for me, that she will damage me. She needs the other to take in something of her fear, yet she remembers the ensuing lack of responsiveness. Perhaps she needs the experience of leaking out some of her failure and deadness and not overwhelming the other. I start to feel him leaking into

me. I notice how much he is with me between sessions, in the days and weeks that punctuate my sessions with Helen. He is within me through dreams, images, and thoughts, and I start to let myself visit him, imagine what he might have been like. He is the baby in the pram, as Mother leans in to check he is still alive. He is the boy, ploughing into the lake, swinging his shirt above his head, as Mother thinks, I wish he was mine. He is the just-turned-teenager, stranded in a place he does not want to be saying 'I just want to come home'. As if a ghost, he waits to get acquainted, articulated into being. Am I imagining, almost embodying, something of her lost moments with him? He is internalised within me, this boy she/I will never have. I hear him tell me that he misses her, but that he is gone.

In session nine, Helen recounts her desire to go back in time before she lost him and have her 'old body' back. When I wonder about reconnecting with how her body carries loss – 'Can you find a space within you, to let yourself feel what comes up for you?' – I notice how frightening and cruel I find it to use these words that refer her back to the place within her that is now empty where he once inhabited. She responds by saying she feels disembodied, that in order to get through that time in her life when she lost him she had to 'leave her body'.

Sitting reflective and curious in the moments before session ten starts, I bring attention to how I take Helen in. I go within myself, to my midsection, my tummy, visualising, listening, and feeling into the spaces where I receive her and him. I feel consumed by traces of him, embodied within me. I see, hear, and feel him kicking, crying, reaching out, wanting to be attended to, wanting form. I try to stay curious about this embryonic space within me that carries both Helen and him. I wonder if

she is showing me her readiness to feel her loss of him, and the resulting confusion about how to approach this pain.

I feel I have brought him into the session with me when she starts off by saying 'I'm not sure talking about him helps. It just makes me think about him even more. I've been thinking about what he would look like, what it would be like if he was here. It's making me more sad'. As I listen within the edges of her struggle to articulate her loss, I again have a sense of him, yet this time he seems to float between Helen and myself. I see him close to me yet moving towards her, fingers grabbing, reaching out to her. I can feel the hurt of not having him.

What appears to be a shift within this phase of our work is the emergence of my fantasies of her no longer avoiding the places where she might find him. I can imagine her, rather than gazing at empty spaces such as the mantelpiece, moving towards spaces where she can feel closer to him, spend time with him. I find myself shocked in session eleven when she talks about another mantelpiece, in her bedroom where she keeps his urn, in a 'memory box'. When she says 'I long to visit him there, but I can't yet', I offer these rather ordinary empathic words: 'I hear you really missing your little boy'. She responds with tears, 'I do miss him...I want to talk about him more here'. I have the image of her spilling out onto the floor, leaving a mess here, yet I notice how she quickly dries herself off, her tears and also her sense of loss. I respond by noticing how difficult she finds it to bring him here.

In session twelve, she again seems to mirror something of my imaginative process. She shares a daydream she had in a moment of closeness with her partner: 'I felt the hole, I felt just how much something was missing, and let myself slip

away. I imagined I wasn't there, that I was somehow with *him*. We need to be together again'.

4.3: Theorising the conception phase

I explore the different facets of recognition within the early phase of our work. Yet I also see the need to move beyond recognition, and here I give consideration to how I witness Helen. Using Bion's theory of containment, I consider how I take her in. I use theory on counter-transference to make sense of how I listen to myself within our psychotherapeutic work and find increased understanding for my embodied experience of her and traces of her son. I consider how our early work offers her the experience of occupying spaces within me, helping her explore the grief she feels in relation to the loss of her unborn son.

4.3.1 Beyond recognition, towards witnessing

I try to hold how it is for Helen to live in a social world she sees as preferring her silence in matters of loss and pain. Attending to my sense of being held at a distance, I notice the part of her that finds dwelling in the loss difficult, the fear she holds that there is not 'a way out'. It helps me understand and empathise with how being within the safe and accepting space of the counselling room is a marked shift not only from her daily social world, but also, as she would soon share more about, from her upbringing. Helen seems to be showing me her struggle to be recognised and how little she has felt able to speak about her loss 'out there'.

Doka (2002: 6) states that societal norms frame and govern 'what losses one grieves, how one grieves them, who legitimately can grieve the loss, and how and to

whom others respond with sympathy and support'. Helen's pain seems compounded by others' reactions, where it seems her grief around losing him was invalidated or disenfranchised (Doka, 2002). The hesitant narration of her pregnancy loss suggests it has not been validated as a significant experience. I try to validate her grief, and our early work centres around how some of her grief responses are shaped by her perception of social responses, that her silence and improved functioning is preferable to her expression of pain. Helen finds it difficult to grieve with others – including myself who is offering to talk about her losses. Affect is regulated after any loss that is not deemed as significant (Butler, 2009). Butler (2009: 50) speaks of recognition and perception: 'we can only feel and claim affect as our own on the condition that we have already been inscribed in a circuit of social affect'. The messages and norms placed on Helen seem to silence her and limit access to her grief.

I notice that Helen seems to feel unrecognised or misrecognised (Taylor, 1994) 'out there', and I offer invitations to *keep* telling 'in here'. My almost constant awareness in our early work of 'out there' might be representative of her experience of what is 'in here' not being viable or accepted, both in the failure of her pregnancy and the failure to meet others' expectations of an appropriate grief reaction. Recognition 'out there' is constructed by discourses of silence; she needs another kind of recognition 'in here'. I try to recognise both her longing to be heard and her longing for the unattainable child by naming 'You can talk about that here' and 'It still hurts'. These simple words feel almost foolish when recorded here, yet I feel their weight when spoken and received in the counselling room. I am quietly alongside her, validating her position as a grieving parent, and see how the

foreignness of this becomes a significant part of the work. Talking about talking, or maybe more accurately what it is like to *not* be able to talk about him, consumes a lot of our work in the early phase.

We depend on others for recognition and to narrate ourselves, yet, as Brison (1997: 21) states, this is difficult when others are unwilling to hear and acknowledge our traumas: ‘we need not only the words with which to tell our stories but also an audience able and willing to hear us and to understand our words as we intend them’. In Helen’s attempts to narrate in the beginning of our work, I notice how detached and affectless she often seems. Tracey et al (1995) speak of affectless narration after the loss of a child due to premature birth, almost as if one is telling a story that originates from someone else. In the gap between narration and affect, I need to recognise what the lack of emotion within Helen’s story might be telling me. Sharing her experience of pregnancy loss, Jolly (2015: 183) names that 'nobody is interested in a talking wound'. This resonates with Helen’s story, where she felt no one could ‘take in’ her loss.

I am struck by how her loss is silenced 'out there' yet very loud in the counselling room. I notice here the volume of her complaint about feeling silenced by others. It lies within the repetition – how she shares certain parts of her story again and again. The way she remembers and recounts her loss, this circular narration, conveys the endlessness in her loss, her need to tell and tell again, years later. Attempts to narrate are attempts to represent her loss, yet how can she ever represent the horror of her loss?

When she seems to keep silently asking ‘Can I use this space?’, I wonder how she feels received out there, in both how she was brought up as a child as well as the

social norm of silence around loss. I notice her difficulty in giving space to the murky edges of her story, experiences, and feelings. Her sentiments often demonstrate a sense that in others' refusal to listen she *should not* speak of it. When I listen more deeply, I hear how something has left her with a sense that she *cannot* speak of it. Around session five, when she speaks of feeling stuck, I realise how much there is to be seen, heard, and felt within the edges of what she is saying. As I attempt to stay with what is unclear and vague within her, I feel freer to imagine and wonder about her story. I sense him emerging, his cries for attention. He may be shrouded in layers of silence, but he is there. I am struck by how invisible he is in her account 'out there', yet how present he is ‘in here’.

In order for Helen to come to be able to use the imaginative space I offer her, I argue that something beyond recognition is needed. Problematising vision and the societal privileging and over-emphasis on the gaze offered to subjects within theories of recognition, Oliver (2001: 16) suggests we move beyond recognition, shifting towards witnessing which includes ‘testifying to that which cannot be seen’. Witnessing offers me a way to start to sense into what is ‘empty’ or ‘invisible’ within Helen. Frosh’s (2013: 1) words capture something of the empty or unsayable: ‘the things that people had gone through…were spoken about in a way that was difficult to hear; or perhaps they were biding their time, wondering when a language would be invented in which they could be properly articulated’. This struggle to say the unsayable, to know the unknowable, is the tension that I often feel with Helen.

She needs a different type of recognition and witnessing. What seems to speak loudest within the early phase of our work is her need to be taken in. She needs a response, my response-ability (Oliver, 2001). Reflecting on our work, I see

that I respond and take her in when I let her resonate within me. The tensions between, the emergence and diminishing of, the fluctuations within my work with her may represent a movement towards and away from response-ability, resonating, and taking in. This is not easy work and I see how my therapeutic listening is not just auditory but a multi-sensory and embodied resonance.

4.3.2: Bumping up against death and faulty containment

Here I notice my body's response to being with Helen and feel into imaginative womb-like spaces within and between myself and her. I wonder what it might mean for me to empathise with and internalise her and all that is within her, including him. I trace some of my struggle in receiving and listening to her and her son as they resonate, register, and reside within me. I consider how containment might be the receptivity and responsiveness that she needs from our therapeutic relationship.

When she says she is like a 'bag of emotions', messy, not able to be tied up, I imagine delicate contents, placenta and membranes, spilling out of her. Her fear that something will leak uncontrollably possibly expresses her vulnerability and her intense infantile anxiety (Klein, 1975), implying something of her early maternal provision. Carroll (2005: 97) speaks of the need for clients to use therapists as an object of relation to help them 'identify, negotiate, and shift between different subject positions'. Helen's core dilemma in this phase of our work, one which she seems to create in the transference, is how to allow someone to respond empathically and to take her in.

Yet as I reflect on how I 'take her in', I realise that I am selective about what I allow between us. In our first few sessions, I feel a lack of connection with her; her

controlled way of speaking seems to create a distance between us. She is very concerned with how she 'should' be within her loss, leaving me experiencing her as detached from her story and her loss, as if she is a stranger speaking of someone else's life. I often have the sense of her being a television news reporter; she comes across as polished, practiced, deliberate. We circle back to well-worn places and struggle to go within the edges. I find it tiresome to hear her repetitive expressions of others' unresponsiveness to her loss of him and of wishing she could respond to her loss as she perceives that others do. Her brightness, the seemingly forced alertness in her eyes, feels jarring and I find myself agitated at her monotonous striving. Yet, I stifle my agitations, possibly mirroring her striving when I respond to her as the nurturing mother, trying to pour empathy into her, as if a mother trying to feed a refusing baby: you will take me in!

As I attend to how I might be taking her in, I find myself turning to Bion's (1959) concept of containment, whereby feelings that are too powerful to contain within oneself are projected into another. Cartwright (2010: 9), following Bion's work on containment, states that the container function is less about being a three-dimensional container and more about attempts to 'hold in mind unbearable psychic states so they gather meaning and understanding'. When therapists offer containment there is the potential for powerful and unbearable feelings to become modified and then reintrojected back into clients (Bion, 1959).

But I am reluctant to take in Helen's projections of the deadness and failure. In our early sessions, Helen responds to my invitations by reflecting on how others in her life do not recognise him, and I wonder here if she hears my offer as a chance to bear him together in our work. I realise I may want him only to be alive, rather than

facing how dead he is. I long for both Helen and myself to be the nurturing mother to the alive son.

Symington and Symington (1996: 55) name that therapists may work with clients exhibiting the absence of a container or one that is 'damaged or porous' and not able to contain. Wright (2005: 538) suggests that 'faulty containment in the preverbal period' brings many clients into a therapeutic relationship. Helen's faulty containment is felt in her frequent checking of the door, her desire for a 'lidded box', and her persistent longing for yet lack of trust that others will be able to 'take her in'. Her perception is that others cannot tolerate or hear her pain. Her recent loss, where she was unable to hold and contain her son, colours this story, but early mistrust also seems infused within it. I wonder about the mother who did not or could not take Helen in and how I am struggling to respond to Helen's failure and deadness. Perhaps I need to acknowledge my own fear of damage and failure, how I have tried to put lids on the intolerable and tidy up the remnants.

Helen's projected longing for him to be alive easily implants within me, as I see my maternal capacity to be one of my strongest qualities. Yet this simplistic offering keeps out something of Helen's need to feel just how absent and dead he is. I feel this struggle between us: her 'I will keep him dead' pulls against my 'I will keep him alive' – deadening a conceiving of our work. Working with Helen evokes my desire to be a nurturing mother, and I stifle my own sense of failure. I hear myself saying, she needs 'a mother like me'. I realise that Helen becomes my longed for ideal child: the one who keeps coming back week after week, the one who needs me. My confidence musters up and then shakes as I flash back to myself as the sister who 'mothered' the deformed child, the teacher who 'mothered' others' less

endearing pupils, the foster parent who 'mothered' kids firmly loyal to the damaging parents. First learning about theories of maternal transference, I was both attracted and repelled. I can do this part, but I am not sure I want to anymore. Yet maternal transference is not about 'mothering' clients, but rather allowing oneself to be used to work through something of the relationship with clients' others, in many cases the mother (Wrye, 1996). I pay attention to times I feel like shouting at Helen 'Can't you see I can handle you well? Get over yourself!' These words cut me open with their sharpness, showing how trapped they may be within Helen.

My fantasy of the ideal mother/child mirrors Helen's longing. Is Helen projecting into me her longing for the ideal mother? Aware of potentially enacting the 'psychoanalytic mommy', only able to be all-giving and empathic (Slochower, 2013), I begin to wonder more about what her struggle to take in and be taken in might be telling me about her struggle to trust me. Following Bion, Symington and Symington (1996: 56) state that a mother who cannot tolerate the infant's fear of death drains the meaning from the fear and feeds back not a more manageable form but rather a more destructive yet mindless version, a 'nameless dread'. Helen fears speaking about death and loss, and this nameless and unspeakable dread fills her, trapping powerful words within her. Bion (1959: 313) states that when an infant cries, it is a demand that the mother 'should have taken into her, and thus experienced, the fear that the child was dying'. The baby Helen cannot contain her fear of death, yet her attempts to project it into her mother (Bion, 1959) may not have been received. I feel Helen attempting to project intolerable impulses (Klein, 1975; Gomez, 1997) into me.

Her unconscious memory of the damaged, faulty container resonates within me as I feel the loss in her not being able to speak of loss, the death in our work in her not being able to speak of death. There seems to be an impasse – she wants to be taken in, I want to take her in, yet she has not had an experience of being taken in – that we must struggle with, wait through, and allow to slowly be conceived. She interrupts the intolerable and therefore interrupts the experience of being contained by me. Being a witness to the intolerable compels me to stay with it, to keep recognising it within her even when she finds this difficult. Symington and Symington (1996: 105) say that therapists who go on 'waiting, watching, and thinking' will eventually see meaning made from intolerable – or seemingly meaningless or repetitive – material. Even though Helen may not be able to accept my containment yet, I try to show I can tolerate her pain, I take in her cries, holding the death that she seems unable to tolerate.

Caper (1999) suggests that in the therapeutic process we move from holding, with its sense of security, to containing, with its sense of insecurity. The conception phase of our work involves not a gentle landing, but rather a tiring struggle which likely re-evokes other insecurities within her. I make spaces for what is impinging and persistent, and, in both the repetition and what she does not or cannot say, she seems to be silently screaming her presence and her need to be taken in. In this beginning phase of our therapeutic endeavour, I feel her and him residing within me, and I attempt to contain the sense of them both living and dying within me.

4.3.3: Containing her

By Helen's account, those who knew of her loss said nothing she could hear or use. When I try to contain and witness her and her story, it seems difficult for her to inhabit space within me. I feel her both living and dying within me. I start to understand more of her need yet struggle to be taken in when I read Zeavin's (2012: 519) account of work with a client who was desperate yet anxious to become pregnant, noticing her client 'treated her interpretations like sonograms, watching for something disturbing, even deadly, that could get into her'. Helen is wary of being 'scanned', of my offer to attend to and contain her. Does she expect that accessing her feelings implies that they will 'leak out'? There is potential for restoration of the containing process within a therapeutic relationship (Wright, 2005), and I have a sense that these metaphoric contents of the womb need to be placed in a safe, more well-sealed space, perhaps within me, within the counselling relationship, for a time.

Throughout the beginning stages of our work, paying attention to my counter-transference helps increase my empathy towards Helen, my ability to enter her frame of reference as if it were my own. Bollas (1987: 255) views counter-transference as an act of empathy when clients see therapists 'not to be a distant interpretive presence, or simply a kind and empathic person, but someone who like himself struggles to know and may often find the struggle painful and unpleasant'. This is echoed in other theory around the containment experienced when the infant/client can sense the mother's/therapist's struggle to tolerate the distress they are bringing (Carpy, 1989; Cartwright, 2010). I hear her frustration in wanting to move on, and I feel my counter-transferential response of frustration in wanting her to attend to her loss. I feel easily moved in the moments that she lets me into her inner world, rather

than keeping me in the periphery of her day-to-day social interactions. This contrast alerts me to how difficult it must be for her to stay with the loss and confusion, and I continue to gain empathy for the parts of her that struggle to feel. I come to see how her well-crafted exterior helps her make her way through the world (Sommerbeck, 2015), protecting the fragility in her inner world.

As I begin to care more deeply about the part of her that needs to carefully decide what she lets others see and hear, I find myself more able to think into how I might be containing her unbearable psychic states. When she seems to be 'reporting back', dutifully telling me of her encounters, interactions, and responses from the previous week, I often feel an emptiness and wonder if I am 'witnessing the infant's desperate effort to implant an image of himself or herself inside the refusing mother' (Bollas, 1987: 195). She seems to be demanding that I see, hear, and feel her emptiness. Her complaints about not being heard resonate within me, and I feel her asking me to stand in the place of the mother she longed and longs for.

Yet this paradoxically evokes my sense of myself as the useless mother, my own 'private and nameless torment' (Kluger-Bell, 1998: 125) around motherhood. The womb within me is worn out, stretched from attempting to mother others and feeling a failure. I find myself considering if Helen and/or I see the therapeutic material we are developing between us as useless, worthy only of being disposed (Wrye, 1996). Within this phase, I feel empty, my creativity and reflectiveness feel shut down. My inability to reflect may speak to the contradiction between Helen's placidity and distress, how she needs to project the distress within me yet has for so long tried to appear placid.

This causes me to consider that Helen never comments about what it is like to be in this space. She floats in, tells a story of her failure to be seen 'out there', completely missing the space in which we inhabit. The soft, only-empathic womb/mother might not be usable to Helen within this phase; she needs a space to enact her response to the mother she can hate. I find I need to get in touch with some of the hate I feel towards the non-mother within me, my own failures in being a mother. I feel the cramp, the ache of impossibility within me. I fumble, wanting to show us both a version of the sweet-smelling baby wrapped up in a soft blue blanket when really I hear his excruciating cries and scratching fingers.

I realise I want her to take him away from me. This is probably my desire for her to offer him the hidden care she has for him, but also to get him out of me. He does not belong with me, he is not mine, and he hurts. Imagining expelling him from me gets me closer to the loss, and I envision the soft baby blue and violet hues of this room, morphing into a red, swollen, aching empty space. I hold onto the sense of failure in the room and feel some of my own, poking within me. Staying with the failure rather than with the familiar 'get on with it' feels a challenge beneath the skin of this attentive therapist, taking me into the place where I carry him within me. He pokes and scratches again, and I find myself saying 'This still hurts', knowing these are my pains and words blurred with hers. This failure and unfulfilled longing in both of us, intersecting here in this moment.

Attending more to my/her losses, I feel Helen re-enter my mind, my pained womb, where I take her in now not just as the ideal, easy baby but also the crying, difficult baby. She seems to need to project what is intolerable into me, her counter-transferential mother. I notice a growing sense of conceiving and bearing both her

and him in the spaces within me, helping me meet her longing for him in session five.

I wonder if being internalised within the spaces within me offers Helen a containment that is both flexible and sturdy, something of both the bag and the box that she speaks. Containing requires flexibility, where therapists mould themselves to fit clients' experiences and needs. I make myself available to meet, receive, hold, and contain Helen. Bollas (1987: 239) names the need for therapists to maintain 'a receptive space for the arrival of news from within the self' which may include 'dream, phantasy, or inspired self observation'. Casement (1985: 82) speaks of the reception of unconscious communication where 'previously unmanageable feelings…become less terrifying than before, because another person has been able to tolerate the experience of those feelings'. I take Helen and him in, let them swirl around within me, and then offer them back to her.

My imaginings and fantasies in this conception phase of our work reside within me. I bring my dreams, images, and sensations into the room with me, albeit not always verbally, and I have no doubt that they impact our work. This is the step within this project where my embodied experience of both Helen and him are recognised as more useful within our work. When I attend to, think through, and respond to my experiences, I have the potential to help her move out of silence spaces. The containing process emerges between Helen and myself, offering her the availability of another who can help her bear her pain. She is allowing me to take her in, and I see her shifting in her capacity to relate with me. In the receptive space between Helen and myself, her words have a chance to get some air and there is something coming into life.

Yet a sense of deadness, hollowness, and emptiness remains. I also view absence as important and, as I argue in the next section, a way into presence. Recognising the hollowness helps me empathise with her and to see other aspects of her experience that may have left her feeling hollow. I often try to hold her in our work, yet I also have the sense of holding something unholdable. I attend to the invisible, ungraspable within me. Bollas (1987: 201) suggests the therapist's 'intuitions, feelings, passing images, phantasies and imagined interpretive interventions' are valuable information about what clients might be unconsciously communicating. By attending to counter-transferential elements, I create 'an internal space which allows for a more complete and articulate expression of the patient's transference speech' (Bollas, 1987: 202). I think back to session eight, how using his name points to some gap between us, a place we cannot go, a lacuna in her story, almost as if he does not exist. I feel scolded, frightened, as if she is reaching out to hold my hand and then slaps me away. Can I tolerate being asked week after week to be curious and caring, yet to be excluded and cast aside? Yet paradoxically, her imposing this limit feels like a breakthrough. When we reflect on this moment between us, she says that there are so many words she wants to say that feel trapped within her. Thinking back to Morrison's (1987: 274) quote from above, I realise there is so much within Helen that was kept from view, hidden, silent. She and I 'look for' and 'call' to what is trapped within her. Perhaps she is exposing the presence and shadow of the unresponsive mother, showing me what it is like for her to feel silenced. Helen also names finding it difficult to express herself in the presence of another, and in the transference I hear her describing her response to her unresponsive mother. Helen is expressing and showing me her experience of her

mother's lack of attunement to her needs. And I also wonder what she might be saying in the silence, as I find myself waiting for her to speak something of her experience of her father.

I notice something unreflective, unresponsive, unfeeling within her. I realise that she came home from her son's funeral and became a seemingly unfeeling mother, one who cannot or will not react to her loss 'out there'. Is she showing me her experience of the unfeeling mother, how loss should not or cannot be attuned to and empathised with? I am struck by how both losing him and remembering are events without witness. In this phase of containing something of Helen's unborn thoughts and feelings, there are cries coming from multiple places of loss and hollowness.

4.3.4: Containing him

A 'lack of existence that demands an existence, a thought in search of a meaning' (Bion, 1984: 109) seems to bring Helen into counselling, and maybe into me, impregnating me with her intolerable sense of him. In this space of conception and containment, I notice how counselling may be a different type of pregnancy, possibly a surrogacy. When she attempts to speak of him, I notice how penetrated I feel, as if she is asking me to take him in, take him from her for a time. She projects him, and possibly her urgent need to 'get better' and 'move on', into me. I feel an urge within me to push, and I find myself wanting to shout at her: 'He needs you, attend to him!'

I feel she projects him into me, yet I feel an absence of her. Britton (1994: 374) names that when clients do not make use of therapists as container, then the therapist 'lacks a sense of the patient inside and feels deprived of the customary

empathetic and sympathetic response'. I feel blank inside, bored when with her, finding it easiest to turn into the demanding mother, waiting impatiently for her to join me. As I feel the demand and frustration within me, something of the hate in my counter-transference (Winnicott, 1949) is activated. I start to feel a sense of helplessness, possibly being projected into me by the infant in the adult within Helen (Britton, 1986). My annoyance or hate tells me something of Helen's experience of not being able to find a space within her mother for her helplessness and frustration.

I feel the space between us lacking creativity, as if the life between us terminates, fails, empties. I deaden, becoming something of the unresponsive mother. I notice within this phase of our work, I almost do not want Helen to see me. I feel both an imposter for my sense of carrying him within me while simultaneously feeling entitled, the only one between us who is capable of carrying him. I want to both cover myself in shame while simultaneously baring him within me. Do not look at me, look at me! As I reflect on Helen's mother's demand around the aunt's funeral, I imagine that her mother did not want Helen to see her loss response. Helen surely sees something of my response to loss within this space, and I wonder how that might be for her. I also wonder if I might sometimes be shielding her from my distress, enacting something of her previous experience of loss being hidden, deadened.

Quagliata (2013: 3) suggests that recurrent pregnancy losses often 'undermine the mother's trust in her creative capacities and raise persecutory feelings in relation to internal objects which are felt to distrust her capacity to become pregnant, to keep the pregnancy, and to give birth'. The deadened generativity between us is likely similar to her experience of an unreceptive mother. Helen's

mother may be the internal object that distrusts Helen's capacity to be creative, viable. Unresolved conflicts within Helen are reawakened and make it difficult for her to explore the possibility of both life and death (Quagliata, 2013). I want Helen to leak out all over the room, to let her loss come out here, to feel her loss here. Yet in her internal world there is no safety, so how can she feel safe here?

Rather than allowing my urgency and deadness to get in the way, they seem to increase my empathy for her, as I notice how much I long for her to be a partner with me in caring for him. This unbearable bearing, this tension of both pushing and waiting softens into an offer that, although upspoken, feels communicated within my struggle: 'Join me, hold this baby with me. Let's offer him the care he needs, the careful conception within us, before we start to push'. This touches me empathically, and I start to wonder if Helen's urgency is less about labour and more about birth, more about her longing for him. The urgency I feel in the room is likely some of her unfulfillable longing for a partnership with her son, and possibly also with her mother.

Both she and he have taken up residence within me. Silver (2007: 416) posits that the 'womb is never empty: It is full of delusions, desires, and perhaps also dreams'. I locate Helen and him within me and feel more 'filled up', as if they are growing within me, when something of what is silent or missing within her resonates within me. Am I feeling the fullness of the space that Helen – or others – had assumed was empty? Am I feeling the fullness that she could not feel?

Within this longing and absence, I try to create spaces for him to be present, for her to be 'with' him in my presence. Yet she seems initially to want him more absent, more dead. It is as if others, and often Helen herself, seem to 'desire the

killing off of something already proclaimed as dead' (Wyatt, Tamas, and Bondi, 2016: 38). Symington and Symington (1996: 103) state that when the desired object is unpleasantly absent, it 'might not be tolerated in the mind long enough to become a thought; instead it might be treated as a thing to be got rid of, a foreign body to be expelled'. This resonates with Helen's previous intolerance of speaking about him, where he had become a ghostly absence to her, unable to have a presence within her internal world. Symington and Symington (1996: 103) name that 'evacuation of the painful experience' leads to 'blockage in mental development'. This evacuation of him took place at the time of the termination as well as over and over in her mind.

In noticing how she evacuated him, I wonder if she also evacuated or perhaps entombed her early relational experiences. I turn to how Helen and I work with this in the middle phase of our work; however, hints of entombment in our early work bring an increased curiousity about what is muted and suspended within her. Abraham and Torok (1994) state that after losing a desired and loved object, if there is no way to speak of one's loss then it becomes denied and entombed within. I hear her repeated wish to have finality, closure, the ability to move on, to 'put it in a box with a lid'. A coffin-like image stirs within me, and I see how she might have entombed uncontainable pain within her. Allowing her stories to resonate within me – for example, her mother's demand that Helen not attend a family funeral – helps me grasp her need to keep well sealed and silent 'out there'.

Does Helen view him as almost crawling back inside, leaking *into* her? She holds herself together so tightly, attempting to keep solitary, sealed up, no leaking in. What appears to be contamination to her, something to keep out, feels to me like an always already presence, something of a ghost perhaps, a haunting from a very

present absence that needs to be felt as both already within her and able to leak out. Bion (1970) uses Keats' concept of 'negative capability' to explore the need for therapists to become disturbed so that understanding can arise from the unknown (as cited in Taylor, 2010). I find myself disturbed by his consuming presence during this phase of our work, especially around session ten. I notice how present he still feels within her, yet how in her not being able to recognise this, he becomes more present within me, haunts me. He seems to be almost floating within me, and sometimes between us, as she struggles to speak about him.

I try to perceive what is within the silenced, shadowy, invisible, or empty spaces. Gordon (2008: 196-197) states that we must put our imaginations towards the '[a]bsent, neglected, ghostly' as we 'have no other choice but to make things up in the interstices of the factual and the fabulous, the place where the shadow and the act converge'. What have Helen and I done with our sense of failure? Like a ghost, it seems to haunt, and I feel him bursting within me, something of him wanting to shout out so everyone can hear: 'I'm sorry'. I lean into the edges of this space, into the womb, to see, hear, and feel into what might be needing attention, what might be alive and growing. Allowing myself to attend to my embodied and sensate experiences – seeing his reaching arms, hearing his cries, and feeling his kicks – helps me to realise how I might be carrying him within me, just how full supposedly failed and empty spaces are.

Bion (1962a) suggests that there are thoughts waiting for a thinker to think them; thoughts exist before the capacity to think them. Symington and Symington (1996) speak of containment as the possibility of 'pre-conceptions' of thought becoming conceptions or realisations. Giving Helen's pre-conceptions space to

develop requires me to stay open. I become a 'receptive organ' to her unconscious communication (Freud, 1912). When I notice a shift, my increasing sense of him within me in sessions eight through ten, I wonder if Helen is using me as a receptive container, pouring into me her sense of loss and failure.

After a mating, an intercourse, of the pre-conception and a realisation, or of the thought and thinker, there comes a 'conception' or a 'new life with each new development of thought' (Symington and Symington, 1996: 53). I carefully attend to these conceptions, to how they seem to enter me and want to remain small and silent, almost unusable in Helen's presence. They seem deformed and frightened, unsure of their existence and desirability. Yet, they remain lodged inside of me, waiting, lingering, much like her pain over losing him. When I attend to how she and he resonate within me and when I tolerate her feelings, they become more manageable and I can pass them back to her. I see how traces of her embodied memory of him seem to be mirrored through my experience of him, as in sessions eleven and twelve. In moments where empathy is offered and received, where I capture a bit of the language of her broken heart – such as when I name my sense of her missing her little boy – there is potential for her to feel witnessed and contained.

4.3.5: Reconsidering grievability within conception

I wonder how the work of containing and conceiving within some therapeutic relationships might add to the conversation about grievability within pregnancy loss. Butler (2009: 50) speaks of recognition, perception, and grievability: 'we come to feel only in relation to a perceivable loss, one that depends on social structures of perception'. In counselling, Helen and I come to perceive his absence and find traces

of him within us. Pushing into new imaginative spaces of containing her and him and making distressing feelings more tolerable seems to make him more perceivable, thinkable, and grievable. Gordon (2008: xvi) states that haunting is a sociopolitical-psychological state where 'we are notified that what's been concealed is very much alive and present, interfering precisely with those always incomplete forms of containment and repression ceaselessly directed toward us'. As Helen and I stay with what emerges, we come across and get to better know some of what had previously been untold or possibly untellable.

Tonkin (2012: 1) explores the traces of 'fantasy children' within childless women's stories:

> they were not always easy to identify in their talk…I find the notions of 'ghosts' and 'haunting' to be helpful because they capture something of their invisible yet potent quality, and of the reluctance to acknowledge them, by both the women and others in their social worlds.

Within the traces resides something elusory of the mother Helen might have been or the child he might have been. In many ways she and I are unforming stories of the formed: we are looking 'out there'. It is uncomfortable, watching our work peel away at the outer, exposing a muted, suspended story of her experience. Moving into the 'in here', we are also forming stories of the unformed, the formless.

Following on from Levinas' work on the Other, Butler (2006: 139) speaks of our awareness of the precariousness of another as vocalisations that are 'not yet language or no longer language'. While Helen may have been silenced by discourses 'out there', she may have also been silenced by what was unbearable within her. Wright (2005: 530) states that a 'preverbal gesture is brought into being – "towards

articulation" – through the mediation of a containing form'. Perhaps she needs me, for a time, to contain and attend to him, and her sense of losing him, within me. I often get the sense that I am carrying her/him, gently caring about her/his hurt. Perhaps she needs me to take in and contain her/him as she starts to feel into these faulty spaces, where there seems to reside questions about failure and the inability to support life. I feel the potential value in attending to him within me as a way to process something of her loss. When the unbearable is contained, she begins to articulate that which to me seems to be speaking loudly within her, pushing against the muteness and the possible disenfranchisement. Helen and I precariously utter at the edges as we find him there.

Perhaps acknowledging my own sense of struggle and failure helps me engage with and do justice to Helen's experience of loss, failure, unsatisfied expectancy. When we do not repeat his name, is she showing me how the space within her was unable to support life, and perhaps how the space between us fails too, ways I fail to take her in? My own sense of unviability is useful as her recognitions of my 'deficiencies, imperfections and fallibilities' can 'usher in the internalization of a more realistic containing function' (Cartwright, 2010: 21). Lafarge (2000) states there is potential for clients' containment of their inner worlds when they have the experience of a therapist who exhibits not just the ability to contain but also the limitations in containing.

Rather than continue to bury her previously intolerable feelings, Helen moves to a greater capacity and space to stay with and process pain, loss, and death. Cartwright (2010: 19) states that 'the therapist as container needs to be internalized by the patient'. Perhaps she internalises me as a 'receptive containing object'

(Cartwright, 2010: 19) leading to the possibility of a containing function within herself. When Helen experiences that I have found a way to contain her, to contain him, it seems it is more possible for her to experience herself as able to contain the emptiness of herself and him. There is 'growth of both the container and the contained' (Ogden, 2005: 103). She seems to experience 'an opening up of psychic space' (Cartwright, 2010: 223), an expansion, a growing space in her to contain her experiences, her loss. I listen into the boundary that she holds, and watch this shift for her as she slowly begins to allow others, including myself, to take her in.

In these spaces of containment and conception within and between Helen and myself, I feel something residing, coming into being. It has been suggested that children, even before viable, are not just physically conceived, but mentally conceived by their parents (Stumpf, 1986). This speaks to the personhood of a child, the ontological position that one might take on what makes a person a person. I argue that personhood begins before birth, and possibly sometimes before physical conception, as in the case of the child that we mentally conceive. Containing Helen's sense of his intolerable death allows for a conception of him, potentially changing him from a life 'sustained by no regard, no testimony, and ungrieved when lost' (Butler, 2009: 15) to a life worth grieving. Being received, taken in, and contained seems to help her approach 'the unseen in vision and the unspoken in speech' (Oliver, 2001: 2). Within the edges of losing him, I feel Helen and myself, often in inchoate ways, finding spaces within where we seem to be conceiving and creating him together.

Containing Helen and creating spaces to perceive him – both how *without* him and *with* him she feels – seems to allow for him to be conceived as both an

absence and a presence.   A noticeable shift in our process occurs in session twelve when she notices that imagining into the 'hole' he has left allows her a chance to be 'with' him again. Bion (1962b) states that when one recognises a 'no thing', an absence, it can become a thought. For example, the movement from present breast to absent breast is 'a presence which is felt to be depriving the infant of what he wants' (Symington and Symington, 1996: 102). This thought, of a present absence, can then take on new meaning, can become a conception. '[N]ew thoughts and meaning are created in the absence of the object' (Cartwright, 2010: 65). Absence, lack, and a sense of nothingness are breeding grounds for attempts to articulate, and in this phase I see Helen start to represent him within her.

As we begin to feel a trace of what is not there and as she finds it more bearable to feel how 'losing him' was for her and how 'without him' she is, she seems to recognise how important he still is to her. As she recognises this 'no thing', as she listens, feels, and sees into the hole, she seems to know it as *not empty*. In this phase of our work, she starts to share her fantasies about him. She moves towards the possibility that crawling into the hole of his loss allows her to be with him. I have this sense of Helen and myself crawling into the womb, noticing his absence. Absence can be viewed as what could be potentially present (Gurevich, 2008), and it seems that with a fuller acknowledgement of failure, of a 'no thing', of what could not be, she is then able to allow for more of a containment and conception of him. We acknowledge the emptiness of losing him and also find a fullness in the longing to have him. Perhaps she needs to feel into his absence in order to feel his presence. She gets closer to him as she enters these spaces and acknowledges his continued presence.

4.4 Conclusion

My reflective and theoretical journey through this phase of our work shows me that while it is often arduous to offer continued recognition of the significance of Helen's loss, this is necessary if we are to work with and beyond her sense of being silenced. In this chapter, I consider how therapeutic witnessing might help push beyond recognition and into that which was considered empty, hollow, useless. Bion's concept of containment offers space for considering how I receive Helen and her intolerable sense of loss. I argue that we start to mentally conceive him together within this therapeutic pregnancy, making him potentially more grievable. I include initial reflections into Helen's early relational patterns and my counter-transferential experiences, which I revisit in the following chapter where I explore a central shifting point within the middle phase of our work.

Chapter 5 Gestation: How do I listen into Helen's early relational experiences?

> My wish to keep you alive by becoming you is not a question of becoming only like you. I remain myself as well; I will be the substance which takes you on, in your absence. Perhaps I might say I am moulded by your absence, that I bear your imprint, that I become your trace (Cousins, 1996: 40-41).

5.1: Introduction

This chapter accesses moments from sessions twelve to twenty and continues the case study into the middle phase of Helen's and my work. I narrate significant moments within our therapeutic relationship, attending to how the work within the 'conception' phase facilitates a shift within this middle 'gestation' phase. I give examples of how she and I offer empathic recognition and receiving to her early relational experiences. I then step back from the story to theorise what might be happening within and between us.

5.2: Narrating the gestation phase: listening to the unseen, unheard, and unthought of early relational experiences

Within session twelve, Helen trails off from her daydream of him and says, 'I'm expecting, waiting for you to tell me to stop…complaining…talking about myself so much'. I start to think more about her early experiences of being in relationship. In her assumption that I will demand that she stop, I see Helen's need to attend to experiences of a mother who demanded that she stop asking for attention.

When I reflect back her words in session twelve, she says she wishes her mother had been more available during her childhood and her recent losses: 'I wish she had responded. She doesn't talk about him'. As she continues, she speaks of not knowing how to tell others what she needs when she talks about missing him, she gets in touch with the longing for a hug. Tears and the words 'I want someone to take me in' seem to pour out of her. Yet this longing does not translate into an easy absorption into the other. I imagine her as a baby, eyes averted, her response to meeting Mother who she does not expect to take her seriously, pick her up, receive her. She ends this session by saying 'I found myself looking everywhere but at you today'.

In session thirteen, she begins to articulate stories of her father. He frequently travelled on business when she was younger, and she remembers how lonely she often was. She describes how her mother would get stressed during these periods when it was just the two of them and would take it out on Helen, shouting at her. She became familiar with the critical glare of her mother and receiving a 'shoulder pat' was the extent of the warmth her 'unfeeling' mother offered. She speaks of how 'dreadful' separations from her father were and how 'relieving' separations from her mother were.

Helen has memories from around the age of eight when her parents seemed unusually close and happy and then all of a sudden a larger rift between them appears. She wonders if her mother had a miscarriage, sending everyone in her family into further separation. Helen, normally a very collected little girl, remembers a period of having outbursts at primary school, where many hours were spent in a confused state of crying.

Her parents divorced when she was an adolescent, and Helen seems to have no vivid memories of this time, only vague descriptions of how her mother, who had a greater share of custody, would tell her to 'get on with it' when Helen was upset or missing her dad. She now has no contact with her dad, a massive loss which until now she has barely acknowledged. When speaking of her dad, she gets in touch with an 'empty feeling', and I see how she holds her losses inside, entombing them within, as it is not safe to trust that others will take her pain seriously.

In sessions fourteen to sixteen, she brings in more stories of how she heard her mother demand that she stop feeling pain. She describes her mother as inattentive, unresponsive, unfeeling. Her mother seems to have left Helen unreflective and unable to face pain. I have an image of her presenting me with a broken toy but then running away from me, out of my sight. This might mirror her response to her mother, how asking for help evoked fear, silence, or the need to run away. I respond by saying 'You are not alone in this'.

When Helen considers in session seventeen about going to a support group, she says 'I worry I would just sit in silence and cry'. When I respond with 'Maybe there are no words for some of this', I think of how revisiting her early experience, a pre-verbal time when there were no words, is likely terrifying. I wonder with her about other times when she spoke of silence and crying, times when she longed for the father who left. The emptiness within the silence seems to help her find words: 'I just want to be with my dad'. Seeming propelled into a space of feeling scattered, as if she is in a sort of limbo, floating about, she then says 'My memory box is just…so empty. I want more of my boy in there. I want more of my father in there too'. I

hear a longing within the emptiness, and she seems to find something there when she names ‘He’s here, but he’s not here’.

In sessions eighteen and nineteen, she names what feels ‘hidden’ between herself and her mother, all the things her mother seems unable to hear Helen say. She articulates her awakened longing for her mother to have offered to ‘take the pain of my loss upon herself’. She explores the way she holds pain, and how she knows when she feels safe to share something with someone. She seems more able to access the internal and integrate it with the external, to make links about her early experiences and her more current experience of loss. Whereas before she previously looked for ways to ‘get on with it’, now she expresses unfulfillable longings. She becomes more aware of how she is ‘holding it on her own’ yet has a readiness to let others hold it, hold him. She seems more able to wonder about her experience of being mothered as well as how she sees herself as a mother.

This serves as a point of change within our work, as this new relational experience seems transformational for her. My sense is that session seventeen is pivotal within our work, where we seem to have entered into a somethingness within a space of nothingness. I wonder about the impact on session twenty, where she says: ‘It really helps to hear you say it’s okay for me to be where I am. It’s like I wanted to please people, so I did it the way they expected me to when really I am *here*.’ – she marks an invisible place with her hand – ‘I want to start saying “This is where I’m at, this is what I need”’. When we wonder about this together, how maybe the external voices have been quieted a bit and now she can attend more to the parts of her that are speaking, she says she can hear a new part of her, one that is whispering.

5.3: Theorising the gestation phase

I explore my wonderings about Helen's early relational experiences. Attending further to my embodied responses to Helen, I develop my sense of a counter-transferential pregnancy. I consider how Bollas' concept of the 'unthought known' helps me further listen into the edges of her story. I make use of theory on ghosts and present absences to help me think into her multiple losses. I return to grievability to consider how the therapeutic work within the gestational phase may address a layer missed in Helen's social world.

5.3.1: Counter-transference and embodied listening

Early within the conception phase of our work, she often seems drawn to remain in the present day's endless story of those who do not care about her loss. Her stories fill the space, gushing out of her in an almost uncontrollable flow, often seeming to drown out my reflections or wonderings. Perhaps this flood of repeated stories helps her avoid the risk of others not being there for her (Carroll, 2005). I listen attentively to how she uses this space, hearing her interrupt herself just as she begins to feel into his loss and notice how she has not been received by others. I wonder about how within this middle phase of our work we move more explicitly between the losses she feels now and those from her past. Staying with what she is communicating about her early relationships, I notice how much her unspoken pain waits for someone to attend to it and what it might mean to respond to her longing to be 'taken in'.

Listening within the beginning phase of our work to her faulty containment, I can hear how much her pain is about others and I increasingly realise the potential of working within the transference/counter-transference relationship. My counter-

transference includes my reactions to Helen, how she is impacting me, and who I might represent for her. In this space within me, I feel shadows and ghosts saying something about the life within the transference, the life within Helen. Throughout our work, the unfeeling/useless mother is in the room with us, and as in Cousins' (1996) quote from above, Helen is 'moulded' by the absences in her life, and she becomes the trace. Bollas (1987: 196) posits that working in a transference relationship may evoke early memories of being and relating in a client, who then often 'handles us in the way that she unconsciously recalls being handled by her own primary objects'.

My counter-transference experiences of her include often perceiving her as deliberate and detached, and I imagine her as the dead baby. I wonder about her internalisation of the uselessness of her mother. In the counter-transference, I hear her shouting to me that as a child her weakness and need were met with indifference and distance. I want to shout back at her, 'I'm not useless! I'm not dead!' This desire to shout is experienced as if the counter-transference belongs to me, originates from within me, yet it is likely projected into me. Shouting was likely a response that would have only brought on further demands for silence or just 'getting on with it'.

In this phase of our work, I notice how I guard what I bring to our shared space. Perhaps I feel compelled to protect her from seeing my 'analytic mind becoming distressed or deformed' (Bollas, 1987: 249) due to me taking her in. In the counter-transference, I often feel myself drowning in the need to be fully formed (not unformed, deformed), to be viable (not terminable), to fill (not leave a void), to fulfil (not disappoint). Is this a repetition of Helen's desire to please her mother? In the

presence of this unfeeling and refusing mother, I feel again an urgency to push not wait, the pressure now located within the need to experience and gestate something of the distress of Helen's early experiences.

My urge to shout as well as my guardedness alerts me to the need to prevent myself enacting the transference/counter-transference relationship between Helen and her mother. After I can start to imagine baby Helen, a shift occurs within sessions fourteen to sixteen, where I feel some of her inexpressible pain – of losing him and also of being denied by her mother – reverberate through me. Does Helen fear she – or he – may never stop crying? Can she trust that another can take her in, not deny her, not prove her a failure? Carroll (2005: 100) suggests that '[p]sychotherapy attempts to maximize the potential of relating by bringing to light how the client is limiting the impact of the other out of fear of what the encounter may or may not bring'. Realising that she may need me to contain both the pushing and waiting, I feel more able to tune into her distress. Being taken in is a novel experience for her, and she is likely waiting for me to repeat the demand to just get on with it, something of the pushing out from her mother.

How clients use the therapeutic space may tell us much about their preverbal and early experiences (Bollas, 1987). I listen with an awareness that early experience gives current experience meaning. Helen's mother did not recognise or receive her pain; she seemed consistent in her *in*attention, dulling Helen's ability to react to her pain and loss. In the transference, perhaps she sees the request of my help as having the potential to reveal me to be the unresponsive or unfeeling mother, to replicate her experience of a mother who invalidated and avoided pain and loss. Something within me feels hollow and cold when she speaks of her mother. Helen

seems to expect me to embody yet alternately combat the hollow mother who was unable to take her in, to internalise her.

I need to explore the ghosts within my nursery (Fraiberg, Adelson, and Shapiro, 1980), which are re-awakened through my work with Helen. Yet, when I feel the stir of my own losses, how much they are disturbed by being with Helen, the desire to put them away again is evoked. My reluctance to take her in, my unresponsiveness, causes me to consider if Helen was the child that came after her mother's dashed hopes. The mother who has her own experience of loss, placing something of that onto Helen. Helen's mum was likely mourning her 'others', and Helen may not have been the desired child. I sit within session twelve, Helen not able to look at me. I know something of this feeling, my four-year-old self drenched in self-doubt: am I allowed to be needy, to be seen? My mother is loving but busy loving others' more obvious fragility. I turn to self-sacrifice, stifling my need and desire to be seen. Helen reveals that her aunt had been ill from childhood, and I feel the ache of the family that expects the baby to be frail, to die. The hope – coming from her mother but possibly also from me – of protecting Helen from this is possibly preventing her from having a grieving experience.

I notice that while she seems to plead for others to take her and him in, it seems difficult for her to bear to see me care for herself and him. Bollas (1987) uses Freud's (1917: 249) phrasing 'the shadow of the object' to capture the impacts of being in relationship with others and the intergenerational nature of the transference. Something of the shadow of Helen's mother is cast here; the emotionally absent mother is evoked and present in the counselling room. I seem to be embodying the mother who tires of Helen's repetitious need, who is mourning the loss of the others

and cannot fully attend to her, who expects her to find a way to care for herself, who fails, or perhaps hates, her. Who hates seeing Helen's failure mirroring her own sense of failure. When Helen cancels a session, the one following session twelve, due to illness, I feel a leap of relief. I first put all my focus on her, holding in mind what progress this feels to be looking after herself rather than getting on with it. Yet as I turn my attention inward, my relief signals I am glad not to feel her pain today. I realise that I am stifling something of the cramps, the sharp pain of the pregnancy forming between Helen and myself. Her embodied memory of the fibroids, the pending miscarriages, the haunting termination play out within me and I want to ignore them, sometimes soothe them away. Helen needs me to feel the pain. I stay within the womb of the counselling room for that silent session, hearing from the complications of our work, the reminders that this still and always will hurt. This persistent pain is not just hers. Am I using her to feel something of my own pain, but trying to put all the responsibility on her, possibly sending her the message: this is your pain and you need to feel it. Resenting her request of how her grief might 'get better', I feel something of the maternal transference of the experience of the useless mother who did not offer emotional care. In session sixteen, I try to respond to my sense that she feels alone within her loss, just as she did with her mother.

For me to be the mother she fantasises is able to carry him – as well as carry her – might stir something within her, possibly show her what she could not have. As I feel into the hollowness of her experience, I empathise with the impossibilities and failures around being held by her mother and holding her child. I hear, feel, and see what seems to echo within her story: the child who was not 'enough', who could

not be received. Maybe she did not feel enough for her mum or her dad. And her unborn son could not be enough for her.

Listening to Helen at the edges of her loss by attending to my counter-transference helps me listen at the edges of hollowness, and I start to feel her more alive within me. I find the therapeutic space increasingly womb-like and potentially transformational when I come to see her as needing me to be sensitive to her struggle to be received. She explores throughout this middle phase of our work her pain in the lack of a consistent, receiving mother, how much she wishes her mother had responded differently to her. When we notice together how difficult it is for her to take in my receptive and empathic responses, she reflects on the lack of empathy she received from her mother both in childhood and more recently in her loss of him. The past being replayed in the present, this muffled and masked pain, this silence, all speak loudly here. When the words 'I want someone to take me in' almost come bursting out of her in session twelve, and are again spoken in subsequent sessions, they are able to land within me, as I have been attending to the place within me where I receive her, helping me to offer simple responses such as 'I'm here with you'. Cartwright (2010: 99) suggests that therapists implicitly convey to clients how they are 'held in mind and "carried through" the therapist's experience'.

This is the point within our work that pauses me, causes me to wonder: is this a different kind of pregnancy, perhaps a counter-transferential pregnancy? Bollas (1987: 199) names counter-transference as a 'complex registration of the psychical and the somatic'. I receive Helen, create spaces for her within me, and allow her to register and gestate within me. In this space, I carry some of her sense of hollowness. How do I give hollowness some shape, find its edges, perhaps speak or

write around it? Within my relationship with her, within this 'pregnancy' between us, the bounds, the boundaries, of her and myself are blurred and I am not sure I can trace where they lie, yet there seems to be an edge, maybe the edge of this hollowness, where I carry her, where I carry him too. She lives inside me and I live inside her, and there is inevitable struggle within this period of gestation as something attempts the continued coming into being and coming into articulation.

Bollas' (1987: 202) views on using transference/counter-transference include the idea that 'in order to find the patient we must look for him within ourselves'. Listening to myself within the environment that Helen and I create helps me put words to the unspeakable within her. I come to better recognise spaces that may be hidden, hollow, or unspoken within her when I listen to my body, to the ways both she and he reside within my body and how I carry them. They reside within the scattered and limbo-like places in me, and I can make tentative knowings of them when I attend to the movement and silent speaking within me. This again speaks to the life within the transference, how ghosts within her are being revived.

I try to listen to my sensate experiences, the embodied information that gets communicated within our therapeutic relationship. As Conquergood (2002: 146) states, attention needs to be given to meaning that is 'embodied, tacit, intoned, gestured, improvised, coexperienced, covert – and all the more deeply meaningful because of its refusal to be spelled out'. I suggest that I allow for the potential for a 'gestation' when I attend to and 'listen' to my embodied responses to Helen, even when there were no words and little understanding around my experiences of her. Bollas (1987: 246) states that the therapist 'creates a space for the reception of communications from the patient'. Nancy (2007: 31) suggests that the body be

viewed as a 'resonance chamber' that 'is listening or vibrates with listening to – or with the echo of – the beyond-meaning'. Attending to how she enters or moves within my psychic interior allows for different types of hearing and knowing. Using my embodied experience of Helen and him, I listen into the counter-transferential pregnancy developing within me and between us.

I try to stay receptive and open to how difficult she often finds it to allow him as well as her baby self to be received here, to be wondered about between us. Winnicott (1956) outlines a theory of 'primary maternal preoccupation', explaining how mothers often offer their babies a heightened level of focus. Hopper (2007: 46) builds on Winnicott's ideas, stating that when clients have not received this, therapists attempt to re-create an atmosphere of preoccupation by offering a 'womb-like space' where clients can 'create the therapist, annihilate her, but then re-recreate her again, adjusting the creation to new information'. In response to Helen's sense in sessions eighteen and nineteen of all that feels 'hidden' between her and her mother, I notice the strong counter-transferential urge, an embodied sensation, to take her hand and gently move into these hidden spaces with her. I am acting as the counter-transferential mother, coming to empathically understand and care about her experiences of loss and desiring to give her what she lacks. I notice myself struggling among the discomforts and unknowns within this gestational period of our work yet recognising a shift within Helen, who is not only allowing me to hold her in mind but also more actively using – creating, annihilating, and then recreating – the space within me.

Gestating and witnessing Helen within the context of a transference/counter-transference relationship may be transformative. The handling I offer to her is

different from her early experiences. Am I a 'transformational mother' (Bollas, 1987) for Helen as I work to transform experience into thought, to make her internal world more articulable? Carroll (2005: 104) suggests that therapists' concentrated attention on clients' 'repetition, a familiar way of organizing' themselves may lead to a 'new pattern, more sophisticated, more relational, more creative'. Together, we recognise and receive her and him within spaces that allow for listening in new ways, which seems to lead onto her experiencing a shift in her object relations, finding new ways to be in relationship with herself and him. There is potential for expansion. Belly swelled, I feel her and him growing between us.

5.3.2: The unthought known

I might be feeling something of Helen kick within me, her prenatal and preverbal experiences needing a place to resonate, attempting to be expressed. Silver (2007: 425) suggests that 'the womb is not a container or a simple organ of reproduction but a space where subjectivity is shaped through coemergence', a process that 'continues throughout life between part-selves and part-(m)others, provides ambiguous, contradictory, and multiple paths to connectedness'. I see myself as being a 'part-(m)other' to Helen, helping her acknowledge her baby self within her. The ghosts in *her* nursery (Fraiberg, Adelson, and Shapiro, 1980) are always going to be present, and she brings her own experience of being a baby into her conception and gestation of him. In her object world, as she forms something of her experience as a baby, perhaps he becomes undifferentiated from her baby self. Perhaps this is a joining up of her experiences and her losses, where baby Helen and he become one.

I try to sit with the silences of her early experiences. Much of our work occurs in the swampy place and time before she had language. Helen's experiences often have a quality of being embryonic, not fully known or able to be articulated. Her ability to experience and to know came before her ability to think about and articulate her experiences and her knowings. The 'infant within the adult person cannot find a voice' (Bollas, 1987: 204), but I can access something of Helen's preverbal experiences as I let myself feel a baby that kicks inside of me, demanding to be heard and attended to.

Bollas (1987: 235) calls the 'unthought known' where 'the patient knows something, but has as yet been unable to think it'. The not yet thought is also not yet articulated. Bollas (1987: 281) acknowledges the wordless: 'The infant-mother dialogue is more an operational and less a representational form of knowledge. And the analyst, like the infant becoming a child, will struggle to move the unthought known into the thought known'. In the gestating womb of our work, I struggle within her internal world. Bumping up against the 'unthought known' of her early relational experiences, my role is to try to feel my way into the hollowness, into that to which she may not have access. I hear ghosts asking me to pay more attention to them. I feel this indistinguishable yet so present womb-like space between us, both giving and taking away life from a kicking and screaming baby.

I hear from another ghost in my nursery, reminding me of my quietness as a child, others would notice my silence. Then upon returning home, my mother would comment at how much I was talking. I see this now as my need to force myself within her, the incessant questions she sometimes could not answer or bear were my insatiable need to know, to know if she could take me in. I notice around this time

that when I process my work with Helen, after our sessions by thinking and writing about it, I find my breath becoming choppy, like a sleepy whimpering baby gasping with exhaustion after crying. The gasping breath within me was likely some of Helen's dread of her mother's shoulder pat, the insufficient care for her hurt, the experience of not being taken in.

Making use of themselves, perhaps many therapists can wonder about what clients are unable to put into words. Bollas (1987) names therapists' thoughtfulness and curiosity as powerful, more so than expressing affect or attempting intuitiveness, and feels it opens space for the unthought to be considered and articulated. I use myself, my countertransference, and my experience of being with her to form a shared sensing, shared consideration, and 'shared knowing' of the unthought known within her (Bollas, 1987: 235), to come to think and articulate into this womb of preverbal experiences and knowings. My counter-transference, especially from the conception phase of our work, is filled with images and sensations – of a baby reaching out. I imagine Helen's baby self here in this room and have a sense of my futile attempts to satisfy this baby. Does Helen fear becoming the unfeeling mother towards her son? As I stay with the hollowness, I hear silence and emptiness echoing between her childhood and her loss of him.

The care she offers me around the 'cup of tea' in the conception phase feels hollow, a disappointment, as if she pats me on the shoulder, missing what hard work this is for both of us. I feel a sense of her being guarded and distant from me in this moment and wonder about her unthought known fear of overwhelming me. I think back to her childhood cup of tea and how it was a replacement for feeling loss.

Within this holding it all in, I see how terrified she is of being overwhelmed by feelings.

But there are overwhelming feelings between us, including my growing sense of her as the disappointing, deformed, or destructive baby. My maternal counter-transference tells me how much Helen may see herself as unworthy of my attention. My sense of approaching deformation with little else but welcoming grace has been previously untroubled within me. I find this becomes a struggle for me within our work, where I need to come closer to how it is for Helen to loathe the deformation that kept him from her. I have a dream that seems to bring me closer to my own need to loathe fragility and imperfection: there is a tablet, a cure for my disabled and deformed sister, but my mother says the only way to get it is to sacrifice herself. I prevent my mother from doing this, allowing my sister to die, my own need being attended to as I find a way to have mum all to myself. This dream brings me closer to both Helen's desire and dread in having mum all to herself.

I continue to welcome deformation, now also allowing it to hurt. I sit with my own memory of fragility and deformation, the thing checked in the middle of the night, hoping it is still alive but anticipating its death. I can feel just how much Helen's lost son is the defective, dead baby, but I realise that baby Helen needs me to also feel her deadness, the repetitive crying out with no expectation for being heard. Perhaps Helen sees herself as a defective or dead baby (Wrye, 1996), feeling a continued sense of rejection from her mother. Reflecting on Helen's memories of her mother's possible miscarriage, I wonder if Helen's unthought known is that she ruined her mother's womb and the chances of life for the one that came after her?

Helen seems to have an expectation of failure, that she will not be taken in when she has needs. Her mother's words of 'just get on with it' were familiar from childhood and now are heard in response to her infrequent but still hopeful reaching out to her mum around her loss of him. In hearing Helen's repeated aim to get on with things, my counter-transferential experience of her is that she is asking me to be numb or hollow with her, to only trace the edge of her loss. Is she creating a sense of an absence, needing me to feel the lack with her? She seems to entreat me to know what it is like to be filled with restraint and hollowness. Is the numbness and hollowness born out of Helen feeling trapped somewhere between hope and dread? Does she hope that I will offer something different from the inattentive and unfeeling responses she is accustomed to and simultaneously dread that it will be the same (Mitchell, 1993)? I see her hope yet dread in her reaching out. She might experience me as her mother, dreading that I will skirt around issues and insist she 'get on' with things. She also might experience me as her father, hoping I am not preparing to leave her in the midst of difficulty.

I notice how many mothers start to flood the room: the unfulfilled mother who can only see what is 'not enough', the blaming mother who accuses the child of damage, the destructive mother who destroys what the child loves, the avoidant mother who refuses the child's reaching out, the forgetting mother who cannot remember how much the child hurts. I sense the rapid switching between the many versions of this mother – possibly within Helen, within myself, and within her mum – and it is difficult to maintain a reflective space to process the impact on both of us.

Helen is throwing qualities of her mother into me. This is a fuzzy, confusing phase of our work, and I find myself turning further to psychodynamic theories of

projective identification and the unthought known to help me make some sense of it, to help me tolerate the blur and spin within me. Helen impregnates me with her chaotic sense of her mother, and, as I feel something of the sickening swirl, we can make more sense of Helen's inability to steadily implant herself within her mother.

When we stay with the story, Helen and I make some movements around the edges of what feels like a vacuous and bottomless hole, yet I also feel us moving into the hole within this phase of our work. There is a void, an abyss that we must enter in order to make meaning and also to feel the emptiness within it. I listen in a way that allows for absences to be present, and our work is partially about acknowledging the weight of her invisible losses. Pushing into these spaces, stoical and hollow as well as attentive and full, provides the potential for thought within the 'unthought known'.

Within sessions fourteen to sixteen, we seem to find something of the 'unthought known' in her long-trapped stories of her mother. I find myself becoming taken over, overwhelmed with, haunted by the unfeeling mother in the room with us. I feel filled with rage at her mother for her demands for Helen's silence and her simultaneous crowding of this space. This is likely Helen's unspoken, unacknowledged rage projected into me.

Carrying Helen – and him, and her mother – is hard work. They push against each other, vying for space with me. The mother crowds out the others within this phase, and I resent her. Like the child that cuts in, takes the attention, leaves me both full and empty. They push against my womb, making it difficult to breathe. I feel bloated, filled with the hateful mother and the hate towards the mother. Get this baby out of me, away from me! I feel something of the hate that a mother inherently

has for her baby, hate that might be born out of the love she must feel despite the physical and emotional excretions a baby brings (Winnicott, 1949). For the first time, I empathise with Helen's mother, her likely sense of sacrifice, doubt, and hurt. I feel the sadness and loss of the mother that hates herself for not being able to simply and only love her baby.

I remember a miscarriage within my family, the baby that came after the deformed yet cherished one. Feeling into the threat that this baby might pose to the mother, to the family, I notice again my empathy for Helen's mother and for the child Helen that had no way of making sense of her mother's losses. I am haunted by something of Helen's mother, feeling both care and rage towards her, which seems to facilitate Helen to acknowledge more of her unfulfillable longing for her mum to take her in. Helen was asked to expel deformation and loss, both her son and her father, and when she says she wants more of them in her memory box, she seems to find something of her need to take both of them back in.

Helen is pulling me into increased awareness and care around her lack of having a space within her mother. Bollas (1987: 251) posits that therapists use the counter-transference to notice how a client 'uses the analyst by coercing the analyst's internal life, much the way an infant or a small child addresses the parent by evoking internal responses, enabling such a parent, through empathy, to provide the right parental act'. She is stirring me, in the transference, to respond as the empathic mother. For example, I feel such a curiosity when she speaks of his picture or the memory box. I long for her to physically bring those items, those fragments of him, here and wonder if she is stirring me to feel some of the disappointment around not being able to see and have him here.

I can acknowledge her experience of the hollowness of her mother, yet also embody and attempt to put words to the fullness I increasingly feel in Helen's presence. She longs for stoic handling to be replaced with an attentive 'taking in'. She wants others to remember, to have the capacity to speak about it, possibly to hold her in mind. If I can offer her this, to hold her and him well, it seems there is the possibility for transformation within her. In sessions eighteen and nineteen, I hear her articulating something of the unthought known and hidden of her experience of being mothered as well as her readiness to reach out to others. Bohleber (2010: 63), following on from work by Bollas, states that the goal of human development is 'the dissemination of the self into the world of objects'. I see her shifting towards being in relationships in new ways, with me 'in here' as well as increasingly with others 'out there'.

5.3.3: Reconsidering grievability within gestation

The gestational phase of our works seems to be marked by movement within the therapeutic process and within disenfranchised grief. Listening into and at the edges of her loss, Helen and I notice what is hollow and absent, and we seem to find not only the loss of him but the layers of loss from her childhood. In this section, I argue that the unseen, unheard, and unthought of her early relational experiences is often missed in the social world 'out there' and, when attended to, has the potential to further enfranchise her grief.

When I consider that 'pregnancy often intensifies prior intrapsychic conflicts' (St. Clair, 2001: 38), I realise the multiple layers of what may be dismissed within Helen. Kluger-Bell (1998: 44) states that '[l]osses never stand alone. New losses

reverberate with the memories of old ones, bringing a new significance to each'. Lieberman (2016: 87) states that a more present loss is unconsciously filled with 'a silent history of earlier losses'. Frosh (2013: 2) acknowledges that trauma reverberates intergenerationally, yet that 'it does not reduce easily to what might have been seen and heard'. In the middle phase of our work, there comes into articulation something of the unseen, unheard, and unthought of her early experiences, which seem to lie beneath her more recent sense of loss. The experience of loss within receiving handling and holding from an inattentive parent might have been mirrored in her more recent loss of him. Butler (2009: 139) states that 'new formations can "emerge" only when there are frames that establish the possibility for that emergence'. Her experience of counselling may offer her a frame that allows for an emergence of her longing for what was absent then – the feeling and responsive mother and the consistently present father – facilitating articulation and gestation of what is absent now – him.

Staying with Helen's nascent and unborn thoughts and staying with how it is for me to receive her is part of what I offer her. Cartwright (2010: 66) speaks of therapists engaging 'a scanning function' and searching for 'qualities in the analytic field that mark the place where "something was"'. Attending to the place where 'something was' in the past, perhaps a ghost, brings meaning to our present. Following Winnicott's (1956) theory of primary maternal preoccupation (PMP), Lloyd Jones (2015: 434-435) expounds on PMP as an experience that is repressed and forgotten by a woman who has lost a pregnancy as she 'is liable to feel preoccupied with death and loss, or even identified with the dead baby, and if she is, she will most likely not be understood, or may be frankly misunderstood by those

around her'. The past is alive in the present and therapy appears to offer Helen a unique setting for these dynamics to be acknowledged, felt, empathised with, and sometimes made sense of. I see how psychotherapy 'intentionally stirs up demons, it refuses to stay silent about trouble and pain, it insists on talking about the things we would much rather hide or lay to rest' (Frosh, 2013: 3), helping her access the words arising out of the limbo-like spaces of session seventeen: 'He's here, but he's not here'. Lloyd Jones (2015: 439) states that a woman might experience 'unconscious regression into her own infantile experience'. When we dwell among how her losses reverberate within her, she seems to be able to stay with the ghosts and unfulfillable longings around him, herself as a baby, herself as mother, her own mother, and her father.

Helen is repeating a familiar way of dealing with loss. Kauffman (2002: 74) suggests that we 'disallow grief according to prior experiences of disenfranchisement'. I see how when we attend to her early experiences, we find something that was excluded, invisible, formless, nameless, elusive, which then helps us recognise him – the whispering from session twenty perhaps – within the spaces between and within us. In the intersection of the present and the absent, 'where the transparent and the shadowy confront each other' (Gordon, 2008: 195), she and I work with what is both past and present. Frosh (2013: 39) works with Bollas's (1987) theory of the 'unthought known', adding that we are left with 'a memory that cannot be openly recalled yet is also never lost' which 'keeps finding its way through into consciousness only to be rejected by the subject'. It seems there has been 'an occasion for the unthought to be given its space for articulation' (Bollas, 1987: 232) when ghosts and hauntings are allowed to be considered between Helen and myself.

In this phase of our work, I find myself hearing stories that have not yet been told, not just because they have been disenfranchised or have a discourse that shapes them 'out there', but also because they have been entombed 'in here'. Her story is haunted by what it excludes of the losses of her son, her dad, her mom. Frosh (2013: 57) states that 'the failure to mourn the lost object means it continues to press for recognition' and that acknowledging the lost object involves 'drawing from it the voices of oppressed people who previously did not have a place, who could not be mourned because their very existence was denied'. The lost object, and the sense of that loss, may be 'swallowed and preserved…buried alive in the crypt' (Abraham and Torok, 1994: 130).

In line with Abraham and Torok's (1994) work, I agree that something within Helen was locked and needed to be found, opened, and retrieved. Extending Abraham and Torok's (1994) work, I also suggest that retrieving the contents of the crypt does not imply simply a finding of what already existed but rather an opportunity for reconstructing the contents, this time with a witnessing other. Helen and I crawl into the crypt together. We explore and (re)create. My capacity for rage at her mother makes space for Helen's emerging contempt for her mother. Once she recognises and articulates some of what had been entombed within her, she starts to rework her loss, opening to the mother as persecutor and capable of hate. She also accesses and reconsiders how much she longs for her absent father.

As she 're-members the object which has gone', she recognises how she bears its trace (Cousins, 1996: 36). What was unthought can now be more grievable and thought about. Acknowledging and attending to the unrecognised or absent seems to counter the silence that has also taken up residence within her. The

unfeeling mother is transforming into one that can recognise and attend to absences, and Helen is more ready to consider and receive herself and her unborn son. Gordon (2008: 183) suggests that the ghost is

> pregnant with unfulfilled possibility, with the something to be done that the wavering present is demanding. This something to be done is not a return to the past but a reckoning with its repression in the present, a reckoning with that which we have lost, but never had.

Helen and I acknowledge the ghosts, the shadows of the past within the present. We come to better know the feeling of hollowness. The goal of psychotherapy is not to no longer be haunted, but rather to notice the haunting (Frosh, 2013), and I wonder if Helen is then able to express something about feeling refused by her parents, but not wanting to refuse him here, wanting to let him be here. By feeling into the hollowness, we feel into the fullness of these internal spaces. This phase seems to allow her to offer her child self and him more care and space to be received.

5.4: Conclusion

I use my sense of the middle phase of my work with Helen to explore how I listen to other ways she struggles to articulate her losses. When I listen into the edges of her early experiences, to what Bollas terms the 'unthought known', we begin to feel into these spaces, both hollow and full, dead and alive. I suggest that she begins to push into these spaces, attending to her child self as well as her unborn son. I wonder about her use of these spaces to reconsider how she may be disenfranchised within her loss as well as how she may be (re)creating what was entombed within her. I

consider the idea of present absences in relation to both her early experiences and her loss of him, which I explore more fully below.

Chapter 6 Labour: How do I listen into Helen's (re)creation of and ongoing relationship with him?

> You think of the children you might have had but didn't. When the midwife says 'It's a boy,' where does the girl go? When you think you're pregnant, and you're not, what happens to the child that has already formed in your mind? You keep it filed in a locked drawer of your consciousness, like a short story that wouldn't work after the opening lines (Mantel, 2010: 20).

6.1: Introduction

As I demonstrate in the conception and gestation chapters, I carry Helen within me, which includes him, and I notice he is as alive within her. Yet the spaces within her seem to need to re-form so he can have space to be considered and cared for. I notice that he is with me directly before our sessions, reminding me to attend to him during the session, telling me he still needs her, she still needs to talk about him. I visit him 'in here', I feel out the spaces within me that hold him. I ask him what he needs. For a time, I feel a surrogate mother to him. Helen seems to transfer something of her son over to me in the conception phase of our work. Then in the gestation phase, after we get in touch with pain carried by the child within her, she seems more ready to (re)take him in, to (re)create him. When she speaks in session seventeen of 'wanting more of him in there', I hear how she longs to fill spaces –the memory box and perhaps herself as well – with him. Perhaps he is the whisper from session twenty.

I notice how the internal spaces within me can be used differently after we work with the hidden and possibly encrypted pain within her. Drawing on what I see as a critical shift in our work in the gestation phase in sessions seventeen through twenty, I wonder about the creation of a more useful space to consider the loss of her son within sessions twenty to thirty-two, which I view as the labour phase of our work.

6.2: Narrating the labour phase: (re)considering and (re)creating him

In session twenty, she says 'I wonder if I'm carrying something right here…' – she indicates her chest – '…a big ball of pain, maybe it needs to come out'. I imagine her carrying him within her. I name with her how she might make space to allow something to 'come out'. When I add that maybe there is something pushing, saying 'Talk about this, talk about me', she does not respond to this part, and I wonder how it is for her to hear me speak in 'his voice'. Perhaps I try to pass him back over too soon.

Yet in the following sessions, unlike the circles we stuck to in the beginning phase of our work, we not only approach the edges but leave the well-worn paths and go to new places, shifting from talking about talking to talking about *him*. In session twenty-one, she speaks of memories from after the termination: 'He was in me, but no longer alive. I had to go home and come back to the hospital the next day…to have him taken out of me'. She then recalls how it was to feel him within her as the car, and its silent inhabitants, went over the speed bumps on the way home.

In session twenty-two, referring to the four weeks she and her partner had to decide about the termination, she says: 'I could feel him moving around in my body'.

I gently acknowledge ‘He was alive…within you.’ She shares from the swamp of dark and painful memories, we cry together. When I feel his presence in the conception and gestation phases, I hold it gently and silently. But as she seems more able to speak about him within the labour phase, I offer my experience of him back to her: ‘He is present here’. She then names her desire for people to acknowledge what she has lost, saying that this would allow her to find other ways of remembering him.

On anniversaries, of difficult scans, of losing him, of his potential birth date, she starts to come into the room more messy; I see her bringing her need differently. In session twenty-three, noticeably less put together, a section of hair sticking out, her tattered notebook drops on the floor, she reveals ‘Today is his birthday. I would have a two-year-old today’. When she later says ‘My friend’s five-year-old said to me “How come you never bring a baby with you when you come around?” There are so many times that it just hurts to have him not there’, I respond with ‘And you *do* carry a baby with you, everywhere you go, others just don’t see him’, hoping to capture something of just how absent yet just how present he is. She continues, saying ‘I’ve never told you this, but when people used to ask me if I have kids, like people I wouldn’t ever see again, say a customer at work, I would lie and show them a picture on my phone of my friend’s daughter. I’ve recently put *his* picture on my phone…I’ve been looking at it more and more lately’. I pause here, remembering my image from the early phase of our work of the empty space on the mantelpiece and see how this has shifted for her.

In session twenty-four, she speaks of the ‘wee teddy jumper’ that her friend gave her when she made it to a milestone week of pregnancy, how she keeps it in the

back of her wardrobe because 'there's hope somehow knitted in there'. She speaks of a tree she planted for him, how she 'feels closer to him there'. When she adds she is 'desperate to keep it alive', I remember my sense from the conception phase of her desperate need to keep him alive, which was then not able to be articulated. She notices here that 'This still matters, he still matters, I still need to talk about him'. I feel movement within this swampy womb between us as she starts, in subsequent sessions, to be more curious about when she can look in the memory box, hold his ashes, show his picture to others, talk about him within the family, spend time with him.

Reflecting on our work in session twenty-five, she says her words feel 'less trapped' within her, that her losses 'don't have to stay in a box', and that talking about him feels like she is giving her loss some 'air'. Perhaps she is feeling just how alive he was within her, and maybe still is, partially because she is no longer avoiding the moments of losing him. Yet, I imagine that keeping a distance from him for so long, knowing only how to feel his absence, not his presence, and now seeing him as alive must have been confusing and terrifying. We may be finding or creating spaces within her for her/him, but these are new and unthought about spaces. Her words 'When I imagine him here, it's the good version, not what he really would have been like', spoken in session twenty-six, show how terrifying it seems to create him within her imagination. She follows this with expressions of guilt for imagining him as alive and healthy rather than deformed.

Then in session twenty-seven Helen brings this dream:

> I was walking through the city and saw my dad. He was cycling. We lock eyes. It's raining and he falls off the bike, he's lying there on the

> ground, hurt, everyone looking at him. He asks for help. I say "I can't help you!" and walk away.

Here with her dad, Helen seems to be moving from not being able to talk about him, then on to the 'good version', then to more a balanced, less idealised version of him being both here and not here. This is mirrored in her shifting experience of her son, as in session twenty-eight she notices herself 'just wanting him to be here, wanting the little boy that he might have been. If he could just be here….even if he was deformed, disabled, difficult to care for …no matter what. I just want to be with him'.

Later in this session, she critiques herself that, at two years after she lost him, she is 'still' imagining what he would look like. I validate that she may always imagine him there with her, at whatever age he would be at any particular time in her life. As I say this to her, my heart races with the memories of the times, especially within the conception phase, that he visited me, the baby, the boy, and the young man that haunt me. She names that being able to hear herself speak about him as well as seeing and hearing my responses to her makes her loss 'feel more real', which simultaneously helps her acknowledge how much she misses him, that she wants him here. I am touched as she finishes this session with her imaginings of what he would have looked like, how he would have played with other kids, how it would be to hold him again.

Helen begins session twenty-nine by naming her desire to have a place to visit him, spend time with him. While this seems nearly impossible for her to do 'out there', I see her starting to go within herself in the counselling room, as when she follows her desire with this dream:

> I gave birth to a little girl, but we didn't even have time to check if she was alright. We left the hospital quickly, we rushed away with her. The best I can do is to put her in a box. It's a small box because she's so small. I just carry her around with me everywhere in a box.

I find myself filled with wonderings about this baby – the box contains a live baby, the baby might be her, she is offering the baby the care it needs – yet I put these thoughts aside for now, wanting to stay with Helen and him. I notice with her just how alive and present he feels in her dream and between us now. She names again 'He's here, but he's not here'. I reflect to her that I have heard how much he means to her, how she still carries him within her. I see her increasing ability to drift away, to imagine into him, and in this moment I feel she and I hold him together. I wonder if this facilitates her sensations of him, which seem to spill out of her in subsequent sessions. Her words such as 'I feel close to him', 'I can be with him again', and 'I'm holding him' are spoken as she gently touches her chest.

She shares in session thirty what it was like for her to be near a friend's baby boy, how she worried she would hurt both physically and emotionally if she held him: 'I wanted to pick him up, give him the attention he needed, but I couldn't bear it'. I think of the baby that lived within her for months, how she seems to again be feeling the weight of him within her, his solid, formed body. Within his absence, she and I seem to be getting more in touch with what it is like to have him alive inside her, both then and now. I notice with her that she seems to come alive when she speaks about him, for example when she says in session thirty:

> At the funeral, when I physically moved closer to the coffin, that was when I felt close to him. I reconnected with him, we were *together*

> again. It was similar to when I was carrying him inside of me. I remembered what it was like to carry him within me.

I imagine her as the attentive mother, holding, nursing, giving the baby what it needs.

In session thirty-one, as Helen wonders about soon bringing our work to an end, she says 'I've been here', making a ball shape with her hands, 'and now I feel I'm on the edge of something, like I might be able to feel different, give myself something different. I want to be on the edge more often'. Within this edge, I see her offering herself and him care. I also see her allowing for the possibility that others might receive her, for example when she notices that she surprises herself 'out there', how a story of him 'just comes out' and she says more than she expects or to someone she did not expect would take her in.

Perhaps Helen and he are ready to come out, are spilling out of me. She is attending to him, his crying and kicking. I think back to my imaginings of him kicking within me during the conception and gestation phase, noticing the absence of this sensation for many weeks. Is she taking him back, (re)locating him within her? Her story in session thirty-one of feeling recognised as a mum at a Mothering Day lunch by her own mum strikes me; I see the significance of this for Helen as well as how it marks the progress within our work of her (re)becoming his mother.

Some moments, he is in the room between us, as in session thirty-two when she says 'I can imagine him here, I'm bouncing him on my knee'. She fills the room with him, and I feel touched as she notices how he seems to 'flow out' of her. As this session comes to an end, I name my sense that she is opening up something that has been closed for so long, that I see more space within her for wondering and

imagining. In her response, ‘I feel like I needed to pass through something’, I hear her recognition of the womb space of our counselling relationship.

6.3: Theorising the labour phase

In the conception and gestation chapters, I use Bion and Bollas to think into how Helen and I explore her intrasubjective experience. Here, I consider how the next phase of our work extends beyond intrasubjective knowing to coming to know her lost son within her. Ogden’s and Benjamin’s work on intersubjectivity and the ‘third’ help me think into the spaces within and between Helen and myself and how we come to (re)create and (re)birth him, helping me further explore my counter-transferential pregnancy. Returning to theory on present absences, I consider how she comes to ‘be with’ him again. I revisit grievability, demonstrating how this phase of our work contributes to new ways of thinking about and working with pregnancy loss.

6.3.1: Spaces within and between us: intersubjectivity

Within the blur of what is mine and hers, I feel us mentally conceiving, gestating, and labouring him between us. Nancy (2007: 12) says that because listening is ‘the resonance of a return’ a separate sense of ‘mine’ and ‘other’ is not possible. I notice how our work resonates within me and is created together. Wading within this swampy womb, glimpsing slivers of hovering images, and hearing whispers course through me, I feel the tension of the unexpressed, unexpressable within me and between us. Cavarero (2000: 35), considering the recountability of memory, notices a ‘silent condensation of an episode that presupposed the entire life-story, as if this

were always internally present, or even unthinkingly sensed'. Helen's story, and the way she tells her story, feel both expanded and condensed within me, where traces of him reside within my body. There lurks a hollow fullness, a consuming void, a delicate inhabitation.

Labour 'out there' for Helen was when she got to see him, outside of her many scans, for the first time. Yet when he was birthed, she did not want to see or be near him, could not bear to see him as dead. I am struck by his death coming before labour and birth. When she first comes into counselling, it is as if she has a profound yet unspeakable attachment to when he was alive within her, in the moments before he died, when his life was still a possibility, when he was less dead or maybe less absent. I find myself wondering how dead he actually feels to her as our work progresses. He is alive in this room between us, within her. She seems to be moving towards tolerating both his aliveness and his deadness and wanting to get to know him as both.

Labour within our work seems to constitute a different type of 'seeing' and 'knowing' him, where she reconnects with feeling him inside of her and senses and speaks into the closeness she feels with him. Helen and I struggle together to sense into what was painfully absent and find just how present he still feels within her. I argue that I engage in emotional and psychic 'labour' when I listen and attend to what is co-created within the therapeutic relationship. Within the labour of our therapeutic work, rather than merely recount him, Helen and I (re)create, bear, and give birth to him. Our labour and birth are not linear, final, nor fully formed, but rather continuously emerge and reconfigure within an embryonic state. When she is allowed to 'keep talking', to tell and tell again, she begins to imagine more varied

versions of him, ranging from deformation and laboured breath to a healthy, playing boy. When she is allowed the time and space to trust, she is able to pass him over to me to hold for a time. She is his mother. But not his only mother. In my counter-transferential pregnancy, I hold him, as in a surrogacy, which seems to allow her to imagine into her experience of him. Helen and I create not *a life* in the sense of materiality, but we create *life*, with both its sense of aliveness and deadness.

Gerson (2004: 71-72) considering the 'relational unconscious' occurring within a dyadic relationship, says that 'the offspring of the two individuals, constituted by each of their unconscious material, and, as in the mix of genetic material, having features both recognizable and novel and always containing marks of mysterious origin'. Do we partially form him? Is he our offspring? I compare what we form together to what Ogden (1994: 17) terms the 'intersubjective analytic third', a space created between therapist and client, or:

> a framework of ideas about the interdependence of subject and object, of transference–countertransference, that assists the analyst in his efforts to attend closely to, and think clearly about, the myriad of intersubjective clinical facts he encounters.

A third subject is created out of the unconscious meetings of Helen and myself. The analytic couple creates something new together, the opportunity for new emotional experiences (Ogden, 2003). He is our psychotherapeutic baby, mentally conceived, spoken and thought into being. Hamer (2012: 789) states it is not just the two people within the counselling room speaking, but a third '*something* is also speaking…a truth that waits to be formulated and articulated, words that wait without end'. We

labour together to form something of this third subject; we push him out, hold him, pass him between us, offer him care, admire him, mourn him.

In this intersubjective mix, I 'listen' to Helen, him, and myself through my counter-transference experiences in order to recognise what might be occurring within our therapeutic relationship. Ogden (1995: 696) states that transference and counter-transference are not 'separable entities that arise in response to one another' but rather 'aspects of a single intersubjective totality experienced separately (and individually) by analyst and analysand'. The 'analytic third' within our therapeutic relationship develops as I share my countertransference experiences with her and as she seems able to take them in and use them to go farther into her story. Benjamin (2004: 13) names the 'third in the one' – the 'ability to maintain internal awareness, to sustain the tension of difference between my needs and yours while still being attuned to you' – as developing within clients when therapists are able to bear projected pain. The transformational potential within therapy often resides within clients' projections into therapists, which may then be re-introjected within clients (Britton, 1998). I work at allowing Helen to affect me, feeling and thinking into her experience of loss, and putting words to our co-created experience. The ways that I make myself available and listen into Helen's stories seem to facilitate a taking in and (re)creating of her and of him.

I am struck by how her experiences of being mothered and of mothering were not ones of 'in here'. Our therapeutic dialogue may give her the chance to not only come to articulate and think through her experiences but also to give life to them. Together, we recreate moments of feeling close to him, reminding her just how alive he is and just how dead he is. As she reconstructs her story, she shows me her desire

within what and how she speaks (Frank, 1997), and I see her reconstructing him. At first, I scan her and myself to get a sense of what we are creating, yet I find myself increasingly peering expectantly into her. She is narrating him, (re)creating him in my presence, and I feel him alive between us.

Helen and I labour together, working with what is inchoate and not formed, making 'unformulated experience understandable' (Cartwright, 2010: 33). Stern's (1983: 94) 'unformulated experience' involves 'the emergence, through curiosity and the acceptance of uncertainty, of constructions which may never have been thought before'. Certain constructions are brought into thought between Helen and myself and certain constructions are made between her and myself. In the intersubjective field of our work, through the co-created and shared attempt to articulate our sense of him (Wright, 2005), we bring him into being. I witness the development of her capacity for relationship, for 'creating recognizing intersubjective thirds' (Benjamin, 2005: 457), both with myself and with her sense of him.

There is a third something through which Helen and I relate, facilitating a recognition of her experiences with him. Benjamin (2004: 16) suggests that 'recognition is not first constituted by verbal speech; rather, it begins with the early nonverbal experience of sharing a pattern, a dance, with another person'. I notice the dance between Helen and myself, the shared movement, the co-creation of something. Does he become a third between us, a recognised presence in the therapeutic field?

Helen and I must recognise each other as separate subjects if we are going to then be able to form an intersubjective experience (Benjamin, 1990, 2005; Cartwright, 2010). She seems to gain more of a sense of herself and him as a subject

through my recognition. Benjamin (2005: 449) speaks of intersubjectivity and recognition as developing the capacity to 'get inside the other's mind and let the other inside us'. Letting Helen get inside me so that I can recognise her/him seems to help Helen recognise him within her. Our separateness yet connectedness helps us (re)create him.

Helen is held in my mind, which facilitates her holding him in mind. Cartwright (2010: 77) highlights the co-created work within therapy, naming that clients may come to internalise a new 'collaborative elaborating couple'. Here I extend my previous suggestion that counselling is a different type of pregnancy, not just where I take Helen in and give her something back, but also where we join together to create something new, 'to create a space of thirdness' (Benjamin, 2005: 452). In moments such as session twenty-nine, where we seem coupled in sensing his presence and absence, I feel joined by her as we find a way to care for him together. We are the 'analytic couple' (Cartwright, 2010), the 'nursing couple' (Winnicott,1975), creating the baby that develops slowly between us. The contained and the container are both active, alive, creative. She and I give him form. I am a 'part-(m)other' (Silver, 2007) with Helen to him, facilitating spaces between us where she can acknowledge her baby son within her. As she moves towards recognising him within her, we move towards a joint consideration of him, a being with him, and I wonder what might be occurring internally within her.

Throughout our work it seems that she moves towards finding or creating spaces for him within her. In the labour phase, perhaps *she* is the container, more sturdy now, and can hold what was always already within her. Helen's material from sessions twenty-seven and twenty-eight show a shift away from entombing her father

and her unborn son. Perhaps she moves towards seeing them as both present and absent, alive and dead. Ogden (1995: 708) suggests therapists work with the sense of aliveness and deadness within the therapeutic relationship by creating 'analytic meaning ('analytic objects') from that which had been unconsciously present in, and powerfully shaping of, the analytic encounter, but had been foreclosed from the analytic discourse'. Perhaps my noticing what is absent and what is present enables me to 'listen' to how Helen is unconsciously communicating what is both alive and dead for her. She is beginning to represent her father, and in both the gestation and labour phases this seems to also facilitate representing her lost son.

6.3.2: Spaces to think and imagine: ghosts and present absences

Within our work, I maintain a thinking space, a third space (Britton, 2004; Ogden, 1994). My attempts to internalise Helen and think through her material mean that she is being met with a different mind each time we are together and this can be transformational in and of itself (Little, 2017). Perhaps Helen and I form openings within her, spaces to think about and be with both herself and him. We make space to 'allow the ghost to help…imagine what was that never even existed' (Gordon, 2008: 57). We create him, so that he can help her keep creating him. We imagine him, his cries, his needs; we imagine caring for him, continuing to care for him. As she moves closer to shadowy spaces, she moves closer to him. He may reside in liminal spaces, somewhere between presence and absence, nowhere and everywhere, or as Helen says 'He's here but he's not here'. Frosh (2013: 169) states that psychoanalysis might show us 'precisely how dependent we are on our ghosts and phantoms to make ourselves alive'. There seems to be a stretching, an expanding, of

what before felt like an inflexible space. Perhaps he is transforming, growing within her, 'in here'.

Gordon (2008: 194-195) suggests finding ways to 'see what is usually invisible or neglected or thought by most to be dead and gone' and promotes a 'vision that can not only regard the seemingly not there, but can also see that the not there is a seething presence'. Helen seems to develop spaces within herself where, as we put our eyes, ears, bodies, and imaginations towards them, we can find what was inchoate within her. Linnell et al (2008: 303) propose that even in the act of speaking there hides something that cannot be spoken. So the act of my listening must attempt to allow space for the emergence of that which is unspeakable. Within the counselling process, Helen and I work at the edges of narration, with often only fragments of a story. We are getting to know the lost baby, getting to know how significant he is for her, allowing for the ghosts. The ghosts seem to 'speak' to what was muted, missing, unacknowledged, unspeakable: the losses within her early experiences, her experience of losing him, and her experience of being reconnected with him.

She seems more able to open up and listen into spaces within her. Maybe she finds that these spaces are not as silent or empty as she thought they were. Movement within her seems to come when she notices she is able to speak to others about her loss more. Her increased use of her social supports, friends and family that are available to hear her, that seem to take her in, make me wonder if there is less fear now in sharing this space 'out there'. Gordon (2008: 205-206) says that

> when you know in a way you did not know before, then you have been notified of your involvement. You are *already* involved, implicated, in

> one way or another, and this is why, if you don't banish it, or kill it, or reduce it to something you can already manage, when it appears to you, the ghost will inaugurate the necessity of doing something about it.

I notice what can arise within Helen when she no longer banishes him within her. I notice what can be created when we acknowledge what is gone. As in Mantel's (2010: 20) poignant words from the beginning of the chapter, the child(ren) Helen never had haunt and remain with her.

Helen's narratives are often shadowy, murky in detail, and not within her control, yet these elusive parts of her narratives seem most potent and resonant for me and I notice how they take form when I attend to them inside of me. Her dreams are filled with ghosts and hauntings that seem to have something to say. He haunts, we linger with him, and I see her starting to recognise him lingering within her. Our dreaming, drifting, drowning, and slipping away, experienced within sessions throughout our conception, gestation, and labour phases, speak to the element in the transference that is elusive and inchoate. These ghostly forms can take more shape within and between us and hold the potential to communicate a depth of affective meaning. They reside within me, I seem to embody them more quickly, allowing for more connections and understanding. We float within the periphery, the edges of something intangible, yet I feel a closeness and centredness between us.

We slip away together in thinking through her dreams, recognising more of what is dead but also alive, ghostly yet so present. There is a freedom within her dreams and imaginings, captured well by the phrase 'the mystery of the dreaming womb' (Silver, 2007: 426). Is counselling a place for her and him to dream themselves into existence (Ogden, 2012: 131)? Does being the attentive rather than

the unfeeling mother within her dreams allow her to make a form where it before seemed formless? Or perhaps to somehow, within laboured breath, give birth to him?

There may not be control within these moments but there is freedom, seemingly within both of us. What occurs for me in moments such as these is an increased sense of being with him. When I give her and him the attention and curiosity they are likely hungry for, Helen also seems hungry to offer herself and him interest and curiosity. My presence, voice, and interpretations seem more welcome, almost needed; I no longer feel like one of many 'out there' who interfere or must be avoided. I no longer feel her running away from me, as I do within the gestation phase. Alongside each other, we drift to places previously covered over, tightly reined, deeply uncomfortable.

In the months of my relationship with Helen, there are mere moments of encountering him, yet they seem to be the most weighty aspects of our work. They are where I feel able to meet her, to validate each tremble, to see the subtle texture and nuance of her story. In these small moments in time, I feel she shifts from *reporting her life* to *discovering life* (Bollas, 1987: 277). This discovering takes place within her and also within the space between us. In these moments of energy, we seem to be re-living something, but in new ways. As Bollas (1987: 278) notes, clients might 'live through for the first time elements of psychic life that have not been previously thought'. Helen's unborn baby is in a sense a form of the unthought known. He was known to her, at a bodily level, he was part of her. Yet he was unformed, unseen. He was held, but not holdable. He was developing, but not

developed. He is everything, yet nothing. One of Lovell's (1983a: 758) participants stated

> If you say to me: 'Stand up and tell me what you're about,' I'd stand up and say to you: '…what I'm about is stillbirth.' I feel it is the most important event in my life. And yet, it is a terrible nothingness.

In these words, and in Helen's words, I hear a woman who seems to dwell within the nothingness, yet her statements are a reaching out, a somethingness arising from a nothingness.

Yet there is much of Helen's story that perhaps can only be known and not thought. Loss is lived, not thought. Grief hangs about in one's body, not lending itself to 'making sense of'. Bollas (1987: 282) names somatic knowledge as not being thought but as how 'we somatically register our sense of a person; we "carry" their effect on our psyche-soma'. Helen carries her son within her and needs spaces to be able to come to (re)know him, in new ways. Willis (2009: 88) says that the 'revolutionary possibility of pain lies in rendering docile bodies into disruptive ones and one of the ways of amplifying this disruptive potential is through words'. I argue that within the process of counselling, Helen accesses discursive agency to work with what is marginalised, within the borders and edges. Her 'edge' from session thirty-one might indicate her need to expand, to (re)birth him. Gordon (2008: 195) acknowledges the difficulty as well as the need for 'imagining beyond the limits of what is already *understandable*', suggesting that 'something more' can be gained by attending to ghostly matters and hauntings. Allowing him to haunt us enables us to go beyond what we already 'know' or are aware of. Morrison (1994: 378) states that 'invisible things are not necessarily "not-there", that a void may be empty, but is not

a vacuum'. What is present is not the only way we feel and know; what is invisible or has a sense of nothingness is valid too. Gordon (2008: 17) notices how 'that which appears absent can be a seething presence'. Her loss of him as well as the invisibility of her early experiences are both present absences. Gordon (2008: 8) proposes that haunting is a way of knowing, as it 'draws us…into the structure of feeling of a reality we come to experience, not as cold knowledge, but as a transformative recognition'. It seems that when what was absent could be acknowledged and attended to, there is space for more life in our work. Symington and Symington (1996: 102) name that when therapists become aware of what was previously unrecognised within clients' material 'its meaning for the patient begins to grow'. He grows between us as we acknowledge his presence.

Parr, Stevenson, and Woolnough (2016: 67), studying families searching for a missing person, name the tension between hoping to find the person in the external world and a more internal attempt to hold this person in mind. Perhaps Helen could not find space for him 'out there' but is now able to find spaces for him 'in here'. Maddrell (2013) uses the term 'absence-presence' in an attempt to capture something of the paradox between the internal presence of someone who is externally absent. He is absent 'out there', and in many ways he is absent 'in here' as well, but there is potential for him to be more present, as taking up space within her.

The concept of a 'present absence' may partially include how an absence is felt so intensely that it feels almost present. Yet Maddrell (2013: 505) argues that absence-presence is not merely the consciousness of what is absent but rather the deceased having 'continuity of presence'. I argue that an important step in Helen's and my work is recognising his absence as significant, which then allows us to give

him form and presence. Maddrell (2013: 505) says that ‘the absent is evoked, made present, in and through enfolded blendings of the visual, material, haptic, aural, olfactory, emotional-affective and spiritual planes, prompting memories and invoking a literal sense of continued “presence”’. Within this threshold between us, in liminal spaces, he is evoked: in session twenty-eight as both the deformed and healthy baby, in session twenty-nine as the fragile yet protected baby, in subsequent sessions as the baby she can feel close to again. At the edges, within the sensory, creative, and intersubjective spaces between us, he is ever present and ever absent, and Helen and I sense into and (re)create his form within her.

Reflecting on her words from the conception phase to describe what she did when she lost him – ‘leaving my body’ – I think of her experience of him ‘leaving her body’. Has he left her? Frosh (2013: 14) puts forward an ethical and political imperative ‘to find ways to listen to…different forms of ghostliness, not only to put them to rest, but also to keep them alive’. When she says in session twenty-five that talking about him feels like she is giving her loss some ‘air’, I image her breathing life into her memory or sense of him – breathing life into this little boy who would have struggled to breathe. In moments like these I see how alive he still is, how she carries him within her and labours to keep him close to her. She becomes less surprised by or afraid to acknowledge that the ‘dead’ seems still so alive within her. Together, we become more in touch with ‘the living effects, seething and lingering, of what seems over and done with, the endings that are not over’ (Gordon, 2008: 195). We attend to that which struggles to find its position as dead/alive, absent/present, invisible/visible, imagined/real. There is ‘a reaching out, then a finding – finding a form to embody the inchoate striving’ (Wright, 2005: 530). He

can be more alive when she speaks about him. He is made viable within her. As she seems to release a long-held breath of silence, she is then able to breathe life into him, into being both with him and without him. Within her breaths, within her words, within the space between us, resides a liminal quality. I think of how he has left her body materially yet seems to float within her now. Frosh (2013: 167) suggests that '[i]f a spirit haunts, then it is not fully lost'; it is both dead and alive, absent and present. He has physically left her body, yet his presence will likely never leave her.

She expresses in session twenty-two that others' recognition of him would help her continue to find ways to remember him. As we cry together, Helen grabs a tissue and offers me one, which I accept. I see her embodying the responsive mother. Together we recognise the ongoing space he holds within her and ways she can spend time with him and feel closer to him. Klass, Silverman, and Nickman (1996) challenge the dominant view that bonds must be cut in order for grievers to move on and use the term 'continuing bonds' to recognise ongoing relationships with the deceased. Helen has a bond, an attachment to him. She knew him, carried him, had a relationship with him. She *still* has a relationship with him, as she recounts: looking at his picture on her phone, holding onto the teddy jumper, and spending time at his tree. Our work seems to support the view that 'death ends a life; it does not end a relationship' (Klass, 2006: 287). As she recognises how close she still feels to him, she acknowledges that losing what she never had is one of the most meaningful parts of her life.

6.3.3: Reconsidering grievability within labour

Butler (1997a) speaks of ways to unsettle current discourses, making way for new intelligibilities. Following Butler (1997a), Youdell (2006: 519) states that 'sedimented meanings of enduring and prevailing discourses might be unsettled and reinscribed; subordinate, disavowed or silenced discourses might be deployed in, and made meaningful in, contexts from which they have been barred'. My work with Helen seems to unsettle the discourses from 'out there' that were lodged within her. Similar to Butler's (2006: 7) charge to 'emerge from the [dominant] narrative perspective', I view counselling as a space where Helen and I can imagine, attempt to find, and practise other meanings and other possibilities. I see how valuable my imaginings and bodily sensations, from the conception, gestation, and labour phases, might have been in helping her start to (re)create him. Much of her narration was prospective, formative, and performative, allowing her to imagine what might have been.

Following on from theories claiming experience and subjects are produced by discourse (e.g. Butler, 1997b), I wonder if revisions can be made to previously-held views on pregnancy loss. Hearing Helen's stories unsettles familiar ways of thinking about pregnancy loss within me. The timeline for grieving and what it means to need to *keep* grieving might have fewer boundaries and what it means to have an ongoing relationship with the lost person might be opened up and rethought when ghosts are attended to. As Helen considers ending counselling, she says she is ready to be in her relationships in a different way; she speaks of depending on others again for emotional support and worrying less about their reactions to her. The churning pain inside of her now seems less stuck: whereas before it kept her silent, minimising and

dismissing her needs, now it is telling her that something within her needs attention. He needs her attention. I get the sense that she finds a way to have a grief response, no longer dimming it or trying to show others she has worked through her grief. Helen and I create spaces for both old and new stories to be told and witnessed. Rather than maintain what may have felt fixed, we open up space to wonder. We can move within this space, allowing for potential to think about what might not yet have been thought, to create new stories, or new spaces for stories, and to open new possibilities and potentials (Fee, 2010), allowing for different types of telling and listening. We push into what needed to be reconstructed.

Throughout our counselling process, we attempt to make her loss more tolerable, thinkable, and real. I argue that we do not fill an empty space but rather feel into the edges of this space, allowing her to hear old discourses in new ways, new ways of relating and knowing, and new possibilities within her. Meijer and Prins (1998: 281) quote Butler as stating that 'the unthinkable, the unlivable, the unintelligible…lives within discourse as the radically uninterrogated and as a shadowy contentless figure for something that is not yet made real'. When she talks about gazing at his picture in session twenty-three, I realise she is making him more 'real' within her. In session twenty-eight, when she acknowledges a shift in how 'real' her losses feel, perhaps she is allowing for and approaching a ghost, which is real for her. Acknowledging the gaping hole, she finds spaces to be with him.

Recognising a present absence or a ghost is a way of knowing, an epistemological questioning of intelligibilities. Gordon (2008: 69) promotes rethinking the distinctions drawn between 'what can be seen and what is in the shadows; what can be said and what is whispering inaudibly; what is true and what is

a lie; what is rational and what is magical; what is real and what is surreal; what is conscious and what is unconscious'. The seeming impossibility of both presence and absence, unseen by Helen's social world 'out there', finds space within the counselling room. She knows of her desires to have him no matter what, to still miss him both as he was and as he could never be. Yet this known is often not able to be thought 'out there'. Gordon (2008: 195) states that we must be willing to approach 'the intermingling of fact, fiction, and desire as it shapes us and the public knowledge we create'. Having a flexible, creative space in counselling perhaps prompts a more fluid intermingling of the fact, fiction, and desire that churns within Helen. Gordon (2008: 179) posits that the ghost will have desires and that we must recognise these desires by talking to the ghost. I argue that in counselling she is able to talk 'into' the ghost, coming to know him better, coming to find his form within her.

Martel (2013: 336) challenges discursive strategies that have focused on 'absence and emptiness' within reproductive loss, putting forward the notion of 'the becoming-unborn' as a 'fleshy, immanent, transcendent, nomadic subject'. This opens up possibilities and potential, 'bodies as in-transformation' (Martel, 2013: 342), rather than being dualistically either absent or present. Silver (2007: 425), while exploring her inability to conceive as well as her relationship with her mother, states that when we let ourselves engage with the subjectivity and creativity of the womb space, it 'enhances the capacity for understanding and accepting Otherness…in ways that challenge the arbitrary binary divides between self/other, living/inanimate, human/nonhuman'. The social norm of silence as well as the binary of either present or absent seem to influence Helen's ability to engage with her experience of the womb. Engaging in the process of counselling facilitates her

exploration of being in, in between, and around this space within her (Silver, 2007) which often previously seemed only empty. She is also in, in between, and around the spaces within me. These intersubjective spaces swell and expand her, expand her relationship to herself and to him.

New intelligibilities of intersubjectivity within pregnancy loss are needed. Butler (2001: 39) speaks of the intersubjectivity, susceptibility, vulnerability, beholdenness, and risk of being in relationship and how we are 'not precisely bounded, not precisely separate, but in our skins, given over, in each other's hands, at each other's mercy'. Church (1997: 94) names the possibility of 'different people owning a single human body' when we expand our thinking into degrees of and partial ownership. Wynn (2002: 5) suggests that the 'baby-in-the-womb bears the mother as much as the mother-to-be bears the baby', each shaping the other. There is a mirroring between the mother/pre-infant and what I experience with Helen within the counsellor/client relationship, just how intercorporeal and co-constituting our relationship is. This includes Helen's and my pains, the contractions, pushes, movements within our work.

I suggest that new intelligibilities are reached within our work, allowing for new ways of relating to loss, and to him in particular, in this labour phase. Working within the edges of her narrative attempts around loss, I keep checking on what we are creating together and notice how I bear him for a time, then we bear him together, and finally I feel her starting to more fully bear him. Struck by her just wanting him to be here in session twenty-eight, no matter what, I wonder if my sense of her carrying him, from session twenty, is coming to life, helping her to bear him into being. When the womb space between us is able to be used intersubjectively, we are

able to (re)create him. This is a new interpretation of working with pregnancy loss that considers both his aliveness and deadness within the intersubjective labour of coming to know him.

I argue that struggling together to sense him as both more absent and dead as well as more present and alive makes him more grievable. Within the labour phase, Helen seems to be allowing herself as well as me entrance and witness to what was previously her 'private and nameless torment' (Kluger-Bell, 1998: 125). As we recognise just how present he seems, how she carries him with her everywhere, we seem to be reminded how absent he is. It seems necessary to acknowledge his absence, to let the ghost remind us of the loss and unattainability. He asks her to turn inward and attend to being both with and without him, allowing her to mourn the lost baby. It is as if she buried him and now needs to revive him, rebirth him, bring him back to life, keep him alive. In her dream in session twenty-nine I hear her speaking of the baby in the box, and I wonder if she is keeping him and also herself alive. The baby is projected, safely contained, and can now be re-introjected within her. She has the ability to sustain the baby within the alive and dead spaces within her. She notices in session twenty-five how her losses, and then in session twenty-eight how he, no longer need to be boxed away within her. She enters the crypt, the memory box, and the lidded box, no longer needing to entomb her sense of him within her internal world.

Butler (2009: 51) says that norms of grievability differentiate ‘the cries we can hear from those we cannot, the sights we can see from those we cannot’. In moments when Helen responds to his cries - when she increasingly acknowledges him here, when she senses what it was like to feel him move inside of her and to

deliver him – he is more grievable. When she says 'I feel close to him', I feel us get closer to a painful hollowness, yet also sense into the fullness of these spaces. She is starting to have moments of being with him again, and I am more able to meet her empathically and feel my sense of him being alive and present increasing. As I witness her trying to (re)know his form, she seems to be experiencing an embodied knowing that he is a life worth living, worth preserving, worth mourning (Butler, 2009). She begins to be aware of how she is carrying him and can now use her body and mind to create him; she seems to access both her embodied experience of him as well as her imaginative experience of him.

Abraham and Torok (1994: 141) add to Freud's phrase 'the shadow of the object' that it 'strays endlessly about the crypt until it is finally reincarnated in the person of the subject'. Helen's ability to again feel close to him, within her body and her imagination, may be such a reincarnation, a coming to life again, as in session thirty-two when he is present between us, being bounced on her knee. Attending to how full we both are of him and how present he is within and between us allows Helen to both grieve him and get to know him anew. I consider our therapeutic work as a process of forming 'spaces' within her to find him, create her sense of him, and spend time with him again.

Her sense of coming to know the unborn, the unformed, is unrecognised 'out there'. The dreams, the ghosts, the liminal, the deformed, and the unthought stay hidden 'out there'. When her words 'This still matters' are spoken, I do not hear her previous complaint about not being received 'out there' but rather her telling him she will continue to bear him, just how intersubjective and co-constituting her

relationship with him will always be. I see her moving into more imaginative spaces within herself. She is joined with him again. He is alive and growing within her.

Carroll (2005: 92) states that as therapist and client develop their relationship 'the subtlety and complexity of their rhythmic exchange increases'. The 'rhythmic exchange' between Helen and myself includes my sensate experiences, where I perceive her/him within the womb-like space of the counselling room and relationship, and speaks of the kicking, the coming to be. The fetus moves and develops within the context of the rhythms of the womb. Wynn (2002) argues that pregnancy, rather than a viable birth, marks the beginning of intercorporeality, or 'bodily intervolvement'. I become aware here that in the pregnancy of counselling, I see, I hear, I feel the three of us trudging within this swamp, these murky waters of the womb that seems to exist between Helen and myself. I notice that the possible ontological significance of myself as a counsellor is as a witness for Helen with whom the partial co-creation of a sense of what was lost is possible. Within our work, I see how we create and co-parent her never born child.

She projects him into me in a surrogacy, he takes up residence within me. He is received and modified, allowing him to eventually be more carriable within her. He is re-introjected into her, as she comes to carry him and birth him anew within her. When she says she feels 'back with him' or 'close to him again', I feel I have carried him for a time so that she could feel him again, when she is ready. I am also holding her within the womb space of the counselling relationship until she is ready, as she says in session thirty-two, to 'pass through'. Wright (2005: 536) names the 'ongoing cycle of exchange – the echoes, mirrorings and recastings of affective states' leading to a containment which he describes as 'the cumulative result of

empathic passage through the other'. Helen resides within me and is passing through me. As she is able to birth him, I feel myself birthing her. She and he seem to be spilling out of me; perhaps this is the birth of her readiness to be with him, to be with him in the presence of the partner with whom she mentally conceives him.

I realise during session thirty-one that I need to find a way to say goodbye to him. Benjamin (1990) highlights the simultaneous connection and separation between two people when considering intersubjectivity. Connection implies eventual separation. I notice that I feel him less within me as I walk out of the counselling room after session thirty-one. He has mostly left me, is no longer within me in such a present way. I do not feel emptied of him, I just feel an absence of his insistence to be recognised. Helen has him back with her, she is carrying him again. I see her both mothering herself and mothering him within her.

Perhaps I need to feel his absence within me though, to more fully empathise with how absent he felt for her for so long. Within session thirty-two, I feel envy as I imagine her bouncing him on her knee in front of me and then bundling him up as she rises to leave. I feel the heartburn within this labour, this ache when Helen has him back, when I am no longer needed, feeling myself as the useless mother. There is creation and loss, love and hate in this work. And I imagine that before she walks out of the counselling room, she lets me hold him, saying 'We formed him together'. I will miss seeing them every week in this womb space we created together, yet I know the work within me has not ended. He will not cease to exist within me just as he will not cease to exist within her.

6.4: Conclusion

I use theory on intersubjectivity to consider what Helen and I create during the labour phase. I explore how we work with ghosts and present absences, those forgotten or never recognised presences 'out there'. Reflecting on how I carry her and him within me, I trace moments when she is increasingly ready to notice and carry him. I discuss how the womb-like space of our counselling work offers a labouring that makes (re)birth possible, allows her to imagine into and articulate what he might have been like, and facilitates ongoing bonds with him. I layer the concept of grievability with the labour phase of our work in order to think through how the intersubjectivity between Helen and myself pushes into new intelligibilities and ways of thinking about and working with pregnancy loss.

Chapter 7 Conclusion: *Grievability within the pregnancy of our therapeutic work*

My focus in this conclusion is to complete the case study by sharing segments from our last sessions. I briefly acknowledge the limits of therapy, but I also argue that therapy can be an opportunity for recognition. I summarise how my research contributes to the field of counselling as well as my personal development within this project.

Helen enters session thirty-three naming her decision to end counselling. She attends counselling for just short of nine months, for thirty-six sessions. Can she and I 'come to full term' within our work together? Is our pregnancy a success or failure? Should we create a birth announcement or a death announcement? How do we recognise both what is *coming into being* as well as the *end of life*?

Throughout our work, I implicitly offer Helen my view of 'working with' rather than 'working through' grief. I problematise coming to term and getting better, as grief defies categories and stages; it is 'slippery, episodic, repetitive. It lacks shape, or landmarks, clearly defined paths. It is a journey leading nowhere, a quest to solve the one problem that can never have a solution' (Jolly, 2015: 60). Is this enough for Helen? Initially, she speaks of being at the start of a swamp that she feels she has to move through. Her later reflections on her grief – 'I'm not sure I can change' and 'maybe it's not "fixable"' – seem to invite an on-going relationship to her loss, to him.

Helen may still be troubled by her loss, but now she is hearing from her ghost. Frosh (2013: 170) states that 'if a ghost keeps troubling us, it may mean that we have missed the point; but it may also mean that we are the only hope the ghost

has left'. Our work seems to offer Helen a familiarity with what might be unfinished, unformed, unknowable. While we work to make something within her more knowable, when I stand at the edges I see how the unknowability within this speaks loudly, how there is an always already absence. Her absent presences are acknowledged, rather than seeing them as 'problems to be solved, ghosts to be exorcised, and wounds to be healed' (Wyatt, Tamas, and Bondi, 2016: 38). She is left with a forever searching, longing. In our last session she describes a 'hole' in her life, one that she is desperate to fill but also aware of never being able to fill.

The complexities of grieving may include these holes, unknowables, and ghosts. I see grievability not just as being 'accorded a "right to grieve"' (Doka, 2002: 5). Counselling may offer a chance at enfranchisement of grief, yet I suggest this chance needs to move beyond recognition as a permission to grieve. Throughout my work with Helen, I realise my primary therapeutic task is to offer her a different type of recognition, one that attends to her multiple losses as well as my own counter-transference experience of being with her, both of which involve the very present absence of ghosts.

Helen has multiple losses that need to be recognised and grieved. Enfranchisement of grief is often neither straightforward nor solely about the loss that brought one to counselling. For many women, pregnancy losses can 'highlight the precariousness and pre-existing unreliability of their internal objects' (Quagliata, 2013: 20). There are many precarious aspects within Helen, ghosts of him, herself as a baby, herself as mother, her own mother, and her father, that need to be explored in order to facilitate grievability. As a result of losing a desired object and/or through transgenerational influences, psychic concealment or entombment may occur,

leaving one with unspeakable secrets (Abraham and Torok, 1994). Pairing Abraham and Torok's (1994) position that the crypt can be unlocked when the entombed experience is acknowledged with Doka's (1999; 2002) concept of disenfranchised grief, I argue that when multiple losses are acknowledged, when ghosts are seen as present absences, they can more fully be grieved. When Helen allows me to witness and experience something of the many losses within her, what secretly inhabited her is made more sensible – and more thinkable, speakable, hearable, visible, feel-able, grievable.

In addition, the recognition found within the transference and counter-transference in our work allows Helen to have a therapeutic experience that enables her grieving. When I can access my reluctance, struggle, and own losses within the transference and counter-transference, I notice the transformational potential throughout our work. Within the context of a therapeutic relationship, I creatively engage with Helen's and my process(es), where I make myself available to feel something of Helen's distress. I take up Butler's (2009) charge to respond affectively. The response I give is to not shy away from my palpable and unsettling counter-transferential experiences with Helen. When both client and therapist can put some of their primitive longings into words, then 'working through of the loving and hateful aspects of the maternal erotic transference and countertransference duet can begin' (Wrye, 1996: 85). As a therapist, I need to allow both my love and my hate into the work. Much of this project is about coming to better understand the work I do to make Helen's and my distress tolerable, and to allow myself to notice the times I am reluctant to take her in. This is learning for me as both a practitioner and more personally, where I realise that I exclude so much of myself and my

experience when I act only as the loving, ideal mother. The empathic, receptive, and imaginative spaces within me are more effectively used by clients when I engage with the shadowy parts as well.

Returning to my initial curiosity of my experience working therapeutically with pregnancy loss, I now am able to speak back to other researchers engaging with this topic. In line with Lovell (1983a), Whiteford and Gonzalez (1995), and Martel (2013), I create a challenge to medical norms of hiding loss and failure, illustrating how we might find spaces for experiences located on the edges of socially dominant grieving rules. This adds to the conversation among other health professionals, such as Patterson, Begley, and Nolan (2016), who also value experience-near accounts and strive to develop both sensitive and creative ways of working with pregnancy loss. My work complements that of Murphy and Merrell (2009), offering an example of how I work with the liminality they notice within pregnancy loss. In addition, my work extends many health practitioners' suggestions to offer reflective self-awareness to clients (e.g. Price, 2008) into a full exploratory case study. Unlike many medicalised studies, I use theory to think with my client work material but not as an intervention for grief resolution. This sheds new light on how some practitioners might experience their clients and themselves within work around pregnancy loss.

Coinciding with work by Malacrida (1999) and Lang et al (2011) around the silence within social domains after pregnancy loss, my case study offers an example of how therapy can provide a form of recognition. I validate the bond one might have with their unborn child, as much research shows, as well as contribute to the conversation about what it means to have ongoing bonds. My thesis also adds to

Lovell's (1983a: 759) critique of a 'hierarchy of sadness', validating the right to grieve all losses and demonstrating ways I join clients in their grief. I bring pregnancy loss out of the silence by revealing not only my client's terror, but also my own. Creating something together through the affective responses of client and counsellor adds to current scholarship, showing how in listening to and feeling with, I enter the struggle to narrate loss.

As I demonstrate in my literature review, many therapists talk about pregnancy loss in a relational way, yet back away. While reading such literature, I find myself wondering if some therapists are skilled at acknowledging the value of using themselves within this work but find that approaching pregnancy loss evokes something within them they would rather keep hidden, silent, at least within the literature. Leon's (1990) invocation for therapists to demonstrate emotional responsiveness provides me with a language to conceptualise what I feel is missing from current scholarship. My work extends writing by therapists, such as Kluger-Bell (1998), who share their therapeutic responses but withhold emotional responses. Writing such as Quagliata's (2013) offers theoretical insight and is useful for delving into my experience of listening therapeutically to pregnancy loss. As much as many practitioner researchers offer new insights into working with pregnancy loss, their process within their published work is often absent. While no published work does not necessarily imply that therapists are not reflecting deeply on their work, I wonder about the untold stories implicit within the literature, finding myself longing for other researchers to join me in sharing their imaginings into their work. Therapeutic engagement with pregnancy loss is hard work, yet to exclude sharing of this layer may be another aspect of disenfranchisement to the experience of losing an unborn

child. This study sheds new light on an experience of enfranchisement and recognition.

Reflecting on Miller's (1999) work and her inclusion, albeit brief, of her shock and tears within client work, I feel validated in my search for increased understanding of what it might mean to respond to pregnancy loss. While much of the literature responds by sharing client-focused or theoretical accounts (e.g. Lloyd Jones, 2015), my work exemplifies and illuminates my use of self as a therapist. This study complements how Mahone (2015) responds in a personal way to clients, however I make use of myself by engaging with a different methodology and theoretical orientation. Through reflecting on psychodynamic theories, alongside writing as inquiry, I make use of my embodied sense of working with pregnancy loss. My exploratory work fills gaps by engaging with aspects other researchers touch on but do not develop, for example, the 'fantasy child' that Tonkin (2012) notices within her work as well as Rich's (1999) observation of how old losses can be revived within some therapists. Using my counter-transference as a source of information within the work brings to life the call that many therapists, including Raphael-Leff (2000) and Cosgrove (2004), make but don't reveal and contributes new understandings of working with pregnancy loss therapeutically.

Therapeutic listening and recognition may include affective struggle to make narrative attempts amongst hearing from our ghosts. Working with women who experience pregnancy loss is powerful and re-awakens my own losses and ghosts. To acknowledge that my ghosts are present and to risk engaging with my and Helen's ghosts offers her a different experience, a new intelligibility. Butler (2009: 162) considers how we might 'expand our existing frameworks or allow them to be

interrupted by new vocabularies', moving us towards new intelligibilities. I view new intelligibilities for Helen as the expanding of potential spaces. I suggest that this expanding not be viewed necessarily as progress, getting better, or even growth but rather as potential for something new to arise, form, or come to life. Helen and I work to recognise just how 'worthy of being mourned' (Butler, 2009: 53) her many losses are. We perceive and receive her losses as grievable, speaking and feeling her grief into being. Movement towards 'hearing beyond what we are able to hear' and 'being open to narration that decenters' us from the dominant discourse (Butler, 2006: 18) seems possible in my work with Helen. Our work offers a questioning and a pushing against the limits of what we can know, hear, see, and sense in both the narrating and the listening.

Perhaps much therapeutic narrating and listening is gestational in that therapist and client might create something together. My conception and gestation with Helen, and my feeling and thinking into what might have been happening between us, could be seen as ordinary phases within some therapeutic work. My contribution to the literature is how my counter-transferential pregnancy enables further work around her need to mother and be mothered. The maternal relationship that emerges within the conception phase, where I struggle to take in and contain her, develops further through the counter-transference within the gestation phase, offering access to something of the unthought known. I also act as a surrogate mother to him – which begins in the conception phase and then re-emerges in the labour phase – attending to him while she puts her attention on her own early experiences. Once she is ready to receive him back, there is potential to intersubjectively (re)create and (re)birth him, and she seems able to increasingly mother both herself and him.

This research speaks into my experience of an embodied, relational, and reflexive counselling relationship. Exploring the spaces between and within us, I suggest that our counselling work becomes a kind of pregnancy, allowing for an imaginative and creative space to create and articulate. Through analysis of theory as well as my client work, I formulate the concept of a counter-transferential pregnancy, which incorporates my views as a therapist on imagining into losses in ways that are seldom done in current scholarship. While these are Helen's and my hauntings – they are particular to our relationship – my exploration of our work may offer a different frame of intelligibility for some therapists working with pregnancy loss. Clients who have experienced a pregnancy loss need a different kind of recognition and response. I suggest that a form of enfranchisement is not just in the narrating of women's experiences of pregnancy loss, but also in the narrating of counsellors' experiences of witnessing pregnancy loss. As I push into potential spaces within Helen and myself, as I listen at the edges, I offer an example of how counselling makes one client's pregnancy loss more grievable.

Within both my writing and my counselling work I conceive, gestate, and labour, coming to know more about my clients, their ghosts, and myself. I have come to recognise meaning that waits within me, waits to be processed, both during and after client work. Symington and Symington (1996) name that containing and being contained can be a growthful experience for both baby and mother, and by implication, both client and therapist. What was deformed, or unformable, takes some form within me and will continue to do so. Helen and her son will never leave me, be 'out' of me. They linger within me, recognised as both absent and present.

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