Coming into Form: The Unique Experiences of Practicing Prenatal and Perinatal Therapists

Patricia Lucas

Abstract: This article presents the results and discussion portions of the author's dissertation research (submitted in 2009 to the Santa Barbara Graduate Institute) that are relevant to the conversations centered in attribute development of PPN professionals. The author's dissertation, *Prenatal and Perinatal Therapists' Experiences of the Psycho-therapeutic Alliance: A Mixed Method Exploration*, investigated prenatal and perinatal therapists' experiences of practicing therapy, exploring the unique and common areas of what it is to specialize in this therapeutic modality. Key themes emerged as a result of this doctoral research. By reviewing the findings of this research, the reader will gain greater insight in what are shared experiences in this specialized practice as well as provide a grounding structure to spark further discussion and inquiry that supports the continuing embodiment of the field of prenatal and perinatal psychology.

Keywords: prenatal and perinatal psychology, prenatal and perinatal therapy, mixed-method research

Recently, the field of prenatal and perinatal psychology (PPN) has had both significant endings and new beginnings in its process of expansion and growth. With the death of one the field's preeminent experts, David Chamberlain, and the launching of a new certification program by APPPAH, a surge of energy seems to be taking place within the community of practitioners. Conversations and gatherings about who we are as prenatal and perinatal educators, therapists, and specialists are occurring everywhere and joining us together across the globe. The larger community of psychology experts within which our field embeds is developing a growing interest and awareness of the significance our earliest experiences. More funding is now being dedicated to prenatal and perinatal psychophysiological research. Studies directly relevant to the field are popping up in mainstream media coverage. Many of these studies support and enhance the foundational premises held in the PPN field.

This article presents the results and discussion portions of the author's dissertation research (submitted in 2009 to the Santa Barbara Graduate Institute) that are relevant to the conversations centered on attribute development of PPN professionals. This dissertation, *Prenatal and Perinatal Therapists' Experiences of the Psycho-therapeutic Alliance: A Mixed Method Exploration* (Lucas, 2009), investigated prenatal and perinatal therapists' experiences of practicing therapy, exploring the unique and common areas of what it is to specialize in this therapeutic modality. Key themes emerged as a result of this doctoral research. By reviewing the findings of this research, the reader will gain greater insight in what are shared experiences in this specialized practice as well as provide a grounding structure to spark further discussion and inquiry that supports the continuing embodiment of the field of prenatal and perinatal psychology.

Scientific research has continued to grow exponentially in important areas relevant to the prenatal and perinatal psychology since this dissertation was submitted five years ago. Areas such as affective neuroscience, interpersonal neurobiology, psychophysiology, and developmental psychology have contributed a great deal of research. Though this dissertation included an extensive review of still relevant research, much has been added since 2009.

Mixed-Method Design and Rationale

A brief review of the methodology is presented here to orient the reader to the main content, which focuses on the results and discussion sections of the dissertation. Mixed method, sequential design was used conduct the research. By beginning with the qualitative portion of this study, the understanding of the research is deepened. The meaning of the therapeutic relationship for prenatal and perinatal therapists was explored through in-depth interviews with four expert practicing therapists. This therapeutic relationship is often referred to as the "therapeutic alliance." General themes were articulated through detailed phenomenological analysis. These themes were then used

to further expand upon the topic of this study through the use of a quantitative survey developed from the qualitative findings.

The quantitative method used in the study was included to enrich and expand the findings. In this portion of the study, a survey was created containing descriptive and relational questions that provided an opportunity to reach a greater number of participants with the economy of a more succinct data collection (Creswell, 2003; Onwuegbuzie & Leech, 2006). PPN therapists who were included came almost exclusively from the membership directories of APPPAH and ISPPM (International Society for Prenatal and Perinatal Psychology and Medicine). Through an initial survey, a pool of 53 qualified practitioners emerged. Twenty-one of these people chose to participate in the quantitative portion of the study. Of the initial group, 19 completed the survey.

The sequential mixed methodology chosen prioritizes the phenomenological, qualitative branch of design and is exploratory in its objective. The focus in the research is in the "lived experiences" of prenatal and perinatal therapists, the basis for phenomenological research. Quantitative methods (survey) were used as a supportive measure to enhance the meaning provided by a predominantly qualitative research question.

Participants

The choice of participants for the two methodological branches employed the use of purposeful sampling. For the qualitative portion, the selection of participants was based on finding therapists so well practiced in the art of prenatal and perinatal psychology, that they have achieved a level of mastery (Moutstakas, 1994; Taylor & Bogdan, 1984). The selection of participants for the quantitative section involved similar criteria. However, practitioners researched in the quantitative section did not require as many years of experience, nor did they have to have seen as many clients in their practices.

Four expert prenatal and perinatal psychotherapist/healers were interviewed for the qualitative portion of the study. The criteria were that they work as prenatal and perinatal therapists, have seen at least two hundred clients for prenatal and perinatal therapy, and have practiced for at least 10 years. Each of these participants had seen hundreds and sometimes thousands of clients in their career.

Participant one is a female practitioner, educator, author, researcher, consultant, and program developer who has been working with families and professionals for over thirty years. Participant two is a female prenatal psychologist who has been in practice for about twenty-one years. Participant three is a male therapist who has been practicing therapy for 37 years. Participant four is a female psychotherapist who has been practicing for over 30 years.

The quantitative participants selected had seen at least 35 clients and were either currently practicing or had not been out of practice for more than three years.

Data Analysis

In a sequential, exploratory mixed method design, data analysis occurs in a specific order (Creswell, 2003; Collins, Onwuegbuzie, & Sutton, 2006). The first phase in this study was the qualitative portion. This analysis was completed in order to develop the second, quantitative phase, which was developed from the results of the first phase of analysis. A third and final stage of analysis occurred after both the qualitative and quantitative pieces were completed. The third stage of analysis of this study was a combination of the themes that arose in the first two phases. For a complete description of the data analysis, please refer to the full dissertation (Lucas, 2009).

Presentation of Qualitative and Quantitative Data

The quantitative data collected from the survey will be directly described in the "Discussion" section of this review, where the meaning of the themes that arose in the work are also illuminated.

This presentation is consistent with the spirit of the research, which utilized the quantitative portion to enhance the dominant phenomenological approach.

Quantitative Data

The quantitative data from the second half of this research was derived from 19 respondents of a total of 53 surveys received from May 5, 2008 through June 24, 2008. The purpose of including a survey in this mixed method research approach was to enhance the thematic findings of the dominant qualitative data. Designed as a Likert-type rating scale, every participant's response to each individual question has been weighted with a rating value.

The following chart gives an illustration of the percentages and rating average for how each theme was covered. Questions differed according to theme. A seventh theme, entitled "Methods" was added in the discussion section to further enhance the scope of the research question.

Table 1: *Theme One*

Questions	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	Rating Average
1. My own pre and perinatal healing has been important but not essential toward providing a successful therapeutic relationship	15.8% (3)	52.6%(10)	5.3%(1)	10.5% (2)	15.8% (3)	2.58
2. My own unresolved pre and perinatal history has not impacted my ability to therapeutically relate to clients.	0.0% (0)	26.3%(5)	10.5%(2)	47.4% (9)	15.8% (3)	3.53
3. My conscious awareness that pre and perinatal life shapes core psychological patterns enhance my empathetic connection to clients.	73.7%(14)	26.3%(5)	0.0% (0)	0.0% (0)	0.0% (0)	1.26

Qualitative Data

The general themes presented here are derived from the extensive and careful hermeneutic analysis of qualitative data that consisted of four interview transcripts, observational notes, and theoretical notes. Though the themes are presented in no particular order, they do follow a phenomenological structure, where the order is taken from verbatim quotes of individual units of meaning in individually structured descriptions of each of the participants. This creates an interconnected structure, where the parts are contained within the whole (Churchill, 2006).

The qualitative analysis revealed six major themes that characterized the therapists' experiences of their therapeutic alliance. Only the illustrations of the general themes are presented here. The general themes presented are: (a) Early Experiences as Foundational, (b) The Therapeutic Alliance as Enlivening, (c) The Experience of the Spiritual as Profound and Sacred, (d) Multidimensional, (e) Beingness is the Ground for Doingness, and (f) The Lived Experience as Teacher.

Theme One: Early Experiences as Foundational. Each of the four participants spoke about the early experiences in their lives that helped to shape their current experience of the therapeutic alliance. With the exception of participant one, who reflected on her early experiences in a mostly chronological order, their descriptions occurred organically throughout the interviews. Two distinguishing subcategories emerged from within the theme of Early Experiences as Foundational.

They were: 1) Training for therapeutic skills and 2) Prenatal and perinatal therapy as personally transformational.

Training for Therapeutic Skills. The participants in the interview portion of this study all made connections with how their early life events contributed to the development of the skills they used and the presence they bring to their work. For participant one, early training as a marriage and family therapist helped her to develop her own self-awareness in the therapy session:

> I was working with adults as an MFT and still we learned a lot of therapeutic skills and a lot of "being" skills. I had five years of intensive training, two times a week. That was my internship, plus my personal therapy for five years was adult therapy. So during that time I really started listening to myself; how I feel, what I believe, what I'm thinking, and being more present in my body and myself, much more close to mutual process where I'm paying attention to both of us in the relationship and in between.

Participant one also contrasted her experiences of developing awareness of the present moment with her previous training to be an obstetrics nurse. She expressed that her early training both contributed to her current skills and provided experiences that taught her to grow. Her decision to let go of much of her early training and begin again in her approach to prenatal and perinatal therapy is an experience other participants shared and is presented in the theme, The Lived Experience as Teacher. Participant three stated that this was the first time he had publicly shared experiences around death, explaining how his early trauma led to him to feel there is "no death." This participant's "near death" experience helped him develop the ability to communicate with what he refers to as "people who have died," giving this participant a "multidimensional" awareness of the human condition that he brings into the therapeutic relationship.

The experience of viewing one's early life as contributing to one's professional expertise was also described by participant four:

> I was a PE teacher, a dance teacher, a hockey player, and a gymnast, and I just really loved that physical aspect of life. Then I had an accident which took me out of active participation. I was going to an England International team; I couldn't because I had a knee injury and then I went on to do counseling. So, I had the body work, I trained as a counselor, but then at the age of 27, I decided to go into religious life because I became a Catholic when I was 21.

Participant four expressed feeling challenged by her early experiences though they ultimately helped her to become the therapist she is today. Participant two also felt challenged by her early experiences and expressed what she learned that she brings to her current therapeutic relationships. Though not always in a clear and pain-free way, the participants in the qualitative section of this study expressed a connection between their early life and the skills and experience they bring to the prenatal and perinatal therapeutic alliance today. They traced their paths from the past to the present moment to illustrate what has gone into this alliance from a lifetime of lived experience.

Prenatal and perinatal therapy as personally transformational. Looking further into the theme of early foundational experiences, each participant spoke to some degree about their own encounters with prenatal and perinatal issues. Participant two simply stated, "In the first sessions, my world opened up, and I went back several times to discuss." When she discovered prenatal and perinatal therapy, she found it so transformational she altered her choice to become a doctor of homeopathy to pursue her current work as a prenatal and perinatal therapist.

Participant four spoke about being a forceps birth, "in a way [this reflects] my forceps birth, it has to be pulled out of me, which is what you're doing, you're pulling the information out of me." Her forceps birth profoundly shaped how she moves in the world and she states that she is "still learning to cope with my life script." Like participant three, the experiences this participant had in her exploration of her early life through prenatal and perinatal therapy are still a part of her ongoing healing process. She is aware of them and they contribute to her understanding of others who may be dealing with similar issues in the therapeutic relationship.

Participant one spoke the most in-depth about how her previous experiences with prenatal and perinatal therapy helped to shape her current practice of the therapeutic relationship, describing her

experiences of prenatal and perinatal therapy as deeply transformational and formative in her own present work:

> I am in the moment as I go through these lived experiences with people who are dealing with their birth or their prenatal period and they are coming from Spirit and first hitting that human field of experiences. So, for me, one of the most important treasures was my own experiences of that territory with not only having the felt sense of some of them but having the healing of them so that as if my holographic field, who I am, and that my lived experience is my holographic being.

A seemingly contradictory perspective participant four had regarding her early experiences gave her a foundation for her current work is expressed in these quotes:

> So, some of the things that I'm going to say I believe aren't necessary even though I highly value them, (pause), meaning, I have these things that I value, like having these experiences of our own early experiences, like our being able to have a self-sense of our field of experiences as they come in line, then I go and see people who are working extremely effectively with people using some of the energy psychology techniques, who don't have any of that.

Even though she holds her own integration of her early prenatal and perinatal trauma to be highly informative to her work, she states it is not necessarily required for therapists who are assisting others in their healing processes. She remains in the question about the truth of this assertion for herself and cautions that the field of prenatal and perinatal psychology may be incorrect in its "assumptions" regarding the necessity of having consciously worked on one's own early trauma to be able to effectively witness others.

This statement by participant one is contrasted by statements made by the other participants about needing to heal their own issues to be able to effectively help others. For example, participant four states, "You can't do this work unless you've done your own personal work" and participant two says, "a direct mission in therapy is the most important thing that needs to be changed, myself first, as I said before, to inspire the client because otherwise their blocks are my blocks. I believe in that exchange of energy." Participant three made strong statements about seeing all his clients as some reflection, "about myself, that I need to look at. And, it continues to happen." Participant one's perspective differed from the other participants in that her experience was that she witnessed healing occurring in a therapeutic relationship where the therapist/healer did not have conscious awareness of his or her own potential early trauma or blocks.

The point where all the research data does appear to converge in agreement, however, is with regard to the need for there to be a "present moment," "here and now" clarity necessary for healing to occur. Early experiences, as described by all four participants, provide the foundational beginnings for their experiences of the therapeutic alliance today. These early experiences have deeply influenced the development of therapeutic skills. In addition, the participants' own personal experiences with prenatal and perinatal therapy have significantly contributed to how they understand the meaning of the prenatal and perinatal therapeutic relationships they create.

Theme Two: The Therapeutic Alliance as Enlivening. Three of the four participants spoke repeatedly about their work as prenatal and perinatal therapists, and the therapeutic relationship specifically, as being enriching, filled with joy and excitement, and enlivening. Participant three expressed the satisfying nature of the alliance with these words, "When I'm inviting someone to receive answers from their whole self, I'm also working with my whole self so, [my co-worker] and I, who are doing this work, are never depleted, no matter how long the session is." Describing the therapeutic relationships with clients as being energizing and not depleting because the therapist is present with the client as his or her whole self, is also reflected on by Participant one, in these words: "My therapeutic alliance is [what] I'm really paying attention to, and I'm living, and that's what is so joyful for me, because when I'm doing this, I'm hooking up with the most of who I am. The fullest spectrum of who I am while I'm trying to connect with other people at the most of who they are."

Participant three also spoke about a way of conducting a session with a "whole self" kind of presence that leads to the experience as being energizing: "I would work for 5, 10, 12, 14 hours in one session. People were finished with the therapy. And then they would say are you must be exhausted and I would say, 'no, I'm completely energized because I'm not working with my personality.'"

Participant four communicated her description of the therapeutic alliance as enlivening because it gave her the opportunity to grow herself. She also expressed her awe and gratitude for being able to witness the incredible adaptability to people "overcome trauma." She states, "You know, I just want to be with people. Umm, I love the work and this is exciting. It has so much meaning for the future of humanity." and "This work enriches me as a person. I learn from every client that I work with."

Participant four also expressed the feeling of being enlivened in the therapeutic alliance as an experience of love: "I haven't mentioned that, I love life, I love people, I love this work and I think that the word "love," when people know that you love them, it comes through in a way….they know that, yes, this person cares for me, they want to help me because it is love."

No participants expressed a feeling of regret, depletion, or sorrow in their descriptions of their work lives and experiences of the therapeutic alliance. Rather, each participant reported a feeling of "awe" or "profoundness" or "destiny" in having spent many years as practicing prenatal and perinatal therapists. Each expressed in some way, a deep appreciation for the "journey,"

Theme Three: The Experience of the Spiritual as Profound and Sacred. The topic of the spiritual aspects of being with people in the prenatal and perinatal therapeutic alliance was brought up by participants in each interview in the qualitative portion of this study. Being witness to the spiritual aspects of being human was described by all participants to be very moving, profound, and stirring a sense of awe. Participant two described the theme this way, "I experience in the physical, I'm present of course at the emotional and mental and I feel that the spiritual is also present as I'm working with people, it's a holy experience without being religious or… it is intimate, with borders." She emphasizes that, in the relationship, she has a greater sense of herself and the client, beyond the physical, emotional, and mental: "That's my experience over time. Most of the mental stuff, so to say, is living in the physical body, when we relate to spiritual aspects, there is no judgment, there is no time, there is no death, that's really where peace and understanding leads to." She calls this experience "holy" and points out that it is not associated with the dogma of organized religion, but rather emerges from within the person.

The feeling of awe in being present with clients dealing with prenatal and perinatal issues is an aspect of encountering the spiritual in the work found in all four interviews. Participant three speaks about the experience of being with clients who have felt a lifetime of pain associated with prenatal trauma. He stated, "people would open their eyes and say, the feeling that mother had was a trauma, the feeling I've had my whole life, it's why I've been in therapy for x number of years. That's so sacred and so profound."

Participant four described a similar sense of the profundity of being witness to the healing of core traumas: "The one thing that really stays with me is the sense of awe, at the expense of the human ability to overcome traumas. Another word for it, it's the endurance. The human spirit endures. It's the strength of human spirit to survive. If my clients can survive some of the terrible things that I have to go through with them then I can survive anything too."

This participant was inspired by the resilience of the spiritual aspects of being human. She describes being "humbled in being given the gift to do this work."

The embodiment of the spirit, the sense of spirit being an essential part of the human experience, and the feeling of the sacredness associated with the healing of the spiritual aspects of prenatal and perinatal trauma, were all a part of every interview. There was a deep sense of respect expressed by all participants for what participant four describes as a feeling of exceeding "the limits of my humanness." The multidimensionality that is touched upon in all the participants' conversations about the spiritual aspects of the prenatal and perinatal alliance is the topic of the subsequent theme.

Theme Four: Multidimensional. All but one participant used the word "multidimensional" to describe their experiences of the prenatal and perinatal therapeutic alliance. For all participants, there was an emphasis on how the more they could bring of their full or "whole" selves to the therapeutic relationship, the more healing and enriching their experiences were for them. One way this particular theme was communicated was through conversations about how some aspect of human existence continues on after death. The healing insight of getting in touch with the multidimensional nature of life, as the above quote illustrates, is also described by participant one:

> As we come in we're resonating with the whole of the person, not just their conscious level, or subconscious or unconscious, I believe we're resonating and experiencing them at all these levels. The more enlivened all those levels are, are connected in a coherent, holographic experience, that resonance, that field of energy, helps that other being connect up within themselves. That's why that's the most therapeutic.

Interview participants were humbled and enriched by the opportunity to be with people who are accessing and healing aspects of their existence at such multilayered levels. For participant four especially, these experiences have given a sense of "knowing that there is something beyond this life too."

The characteristic of limitlessness is associated with what it means to be human in the participants' descriptions of multidimensionality of life found through the therapeutic relationship. For example participant four spoke about it this way:

> I'm in this world, but I'm not of it, and I think that's where we all are, we're in this world but we actually are not of it. (pause) I think that's where we all are. I absolutely… one of the things abortion does, it's given me a tremendous belief in the after-life, whatever that might be…It's multidimensional.

The topic of abortion is also spoken about by participant three as an issue that arises in prenatal and perinatal therapy that has given him a sense of the many dimensions of life:

> This is very interesting because I have written a paper on abortion and one of the things that we have found, back in the 60s, was that in moving into prenatal psychology, occasionally when someone had known there had been an abortion earlier in their mother's life before their conception, that the client is…what we discovered was that sometimes the same child, the same soul comes back to that same mother.

This participant goes on to say: "A child can even have the memory of being aborted but there is no death, see that's the key. We are in such a huge multi-dimensional cosmos."

Participant two talked about the guidance she provides for her clients to release the "blocks" that keep them from being present with who they fully are and re-claiming what she calls their "initial power." For her also, this is connected to the fact that there is no death, "I often think that time is just relative; there is no time frame so maybe all the human beings may live a few months, a few years, and yes, [inaudible], there's no judgment about it, people fulfilling their life purpose."

The multidimensionality of life is what all participants express both embodying and holding a continual intention to embody in the therapeutic relationship. Participant one spoke most extensively about this phenomenon:

> So, for me, truly therapeutic alliance is multidimensional and it is holographic, I cannot separate out even though I can look at a sliver, but what I am always asking to have is to be as conscious as I can, which means as conscious as I can, I also value unconscious, subconscious, I value nonlocal, verbal information, my divine work, my intuitive perception which is out of the nonlocal field, my energetic information that I'm getting, along with my more dramatic emotional, mental, usual, way of relating at a consciousness level, of a human to human, gestural, talking level, all of that, you know.

Many times in her interview, this participant described the experience of herself as multidimensional as she reflected on the prenatal and perinatal therapy alliance. As participant two expressed, there is a quality of no space and time, and a cohesive experience of the whole self that

cannot be truly divided into pieces to keep the meaning of her experience true. She describes her early feelings of her multidimensionality this way:

> It was [during] that early time that I would often say I feel like I just entered the dream time, like the Aborigine dream time, I didn't have words to how to express my self-sense experience of the alliances and my experience of being with a little kid when they would be touching these experiences. I would feel as if time and space got more fluid, they literally, the space in the room would feel full of something.

Connected to the theme of the multidimensional nature of humanity is a quality of beingness. The multidimensional nature of oneself is described as a kind of "who I am" statement rather than "what I do." This quality of presence associated with the participants' descriptions of the many layers of human life is presented as its own theme in the following section.

Theme Five: Beingness is the Ground for Doingness. The theme of the quality of beingness as the source from which doingness arises runs as a constant current of understanding throughout the qualitative data researched for this study. This is simply expressed by participant four who, in describing how she works with clients states, "It is so who I am." The subject of "how I am being" as opposed to "what I am doing" comes up again and again in the interview transcripts. Participant four shared:

> In so many ways, it's fields of enlivened beingness that replace doingness, as a foundation of a therapeutic alliance. I'm sure we're doing, all the time, only the doing is totally on top of the foundation of beingness in the therapeutic alliance, when we do this as therapists, not only are we the most therapeutic, but that's where we have the most enlivened experience.

Participant one contrasts her current experience with one she had earlier in her career to draw out the uniqueness of the beingness quality she brings to the alliance in these words, "I would call therapeutic alliances way back then were very much at a doing, teaching level. And, very much, at a physical level of being, physical/emotional. And it was very much doing a skill."

In her description of how she currently works, she stated:

> For instance, I'll get a picture and I'll get - not a picture - I don't usually get pictures, I'll get a felt sense of a frequency, a felt sense of a field, and sometimes I'll get an image or a memory with that, possibly a memory with that, it's just a felt sense just an anesthesia field or a howl of loneliness field, or something like that.

Boundaries. Learning how to bring a quality of presence to the therapeutic relationship is often expressed as a process of negotiating boundaries by other participants as well. Participant one stated:

> So, from the beginning I think one of the skills that I very much value is how do we bring our Self more into a neutral witness where we're receptive as if we're receptive to what's coming up for us, receptive for what's going on for other people, but there is also this other part of us who is the neutral witness who can hold all of it. And for me, that becomes a central part of the therapeutic alliance

The skill that is necessary to hold the boundary with prenatal and perinatal issues is described as challenging. Participant four stated:

> You know I'm a pioneer in this work and I can get stretched too far and one of the boundaries I've learned is that I have to know when to stop. I have to know when to stop working on myself and that is because I can over-reach with the skills I have. I've done so much work on myself and I believe that this is work that is done at such a deep level, that it brings out the tension in people that they have to learn to handle and this may be a point that's missed.

The "tension" that this participant refers to was also brought up in participant one's description of her personal challenges with holding boundaries with prenatal and perinatal therapeutic work:

> One of the biggest challenges for pre and perinatal [practitioners], especially with the earliest of materials is the field gets more and more, especially around conception and that whole period, the fields of experience can get boundless, without boundaries, and there's a whole lived sense of that, a skill level to work with that and still stay present as a therapist, here and now, as well as be in therapeutic alliance with them.

Intention to be open and receptive. One way these expert therapists/healers described being able to stay present with their beingness is to set an intention to be open, receptive, and aware. Participant four expressed her intention to be fully present and honest with whom she is this way:

> So, again, in that development of myself I have to know who I am, I have to know where I'm coming from, I have to know the difference between telling the truth always, and being the opposite of that. Just being with someone and going along with them because that's where they are. No, I can't do that.

Intending a quality of presence that is open, receptive, and honest is a critical part of these therapists' experiences of the alliance. Participant one expressed this eloquently:

> I set the intention to be open to perceiving and receiving those stories. Then, I would actually have the experience of being in the presence and in a relationship with a child doing this, and I would feel this, and I would have this felt sense of being in relationship and being present when that material was up. I don't know, it's something in me, that I know, I feel, I can catch what's going on with that person, and, like any counselor, I go along with them. I go along with where they are.

Though she describes her ability to connect by bringing her presence, "you know, up in that third eye" to the alliance as a gift she has, this participant also recognizes this experience has been cultivated from the years of her own personal self-examination.

Empathy. Another aspect of the being presence that appears to be an important part of the experience of the therapeutic alliance, but is only directly spoken about by one participant (four), is the feeling of empathy. All participants only expressed positive regard for the experiences they have had with countless clients over their many years of practice. Their many expressions of love for their work and being humbled by the opportunity to witness others in what were not just called therapeutic sessions, but were referred to as sacred and divine experiences. There is a great deal of respect present in the reference to clients. Tears were also shed with clients, as participant four shared:

> I do weep with clients sometimes. People have been through so much. It's ok. I don't find that bad, I don't do it very often. I find that I can. My tears are seen as compassion there, and I know where they are coming from. One of the things I would say is, I'm listening to you, but I'm so interested I want to hear you in your story and I want to be with you in your life story, to come with you to help you come through whatever it is you need to do.

Connecting in a compassionate, honest, present moment partnership with the client is an integral part of the experiences of the therapeutic relationship expressed by all the participants in this portion of the study.

Theme Six: The Lived Experience as Teacher. The final theme that emerged from the analysis of the qualitative data in this study is the power of the "lived experience" to be the main guide for the participants' expertise in prenatal and perinatal therapy. For most of the participants, when they first started practicing prenatal and perinatal therapy, there was no training for it. Participant four states, "When I came into this in which was in 1976, 1977, there were no therapists doing the work." Her path in to the experience of becoming a prenatal and perinatal therapist was not planned, and she, "didn't do it on purpose. I didn't do it with any plan. This was like destiny

really. It was my job to do this work." For this participant, the way to the therapeutic alliance was experienced as a kind of calling. Her early experiences led her to the type of work she does today. For Participant four, there is a sense that not only have her life experiences trained her, but her training was also guided by something greater than herself, like a kind of spiritual calling, "I wasn't trained for this work, it was through life experience and being that pioneer, and, so I wasn't trained at any level, I've been trained by life, by something beyond me.."

Self-training is something participant four continues to do, as she described it, "I've had to have a time of re-creating me. And so I'm back in therapy now to see what I need to shift to go forward now, what else do I need to be for teaching. I think the responsibility, the responsibility of any pioneer, you can actually go under with the work if it becomes too much."

This same intention to continue to "work on" oneself was also expressed by participant two, "I discover either inhibition or talent from myself. And [I am]…quite serious in growing and evolving those aspects which I recognize in my client and have no doubt [are also] with[in] myself. I take it very seriously."

The awareness that the alliance is a constantly changing and evolving experience is expressed in all the interview data. The need to grow with what presents itself in the therapeutic relationship is an aspect of self-training all these participants reported. Participant three phrased it this way:

> That's one of the things we're very conscious of. Whatever…whole-self philosophy, education, and psychology have changed. In 10 years we'll be teaching some other aspect of it. Right now, the very simple truth that we were given, when the child is born, it is born with the charged emotions and the charged thoughts that the mother and the father through the mother were experiencing in the nine months before birth. That's a fact now. And, when I taught that 30 or 40 years ago, people thought I was crazy.

The journey of this work has largely been self-created by this participant. His work is constantly adapting to where he is on his own personal path and in the culture in which he lives. Participant one expressed a similar awareness of the changing nature of her work. In her references, the theme of following her own lived experiences as teacher is equally strong:

> Because that was kind of the going style of therapy at that time and what I felt was a tension pattern within myself between stretching to new realms but then containing myself to do it in a specific way. It was as if I was recapitulating, kind of my core pattern of coming in, of trying as a human being to fit within the family constellation to do the things the way you're supposed to do.

Along her path of evolution, she made the following decision to deal with the "tension pattern" she felt. She decided:

> …to suspend previous things that I believed to be true, things that I had been taught, things that I had read from other experts, things that were culturally or professionally accepted, so that I could be more in truly in touch with my lived experience with my kids because that's who I started working pre and perinatal training with.

Following their own lived experiences is central to the meaning they have found in being a part of the prenatal and perinatal therapeutic alliance. "No guru, no method, no teacher" could serve as a kind of mantra for how all these expert therapists describe their experiences of providing a healing therapeutic relationship. Participant four expressed this beautifully when she said, "When you are prepared to go to the depths of the work you need to do, that's when the creativity becomes divine."

Discussion

Theme One: Early Experiences as Foundational

The theme of Early Experiences as Foundational arose from the four interview participants' descriptions of personal events that shaped their current experiences of the therapeutic relationship. For example, participant one discussed her early years as an obstetric nurse and a marriage and

family therapist as being influential parts of her journey. Participant two spoke of her training to be a nurse as place from which she grew and learned to "speak out." Participant three described his "interdimensional awareness" as developed from early traumatic events. Participant four spoke about her varied experiences as a dancer, teacher, hockey player, and gymnast, coupled with a serious accident contributed to the awareness she brings to her clients in the prenatal and perinatal alliance.

Moving to the quantitative data, some of the survey open-ended question responses also reflected the importance of "both professional and nonprofessional experiences" as one participant said, in shaping their lives as prenatal and perinatal practitioners. These results reveal that what brings meaning and has value for therapists in the prenatal and perinatal therapeutic relationship extends beyond their professional instruction. This finding is congruent with the review of literature that suggested pre-assessment for a particular therapist training program should take in account a therapist's history as it appears to be factor in the success of a therapist's effectiveness (Alberts & Edelstein, 1990; Baradon, 2002; Siqueland et al., 2000). The findings of this study establish that early experiences are significant for PPN therapists. Examining the life experiences (particularly those experiences that are connected to understanding and providing insight to human behavior and relationships) of a person entering into a training program for becoming a therapist seems a relevant factor in understanding the potential readiness and fit that person has for this career choice (Summers and Barber, 2003). More research on common characteristics that practicing prenatal and perinatal therapists have developed from previous life experiences needs to be conducted to begin to understand pre-existing factors that may contribute to being an effective practitioner in the field.

From a theoretical perspective, research is beginning to support the idea that it is more than professional techniques that contribute to a therapist's success (Dunkle & Frielander, 1996; Schore, 2003; Siegal, 1999; Tronick, 2003; Weatherston, 2005). Qualities of being, such as the capacity for empathy, self-regulation, and an expanded awareness of consciousness, also contribute to becoming a healing presence for others. There is some disagreement among psychological researchers as to how much these being qualities can be trained in those wishing to become therapists (Bachelor & Horvath, 1999). The findings of this study suggest that a broad spectrum of experience contributes to the successful prenatal and perinatal therapist. As a number of participants reflected, it is important to recognize the whole person of the therapist, a large spectrum of qualities, some perhaps trainable and perhaps not, when researching what contributes to the therapeutic alliance. As both the qualitative and quantitative data in this study suggest, successful therapy is achieved through a lifetime of preparation on the part of the therapist.

For both phases of this study, another aspect of the theme, Early Experiences as Foundational, was the role their own experiences with healing prenatal and perinatal trauma played in the participants' development as therapists. As illustrated in the results, among the interview participants, there was disagreement about whether or not this type of healing was essential to be an effective therapist. Of survey respondents, 68% expressed that their own prenatal and perinatal healing was important to providing a successful alliance. Almost 74% reported that their unresolved prenatal and perinatal history might impact how they relate to clients. No respondents expressed that their own early prenatal and perinatal personal healing was not necessary to their success as practitioners and the open-ended responses to the survey expressed strong feelings about the impact of their own healing as "essential to my success and effectiveness as a therapist."

Looking at all the data from both the qualitative and quantitative phases, most prenatal and perinatal therapists were in agreement about the experiences of their own personal healing work being crucial to their development as effective therapists. In fact, 100% of survey respondents confirmed that their conscious awareness of prenatal and perinatal life enhanced their empathetic connection to their clients. However, the data from both phases of the research also reflected that some therapists expressed that their own personal healing was not essential to their ability to provide effective therapy. For example, looking at the data from question one from the survey (My own PPN healing has been important, but not essential toward providing a successful therapeutic relationship); exactly 15.8% of participants responded as either "Strongly Agree" or "Strongly Disagree."

Though the percentage of therapists (15.8%) expressing strong disagreement with the need for personal healing was small, it is significant enough to contemplate possible reasons for the diversity of responses. Perhaps the wider span of responses is due the variety of ways practitioners work. For example, participant one, who questioned the necessity of having healed one's early wounding, practices with energy psychology techniques. Participant four, who saw her own healing to be a necessary prerequisite for her success, came from primal therapy training. More research needs to be conducted on the variety of methods employed by prenatal and perinatal therapists to develop more understanding of the role of the therapist's own healing in the therapeutic relationship.

The data regarding this theme of healing early wounding and becoming a successful prenatal and perinatal therapist also points to researching the common psychological phenomena of counter-transference in the therapeutic alliance. The emergence of the theme of early experiences as foundational suggests a good area to examine more deeply is the potential areas of counter-transference that prenatal and perinatal therapists may be vulnerable to bringing into their client relationships. An example from the qualitative data, can be seen in this statement from participant one, "The more healing I did the more clarity of the territory I would feel. So, that when someone would have an anesthesia experience and I was resonating with that I could have clarity of the witness that I'm resonating with that [experience, but I'm not caught up in it as if I'm feeling it myself."

The findings also promote discussion and research of a deeper awareness of the areas of counter-transference all psychotherapists face, because most training programs give little to no attention to the psychological impact of prenatal and perinatal life. As the literature review presented, as therapist's attachment style has an impact in the therapeutic relationship (Mohr, Gelso, and Hill; 2005, p. 305). The understanding of the effects of attachments styles of therapists in the therapeutic relationship is growing, but research on the impact of prenatal and birth events in life and their potential for counter-transference is rarely, if ever, addressed.

Theme Two: The Therapeutic Alliance as Enlivening

All of the interviewed participants expressed a deep appreciation for the work they do, and reported that they have greatly benefited from their many experiences practicing prenatal and perinatal psychology. None of them expressed being depleted from the rigors of providing therapy, but rather, as participant three expressed, "I'm completely energized, because I am not working with my personality." Words such as "joy," "enlivening," "love," and "awe," were used to describe experiences of being in the prenatal and perinatal exploration with clients. Their work as therapists was experienced as deeply meaningful and held opportunities to grow for each of them.

The quantitative data explored more deeply the satisfaction other prenatal and perinatal therapists may experience in their work. The data here provided many similarities and also a few differences. Five percent of survey participants shared feeling depleted at times from their work as therapists. One survey participant said he "wouldn't advise anyone to go into this field" because awareness from other mental health professionals is so low. However, 94% found that being a prenatal and perinatal therapist was a fulfilling career choice.

These findings reflect a largely shared feeling among practitioners that providing the therapeutic alliance for clients is satisfying and fulfilling as a career choice. The work itself appears to have an enriching nature and one that enhances the development as a person of those who practice it. The literature review revealed that a therapist's positive attitude in the client-practitioner relationship has impact on the success of therapy for the client (Bachelor & Horvath, 1999). It is possible to infer from the findings in this study that most practicing prenatal and perinatal therapists are providing the therapy relationship with clients with a sense of competence and fullness (as opposed to depletion), thereby contributing to a successful healing relationship.

It is interesting to find that PPN practitioners experience a greater sense of well-being as they practice their therapeutic work. Though the literature review conducted for this study uncovered no research that directly spoke to the phenomena of therapists experiencing a growing sense of happiness and enrichment in their practice of therapy, the experience of compassion fatigue and

burnout was a part of a number of studies reviewed (Martin, Garske,& Davis, 2000; Neswald-MacCalip, 2001; Summers & Barber, 2003; Weatherston, 2005). The positive effect providing prenatal and perinatal therapy has for practitioners, as reflected in this study, is a potentially fascinating area of research to explore. A more comprehensive understanding of this theme is needed and has the potential to benefit psychological practitioners from disciplines other than prenatal and perinatal psychology.

Another aspect of this theme, revealed in the data, was a concern for the level of awareness and respect for the field of prenatal and perinatal psychology among other professionals. The experience of respect from other experts is evidenced from the quantitative results to the question, "I find my expertise in PPN psychology is respected by other professionals in the mental health fields." Almost 37% of practitioners only sometimes or rarely find this to be true for them. Though a majority of participants frequently found they are respected by others (47%), only 15% found this always to be the case for them. These statistics highlight the need to foster more connections with other professionals about the important work being done by practitioners in this field. Facilitating a broader awareness of prenatal and perinatal psychology is likely to provide even greater satisfaction for prenatal and perinatal professionals as well as sharing the wealth of knowledge the field has to offer.

Theme Three: The Experience of the Spiritual as Profound and Sacred

Addressing the spiritual aspects of people in the healing relationship was a commonly shared experience among the majority of both qualitative and quantitative participants. Each interview participant described their experiences in the client-practitioner exploration as including a profound and sacred quality they felt as the spiritual aspect of being human. Seventy-two percent of survey participants responded that they frequently address the spiritual in their work. These findings point to the significant role the spiritual nature of people plays in the prenatal and perinatal therapeutic alliance.

Because prenatal and perinatal psychology focuses on human development from conception (and often pre-conception) onward, a focus on the spiritual or the embodiment of spirit is not a surprising finding. One of the core tenets of the field is that humans are conscious at the moment of conception. Discussions of how spiritual aspects of ourselves are connected to core beliefs about who we are widely engaged in and accepted. However, research into how practitioners are working with the spiritual aspects of their clients in prenatal and perinatal work is wide open for further exploration. The role spirituality serves in the therapeutic relationship has the potential to deepen the theoretical tenets of the field.

What was also interesting to explore in the qualitative data in particular, was the description of the relationship as having a spiritual quality. Though survey participants responded that they address the spiritual characteristics of their clients, the interview participants spoke of the relationship itself as having a spiritual component that is different than the witnessing of the spiritual journey of another. Participant four speaks to this with these words, "I believe that changes always take place in sacred space." The topic of the prenatal and perinatal therapeutic relationship as a spiritual experience or, as "so sacred and so profound" (participant three), is also found in the open ended questions from the survey data when one participant states the therapy alliance "exceeded the boundaries of humanness." Interview participants described being in the space of the therapeutic relationship as often filled with "awe."

One more component of this theme that was explored more in depth is found in the survey question, "In the therapeutic approach I take with clients, I consider their possible past life incarnations." This question was included because it was a subject area that came through in the interview data for three of the four interviewees. It is interesting that 73% of survey participants responded by saying they have addressed past life issues in therapy, although 42% did respond with "Rarely" (choices being always; frequently; sometimes; rarely; never).

The reality that most practitioners in the research conducted for this study have engaged in work that has included a past life component can again be seen as reflective of the basic premise the

field of prenatal and perinatal psychology holds that consciousness is present at conception. If consciousness is present at the first spark of life, then the fact that the soul of a person extends beyond the current incarnation is not a large leap for a practitioner holding this container for what it means to be human. However, being aware that this study's data also reflects a concern regarding having the respect of other mental health professionals and researchers, the topic of reincarnation holds potential for problems.

The topic of reincarnation in western societies has not held much scientific validity and has often been associated with the non-rational and thus, non-provable, less authoritative knowledge. A review of the psychological research with regard to past life regression therapy highlights the controversy that exists in the field with regard to the validity and effectiveness of this type of therapeutic practice. For example authors such as Brandon (1998) argue that false memories by clients can be created through the practice of hypnosis and certain regression techniques. He states that the best results are obtained through a "good psychiatric practice" that does not use these techniques (Brandon, p. 278). Another researcher, Spanos, reporting on regression work done with multiple personality disorder (now referred to as dissociative identity disorder) found that there was no evidence to support what patients remember that can be accurately verified with regard to regression and past life regression work (1996).

Studies such as the two mentioned above are in contrast to authors such as Jenny Wade (1998a; 1998b) and William Emerson (2001,2002), both covered in this study's review of literature, and who's research with regression techniques have shown their healing effectiveness (Emerson) and potential for verification through a comparison of near death experiences (Wade). Other authors such as Jue (1996) have described powerful emotional releases and healing through the use of past life therapy and documented his observations through case study presentations.

The findings of this study show that regression therapy and past life awareness are present amongst PPN practitioners. It is possible that many practitioners may be addressing issues of past lives in their work and this holds the potential for further exploration and contributions to an area of psychological research that has been potentially misunderstood and underserved. Furthering research in this area of PPN study deepens the field's theoretical framework and holds the potential for contributing a richer understanding of human consciousness that considers such topics as reincarnation with greater depth and clarity.

Theme Four: Multidimensional

The topic of multidimensionality of the prenatal and perinatal relationship was described by both the qualitative and quantitative participants as having "energetic" qualities with a "non-local" or expanded awareness and attention to the whole person. The awareness of themselves and their clients beyond just the thoughts shared and the importance of the development of a "psychic and energetic link" between client and therapist, as one survey participant wrote, was frequently repeated.

A deep awareness of the limitless qualities of human existence and the lived experience of "no time" and "no death" were expressed eloquently by the interview participants. This expanded sense of what it is to be human or "spirit beings in human form" as a survey respondent wrote, emerged from the data as a shared experience by many of the participants (63%). These findings provide a glimpse of what is happening in the prenatal and perinatal therapeutic experience for both client and therapist.

The results also highlight the skill of tracking many aspects of behavior, such as bodily felt senses, emotions, verbal information, intuitive information, and energetic information as part of what the prenatal and perinatal therapist does in therapy. As one participant wrote:

> The quality of being present in energetic attunement and strongly empathic resonating with the deeper aspects of what the client is sharing with me as a bodily felt sense and/or sense perception has been instrumental in order to acquire a more precise attention to what really matters most deeply to the client and to reveal what is truly blocking their manifestation of their deepest longing.

The literature review reflected that prenatal and perinatal psychology has drawn from a number of disciplines to shape the knowledge base of the field. Core influences in prenatal and perinatal research come from such disciplines as developmental psychology, craniosacral therapy, obstetrics, midwifery, trauma specialists, neurobiology, energy psychology, primal therapy, and somatic psychology as well as others (Lucas, 2009, pp. 31-73). With such a variety of practices shaping the field, prenatal and perinatal therapists are likely trained and inspired to develop a wide range of witnessing and observation competencies in their own work as therapists. This reality may have influenced the shared characteristic of multidimensionality that one survey participant described as "my work is to appreciate and reflect the wholeness for clients as they begin to see it in themselves."

Looking at one of the specifics within the theme of multidimensionality, a survey question asked participants to rate how often they experienced a client's conception to be a relevant part of their work. There were no participants who answered that they never found conception to be relevant and almost 53% said they found it Frequently or Always relevant. This finding is interesting in that so little research has been done on the impact of conception, especially from a psycho-spiritual perspective. Nearly half of all participants surveyed expressed that conception is frequently a part of the therapy they conduct. It is important for continued research in the field of prenatal and perinatal psychology and its theoretical foundations that practicing therapists, like the participants in this study, gather and publish data on what they are seeing in terms of the impact of conception on psychological development or, at least, keep records of how they are working with conception with clients.

Currently in the United States many people are seeking an assisted or artificial means of conceiving a child. According to CDC's 2012 ART Fertility Clinic Success Rates Report, 176,247 ART cycles were performed at 456 reporting clinics in the United States during 2012, resulting in 51,267 live births (deliveries of one or more living infants) and 65,160 live born infants. Although the use of ART is still relatively rare as compared to the potential demand, its use has doubled over the past decade. Today, over 1% of all infants born in the United States every year are conceived using ART (CDC, 2014). Coupling this study's findings with regard to conception issues with these statistics, a potential for further research arises for more in-depth exploration of some of the possible psychological effects of this type of technology may have on early development. Reviews of the research on the impact of the use of ART have shown that people conceived this way show comparable social/emotional competencies, but more behavioral problems and lower IQ scores (Zhan, Pan, Xu, Lou, H., Lou, Y, & Jin, 2013). As research from the PPN field grows, it will be interesting to see whether the findings continue to reflect the current understanding of the impact conception plays in psychological development.

Another topic addressed in the theme of "multidimensional" is abortion. Two of the four participants brought up that, in their work, their experiences with clients who had abortions as well as were survivors of abortion attempts gave them the sense of the "huge, multidimensional cosmos" as being "so infinite and so profound" as participant three shared. For both participants three and four death was also understood in a multidimensional way. Participant 4 stated, "It's given me a tremendous belief in the after-life, whatever that might be" and participant three said, "A child can even have the memory of being aborted but there is no death, see that's the key."

The topic of abortion is a sensitive one and it is my experience that the representative experts in the field of prenatal and perinatal psychology have predominantly chosen to remain private with their personal convictions and have not made many public statements advocating one side or the other of the abortion debate. A few prenatal and perinatal psychology authors, such as David Chamberlain (1994) and Thomas Verny (1986) have written thoughtfully on this topic, but more information from the field needs to be shared to deepen the discussion regarding abortion. The results from this study show that abortion, though most often understood only as a negative, traumatic, and last resort experience, was associated with the almost opposite experience of the affirmation of life and a deeper understanding of the multidimensionality of the human condition. As the abortion discussion continues, it seems a worthy endeavor to be informed by both the positive and negative experiences associated with it.

Theme Five: Beingness is the Ground for Doingness

Beingness is the Ground for Doingness was a major theme that ran through the qualitative data like a connecting thread for the first phase of this study. If one were to use the body as a metaphor to represent this study, the theme of Beingness could be considered the heart of its anatomy. The interview participants spoke eloquently about this aspect of their experience of the alliance, "In so many ways, fields of enlivened beingness replace doingness, as a foundation of a therapeutic alliance" (participant four). The ability to hold the boundaries for clients was another aspect of this theme. Participant four expressed this way, "You know I am a pioneer in this work and I can get stretched too far and one of the boundaries I've learned is that I have to know when to stop." The ability to bring one's whole self into relationship "communicates" to use the words of participant three, "they [the client] are free to express who they truly are" and are less infringed by "personality."

The results from the quantitative data reflected that 78.9% of participants in this study rely on their "Beingness" in the therapeutic alliance. It was also interesting that survey participants chose only Frequently or Always, (leaving 0% in the categories of Rarely and Never) as descriptors for how often they relied on their "beingness." Similarly, many of the open ended questions generated responses that spoke about the importance of being in the present moment, as one participant shared, "A capacity for presence is vital: Staying in the present moment, here and now, and within relationship, I and thou."

These findings suggest that the quality of "being" or "presence" holds considerable meaning for prenatal and perinatal practitioners in their experiences of the therapeutic relationship. Who they are being is "foundational" for what they are doing, as participant one stated. Theoretically, this finding falls in line with the research reviewed for this study and is also reflective of core teachings in the field of prenatal and perinatal psychology. For example, Allan Schore, a neurobiologist and influential theorist, offers an opinion on the importance of presence when he states.

> We can directly engage and therefore regulate the patient's inefficient right-brain processes with our own right brains. On the part of the therapist, the most effective interpretations are based on the clinician's awareness of his own physical, emotional and ideational responses. (Schore, 2003, p. 53)

From the results presented here, it seems that prenatal and perinatal therapists are clearly finding what Schore and others have expressed to be exactly what is effective and vital to healing change for clients. What is interesting and perhaps somewhat obvious about this finding is its relationship to the fact that prenatal and perinatal therapists have long recognized that relationship and primary relationships in particular, profoundly shape human development (Castellino, 2000; Chamberlain, 1986; Lyman, 2005; McCarty, 2002; Verny & Eichhorn, 1999).

Again revisiting the literature reviewed for this study, research supports the knowledge that no particular psychological technique is more effective than another in helping clients (Alberts & Edelstein, 1990; Asay & Lambert, 1999). Better outcomes do seem be associated with certain qualities of therapists however, such as optimism, empathy, experience, being present, and fairly secure attachment qualities (Alberts & Edelstein,1990; Bachelor & Horvath, 1999; Trusty, Kok-Mun, & Watts, 2005). The fact that the findings of this study reflect that many prenatal and perinatal therapists are also naming the importance of who they are being in relationship to their clients is in synchrony with the foundational premises from their own field. Furthermore, the findings align with studies in a wider cross-section of psychology and serves as an indication that the field's approach to providing therapy is supported by broader evidence based research.

Research that has looked at the role of the therapist found that therapists who focus on the therapeutic relationship, rather than techniques or treatment models showed better outcomes (Sparks, Duncan & Miller, 2008). Furthermore, the individual characteristics the therapist brings into the relationship matter as well (Sparks, Duncan, & Miller, 2008). These findings affirm what prenatal and perinatal therapists are describing as necessary components of the therapy they experience. Who they are as people, their empathetic and energetic connections with clients, is what

the practitioners reported as necessary to their work and as one participant wrote, "key to their (client's) healing."

Finally, the theme of Beingness reflects an understanding by prenatal and perinatal therapists, that their effectiveness is tied to their ability to offer a secure base for clients. Prenatal and perinatal practitioners reflected that their experience of the therapeutic alliance was to be in the present moment and to develop an expanded awareness of the fullest sense of their clients. The expert therapists interviewed expressed that the ability to be fully present was a "primary healing instrument" (participant four) for them.

Psychotherapists Fosha and Yeung (2006), whose work is deeply influenced by attachment theory, have stated in a description of a case illustration of their work:

> The therapist facilitated the patient's bodily experience and expression of deep emotional pain, helping him viscerally access his grief, all the while maintaining the moment-to-moment dyadic regulation of affect. The patient's completion of an intense but corrective affective experience led to the emergence of healing affects. (p. 181)

Fosha and Yeung articulate an experience of therapy representative of the descriptions provided in both the qualitative and quantitative data in this study. The similarity of the findings described in the theme of Beingness to attachment theory informed psychotherapy implies there is a strong influence of this understanding and approach to healing that is being expressed through the work of prenatal and perinatal practitioners. The theme of Beingness as the Ground for Doingness stood out as the heart of the main themes that arose from the qualitative and quantitative data.

Theme Six: The Lived Experience as Teacher

The final theme of the qualitative phase of this study was The Lived Experience as Teacher. This theme emerged from repeated expressions by the interview participants about their experiences of being among the first pioneers in the prenatal and perinatal field to discover what has now become a knowledge base for others. As participant four stated, "When I came into this, which was in 1976, 1977, there were no therapists doing the work." The interview participants spoke about their journeys in this field as being largely self-taught. They each individually expressed the faith they had in their own experiences as being the truest voice of authority for them.

The survey data looked specifically at how often prenatal and perinatal therapists referenced their own prenatal and perinatal healing as an enhancement for the theme, Lived Experience as Teacher. About 50% of the survey participants reported utilizing their own healing experiences in their work with clients. Other research that has examined therapist self-referencing in the therapeutic relationship also found this a useful approach to providing therapy. For example, Oakes (2000) found that most therapists reported that self-disclosure had a positive impact on therapy.

Revisiting the data from survey question one, that asked whether a therapist's own prenatal and perinatal healing was "important, but not essential" to a successful alliance, 31.5% reported somewhere between Not Sure and Strongly Disagree as an answer. Comparing this response rate to the 50% of participants who reported referencing their own healing with clients, the data indicates that this is an area of prenatal and perinatal psychology where practitioners are significantly varied in their experiences. This diversity was also seen in the qualitative data where participant one expressed doubts as to the necessity of practitioners to have healed their prenatal and perinatal wounds and participant four expressed feeling that she did not think she could have become the therapist she is without continued working through of her own wounding.

The diversity of experiences expressed by these findings is consistent with the diversity of views expressed in the field of psychology in general. Controversy regarding the necessity of requiring personal therapy for therapists exists in the current psychological literature. For example, Wiseman and Shefler (2001) found, "personal therapy is perceived not only as an essential part of the training phase, but as playing an important role in the therapist's ongoing process of individuation and in the development of the ability to use the self" (p. 129). However, McEwan and Duncan (1993) found that there are potential risks to requiring therapy for graduate students, particularly in the violation of

ethical boundaries and dual relationship issues, "The large number of respondents who perceived therapy as entailing at least some risk to the trainee, regardless of whether that therapy is optional or required, suggests that the potential risks of personal therapy should be carefully reviewed before a decision is made to include therapy experience as a required aspect of graduate training" (p. 194). In light of the current research debate on this topic, any further exploration of the findings presented here on the diversity of prenatal and perinatal therapists experiences and personal therapy should consider the potential risks to students in making this a requirement of training.

In another area of the theme of Lived Experience as Teacher, 89 % of survey respondents said they Frequently or Always look for relevant prenatal and perinatal experiences with their clients. The question as to whether prenatal and perinatal therapists are looking for prenatal and perinatal experiences that may be relevant may seem to be an obvious "yes," at first glance. However, only 47.4% of respondents said "Always." 52.6% responded with Frequently or Sometimes. The breakdown of responses provided by the quantitative data indicates that though practitioners may refer to themselves as prenatal and perinatal therapists, the therapy they provide embraces a wider range of psychological experiences than just the prenatal and perinatal.

More than half of respondents are providing therapy that, at least occasionally, does not have a prenatal and perinatal focus. The results highlight how often therapists in this field are giving their attention to prenatal and perinatal issues. This has the potential to help shape how prenatal and perinatal therapists are trained and provide an evidenced based focus for what practitioners are finding to be relevant to therapeutic alliance.

Another aspect of the theme, The Lived Experience as Teacher, is drawn out by the survey results was that 26% of respondents reported having doubts Sometimes, about how effective a focus on prenatal and perinatal issues is to help clients heal. With little indication from the open ended questions regarding the specifics of these doubts, it is difficult to ground in evidence from the data, any discussion of why this was so. It is noted that the doubt prenatal and perinatal therapists expressed through the survey question did not come through in the interview data. All the participants from the qualitative phase expressed only confidence in the effectiveness they experienced prenatal and perinatal therapy providing. This contrast of experiences could possibly be due to a difference in experience levels (interview participants having significantly more experience in the field). Perhaps as one practices for more years, confidence grows. Also, it is possible if the interview participants were asked directly (as survey respondents were), if they had any doubts about prenatal and perinatal therapy's effectiveness, their data may have shown more similarities with the quantitative data.

Theme Seven: Methodology

The theme of methodology was included as part of the quantitative phase of this study to enhance the scope of the overall findings. The types of methods used by practitioners did not emerge as a major theme during the qualitative phase, but were added to the survey portion of the study because it provided potentially interesting and important information on similarities and differences of the working styles and techniques of prenatal and perinatal therapists. The results of the five questions asked regarding this theme indicated a strong similarity among practitioners in terms of the frequency with which they used the following techniques; memory regression, the use of a reflective practice (supervision or consultation with colleagues), somatic and emotional tracking, attachment or bonding methodology, and identification of common patterns of healing.

No respondents expressed having Never used these techniques and practices. Slightly over half (52.6%) said they Always used; moment to moment tracking of emotional and somatic experiences, a reflective practice, and a focus on issues of bonding. Over 94% of practitioners see common patterns of healing in clients Sometimes or higher, and over 90% say they have used memory regression Sometimes or Frequently. Except for memory regression, 94% or higher of respondents chose at least Sometimes to indicate the frequency with which they used the techniques surveyed.

A majority of the survey participants for this study share similar use of therapeutic approaches. Most of the techniques surveyed were used Frequently or Always. The answers respondents gave

provide insight to some of the ways practitioners are working with clients. They highlight theoretical areas and clinical skills that therapists are drawing from to provide therapy. Almost no research in this area exists in prenatal and perinatal psychology. Therefore, to see that half of all therapists are always focusing on somatic and emotional tracking, and bonding and attachment issues for example, is an interesting finding to know for the field of prenatal and perinatal practitioners as they continue in their own professional development.

The topic of reflective practice in particular, is emerging strongly in the mental health field. Prominent infant psychology researchers such as Robert Emde have named reflective practice to be a necessary element of supportive environments for mental health (Emde, Bertacchi, & Mann, 2001). The closely related field of infant mental health is beginning to name reflective practice as being part of a "best practice" model for professionals. The findings in this study show that 78.9% of the participants surveyed engage in a reflective practice. These results indicate that prenatal and perinatal therapists have discovered the benefits of having a reflective practice to support providing a good alliance with clients. As prenatal and perinatal psychology develops its own "best practices" model, it is likely that reflective practice will also be included as an integral part of what is recommended for therapists to provide a successful alliance.

The use of memory regression techniques with clients was the least used technique among the survey participants, but still almost 89% reported using these techniques Sometimes or Frequently. This high percentage indicates that practitioners are finding this a useful skill to bring into the therapeutic relationship. It is not surprising that memory regression techniques would be highly utilized in prenatal and perinatal therapy because some of the pioneering experts in this field began their work with a similar focus. David Chamberlain, for example, provided groundbreaking research in the area of birth psychology by his clinical experiments using memory regression with mother and child pairs that verified that people do indeed recall their prenatal and birth experiences and furthermore, that these experiences are deeply meaningful (1986).

With such a widely shared use of memory regression techniques it seems that acquiring this skill as preparation for becoming a prenatal and perinatal therapist may be valuable. However, this study's results provided insight as to how often this skill was used by therapists. More research on the effectiveness of this widely used technique is also needed.

A final area the theme of Methodology sought to explore was how often prenatal and perinatal practitioners were seeing common patterns of healing in their clients. Almost 95% of survey participants said they expect to follow certain patterns of healing in the clients they serve. This question was asked because the experience of witnessing certain shared patterns of behavior among clients suggests that practitioners are able to identify repeated processes of healing. This provides a ground from which to better establish theory and practice in this still emerging field. The results of this study suggest that practitioners are experiencing the type of therapy they provide as repeatable and thus potentially available for others to reproduce in their own practices, as is one of the basic tenets of the scientific method. What are the common patterns practitioners are seeing? How are they similar? How do they differ? The answers to questions like these will serve to further establish guidelines for theory and practice in the field of prenatal and perinatal psychology.

Scope and Limitations

The mixed-method, qualitative, dominant, sequential design of this study was utilized to explore in-depth the experiences of prenatal and perinatal therapists. The study was confined to prenatal and perinatal therapists currently in practice. The findings of this study emerged primarily from the interview data of four different expert prenatal and perinatal therapists and the results of a survey conducted among practicing prenatal and perinatal therapists.

The field of prenatal and perinatal psychology is still in its emerging stages. The number of practitioners is relatively small. Therefore, the number of qualified people from which the research could draw is limited.

Dependability of data in this study was achieved through the careful and systematic process by which information was gathered for both interviews and in survey responses. This was done in an

effort to answer the study's research question as accurately as possible. As is part of the process of conducting phenomenological research, these steps were outlined for the reader in the methodology chapter of my dissertation. However, it is important to state that researcher bias cannot be completely eliminated in any research (Patton, 2002).

Suggestions for Further Research

A primary reason for mixed method design approach of this study was to begin to lay a foundation from which to further research the prenatal and perinatal therapeutic relationship as it is experienced by practicing therapists. Research that examines the field of prenatal and perinatal psychology in general is scarce. This research was conducted to begin to establish a base understanding of the experiences of practitioners in the field of prenatal and perinatal psychology to better identify patterns and methods of working.

First, the results of this study pointed to a number of shared characteristics and practices of prenatal and perinatal therapists. However more in depth research on the attributes of prenatal and perinatal therapists is needed. If the goal exists in the field of prenatal and perinatal psychology is to become more identifiable and established, an effort to document and study the characteristics and practices of those in the field will be crucial. More surveys on an international level and detailed observations of therapeutic sessions are needed to begin to establish proven working strategies and cohesive "best practices" models.

As B.J. Lyman (2008), a former editor of the Journal of Prenatal and Perinatal Psychology and Health stated:

> One reason that PPN (prenatal and perinatal) psychotherapy principles have not become integrated into mainstream psychology, this author suggests, is that there has been a lack of critical appraisal of its assertions, claims, and methods of inquiry. That is, our basic assumptions have not been clearly defined and systematically tested using evidence-based methods. (p. 190)

Though this study is a step in the direction, Dr. Lyman suggests that much more research is needed "to ensure competence" and to establish the guidelines for models of prenatal and perinatal psychotherapeutic care (Lyman, 2008, p. 190).

In addition, this study's results point to the need to further examine the pre-existing characteristics and life experiences that prenatal and perinatal therapists are finding supportive to their therapeutic relationships. From primary caregivers to co-workers, the results of this research show that practitioners are relying on what they learned prior to their therapeutic training, in previous relationships, to provide successful therapeutic relationships with clients. This is a topic understudied across psychological disciplines and more research will help to establish the criteria for good candidates for the psychological professions in general.

Secondly, more research on the methods used by prenatal and perinatal practitioners is needed to further create guidelines for training purposes. This study highlighted some of the areas of psychology and related disciplines from which practitioners are drawing to provide therapy, but much more research is needed.

To become a prenatal and perinatal therapist currently largely means you design your own training through mentorships and independently designed specializations. As more programs grow (like APPPAH's new certification program), having "evidenced based" curriculum plans will be essential to establishing proficiency in the specialization of prenatal and perinatal psychology. Also, with the increasing role licensure is playing in career opportunities for the mental health professions, developing research based criteria for practicing prenatal and perinatal therapy may point to the need to develop current or new licensure that more aptly fits this specialization.

Lastly, participants in this study expressed that one of the most powerful experiences they have had as therapists is that their "Beingness" nature, which includes spiritual aspects for almost all practitioners, is central to their work. They rely on present moment awareness of what is happening for them in the alliance as a foundation for facilitating clients. A common experience for this researcher was that articulating the "Beingness" aspect of their work both in the interviews and

through the survey, was sometimes challenging for participants, though I perceived we shared an understanding for what they were expressing regarding this topic. Though qualities of Beingness have been written about in philosophical and some religious literature, it is only recently that psychology has begun to pursue research and theoretical conversations that have addressed this aspect of healing relationships. Psychology is still developing adequate language for this phenomenon. More collaboration and integration with other scholarly resources that address qualities of Being such as with spiritual and philosophical circles is needed to better understand this central aspect of prenatal and perinatal therapy and psychology in general.

Imaging of the brain and computer analysis has exploded in research in the last few years. Magnetic image resonance scans now may diagnoses such as depression as a certain brain configuration. It is possible to now scan a person's brain, feed it to a computer that holds a number of templates for various pathological states and determine a best matching diagnosis. Some DNA testing is adding to diagnoses testing as well. We are associating certain patterns in brain imaging and DNA analysis that are not only associated with certain mental health pathologies, but are also used to predict outcomes based on genotypes and certain environmental exposures (Kim-Cohen et al., 2006).

With the future of mental illness treatment moving in this direction, it seems even more relevant to increase research on a holistic view of what it is to be human. In the above discussion of a new diagnostic method, many questions arise around how imaging may be affected by the circumstances of the test for example, who is conducting the scan, what is the current state of being of the client/patient? Can we really point to which environmental influences accurately? Further research on what prenatal and perinatal therapists are stating to be a foundational aspect of their practice; the present moment awareness of themselves in relationship with their clients, is necessary to better understand what is and is not contributing to healing in a therapeutic alliance.

Concluding Remarks

My dissertation research and discussion are presented here with the goal of providing insight into the nature of the experiences of prenatal and perinatal therapists in the practice of psychology. Phenomenological research is well suited to the early study of a still-emerging field like PPN psychology. Phenomenology seeks to study through systematic reflection, the essential qualities and structures of a thing rather than looking at something as object with an objective, reductionist view. The qualitative portions of the research presented here provide the reader with a glimpse into the dynamics of therapy practice in this area of specialization. It is an exploration rather than a conclusion; a subjective presentation of truth. The quantitative results provide measurement of what may or may not be shared amongst the practices of PPN therapists. My hope is that readers will find meaning in what has been shared through my research and that this will spark further research, conversation, and interest in learning more about what it means to specialize in this area of psychology.

References

Alberts G., & Edelstein, B. (1990). Therapist training: A critical review of skill training studies. Clinical Psychology Review, 10(5), 497-511.

Asay, T., & Lambert, M. (1999). The empirical case for the common factors in therapy. In M. Hubble, B. Duncan, & S. Miller (Eds.), The heart and soul of change (pp. 23-56). Washington, DC: American Psychological Association.

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller, (Eds.), The heart and soul of change: What works in therapy (pp. 133-178). Washington, D.C.: American Psychological Association.

Baradon, T. (2002). Psychotherapeutic work with parents and infants: Psychoanalytic and attachment perspectives. Attachment and Human Development, 4(1), 25-38.

Brandon S., Boakes J., Glaser D., & Green R.(1998). Recovered Memories of childhood sexual abuse: Implications for clinical practice. British Journal of Psychiatry 172, 296–307.

Castellino, R. (2000). The stress matrix: Implications for prenatal and birth therapy. Journal of Prenatal and Perinatal Psychology and Health, 15(1), 31-62.

Centers for Disease Control. (2014). 2012 assisted reproductive technology success rates. Retrieved August 20, 2014, from http://www.cdc.gov/ART.html

Chamberlain, D. (1986). Reliability of birth memory: Observations from mother and child pairs in hypnosis. Journal of the American Academy of Medical

Hypnoanalysts, 1(2), 89-98.

Chamberlain, D. (1994). How pre- and perinatal psychology can transform the world. Journal of Prenatal and Perinatal Psychology and Health, 8(3), 187-200.

Churchill, S. (2006). Phenomenological analysis: Impression formation during a clinical assessment interview. In C. Fischer (Ed.), Qualitative research methods for psychologists (pp. 79-110). Burlington, MA: Academic Press.

Collins, K., Onwuegbuzie, A., & Sutton, I. (2006) A model incorporating the rationale and purpose for conducting mixed-method research in special education and beyond. Learning Disabilities: A Contemporary Journal, 4(1), 67-100.

Creswell, J. (2003). Research design. Thousand Oaks, CA: Sage Publications.

Dunkle, J., & Friedlander, M. (1996) Contribution of therapist experience and personal characteristics to the working alliance. Journal of Counseling Psychology, 4, 456- 460.

Emde, R., Bertacchi, J., & Mann, T. (2001, Aug.-Sept). Organizational environments that support mental health. Zero to Three Journal, 17-22.

Emerson, W. (2001). Emerson recapitulation theory. Petaluma, CA: Emerson Training Seminars.

Emerson, W. (2002). Somatotropic therapy. Journal of Heart-Centered Therapies, 5(2), 65-90.

Fosha, D., & Yeung, D. (2006). ADEP exemplifies the seamless integration of emotional transformation and dyadic relatedness at work. In G. Stricker & J. Gold (Eds.), A casebook of integrative psychotherapy (pp. 165-184). Washington, DC: American Psychological Association Press.

Jue, R. W. (1996). Past-life therapy. In Scotton, B. W., Chinen, A. B., & Battista, J. R. (Eds.) Textbook of Transpersonal Psychiatry and Psychology. (pp. 377–387). New York: Basic Books.

Kim-Cohen, J., Caspi, A., Taylor, A., Williams, B., Newcomb, R., Craig, I.W., & Moffitt, T. E.(2006). MAOA, maltreatment, and gene-environment interaction predicting children's mental health: New evidence and a meta-analysis. Molecular Psychiatry (11), pp.903–913.

Lyman, B. (2005). Prenatal and perinatal psychotherapy with adults: An integrated model for empirical testing. Journal of Prenatal and Perinatal Psychology and Health, 20(1), 58-76.

Lyman, B. (2008). Prenatal and perinatal trauma case formulation: Towards an evidence-based assessment of the origins of repetitive behaviors in adults. Journal of Prenatal and Perinatal Psychology and Health, 22(3), 189-218.

Lucas, P. (2009). Prenatal and Perinatal therapists' Experiences of the Psycho-therapeutic Alliance: A mixed method exploration. Dissertation Abstracts International.

Martin, D., Garske, J., & Davis, M. (2000). Relation of the therapeutic alliance with

outcome in psychotherapy: A meta-analytic review. Journal of Consulting and

Clinical Psychology, 68, 438-450.

McCarty, W. A. (2002). The power of beliefs: What babies are teaching us. Journal of Prenatal and Perinatal Psychology and Health, 16(4), 341-360.

McEwan, J., & Duncan, P. (1993). Personal therapy in the training of psychologists. Canadian Psychology/Psychologie Canadienne, 34(2) 186-197.

Mohr, J., Gelso, C., & Hill, C. (2005). Client and counselor trainee attachment as predictors of session evaluation and countertransference behavior in first

counseling sessions. Journal of Counseling Psychology, 52(3), 298-309.

Moustakas, C. (1994). Phenomenological research methods. Thousand Oaks, CA: Sage Publications.

Neswald-MacCalip, R. (2001). Development of the secure counselor: Case examples supporting Pistole and Watkins's (1995) discussion of attachment theory in

counseling supervision. Counselor Education & Supervision, 41(1), 18-28.

Oakes, L. (2000). An investigation of the content and impact of therapist use of self-reference. Retrieved from Dissertation Abstracts International (Vol. 60(8-B), 4242)

Onwuegbuzie, A., & Leech, N. (2006). Linking research questions to mixed methods data analysis procedures. The Qualitative Report, 11(3), 474-498.

Patton, M.Q. (2002). Qualitative research and evaluation methods. Thousand Oaks, CA: Sage.

Schore, A. (2003). Affect regulation and the repair of the self. New York: Norton and Company.

Siegal, D. (1999). The developing mind: Toward a neurobiology of interpersonal experience. New York: The Guilford Press.

Siqueland, L., Crits-Christoph, P., Barber, J., Butler, S., Thase, M., Najavits, L., & Onken, L.S. (2000). The role of therapist characteristics in training effects in cognitive, supportive-expressive, and drug counseling therapies for cocaine dependence. Journal of Psychotherapy Practice & Research, 9(3), 123-130.

Sparks, J., Duncan, B., & Miller, S. (2008). Common factors in psychotherapy. In J. Lebow (Ed.), Twenty-first century psychotherapies: Contemporary approaches to

theory and practice (pp. 453-497), New York: John Wiley & Sons.

Summers, R., & Barber, J. (2003). Therapeutic alliance as a measurable psychotherapy skill. Academic Psychiatry, 27(3), 160-165.

Taylor, S., & Bogdan, R. (1984). Introduction to qualitative research design. New York: John Wiley and Sons.

Thomson, P. (2007). "Down will come baby": Prenatal stress, primitive defenses and gestational dysregulation. Journal of Trauma and Dissociation, 8, 85-113.

Tronick, E. (2003). "Of course all relationships are unique": How co-creative processes generate unique mother-infant and patient–therapist relationships and change other relationships. Psychoanalytic Inquiry, 23(3), 473-491.

Trusty, J., Kok-Mun, Ng., & Watts, R. (2005). Model of effects of adult attachment on emotional empathy of counseling students. Journal of Counseling and Development, 83, 66-77.
Verny, T. (1986). The psycho-technology of pregnancy and labor. Journal of Prenatal and Perinatal Psychology and Health 1(1), 161-186.
Verny, T. & Eichhorn, D. (1999). The biopsychosocial transactional model of development: The beginning of the formation of an emergent sense of self in the
newborn. Journal of Prenatal and Perinatal Psychology and Health, 13(3-4), 223-234.
Wade, J. (1998a). Two Voices in the womb: Evidence for physically transcendent and a cellular source of fetal consciousness. Journal of Prenatal and Perinatal
Psychology and Health, 13(2), 123-147.
Wade, J. (1998b). Physically transcendent awareness: A comparison of the phenomenology of consciousness before birth and after death. Journal of Near
Death Studies, 16(4), 249- 275.
Weatherston, D. (2005). Returning the treasure to babies: An introduction to mental health service and training. In Finello, K. (Ed.), The handbook of training and practice in infant and preschool mental health (pp. 3-30). San Francisco: Jossey-Bass.
Wiseman, H. & Shefler, G. (2001). Experienced psychoanalytically oriented therapists' narrative accounts of their personal therapy: Impacts on professional and personal development. Psychotherapy: Theory, Research, Practice, Training, 38(2), 129-141.
Zhan, Q; Pan, P; Xu,X; Lou, H; Lou, Y; Jin, F.(2013). An overview of studies on psychological well-being in children born following assisted reproductive technologies. J Zhejiang Univ Sci B. 14(11), 947–960.