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How a Skeleton Grows New Skin: Transformation for the Reproductive Client.

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Introduction

Reproductive challenges can befall any woman, from any socio-economic arena, colour or ethnicity. A woman may experience the tragic loss of a baby (through miscarriage or stillbirth) or her world may be turned upside down after years of failing to fall pregnant. She can be struggling with a birth that went awry or feel she is drowning under a tsunami of postnatal depression or anxiety.

In this article I will examine these challenges over the period of time that spans a woman's fertile years- the reproductive period, which is broader than the term perinatal implies. My intention is to shine a light on a chapter in a woman's life that can often be hugely turbulent - particularly in the fast paced times of the 21st Century- but, with support, can ultimately become transformational. I will take a closer look at the lack of support some women experience during this phase and its repercussions on their lives. I will also introduce the ancient Inuit myth, *The Skeleton Woman*, made famous in the 1996 Clarissa Pinkola Estes book, *Women who Run with the Wolves*(p. 132). Using her story as a metaphor can be a guide for the reproductive client, in that it underlines the potential for growth - or its polar opposite, destruction, due to unfinished business. Using Pinkola Estes' version of the tale, I will re-interpret The Skeleton Woman's story by narrating it in first person. This is an intentional literary device instigated to highlight and embody the experience of a nameless Inuit maiden who transitions into *The Skeleton Woman*.

I suggest that *The Skeleton Woman's* narrative parallels that of both I-thou and I-it experiences of the reproductive client in many significant ways (I will use a section of the myth to illustrate). When examining *The Skeleton Woman* from a metaphorical standpoint, I will suggest that her story can mimic that of the reproductive client's.

I will argue that a part of the work a client-therapist will undergo together is to place the client firmly back into the centre of her own story, as often many of these women have felt sidelined by medical fraternities

or misunderstood by loved ones. As such, they have lost their place in their own story. I will illustrate this by using the same small section of the myth mentioned above; that is the time the Skeleton Woman spends underwater.

The Myth: A Maiden - to - Skeleton - to - Woman – A Tale of My Transformation

The day my life ended was no different from any other. I had committed an offence, something that brought down a rain of terrible disapproval from the hulking man they called my father. No one remembers my crime, certainly no one in the village recalled what it was. It was of no matter, for the man they called my father, thundered through the village to the secret place where I had fled, a seething sea of fury. He found me easily, up a tree and clinging up to a branch, and he reached up, grasping a foot. I fought well but he yanked me from the branch, and as I tumbled he clutched a handful of my long hair and dragged me in that manner, back through the village where villagers shut their doors to my desperate screams, begging, pleading anyone to, please open their door and help. No one intervened as he continued to drag me out the other side of my village and up the mountain.

This was family business, not village business.

Lugging me over his shoulder like a sack of beans, the man they called my father steamed up the mountain path to the cliff face, where he unceremoniously tossed me over the side. The force of his javelin-like throw, propelled my body over the edge like potato peelings. The jagged mountainous rocks broke my body apart as I fell, a collapsed bird falling into the sea. When my split and broken body hit the water, there was not a soul to witness it, not even that man, for he had turned and marched away.

My broken body sank beneath the icy waves, wiped from the face of the earth, as if I had never existed.

Fish and small creatures feasted on strips of my broken flesh. Before long a skeleton was all that remained of the maiden, my story, and me. An innocent, reduced to an it, and maiden girl from nowhere lying here, somewhere. The deepest betrayal for which I paid with my life.

I lived for many years in my sandy grave, in a dark part of the harbour where no one ever ventured and I grew happy here for it was quiet. And safe. One day a young fisherman rowed his kayak into my uncharted part of the harbour, and quite by accident, snared me on his fishing line.

He had ventured here to the forbidden waters, rowing quietly with his kayak, full of youth and ambition, yearning to catch a big fish. When his line hooked into my chest cavity there on the bottom of the sea, he heaved

that line with all his strength. He knew by the pull on the line, that the size of this fish was mighty and that he grinned. He would be the envy of the other fishermen He would be accepted. The kayak thrashed under the force of the fish he'd hooked, the sea frothing. But he wouldn't let this one get away.

I was the catch of a lifetime.

And so I was hooked on the line of The Fisherman, a haul lifted from the ocean floor, grabbing fish to eat during my ascent. I burst the surface of the water, jangling and bumping out into the air, terrifying the young man who fled in his kayak rowing away and shrieking in terror. But I was tangled in his nets and the more he rowed homeward, the more I bounced behind him. He stumbled to the snowy shore, heaving with horror, stumbling up the tundra and bursting into his hut where he lay in the dark panting, his heart beating like a drum.

I followed him there, so entangled was I.

When he calmed he saw me my vacant eyes staring back at him, the light of his small whale lamp casting a more favourable hue. What he saw was me lying half in and half out his hut, one heel lay askew over a shoulder bone, a kneecap trapped inside my rib cage, another foot thrown over my skull. This time The Fisherman did not flee and instead he felt pity rising for me, a bag of bones before him. He reached out a hand and singing a song of his mother, began untangling my toes, ankles, shinbones; arranging me into a more human shape, and dressing me in his warm furs. I did not dare make a sound, lest I be cast back into the sea. The fisherman then fell asleep and as he slept, a tear escaped his eye - a big teardrop dribbling down his cheek which was slack with sleep. I saw that tear, crept over and started to drink. Oh my thirst! The tears flowed faster and I drank his river of tears until my thirst was sated. Then I saw his heart, and I reached in and wrested it from his rib cage, a tender, yet mighty drum. I pounded upon it.

'Boom, Boom.'

I recalled a song too, from long ago, and began to sing as I drummed,

'Flesh, flesh, flesh, flesh.'

My body filled with skin and flesh and blood and sinew. Ecstatic, I then sang for eyes and hair and nice fat hands. I sang the deep divide between my legs, and breasts, which could suckle a young one. I sang for all that a woman needs. I then gently returned the heart back into its slumbering owner's cage and crawled into bed next to my Fisherman.

When morning came, he awakened, with me, a flesh and bone woman, curled beside him. Two people, two bodies, tangled from their night of love in a way that can only be good and long lasting.

We live here as a pair today, together, in the same hut, on the same tundra. We feast from the creatures of the sea that had befriended me during my life under water; there is never a shortage.

Defining the Reproductive Client

For the purposes of this paper I will amalgamate the many terms used by the medical profession for women in their childbearing years. In particular I've avoided the narrow term 'perinatal'. Instead,I've coined the term, *The Reproductive Span*: the time span during which a woman is trying to fall pregnant, is pregnant, and has birthed or/and is parenting a baby (living or not). It's even more important for a client who has lost her baby to understand this, as she's a mother to a person who has a name, a grave (hopefully) and an identity. She carried a baby and her body has knowledge of this; she also would have had to birth her child, and her body will bears the hallmarks of this, including possibly producing breast milk. A client who seeks support for anything occurring during this period is a *Reproductive Client*. I have used the word client because they are not the patient, and I am not their doctor.

I have divided the Reproductive Span into five Stages:

Stage one: Trying to Conceive - the time when a woman is trying to fall pregnant.

Stage two: Introducing Intervention – when a woman is still actively trying to conceive but is unable to fall pregnant or she experiences pregnancy loss. During these months or years, an obsessive state of mind can overtake her life. It is during this period of time that such women can turn to interventionist methods, either science based (IVF) or alternative medicine.

Stage three: Pregnancy – the moment an embryo is fertilised, whether this is recorded scientifically or intuitively known. This time frame covers the entire pregnancy until birth.

It must be noted that with advancements of pregnancy home testing kits and medical urine tests, many women can have pregnancy confirmed earlier than they have historically. Previously it was a mere 'hunch'. However, if the same woman goes on to lose that pregnancy before an ultra sound is able to detect a heart beat or gestational sac, it is considered a chemical

(or biochemical) pregnancy. A chemical pregnancy is the period of time after a pregnancy test or urine sample confirms a pregnancy and before a "gestational sac or heart beat has been detected in a scan" (Armstrong, 2014, unp). This will routinely be confirmed by measuring the levels of hCG (human chorionic gonadotropin), which is a key hormone for measuring pregnancy, and which elevates as a healthy pregnancy progresses. This deserves special mention because often these women feel the same grief as any other woman experiencing miscarriage, yet medical or psychological support teams as well as well-meaning loved ones can unwittingly disregard her grief, under the false belief that a chemical pregnancy is not a real pregnancy.

Stage four: Birth – when a woman's pregnancy will end and she will give birth to her child/ren living or otherwise.

Stage five: Early parenting – the transitional phase of moving from a single person or couple to a person or couple who are now parents of a dependent baby or babies (including siblings) living or not living.

Putting Flesh on the Skeleton - The Modern Woman

Note: in the following sections I have changed the names of clients and removed any potentially identifying material in order to protect privacy.

In my private practice I have seen a theme of 'being overwhelmed' arising in women struggling within any of the Stages of the Reproductive Span, particularly for clients in Stage two of the span. A Stage two client can be overwhelmed by her situation, and as well as, by the sheer number of practitioners available to her - practitioners from every modality and corner of the medical world as well as alternative models. There are GPs, reproductive doctors and nurses (if they're undergoing reproductive technologies such as IVF), scientists and obstetricians, midwives, birth coaches, osteopaths, pregnancy masseurs, doulas, nutritionists, naturopaths, or practitioners of Traditional Chinese Medicine. Further afield there are kinesiologists, craneo-sacral practitioners and even fortune-tellers (a desperate woman will try anything).

When there are a plethora of practitioners on tap, a woman can end up with scattergun approach to her fertility. But there's another less discussed and yet to be researched impact of this: when a woman sees practitioner after practitioner she must repeat her story over and over again, which cements her version of her story. This can also lead to a re-traumatisation along the way. In addition, it is rare for any of these professions to case share with

other practitioners throughout all five Stages of a woman's Reproductive Span. This means, by default, not only do the practitioners not talk to one another, but that the responsibility falls on the client to fill in the blanks of her experience. It is important to state that this is not a comment on the medical profession or their standard of work - indeed this community is more often than not filled with caring human beings who have gone into their professions passionate to affect change in their clients. However, such work can be coupled with a non- dialogic way of relating with patients, as getting to the root cause, for the practitioner, is par for the course. To clarify- the woman's story, which to the reproductive client is their entire experience, is for a practitioner, a mere necessary means to try to find a cure. From a Gestalt standpoint, this is an I-It stance, which Dave Mann describes as being "concerned with doing and achieving in the relationship, rather than being in the relationship" (Mann, 2010, p. 176). When an outcome is sought - ascertaining why a woman can't fall or stay pregnant - there can be fallout. This is evidenced by the growing numbers of patients who believe they have been treated in a desensitising manner, often through no fault of the professional who just wants to work out why their patient is not thriving. Having said that, I have also written before (Lipschus, 2016) about the impact clinical language has on women's sense of self from Stages one through to four, and have interviewed women about their experiences with IVF. Almost all the women felt they were treated insensitively. Indeed in my private practice, the low opinion towards reproductive doctors comes up time and time again. One woman interviewed for research into this topic – Rowena, described her IVF clinic of choice as such, "It was nice, with a great doctor but who had a terrible bed side manner. Shocking. He was so rude, cold. Horrible. I actually felt nervous going to see him every day. He didn't look at you, shuffled papers, was rude [but] he had good results, and he was respected." (personal communication, July 2015). There are many repercussions of these attitudes ona reproductive client's life.

Many women report this time in their lives as deeply painful, lonely and isolating. Another interviewee, Maren describes her sense of shame. "I didn't want to tell anyone. For example, my husband's parents even now, they don't have a clue. And I don't think they'd understand". (personal communication, July 2015). Maren went on to describe the strain on her marriage, "We went through rough patches where I don't think he realised how important it was for me. And the hormones did crazy things for me. I didn't have any physical symptoms, like bloating or anything like that, but mentally it does things to you".

Needless to say, for women in partnerships, sex takes on a life of its

own. What should be a bonding and loving act between a couple, alters. The act can become a chore, enacted just for procreation. In my practice I often describe the time a reproductive client is ovulating as the: 'act like a whore and roll out the stallion moment' and clients always nod vigorously in agreement. Comments such as, 'at least it's fun trying' could not be further from the truth.

As well as impacts on self and relationships, many women struggle with concealing their IVF journey due to fear of discrimination at work. Women undergoing IVF do so furtively. Women are requested to self-administer combinations of injectable patches and pills. They may feel they should hide syringes in paper bags in work fridges and secreting away to a bathroom cubicle floor to inject themselves (injections usually require women to lie down for thirty minutes). It's no surprise that stress is elevated during this time, causing cortisol surges. In 2004, Petra Arck of University of Berlin conducted studies on pregnant women. Her team found stress directly affects pregnancy. Why? Arck explains, "As cortisol levels rise in the bloodstream, they suppress the production of progesterone, a hormone that is crucial to maintaining a healthy pregnancy"(as cited in Coghlan, 2004, unp.).

Within the IVF process, and during interactions with service providers, women can lose their sense of self. But sadly it is not uncommon that women throughout each Stage of the Reproductive Span, including those who experience Post Natal Depression, have experienced feeling let down, dehumanised, injured, offended, belittled and isolated. I can speak personally about this as my own journey to parenthood has been littered by such experiences. There are too many women walking around as skeletons, and it is they who often turn up in the therapist rooms, desperately seeking support and, for their story to be validated.

Few medical focused practitioners have also been trained in working with, or are able to take responsibility for, the psychosocial or psychological turmoil in their reproductive patient, who essentially is a woman in the midst of upheaval - an upheaval, which for all intents and purposes looks and feels a lot like being flung from a cliff into an icy ocean. Our nameless maiden from the myth is a clear metaphor at this juncture in a reproductive client's journey. The Skeleton Woman has no name and has never before now been able to tell her story in her way. Similar is the experiences of loss self-hood for the reproductive client. Staying with our reproductive client for a moment, it is important to mention that there is an additional element to their sense of overwhelm. Living in the 21st Century has an impact and women are by no means immune. In the last two decades the internet and

mobile phones were born as well as both becoming mobile – they are with us wherever we go. Sarah Wilson, in her book on anxiety, *First We Make the Beast Beautiful*, states that anxiety related problems "have increased from 3.8% of the population in 2011, to 11.2% in 2014-15" (2017, p. 117). Life today often ignores the basic need for humanity to rest and recuperate. Estes defined women as "… a blur of activity. She is pressured to be all things to all people" (1992, p. 4). Today in 2017, with the increasing usage of communication devices and with the social media era well under way, Estes' words, written two decades ago, are almost prophetic. As a race we spin faster than we've historically experienced before and, our brains have not yet evolved as fast as technology has. Essentially they're still playing catch up.

Libby Weaver, a New Zealand based naturopath, and author of *Rushing Woman Syndrome*, defines her proposed syndrome as: "… always being in a hurry and the health consequences always being in a hurry elicits" (2011, back cover). She claims our rushing lives create stress and anxiety which in turn create serious health consequences, listing liver issues, weight gain, digestive system issues and fertility impacts such as oestrogen dumps, progesterone issues to name a few.

Dr. Oscar Serrallach (2017) has also addressed the broader health issues related to post Stage 4 experiences, particularly for mothers who have children late in life. He claims they're more likely to experience a high rate of physical consequences such as lethargy, memory disturbances and poor energy levels, a condition he calls "Postnatal Depletion". Serrallach proposes that depletion can mask Post Natal Depression [PND]. From a therapeutic perspective he notes that recovery from Postnatal Depletion depends upon holistically addressing and attending to a mother's biology, psychology and life-purpose.

Serrallach's approach would be supported by David Mann (2010) who describes humanity now as living in a "culture that de-emphasizes the unitary nature of human beings" (p. 144). The need to label seems to be necessary but it can also be problematic. For adults, the result is a turning away from self and towards the plethora of experts who can name or validate an experience. Yet for others it provides respite. "I was relieved to have a name for my PND because it meant I wasn't crazy. I had an illness."(Emma, personal communication, August 2016).

I turn now to grief itself - a concept that is sadly under reported in reproductive clients yet is worthy of conversation. In an article called, *Rewriting the Rules of Grief*, Lynne Shallcross reported that, "Grief over a miscarriage sometimes falls under the category of 'disenfranchised grief',

counsellors say, because it often goes unacknowledged" (2009, unp.).

Clearly a large population of women in their fertile years struggle - they may be simultaneously grieving loss, whist yearning for a future time when a baby may come into her life. Or indeed for a new parent may be yearning his or her lost life whilst in tandem, struggling with a new baby and trusting their own parenting instincts. I propose that where fertility is concerned, grief should be a far more significant part of therapeutic conversation. The fact that this is an area of little research in psychology circles. In comparison in Australia alone IVF is a $500 million industry annually and was privatized in 2013 when the first IVF clinic floated on the stock exchange (Meadow & Baker, 2013). Yet, still women report feeling disenfranchised and disconnected from their story and absent from the larger conversation. From personal research, from clients' experiences and also from my own personal journey, a theme strongly presents itself that is hard to ignore. That is, when an environment of distrust is fostered and that environment encourages distrust of one's feelings and stories, this can sever a woman from her own instincts. The Skeleton Woman is so fundamental for me, as she sits in the other world realm, under the sea, in a non-descript land, far away, where the veils between the worlds lift and women trust their process, however deep, however painful, because they are connected to their instinctual nature and to their spirituality. Feelings and instinct can't be measured; aren't considered scientific. Yet, sidelining them in favour of science or other people's 'expertise' only severs women from their own instinct. There is much value in 'knowing what to do' or how one feels. Cara is a young woman who, in a recent workshop, broke down describing her angst in her lack of connection to her small child, "I feel nothing! I can't love my partner, my child feels like he's someone else's. I can't feel my body. I can't feel. *I want to feel*" (personal communication, February 2017).

The question raised in this example is: how do we as therapists, facilitate a reproductive client's ability to integrate her emotions when she has been told to ignore them or worse, that her feelings and instincts are irrelevant? How can we introduce the themes of unfinished business? For, surely this is at the core of a reproductive client's journey? My answer will follow, but the first place I start is at their story. How can storytelling hold a key and why indeed, is story such a lynchpin? And finally, how is Attachment theory relevant within this discussion?

Story Telling in the Therapy Room

Kate Forsyth is an Australian novelist and master storyteller. In an interview

with Richard Fidler (2015) on ABC Radio's Conversations, she describes the purpose of fairy tales: "Fairy tales are stories of transformation and they are often stories about secrets, disguises and hidden truths. But they also give us a kind of star map into the future and how to learn to overcome evil and give us hope that transformation, change, triumph and love are possible...we have the possibility to change, not only ourselves, but our world. It's an incredibly powerful and important message that's carried encoded in the heart of fairy tales"(Forsyth, 2015).

There is no end to the giving potential of story; a story asks nothing but to listen; a story can teach the most unwilling student and heal the most blistered of wounds. For millennia human beings have made sense of life, of moments within lives, painful or other, by telling stories, by being in relationship and being heard in an I-thou manner so that the experience can be integrated and transform into an I-it event, a mere memory. Sandy McFarlane, a trauma psychiatrist, during an interview with Richard Fidler (2015) on ABC Radio's Conversations, highlights story telling as essential for recovery from trauma. McFarlane suggests that some traumatic experiences are too indigestible to comprehend or process, but if one uses story as therapy, this enables a horrific life event to be broken down into a palliative form. "Often these memories are actually stuck in non-verbal forms. They may be smells, sounds, and sensations. And they're actually not converted into a verbal narrative. So the treatment is really about finding a language to try and grasp and integrate these experiences that still haven't been properly processed" (McFarlane 2015). Fidler queries him further by asking, "Are you saying these need to be contained in a story?" The resounding answer is: "Yes".

Sharing is well and good but can often be difficult at the best of times, often maintained by a societal status quo that reinforces silence, and commands you to instead, 'tough it out' as one client once told me was her strategy. The sense I get is that toughing it out calls for a moving away from 'feeling' and the impact of this is to repress instinct. Surely when there is a deep distrust of one's sense of self, felt emotions and embodied self are jettisoned? Yet for pregnancy, birth and mothering instinct is what unites a mother to her child. As a therapist an active listening stance is key and comes down to the I-Thou stance and further, to bracket any sense of judging the client's story. Margherita Spagnuolo Lobb words it perfectly in Philip Brownell's *A Guide to Contemporary Practice of Gestalt Therapy*. She claims the role of the therapist is to "… support the positive process that presents itself in the client, the aesthetic of the client's process, rather than to dichotomize the process into good and bad" (2010, p. 58).

As therapists if we can create a safe space for women to speak and lean into their experience we can return her ownership to her own story so that she not only brings it back into her experience, she also experiences an instant reinstating of connection. The renowned feminist Gloria Steinem sees this is as the antidote to isolation, and in a recent interview (Barclay, 2016) she described the impacts of feeling alone in your experience. She describes what happens when women share their story, their experience "... but because we're sitting in a circle or because we have friends or because we're in a movement (and this is what movements are for) we tell our story and suddenly six other people say, 'You know I've felt like that', or 'that happened to me'. And you realise that you're not alone."(Steinem, 2016). What Steinem advocates is what I call the three S's: storytelling, sharing, support. When this doesn't occur then stories pop up such as Rowena's, who describes her sense of isolation thus:"You don't have anyone to talk to, and your family sort of know what's going on but it's delicate and they don't know what to say to you. And then you've got a couple of supportive mates who don't know what to say and are well meaning but still say "It'll happen. You'll get there, but, let's now change the subject and talk about something else" (personal communication, July 2015).

Attachment Theory

In the nineteen fifties, John Bowlby conducted thorough studies on separation of loss of a primary caregiver on a child. It was Bowlby who first recognised the "biological based evolution necessity of the attachment of a child to his caregiver" (Wallin, 2007, p 11). It was also Bowlby who turned to a child's experience of abandonment from the child's point of view and, as Wallin goes on to explain, it was John Bowlby who realised that our relationships, "..from cradle to the grave revolve around intimate attachments and our stance toward such attachments is shaped most influentially by our first relationships" (2007, p. 1).

More recently, building on the gifts of brain mapping technology and neuroscience,Dan Siegel, believes a baby comes into the world with still developing nervous system and the shaping or the organising of that nervous system post-natally is " … crucial during the early years of childhood. Patterns of relationships and emotional communication directly affect the development of the brain" (Siegel, 2012, p. 4). He goes on to say, "At birth, the cortex of the infant's brain is the most undifferentiated part of the body. Genes and early experience shape the way neurons connect to one another and thus form the specialized circuits that give rise to mental processes. The early years are when basic architecture in the brain is laid down. Early in

life, interpersonal relationships are a primary source of the experience that shapes how genes express themselves within the brain" (p. 14).

To illustrate, imagine a crying newborn waiting for milk. This baby isn't to know food is actually forthcoming; she knows only the pain in her belly and it distresses her. Mother hears her child's escalating cries, picks her baby up, all the while starts to tell baby that milk is coming whilst undoing her top and bra. Baby hears mother's soft tones and begins to quieten. She's flipped on her back and the breast is presented. Cries cease as she latches her small mouth to the nipple and begins to drink. In this short exchange this little girl's brain has learned that when distressed, "these changes caused by her mother's intervention signal a relief" (Stern, 1990, p. 39). This is the most basic form of dialogue where "presence, acceptance and commitment" (Brownell, 2010, p. 106) are displayed, in this instance, by the mother toward her child. The baby may not be able to articulate a story but I-thou contact is what she responds to and as Stern states, "The combination of physical contact and upright position permits [baby] to feel that everything is shifting – that is, reorienting or going back to normal" (p. 139). This is a movement towards the I-thou.

In the therapist room and working with adults, we circle back now to John Bowlby, who said "… the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world" (1988, p 140). By understanding a client's attachment patterns, a therapist can gain great insight into, not only how they are when in the midst of grief and despair, but how they bond in adult relationships and also potentially, how they will parent themselves and any eventual babies. There are parallels between dialogic relating and an attuned attachment therapist. David Wallin suggests that a therapist's task is to "co-create a relationship with our patients that allows them to make sense of their experience, to feel more together and to relate to others more deeply and with greater satisfaction" (2007, p. 133). From a Gestalt standpoint these are: "… the four qualities needed to work dialogically - presence, confirmation, inclusion and open communication" (Joyce and Sills, 2010, p. 45). They add that when a gestalt therapist allows themselves "… to be touched and moved by the impact of the client, to be affected" (p. 45) it reflects in their client. And it is through such access points, neurobiologically, that early attachment wounds are healed. Thanks to brain mapping technology we know now our brains are far more fluid than previously thought, and this goes the same for attachment styles. Learned secure attachment can be formed and that "Like the developing child, a patient in the quintessentially intersubjective context of psychotherapy has to opportunity to learn

that feelings can be recognised, shared with others, reflected upon and potentially altered" (Wallin, 2007, p. 144).

Working with a Reproductive Client

Let us now meet Barbara 34. As confidentiality is paramount, it must be stated that Barbara is an amalgamation of some of the stories I've been privy to, but not modeled on any one individual. She is a purely fictional character, a construct, influenced by the many incredible clients, and therefore is a fusion of their stories as well as some parts, which I have made up. The quotes serve merely to indicate speech.

Barbara arrives into my rooms and seats herself swiftly, sitting bolt upright. She is very still and looks at me directly in the eye throughout our first meeting. She is very well dressed, immaculately groomed but throughout our first sessions, she clasps and unclasps her hands repeatedly and when asked to describe her mother in three words she chooses, "Absent, pre occupied and unpredictable."

Barbara is married and says she doesn't trust easily. She doesn't want to be here but admits she doesn't know where else to turn. She recently experienced profound loss when her baby died in very traumatic circumstances just a few hours after a very premature birth. Barbara is very private, often letting me know she is awkward sitting in the chair - I feel often as if I'm intruding on her quiet time. She takes a long time to speak, thinking long and hard before she opens her mouth, yet drip feeds me significant moments in her life like, "My sister died six years ago in a car accident, and I'm missing her a lot right now". It also takes many sessions to elicit her story, and she plays down the apparent drama of the baby's early arrival. A comment Barbara tosses into the room around six weeks into therapy is about her mother's intrusion into her life. When I ask for an example Barbara says, "Well, for instance she let herself in to my house when we went into early labour - she lives very close - and wouldn't leave. My husband was on the phone to the ambulance and was imploring her to leave. It was a total invasion and she was there for her fear not mine". When I enquired as to the urgency at the time, Barbara informs me the beginning of labour was so dramatic that there wasn't even time for the ambulance to show up. They were instructed on the phone to get in the car which they did, ignoring red lights all the way to the hospital. Barbara appears to be avoidant or dismissively attached, and this theory assists me throughout our months of therapy as avoidantly attached babies and adult often experience the same stress as anxious ambivalently attached people, However avoidantly attached people have "learned to suppress the

automatic expression of emotions associate with separation and attachment" (Wallin, 2007, p. 88). Barbara never raises her voice, never shows agitation and when she cries, does so very quietly, dabbing tears as they fall.

Compounded into the story is Barbara's desperation for another baby. At the beginning of therapy it has been only six weeks since the death of her daughter and she already is undergoing acupuncture and considering starting a round of IVF. She also claims to be "tired all the time" and yet has no appetite. Barbara also describes trying to protect many of her close friends and family from having "to endure" her story and when I gently probe, she withdraws with comments such as, "I can't burden you with that kind of detail. You must get so tired of stories like mine"

Barbara speaks with a flat affect and yet I suspect her anxiety levels are higher than I can confirm in body language. She tells me during one session, "I walk around the streets. Everyone has a baby but me. They're all smiling but I'm dead inside, yet I'm like a tiger in a cage" - justified resentment that needs to not be disowned. Yet Barbara follows the comment expressing guilt for even saying this aloud. The other theme I note, as with many reproductive clients is Barbara's ability to time travel. She can slide from the past, referring to the baby or her dreams, to the future where maybe another baby could come (yearning), all in the blink of an eye. For example, Barbara can discuss the purchasing of a new more "baby orientated car", which she didn't do during her pregnancy, to prepare for the next pregnancy and baby. In seconds she will then slide back into the past and say, "My baby girl never even had a chance to lay in her cot. And now it will be the bed of another child": a child that hasn't yet been conceived.

I believe Barbara straddles two stages of my reproductive model. She is in Stage five – what would be considered early parenting - she has given birth and yet her child has passed away. She is however, also in Stage two in that she has recently decided to attempt assisted reproduction for a second child. She is an important example of how the stages interconnect and influence each other and the importance of practitioners need to remain mindful of a client's complete reproductive history.

During our work together we discussed the time travelling metaphor and over coming weeks Barbara came to have an awareness about the times in her thought process that she time travelled, as well as whether it was to the past or the future. We then began to work with the here and now and also connecting her to her body - with her sense of numbness. A breakthrough moment came when I had Barbara hold her belly and recall what her pregnancy with her daughter felt like. She was quiet a long time and finally opened her eyes and said, "I can't remember". I asked if her

baby moved a lot and she finally managed to recall her kicking "… often low in my belly and on my right side." I watched her hands move to her lower right side belly. When Barbara opened her eyes she said she loved pregnancy and broke down, admitting she wanted that feeling back, to be pregnant again. Desperately so. But also she said, "I want her. The only baby I want is her".

The Time Under the Sea, Barbara and The Paradoxical Theory of Change

The Paradoxical Theory of Change states that "change occurs when one becomes what he is, not when it tries to become what he is not" (Beisser, p.77), who incidentally also emphasizes non-coerciveness in the therapy process.

We have identified that both The Skeleton Woman and the Reproductive Client have been cast off a cliff, become fleshless and have been forced to sit on the ocean floor, set apart from humanity. Barbara highlights this when she describes the awkward reminder of her grief socially- the many occasions at social events when she is asked whether she had children or not. When she once ventured, "I do have a child. Well I did. But she died." This inadvertently created discomfort in others and for herself. Barbara felt ashamed for making others feel so awkward and vowed never to be placed in a social situation where this question could present itself. In those first years after her daughter's death, Barbara, like the Skeleton Woman existed apart from humanity.

The Skeleton Woman also grew 'used to' her time under the sea, and it became a safe and quiet place. In the myth, little is spent on the period of time that took her to adjust to her new environment, but if I were to hazard a guess, I imagine the Skeleton Woman too had rage at her father for his murderous act, as well as moments of agonising grief for all she lost (her life for one) and other moments riddled with yearning for all that could have been. A lot of time travelling before arriving at that moment of quiet acceptance. I suggest that her time under the sea, is quintessentially about the Paradoxical Theory of Change, as is the reproductive client's journey in the therapy room.

As Mann states, Gestalt therapists don't believe true and transformational change can occur until whole acceptance of the individual's …"personhood, including embracing aspects that the client may wish to amputate from their being" (p. 62). The year we spent together accompanied Barbara's second journey into IVF. Her medical team, however, didn't feel her past history had much relevance to her current state, and felt nothing awry in

setting up round after round of IVF, month in and month out. This had a huge impact on her health. Barbara lost a lot of weight, which concerned her teams (and me), and yet she felt driven to try to fall pregnant again with no break between each round, in order to rest her body. Much of this year was focussed on encouraging her to explore her embodied experience and the potential emotional connection to grief. This was in accord with the paradoxical theory of change, for her to enter, "as fully as possible into all aspects of his [sic] own experience and bringing them into full awareness" (Joyce & Sills, 2010, p. 39).

It was deeply painful for Barbara to make contact with her grief, and adding insult to injury to also have to further to come to accept that she was not pregnant with a second child. Confronting the part she wanted to "amputate from her being" (Mann, 2010, p .63) was her grief, which could only be tolerated in small amounts, but also the ideal that she had to have a baby by thirty five years of age and that she was now thirty seven. Working with "what is" (p. 64), gave Barbara permission to feel her body once more, even the broken parts. She could only then feel the impacts of being so underweight and this made her focus then turn to diets, as she began to see that body weight would impact any pregnancy (previously she didn't consider this matter, so long as she just fell pregnant). Given her history, Barbara came to see that she had to be healthy when she conceived and she began to slow down her attempts at falling pregnant and focus on her own health.

After a few months Barbara brought in a pink photo album. Inside were photos of her husband, and other family, as well as herself, holding the tiny little baby with a perfectly formed face. In this act, as we sat together I saw Barbara as the mother for the first time. The young woman in the picture cradling her closed-eyed daughter, with a look of such love and tenderness that even recalling the photo still moves me. No time travelling in that moment. Nor the one where she quietly said "You know I never saw her eyes open. But I know I'll always be her mother as much as it will always hurt in my heart. I just have to learn to live with that".

Barbara did eventually go on to have a healthy pregnancy and gave birth to a baby boy around two years later.

Conclusion

On the ocean floor we three sit, Barbara, The Skeleton Woman and I. As much as Barbara doesn't know if she'll feel joy again, nor whether another baby will come into her life, the Skeleton Woman doesn't know what will happen once she rises from the ocean floor, nor that she will become flesh

again. Yet as we begin to accept that this is where we have landed, in this moment, it is then that we can begin our ascent. What comes after we are above the sea again, is the magic and unpredictability of life. The 'who knows?' But first we needed to be there on the ocean floor, for a time. As author and columnist, Cheryl Strayed, who lost her mother to cancer, says so eloquently, "Let yourself be gutted. Let it open you. Start here" (2012, p. unknown).

As I conclude, I ask the reader to ponder the following questions going forward with their own clients: as therapists can we facilitate a space where a reproductive client can truly see their own story as relevant? How can we best expedite a heightened awareness around themes that arise for these clients, whilst supporting the reintegration of trust and instinct within the personality? Sometimes life does indeed toss us over the cliff, and no one escapes life without adversity. However, once we're there, we do have a choice, and how we react. To choose acceptance in the here and now is a giant leap in the healing process, yet it is a step that can't be omitted. It doesn't negate the fact that it's a difficult step, yet if a therapist can facilitate a space where a client can truly see the relevance of their own story in their future healing, there is a natural progression towards acceptance. The possibly long duration taken to negotiate this process is one worthy of taking. We can thank you, *Skeleton Woman*, for teaching us that.

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Biography

Kimberley Lipschus is a psychotherapist, counsellor, writer and filmmaker. She has a long-standing fascination with storytelling - stories foster in human beings empathy and teach social skills. They can also provide insight and healing. In her private practice Kimberley works mainly with reproductive clients; her work is deeply entrenched in gestalt, attachment theory and story telling; also touching upon a systemic approach when working with couples. She is currently writing a book on fertility, called *The Space Between*.