

The Therapist's Pregnancy: Toward a Therapeutic Fourth
A Two-Paper Examination

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Dedication

For Fiona, my first, my only, my inspiration for the fourth...

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Abstract

This two-paper dissertation reports on the findings of a qualitative study that was designed to capture the clinical dynamics that emerge when a therapist becomes pregnant during treatment. Raphael-Leff (2004), a psychoanalyst known for her research on pregnancy as well as her own psychoanalytic theory of mothering orientation, has outlined procreative mysteries, or anxieties, that are deemed universal by pregnant women. She defines them as anxieties about formation, containment, preservation, transformation, and separation. Pregnant therapists are not immune to these anxieties, and in some instances, may even feel them to a greater degree. While there have been some empirical studies that have captured the pregnant therapist's perspective, it is a sparse amount in comparison to the vast number of women therapists who become pregnant, and there have been to my knowledge no studies that have actually interviewed clients of pregnant therapists. This study seeks to begin to redress that crucial missing perspective by interviewing the clients of pregnant therapists, as well as first-time, formerly pregnant therapists. Using both object relations and intersubjective theories as a conceptual lens, this two-paper dissertation aims to uncover some of the processes of conscious and unconscious communication that comprise the therapeutic dyad when the therapist is pregnant. Additionally, it seeks to offer guidelines on what both practitioners and supervisors might expect when a therapist becomes pregnant during treatment. The first paper will look at the coded results of this qualitative study and its emergent themes. The second paper will expand on the findings and look at particular object relations and intersubjective theories that can be important in understanding and working with this particular "intrusion in the analytic space" (Fenster, 1983). In the second paper, I will introduce a concept I am calling "the fourth" which represents not only the therapist's pregnancy in a literal sense, but also the figurative, symbolic, conscious and

unconscious meaning which the therapist and patient each attach to the pregnancy as well as new motherhood, and their co-created meaning.

Two-Paper Introduction

Psychotherapy is a profession dominated by women, many of whom are in their reproductive years and may well become pregnant and carry a child to term while also practicing. Despite this, there is a dearth of empirical literature on the pregnant therapist (Baum, 2010; Imber, 1990; Katzman, 1993; Korol, 1996; Laydon, 2013; Raphael-Leff, 2004; Tinsley et al., 2003;; Toomey, 2011, Whyte, 2004), and the majority of literature that exists is primarily focused on the therapist's perspective, precluding the actual client/patient perspective.

Pregnancy can be a time of vulnerability for the therapist, especially if it is a first pregnancy and she is unsure of what to expect. In her review of the literature on therapist pregnancy, Whyte (2004) states, "This critical transitional phase in a woman's life is inevitably associated with a resurgence of past conflicts and anxieties, calling into question previous psychic equilibrium. The pregnant analyst is not immune to the considerable challenge and turbulence associated with such change" (p. 17). It is crucial that therapists have the resources available to deal with these changes, yet Korol (1996) contends that during professional training, there is often pressure to deny the effects of pregnancy. In contrast, this qualitative study and two- paper dissertation seeks to highlight the effects of a therapist's pregnancy on the therapist herself and her clients.

Whyte (2004) reviewed the existing literature on the pregnant analyst and found 80 papers between 1974 and 2003, noting a shift from the earlier literature which focused mostly on therapist accounts of the effects of pregnancy on the patient, to a deeper exploration of the therapist's countertransferential responses, including how best to work with these conscious and unconscious responses in the clinical work. This trend shows the growing interest in the pregnant therapist herself, and how her pregnancy informs the work. My study adds to this focus, and includes the much neglected, actual client/patient perspective.

This two-paper dissertation is informed by a qualitative study that seeks to begin to redress these gaps by interviewing both first-time previously pregnant therapists, as well as female clients/patients whose therapists have been pregnant; in doing so, I hope to highlight the ways in which the therapist's pregnancy is of paramount importance for the treatment process. This qualitative study was designed to capture the clinical dynamics that emerge when a therapist becomes pregnant during treatment and answer the following questions:

- How are pregnant psychotherapists affected by their pregnancy and their patients' reactions to it? How does this affect the treatment process?
- What is the meaning of pregnancy for a pregnant therapist?
- What is the meaning of the therapist's pregnancy for the patients and how do they feel it impacted their treatment, as well as their relationship to the therapist?
- How do the above meanings meet in the therapeutic pair as demonstrated through transference and countertransference reactions?
- Is there a co-created meaning shared by the therapeutic dyad? If so, what might that look like?

The first paper will examine the coded and emergent themes that resulted from the qualitative study that utilized constructivist grounded theory (Charmaz, 2006). These themes will be explored in depth and in many cases will provide participant quotes to illustrate the data. While the study is not made of matched pairs (there was only one dyad), the voices represent both sides of a therapeutic dyad in hopes of giving the findings a more balanced perspective. In addition to the themes that emerged, there will be a section devoted to advice for pregnant therapists. This first paper and the study itself, provide the scaffolding for the second paper, which is more conceptual in nature.

The conceptual lens for the second paper utilizes both object relations theory and intersubjective theory, as neither are mutually exclusive, and, to borrow from Benjamin (1990), I hope “ to account both for the pervasive effects of human relationships on psychic development and for the equally ubiquitous effects of internal psychic mechanisms and fantasies in shaping psychological life and interaction" (p. 35). The theories of Bollas, Fairbairn, Benjamin, and Raphael-Leff shape the conceptual lens through which I consider the therapist’s pregnancy. In addition, I will use my own personal experiences as a formerly pregnant therapist as well as the experiences of the therapists and clients I interviewed to illuminate this clinical phenomenon and enhance the clinical skills of the pregnant therapist and stimulate more discussion in this under researched area. Further, I will introduce a concept that I am calling “the fourth” which represents not only the therapist’s pregnancy and new motherhood in a literal sense, but also the figurative, symbolic, conscious and unconscious meaning which the therapist and patient each individually and together attach to the pregnancy as well as to new motherhood.

Winnicott (1956) espoused, "I do not believe it is possible to understand the functioning of the mother at the very beginning of the infant's life without seeing that she must be able to reach this state of heightened sensitivity, almost as an illness, and then recover from it" (p. 302). This heightened sensitivity has also been used to describe pregnant women, and, more to the point, pregnant therapists. Raphael-Leff contends, "the analyst's pregnancy offers a window on bilateral processes of unconscious communication, often obscured in psychoanalytic theorizing" (p. 317). The results of my study, which are imbedded in the following two papers, intend to look through the aforementioned window in hopes of making these processes more transparent and accessible to both future pregnant therapists as well as those who supervise them.

Paper One:
Examining the Experiences of Clients of Pregnant Therapists and Formerly First-Time Pregnant Therapists: Findings of a Qualitative Study

I underestimated how difficult pregnancy would be, and how much time would go into figuring out how to disclose, explore and respond to my patients. I knew it was big, but it was even larger than I imagined. (Therapist I)

It was always about me for her, it was what was going to be best for my therapy. I could stay with her or she could help me find somebody else, or at any point I could change my mind if it was getting to be too much, and so she did a very good job taking care of my needs and I felt that I was always supported. (Client G)

Introduction

Psychotherapy is a profession dominated by women. Many of these women are in their reproductive years and some will likely get pregnant and carry a child to term while also practicing. In 2006, 81% of licensed social workers in the United States were women, and 39% of licensed social workers were under the age of 44 (NASW, 2006). Despite this, there is a dearth of empirical literature on the pregnant therapist (Baum, 2010; Imber, 1990; Katzman, 1993; Korol, 1996; Laydon, 2013; Raphael-Leff, 2004; Tinsley et al., 2003;; Toomey, 2011, Wolfe, 2013), and the majority of literature that exists primarily reflects information gathered from therapists, precluding the actual client perspective.

This article reports on a qualitative study that seeks to begin to redress these gaps by interviewing both first-time previously pregnant therapists, as well as female clients whose

therapists have been pregnant. In doing so, I hope to highlight the ways in which the therapist's pregnancy, as well as new motherhood becomes of paramount importance for the treatment process. Chodorow (as cited in Lyndon, 2013, p. 52) contends that "many women experience what feels like a drive or biological urge to become mothers, but this very biology is itself partially shaped through unconscious fantasy and affect that cast what becoming pregnant or being a mother means in the context of a daughter's internal relation to her own mother." This quote speaks to the complexity of the mother-daughter relationship and also the parallel process of therapist-patient relationship in regards to the maternal transference. When a therapist becomes pregnant, these same dynamics become all the more complex in the treatment of female clients. This study considers the dynamics of the transference and countertransference between a pregnant therapist and her female patient in this unique treatment situation, and will serve as somewhat of a road map for pregnant practitioners, helping them to recognize the associated challenges and opportunities. In this article, and the subsequent article I will use the terms client and patient interchangeably throughout, as much of the psychoanalytic literature uses the term patient, while many social workers, as well as other mental health professionals, tend to use the word client.

Literature Review

As noted above, as well as expressed by multiple authors, there is a surprising dearth of empirical studies on pregnant helping professionals, especially in recent years (Baum, 2006, 2010; Imber, 1990; Korol, 1996; Raphael-Leff, 2004; Tinsley et al., 2003; Toomey, 2010, Wolfe, 2013, Lyndon, 2013). My search used the keyword pregnancy in conjunction with multiple types of professionals, including: therapist, psychoanalyst, mental health professional, social worker, counselor, psychologist, psychiatrist, and helping professional. While my research question is

geared toward psychodynamically or psychoanalytically oriented therapists, it is important to consider the experiences of other types of practitioners. My literature search yielded relatively little in the way of empirical studies (Berman, 1975; Baum and Herring, 1975; Naparstek, 1976; Fenster, 1983; Bassen; 1988, Bashe, 1989, Grossman, 1990; Katzman, 1993; Fallon & Brabender, 2003; Napoli, 1999; Motozzo, 2000; Byrnes, 2000; Baum, 2006, 2010; Baum & Itzhaky, 2006; Toomey, 2011; Zackson, 2012; Wolfe, 2013; Lyndon, 2013). I found 19 in total, 7 since 2005. I will focus in-depth on those studies that are the most relevant to the scope of my study. I will then synthesize their commonalities and variations, and finally, I will discuss some of the case literature as it relates to this topic.

Lyndon (2013) conducted a qualitative study of eight first-time mothers who had their first child while in a doctoral program for clinical psychology. This research explored the changing experience of the student/mother through pregnancy, maternity leave and return to school or work, and looked specifically at the ways in which they navigated between their often conflicting maternal and professional roles, as well as the transition from student to professional psychologist. A primary feeling among these women was guilt when choosing to attend to their careers. Lyndon found that both social and cultural expectations to mother in a certain way exacerbated feelings of guilt and conflict. The data also revealed that therapists felt greater empathy as well as an ability to connect with the child aspects of their patients and that in general their experiences as new mothers positively enhanced their clinical work. Lyndon (2013) contends that, “by expanding our conception of maternal subjectivity so that mothering includes not only the physical and emotional care of a child but also the modeling of independence and passion some of these conflicts will be mitigated” (p. ii).

Bassen (1988) conducted a retrospective qualitative study of 13 psychoanalysts (including herself) who had been pregnant while practicing analysis. She used semi-structured interviews of approximately one-and-a-half hours in length, administered either in person or by phone. The findings identified themes focusing on acting out, the overall impact of pregnancy on treatment, countertransference and technical issues of handling pregnancy. All of the analysts interviewed felt there was an intensification of both resistance and transference by their patients in response to their pregnancies. While many of the analysts found their pregnancies to be facilitative to the analytic process, this seemed to be related to whether they were able to effectively analyze the resistance and uncover deeper meaning. Most of the analysts admitted to difficulty facilitating patients' expressions of hostility and anger. Many of the analysts acknowledged feeling guilty either about their maternity leave or about being more fortunate than their patients in what their lives looked like, and some identified feelings of anxiety. Bassen (1988) also saw early disclosure of the pregnancy as collusion with the patients against understanding the symbolic meaning of pregnancy.

Katzman (1993) looked at the reactions of 24 bulimic women to their therapists' pregnancies; it is unclear whether Katzman is the treating therapist in this study. The therapist and an outside coder (her secretary) completed behavioral checklists before and after the pregnancy was announced. The checklist consisted of lateness, missed sessions, and questions about the therapist, the exact nature of which was not specified. The therapist also recorded changes in weight, dress and appearance of the client. Process notes, before and after the pregnancy was announced, were used to find emerging themes. A multiple-choice follow-up questionnaire was sent to the clients a year after the pregnancy was announced. Results showed that those diagnosed with borderline personality disorder had the most intense emotional and

behavioral reactions. All clients were said to have “primitive, affect-laden responses that were not discussed spontaneously” (p. 26). These responses concerned loss and abandonment, competition, jealousy and a desire for children. A number of women became sexually promiscuous, and three women became “accidentally” pregnant.

In the follow-up questionnaires sent to participants in the Katzman study (1993), women expressed value in the therapist’s pregnancy in helping them to identify their own desires, and allowing them to address the conflicts between professional and personal goals. These positive findings should be read with caution, as only 63% (15 women) of the relatively small number of clients returned the forms. Those who did not return the forms may have experienced negative feelings. It should be noted that the participants were sent letters telling them that they were part of a large multi-site study and their responses would be sent to a third party; this was a “cover story” for the purposes of reducing bias against negative responses if they knew they were actually writing to their therapist. There is no mention in this article of any IRB involvement. The research subjects were all informed after submitting the materials about the “cover story” and its rationale. The findings are limited in that the responses were based solely on the treatment with the same therapist and limited to an eating disordered population. This, however, was the only study found in which the responses of the clients were elicited directly.

Baum (2006) conducted a qualitative study of 10 first-time pregnant Israeli social work students. Baum reported the findings of this study in two separate papers (Baum, 2006; Baum, 2010), one of which focused on the theme of guilt and its various determinants; and the other which identified feelings of inadequacy in direct clinical work, and over functioning in matters that did not involve direct client contact. While Baum's sample size was small, her findings, supported by many direct quotes, were rich and strongly illustrated the themes presented. The

methodology, measures, and procedures were sound. Baum's recommendations were geared toward supervisors, urging them to provide students with a safe, supportive place where they could discuss their feelings, hopefully freeing them up for better interventions with their clients. This study, while important, does not give voice to full-fledged professionals already in the field. While many of the themes certainly would be similar, the technique in handling issues that arise likely would look different; a student's potential insecurity and feelings of professional inadequacy may have them floundering more than an experienced therapist who should be better able to use the material in a clinically useful way. This qualitative study should be replicated with therapists who have been in the field for many years. In addition, this study was conducted in Israel and cultural factors should be considered in determining its general applicability.

Another study by Baum and Itzhaky (2006) specifically looked at supervisors' reactions to their pregnant supervisees. The sample consisted of five supervisors, all of whom were married with children, and had between five and ten years of experience in the field; their supervisees were younger, full-fledged professionals with a few years of experience who were having their first child. The supervisors were Jewish but non-observant, while the supervisees were orthodox. The author cites cultural differences and often tensions in the views of those representing these different lifestyles, with orthodoxy placing more importance on procreation. The findings showed that the supervisors were judgmental of their supervisees' pregnancies; many saying they did not think the supervisees were ready to have children. Some remarks were even interpreted as hostile. The supervisors did not see the supervisees' decisions to wait to disclose their pregnancies until after the first semester as a practical or precautionary matter, but instead seemed to take this personally and interpreted this as "secrecy". The limitations to this

study are its small sample size, as well as the potential cultural conflict between supervisors and supervisees.

The only quantitative study that I found on the pregnant therapist was conducted by Napoli (1999), using a very small, sample of convenience (n=6) to look at both cancelled sessions and fee arrangements during a therapist's pregnancy. This study used a two-way ANOVA to look at the patterns before, during, and after the pregnancy. The author admitted the small sample size could only represent a portion of the normal curve and reported that the analysis of variance took the sample size into consideration and adjusted the results accordingly. The findings after these adjustments showed that patients did in fact miss significantly more appointments during and following the pregnancy as compared to prior patterns. The fee-paying pattern did not show any significant change. The results of the fee-paying arrangement are even less telling as the results were based on only the four adult patients; the other two patients were excluded from the analysis as their parents were the ones who paid the fee. The results from this unusually small quantitative study can only be interpreted with great caution; however, the questions asked by the study are important and might be better answered qualitatively so that the "why" behind these potential issues can be anticipated and perhaps addressed early on.

Fallon et al., (2003) interviewed 29 female group psychotherapists who had been pregnant. The majority of therapists were reporting on their first pregnancy. These therapists were given a questionnaire and asked to organize their observations into four time periods across trimesters and during their return to work. Clients included women and men, and themes that emerged were: a) abandonment, deprivation, and loss; b) sibling rivalry; c) envy; d) parenting; e) sexuality; f) information seeking about pregnancy, and g) positive feelings toward the therapist. The questionnaire asked therapists who practiced in both individual and group modalities to

make direct comparative judgments about the differences. The researchers found that negative affect appears more intensely in individual therapy. The theme of loss and abandonment was primary for both group and individual modalities, with individual therapy patients reacting more intensely. They also found that women might be more open to therapeutic opportunities regarding the pregnancy than men.

Grossman (1990) interviewed 16 therapists at the time of their pregnancy, all but three being first time mothers; follow-up interviews were conducted 3 months after the participants gave birth. Both group and individual interviews were conducted over a 12-month-period which the researcher considered a “multiple case study approach.” All interviews were transcribed and coded and the researcher was specifically looking for predetermined themes of power and nurturance, which were indeed found in the material and described as: Nurturance, Unconditional versus Conditional, and Power versus Vulnerability. Other themes that naturally emerged included: Guilt: Responsibility/Reliability versus Selfishness/Abandonment, Identity: Personal and Professional, and Limits and Boundaries. A strength of this study is that it did not look at only retrospective accounts.

Some of the much older empirical literature deserves mention. Fenster's (1983) study interviewed twenty-two therapists during their third trimester and followed up with them for a second interview six months after giving birth. This study also did not rely just on retrospective accounts. The results of this study supported therapists' increased avoidance of hostile patient material, as well as the intensification of transference and countertransference dynamics during pregnancy. In a retrospective interview study of 32 psychoanalysts who had given birth within the past two years, Naparstek (1976) reported that therapists emotionally distanced themselves from both anger and hostility directed at them by their clients and in most cases had difficulty

tolerating any negative expression (Stockman & Green-Emmerich, 1994). Bassen's (1988) study, previously discussed, supports this finding.

Bassen (1988), Baum (2006), Baum & Itzhaky (2010), Grossman (1990), Fenster et al. (1983), Fallon & Brabender, (2003), and Lyndon (2013) have found that the pregnancy of either the full-fledged therapist, or the therapist-in-training, may arouse feelings of guilt in the therapist for various reasons. All the therapists seemed to experience conflict around attending to their patients versus attending to what was happening simultaneously in their bodies; this preoccupation seems to have aroused some of the guilt. Bassen (1988) speaks of anxiety, while Baum (2006, 2010) talks about feelings of inadequacy.

The vast majority of aforementioned studies seem to speak to a predominant avoidance by therapists in regards to aggressive patient associations. The Katzman (1993) study differed in that it did not discuss feelings of the therapist, only those of the patients who themselves also avoided directly expressing angry feelings. Bassen (1988), Katzman (1993), and Napoli (1999) all discuss missed appointments as relevant clinical issues in reaction to the therapist's pregnancy. These findings are from two different cultures, Israel and The United States. Supervision is discussed as critical in all of these studies, making the Baum & Itzhaky (2006) study stand out as to why it is critical that supervisors are trained to handle issues around pregnant supervisees. Most authors agree that supervision is critical for the pregnant therapist and, indirectly, benefits the patient. While the aforementioned articles were empirical in nature, most of the existing literature consists of either conceptual articles, or, more often, case studies.

Case Literature

Lax's (1969) paper is one of the earliest articles on the pregnant analyst.

Lax highlighted the pregnant therapist's vulnerability to patient transference and underscored the importance of being on guard against countertransference reactions. While she noted transference themes of abandonment and envy by the female patient, she contended that their specific transference responses were a reactivation of their own infantile conflicts. She found patients recreated their childhood conflicts and cast her in the role that the child originally experienced their own mother. The females had much more intense transference reactions than the male patients and seemed better able to explore the meaning of the analyst's pregnancy usually employing identification as their main defense. Lax (1969) concluded that if pregnant analysts have worked through their own infantile conflicts, this should mitigate intense countertransference responses evoked by heightened patient transference.

Imber (1990) explores how the analyst's increased vulnerability while pregnant, can lead to the avoidance of negative countertransferential feelings. She conveys, through personal case material, how critical it is to examine these feelings, as avoidance can impede the treatment process. Additionally, Imber (1995) addresses what she sees as a gap in the literature on effectively supervising a psychoanalyst in a time of 'personal crisis' specifically pregnancy. Imber offers three clinical vignettes from her own supervision of pregnant analysts which highlight the supervisor's role in working with the transference and countertransference dynamics, with special attention to the pregnant analyst's blind spots. She sees the role of the supervisor as important in helping to facilitate, rather than disrupt, the treatment of a patient while the analyst is pregnant. She believes there is a greater need to be reassuring and supportive, and even to offer interpretations during this time.

Dyson & King (2008) contend that a woman's pregnancy "leads to an

increased accessibility to unconscious processes” (p. 30). They focus on the dual role of the therapist having to work intrapsychically, as well as with the disrupted therapeutic relationship caused by the therapist’s pregnancy. They discuss the three trimesters of a therapist’s pregnancy and themes that may emerge at different stages, including the various considerations regarding when and how to disclose the pregnancy. They discuss countertransferential aspects which may include a denial of the impact the pregnancy has on the client, as well as a denial of the therapist’s own intrapsychic difficulties; the therapist’s increased vulnerability may lead to less tolerance for hostility or client aggression and the critical working through of these feelings.

Suchet (2004) presents a compelling case study of the unconscious communication that occurred between herself as a pregnant analyst, and a patient who reported multiple dreams which communicated the analyst's intrapsychic world. Suchet says, "Countertransferentially, I wondered if I was leaking my own baby fantasy and fears (p. 270)," and then later, "I felt as if I had no protective barrier (...) it was as if she were in my uterus, in a co-created space whereby mother and fetus communicate less with words than with feelings and nonverbal (p. 283)." This particular case study speaks to the increased vulnerability of the therapist, as well as the opportunity for an examination of the unconscious dialogue that may be more likely to happen at the time when a therapist is pregnant.

Bienen’s (1990) paper examines the theme of guilt as a counterransferential response her pregnancy. Her disclosure of her own pregnancy juxtaposed with the unfortunate timing of a patient’s abortion, highlights the sensitivity and complexity of inevitable disclosure, as well as avoidance by the analyst of exploring certain transference responses. Bienen avoided interpreting rage and envy based on her own feelings of guilt and anxiety over her own baby’s health. She admitted that because of her own need for self-protection, and possibly her

unconscious wish to remain the idealized analyst (good enough mother), she colluded with the patient's avoidance of exploring the meaning of both of their pregnancies, and noticed her therapeutic approach at this time was more supportive. Ultimately, Bienen and the patient were both better able to tolerate and explore these meanings when she returned from maternity leave. McGarty (1988) supports this need for self-protection when she observes, "We choose to bring ourselves into the arena of our patient's intense emotional reactions. We do not choose to put our children there" (p. 686).

Hjalmarsson (2005), discussed three case vignettes depicting her interaction with clients during her own pregnancy. This article is unique in that it seems more prescriptive in advocating for a specific approach; she feels the therapist needs to be more interactive, including increased self-disclosure during her pregnancy as a way of working through the client's various feelings. She espouses that the therapist should actively facilitate and respond to a client's pregnancy related material in an open and honest way, allowing "greater involvement in the analyst's life event" (p. 2).

Pregnancy Theory

Raphael-Leff (2004), a psychoanalyst known for her own psychoanalytic theory of mothering orientation, feels that heightened sensitivity and perceptiveness, along with co-constructed transference-countertransference configurations, creates the breeding ground for profound unconscious communication between a pregnant therapist and her client. She identifies three components that make up this unconscious dialogue: how the pregnancy affects the therapist herself; how the analyst's pregnancy affects the patient; and how the patient impacts the pregnant analyst.

Raphael-Leff (2004) has outlined procreative mysteries, or anxieties, that are deemed universal by women. She defines them as anxieties about formation, containment, preservation, transformation, and separation. Pregnant therapists are not immune to these anxieties, and in some instances, may even feel them to a greater degree. What happens when this anxiety mixes with projective identifications and hostility from the patient? These types of dynamics are important to highlight and understand, as therapists who are pregnant, or planning to become pregnant, need to be aware of the potential dynamics that could arise in the treatment process. It is equally important, that supervisors understand these dynamics, and the implications for treatment.

It is critical that therapists are aware of the aforementioned anxieties as they can be unconsciously shared with the patient, and, in some instances, may exacerbate anxieties already present in the patient. Pregnancy is a powerful stimulus. Raphael-Leff (2004) maintains that universally, the emotional effects of pregnancy radiate beyond the pregnant matrix, and while interpretations may vary within different cultures, the pregnant belly galvanizes not only the expectant mother, but, just as importantly, those around her. By utilizing structured interviews with both first-time previously pregnant therapists and clients of formally pregnant therapists, my own exploration takes a closer look into what exactly the pregnancy evokes for not only the therapist and patient, but also for the therapeutic pair.

Cultural Aspects of Pregnancy

In order to better understand the dynamics and meaning that might contribute to the relationship between a pregnant therapist and her client, it is important to explore the history of pregnancy, including specific cultural variations. Balin (1988) outlines some of the cultural meanings of pregnancy and childbirth. The Ancient Greeks, for example, did not recognize

biological motherhood except as a medium to the spiritual creation of a child, thus they placed little emphasis on pregnancy and childbirth itself. There was a similar lack of emphasis in Aboriginal society, which viewed the woman as simply the medium through which the child appeared. Other societies, according to Balin, elevate pregnant women and childbirth to a status that is considered sacred. In Sri Lanka, Jamaica, Latin America and many Arab cultures, the parturient woman is made a special and protected member of society. Balin contributes to our understanding of the cultural meaning by studying the ritual and sacred dimensions of both pregnancy and childbirth in American society. Through her qualitative ethnographic study of pregnant women, she concludes, “the women’s stories underscore the symbolic and real dimensions of pregnancy as a rite of passage” (p. 299). She hypothesizes that within the Judeo-Christian religious heritage of American society, “life is symbolically expressed as a sacred gift from God” (p. 299), but found that, “The sacred and liminal status accorded pregnant women acts in some respects to disempower the pregnant woman ... while empowering those who guide her through the rite of passage” (p. 300). Balin questions how pregnancy is expressed within the healthcare system, specifically within the culture of hospitals and delivery rooms. In a similar way, this dissertation will look at the meaning of the therapist’s pregnancy within the culture of the therapist-patient relationship.

Research

There has been only one study focusing on the client’s perspective of the therapist’s pregnancy (Katzman, 1993), and this was done through surveys and questionnaires of patients of one particular therapist. To begin to address this gap in the research, using constructivist grounded theory, as described by Charmaz (2006), I developed a qualitative study that interviewed both clients of pregnant therapists and first-time pregnant therapists. With the

exception of one dyad, these cases do not represent matched pairs. For the one matched dyad, I left out, diluted or disguised any clinical material linking them, to protect confidentiality.

However, I have included this material in the coding process. In addition, in order to protect the confidentiality of all participants as well the people they discussed, I have disguised or slightly altered some of the data.

Recruitment and Sample

I found my participants through convenience and snowball sampling. The sample was comprised of eight clients of formerly pregnant therapists who had been in treatment with the therapist for the length of the pregnancy or until the therapist took a leave; six participants had been in treatment with their therapist for an average of 4.5 years prior to the pregnancy, and two were with the therapist for more than one year. Most clients found out about the study, directly or indirectly, through flyers posted on various college campuses, and were from areas in or surrounding New York City, Philadelphia or Boston. One client in this study had actually been in treatment with two separate pregnant therapists. All clients were female and had some level of college education, and most were working towards higher degrees or had already achieved professional status in various fields. Client ages ranged from 21-38 with a mean age of 31. At the time of treatment 5 clients were single, two were divorced or separated, and one was married with a child; the latter participant was the only client who had a child. Six participants identified as “White” or “Caucasian”, one identified as “Black” and one identified as “Hispanic.” Seven identified as “straight” or “heterosexual” and one identified as “queer.” Reasons for treatment varied, with some participants providing more than one reason or diagnosis: Bipolar disorder (2), Depression (2) Anxiety (1), Post Traumatic Stress (2) School and Career Stress (1) Fertility and Relationship Issues (2).

Eight therapists participated in this study and all were pregnant for the first time within the past 5 years; six of the participants had given birth within six months of the interview, one participant within the past year and one participant had been pregnant 5 years ago. Therapists were found through a variety of list serves and word of mouth. All identified as psychodynamically or psychoanalytically oriented, and their years of experience before becoming pregnant ranged from 3 years to 14 years, with the mean being 8.4 years. Five were social workers, two were psychologists and one was a mental health counselor. Seven of the eight therapists identified as “White” or “Caucasian” and one identified as “African-American.” Seven of the eight therapists were married, including one who was in a same sex marriage, and one therapist was living with her partner. Six identified as “straight” or “heterosexual”, one identified as “bisexual” and one identified as “queer.” Four of the therapists were exclusively in a private practice setting, two were exclusively in a clinic setting and two were in a combination of private practice and clinic settings.

Data Collection

Data was collected through either face-to-face interviews in a private office or via Skype videoconferencing technology. All participants provided written consent to be interviewed and audio-recorded, and all agreed to allow the use of anonymous quotes for publication purposes. The University of Pennsylvania’s Institutional Review Board preapproved the research project. The interviews lasted between 45 and 60 minutes. Participants were compensated \$15 at the conclusion of the interview.

During the interview, I used a semi-structured interview guide (I had a separate guide for each group). I utilized the guide in a flexible way, allowing for themes to emerge outside of the

interview questions. At the conclusion of the interview, I asked all of the therapists and most of the clients to offer advice to future pregnant therapists based on their own experiences.

Data Analysis

An independent research assistant or I transcribed verbatim the audio-recorded interviews; although I was the only one who knew the actual identity of the participants, the research assistant signed a confidentiality agreement approved by the IRB. All eight client interviews were analyzed by me using line-by-line coding. The research assistant who had transcribed approximately half the interviews engaged in line-by-line coding of one full client transcript and one full therapist transcript. We compared our open codes and after discussing the minor discrepancies (mostly having to do with code length rather than content) we came to intercoder agreement (Campbell et al., 2013) and we adjusted several of the codes. We both independently engaged in focused coding (I compared the open codes of all transcripts to one another) while my research assistant looked for emergent themes in five of the transcripts that she had not open coded. After comparing and discussing at length our independent focused codes, I added one of her focused codes and collapsed some of hers and some of mine into subcategories of the focused codes we agreed upon in a process called axial coding (Charmaz, 2006). We applied the same process to the therapist transcripts, although I only engaged in line-by-line coding of four interviews before beginning the process of focused coding on the remaining transcripts. The research assistant independently open coded one interview and did focused coding on three others. We then met to establish intercoder agreement.

Findings

I will present in detail the findings that seemed unique and particularly salient to this study, especially when the same themes emerged for both the clients and the therapists. The

themes that will be discussed are as follows: 1) “The rules of pregnancy”, disclosure, denial and repression; 2) Waiting and watching: anxiety about the pregnancy and patient response; 3) Knowing and being known by the therapist: trust, identification and deepened connection; 4) Altered therapeutic response: conscious and unconscious shifting of boundaries; 5) “Bad Timing” disruption, abandonment and distancing; 6) Revisiting Rapprochement; 7) Role reversal: manifest need to nurture and protect; 8) Life vs. Loss: Desire vs. Regret; 9) “How you never want to feel as a therapist” 10) Supervision in handling hostility; and 11) Advice for pregnant therapists.

The Rules of Pregnancy, Disclosure, Denial and Repression

The disclosure of a therapist’s pregnancy is clinically complex. In many cases, pregnant therapists waited for their clients to notice their pregnancy, and while clients often did notice, they found it impolite and not their place to mention it. Consequently, if therapists do not acknowledge their pregnancies, their clients may repress their own knowledge or suspicions and deny that there are any implications regarding their treatment. This can easily leave clients completely unprepared for the ultimate acknowledgement of the pregnancy and, in the words of one client, feeling, “left out in the cold.” One therapist who did not disclose her pregnancy until the beginning of her last trimester said that several of her patients had noticed she was pregnant, and one client admitted that she felt it was impolite to ask. The therapist said, “I understand this reluctance to ask to some extent, but it still seems odd that it went unmentioned for so long.”

(Therapist H) The findings of this study reveal why a client might be reticent to ask if her therapist was pregnant. One client articulated the nature of this reticence in the following way:

I think it’s interesting in our culture how pregnancy is almost taboo in a weird way. It’s taboo to talk to somebody about their pregnancy if they haven’t brought it up with you.

Fifty years ago it was something you were expected to hide, we still have this aversion to pregnancy in a way where it is considered a very personal thing. There is a weird sort of protocol about how you're supposed to act: if you know someone is pregnant its very polite to ask about it if they have shared it with you, but it's very impolite to talk about it if they haven't. (Client C)

One client, who had been in therapy with her therapist for years, described her experience in this way: "It was a bit like a game of chicken; we were both waiting for the other person to say something." (Client H) One therapist who had to cancel sessions because of health issues related to her pregnancy, tried exploring her clients' feelings around this, and noticed that this line of questioning seemed to annoy some patients. She said, "It's as if no one felt they were allowed to be annoyed and no one would get mad at a pregnant woman." She felt the "rules were getting in the way of genuine feelings." (Therapist I) The fact that cultural rules regarding pregnancy exist and that clients, for the most part, feel bound by these rules (Bassen, 1988, Fallon et al. 2003), is critical information for pregnant therapists to know. In the therapeutic setting, it would seem to be imperative that the "rules" around discussing pregnancy need to be recognized and explicitly addressed and challenged by pregnant therapists. It should be noted that none of the clients in this study were in an analysis where one of the rules is to say anything that comes to mind; however, one of the therapists in this study did have a patient in a formal analysis, and that patient also did not mention the pregnancy, and later denied having any suspicion, despite the fact that the therapist said it was quite obvious at that point in which she revealed her pregnancy.

Five of the eight clients suspected their therapists were pregnant before it was disclosed. Only one of the five shared her suspicion with her therapist, she suspected at roughly the same

time the therapist found out herself. This particular client had been with her therapist for close to ten years, and this dyad's therapeutic culture likely made it safer for her to share her suspicion. The other four waited for the therapist to tell them and all stating in some way that they didn't want to be rude or pry. In three of these cases, the therapist was in the third trimester and obviously pregnant before the disclosure took place. While all of these clients said they knew the therapist was pregnant, it never occurred to any of them that the pregnancy would have any impact on their treatment until their therapists explicitly told them that they would be taking maternity leaves.

The following client quotes would seem to be indisputable testaments to the power of denial:

Obviously she's pregnant and of course she's going to take a maternity leave but I didn't think about it. I assumed I would continue to see her, which is silly because it should have occurred to me sooner, but it didn't. I really didn't think about how it would impact me until she mentioned it. (Client C)

Similarly, Client H said:

I probably knew at the end of the first trimester. It didn't occur to me that she would take a maternity leave until she told me, then I was like, oh I guess that makes sense. I don't know why I didn't think about it, why it didn't strike me that she's probably going to take a maternity leave when she has the baby. Client D said:

I figured out she was pregnant but didn't know she was leaving. I wasn't thinking of the fact or even potential that she would leave, it makes sense that she would leave, but I hadn't thought about it. I didn't put the pieces together.

Client F, who suspected early on that her therapist was pregnant and was told at the beginning of the second trimester, said:

I thought she was pregnant, it was a feeling I had, she definitely didn't look pregnant but something was different. When she told me, right in the moment, I was really excited for her, but in the back of my mind, thought oh no she's going to be gone. She told me her due date but I sort of forgot about it until it got closer to the end.

Wedderkopp (1990) views the dearth of literature on the pregnant therapist as the therapists' collusion with the denial that many clients experience. It should be noted that the two clients in my study who were with their therapists throughout their pregnancy, but for less than a year, were told about the pregnancy in the last trimester and given the least notice. Both of these clients reported feeling attached to their therapists. Many therapists struggle with the question of when to tell their clients. Kofman and Imber (2005) agree with Golberger (2003) that telling too early forecloses the opportunity of working with spontaneous client material that may emerge in response to the pregnancy, but think that if clients have not said anything to their therapists by the end of the second trimester, these clients should be told so they have time to process what this means. One therapist in my study advised:

Be patient. Part of me, before it was even a question of showing, felt like I should go ahead and tell. There was something that felt secretive or not genuine about waiting until someone brought it up. In the end, I'm glad I didn't just jump to tell straight away because I don't know that some of the material would have emerged if I had disclosed prematurely. I brought it up in a way that was related to their material and that felt helpful. (Therapist B)

Client H, while initially upset that her therapist did not tell her sooner, said:

It was a smart decision not to tell me earlier. I think it would have dominated too much of our sessions. She probably knew, knowing how I react to people who need caretaking, that I probably would have done that a bit in our sessions.

A concern with waiting until the third trimester is that the therapist could have the baby prematurely. Three of the therapists included in the study and three of the client's therapists (6/16 – just under 40%) in this study had their babies either prematurely, or went on bed-rest due to medical complications. One client's therapist had her baby unexpectedly at 27 weeks; luckily this client had been told earlier and coverage options had been detailed for her. This client, who had at first opted not to see a covering therapist, changed her mind, "When I heard, I thought oh this is going to be a very long time without therapy, so I called the covering therapist and started seeing her." (Client E) Another client who was told 5 weeks before the therapist's permanent leave, felt she was not given enough time to find a new therapist, at least one that she could actually afford, so she didn't see anyone for a while.

Katzman (1993) found that, "telling clients earlier would not only allow a greater opportunity for emotional exploration, it would also place the burden of exposing an obvious, but mutually unaddressed secret, on the therapist" (p. 28). My findings corroborate that it is the therapists' obligation to disclose their pregnancies to their clients in ways that allow enough time for both exploration and logistical coordination. That said, it is also important to remember Bassen's (1989) admonition that disclosure should not occur so early that it forecloses a careful exploration of the meaning of pregnancy.

Waiting and Watching: Anxiety about Pregnancy and Patient Response and an Increase in Nonverbal communication

Consistent with the literature, most of the pregnant therapists I interviewed reported feeling anxious. They were concerned with their own health and their patients' reactions and wellbeing, and were more aware of their patients' nonverbal cues; in some instances, their anxiety was associated with waiting for their clients to say something. A few of the therapists admitted that their work helped distract them from the anxiety regarding the pregnancy itself.

I was anxious about the baby and about childbirth so I liked coming to work, I found it both grounding and distracting. I was not a comfortable pregnant person so it was nice to have something that could engage me away from that. (Therapist G)

While with others, the anxiety was centered around the reactions of their patients,

I was more sensitive to the fact that I was pregnant, especially if the baby was kicking, especially with patients I thought it might trigger something I think, I don't know if I showed it, but internally, I was like 'oh god'. (Therapist D)

In one instance, there seemed to be a shared somatic state around the anxiety that was brought on by the pregnancy, both the patient and therapist felt the "flutter of butterflies" in their stomachs in relation to an increase anxiety.

One client who noticed her therapist might be pregnant at roughly the same time the therapist found out herself, said:

I'm sure it was, in part, unconscious fantasy. I think on the surface it was something about the way she got up. I think she pushed herself up in a way that I'm accustomed to seeing people with back pain or people who are pregnant. (Client A)

Therapists and clients noticed a change in non-verbal communication. "I noticed the eye contact was different, glances at my belly and then sort of maybe an embarrassment that they might be caught looking. I also noticed one woman scowl at my belly." (Therapist I)

Many of the therapists reported their clients had an increase in dreams related to their pregnancy, and one of the clients in this study reported multiple dreams that she understood as directly related to her therapist's pregnancy. Speaking about one dream she commented, "I understood it as a wish to be more involved in her pregnancy" (Client A)

Knowing and Being Known by the Therapist: Trust, Identification and Deepened Connection

In speaking about the therapist's pregnancy, Zackson (2012) says it offers "both the therapist and patient an unusual, evocative, and reparative moment within the treatment, a chance to meet each other more simply and directly, a moment which holds out the possibility of mutual caring and concern" (as cited in Wolfe, 2013, p. 123). The findings of this study support this notion. Many of the therapists and clients reported feeling a deeper connection with each other because of the pregnancy. This is illustrated in the following:

I don't know if I have any evidence for this but rightly or wrongly I feel my patients had a greater trust in me while I was pregnant. I don't know if it was them watching me struggle, or my vulnerability that made them feel safer with me (Therapist N).

Many, but not all of the clients in this study, expressed a deeper sense of trust and connection to their pregnant therapist. One of the clients who had been in therapy with two pregnant therapists said, "When I know something about the therapist it makes it easier to open up in a less scary way, it makes me feel more connected to her." Another client said, "Her pregnancy and the fantasies I had around the pregnancy made me feel more connected to her—it made me feel like she understood me better." (Client A) In a few cases, the deeper sense of connection seemed

related to the therapist's vulnerability. The therapist of a client who struggled with her own fertility issues, had an unexpected early delivery, the client said:

I only want the best for her, it was hard to be that close to somebody and yet not be able to ask and not know any of the details of her life, yet also care very much. In a way, the fact that her pregnancy wasn't perfect, made me feel like I could relate to her better-I struggle with these everything is perfect scenarios. (Client G)

Perceptions of the other seemed to change on both sides. One therapist observed:

There was one young woman whom, for whatever reason, I always found myself being annoyed with. After I got pregnant, I began to sort of imagine her as my daughter and for the first time, I started to find some of her personality traits as very endearing. I felt like something about being pregnant opened me up to her in a different way. (Therapist I)

Speaking about a different client, this same therapist said, "My pregnancy seemed to soften her. She was able to talk about what she imagined it would be like without me, whereas before she would disavow feelings of attachment or disappointment." (Therapist I) Another therapist who had no choice but to disclose that she might need to leave the session as a result of morning sickness or the need to use the bathroom, said, "I felt in both of these cases, these disclosures actually made my clients feel closer to me." (Therapist P) One client said,

It's funny because I knew that she already had a child, so its not like, oh now she's going to be a mother, she's this maternal type, but for some reason when she became pregnant she became more nurturing and maternal in my mind (Client E)

The aforementioned dynamics result in increased maternal transference on both sides of the dyad, and in this context when the pregnancy was disclosed early enough, increased feelings of connection.

Like Winnicott, Chodorow points out that the most important feature of an infant's development is that it 'occurs *in relation* to another person' (77).

Chodorow works to articulate a view of motherhood that reproduces itself over the generations via the mother-daughter relationship, inscribing itself into the culture along the way (Lyndon, 2013, p. 52).

In that same way, a client and pregnant therapist have a unique opportunity to look at the multiple constellations of mother-daughter relationships: the client with her own mother; the client as a potential mother; the therapist with her mother; the therapist as a mother; and the maternal feelings (from both the client and therapist) that arise and interact in the therapeutic relationship. The transference might also become eroticized, as was the case reported by one therapist in this study, "I actually thought there would be more maternal transference with him but he went the more erotic route which was interesting." (Therapist K) Some eroticized transference may represent a yearning for an earlier maternal figure, something the therapist's pregnancy could very well evoke. Benjamin (1994) sees this type of transference, as stimulated by the possibility that the analyst could be viewed as the all powerful, longed for and/or dreaded, "bestower of recognition."

Altered Therapeutic Response: Conscious and Unconscious Shifting of Boundaries

The undeniable reality of the pregnancy introduced new clinical challenges for most therapists; they were faced with decisions on how much they wanted to disclose, as well as how these disclosures might affect the transference relationship. As one therapist-respondent put it:

The therapeutic relationship is very special and you never truly know how your patients are seeing you and being pregnant interrupts whatever fantasy they might be having

about you in a way that's kind of undeniable to both of you so you might as well talk about it. (Therapist N)

Fallon et al. (2003) divided patient responses into three categories: "real" vs. "transference" relationships and a combination of the two. "The therapist's grasp of the transference versus realistic component of the patient's response is important in that the therapist's understanding of the nature of the response serves as a basis for all of the decisions that arise during pregnancy" (Fallon et al. p. 38).

My study confirms that there is always a combination of the two and therapists must make decisions on how to handle the spectrum of responses between fantasy and reality in a way that is clinically helpful. One therapist reported that,

It was hard when most people just assumed I was married to a man versus asking, It didn't feel like there was an opening to question the assumption in a way that would have been helpful for my patients. (Therapist K)

This therapist made a decision that allowed the transference relationship to continue without disclosing the reality of her circumstance. One client admitted to feeling closer to the therapist based on her "fantasy" around the reality of her therapist's pregnancy,

I don't really know what her story was, but it was affirming for me that she could understand the desire to be pregnant and I had fantasies that she very much wanted this pregnancy and to be a mother. (Client A)

Most therapists I interviewed reported feeling less inclined to explore the transference responses and some admitted to feeling the need to alter their technique.

I don't disclose a lot of personal information normally and so it just felt a little more personal and I also felt like well if they have to watch me go through my pregnancy you

know it's in the room. I felt inauthentic to be all coy about this after having told them this thing and here I am going through 9 months of pregnancy in front of them. (Therapist P).

While therapists may have been somewhat disclosing before, the more personal questions that ultimately arise from the pregnancy present an additional clinical challenge. One therapist said she did not feel she needed to alter her technique too much,

It's always a clinical judgment about when to just answer, you know do we need to be two human beings in the room right now or do I think this is worth exploring or is it going to be a narcissistic blow. (Therapist I)

For other therapists, however, this was something that they felt they needed to address much more while they were pregnant.

The findings in this study are consistent with Fenster et al. (1986) and Hjalmarsson (2005) who concluded that in many cases, increased disclosure had a positive impact on the therapeutic relationship. However, as will be shown in the subsequent section, this is not always the case, or rather it can have both positive and negative impacts simultaneously, or at different points in the treatment.

“Bad Timing” Disruption, abandonment, distancing and avoidance

Regardless of whether the therapist's pregnancy helped to ultimately facilitate a deeper connection, the clients in this study almost unanimously said that the therapist's pregnancy, early labor, or even planned maternity leave, always represented “bad timing.” One therapist described her pregnancy as, highly disruptive:

I'm very glad I have my baby, but I was so worried about my practice and my patients. I really struggled with nausea and with just different types of pain, at times, I would have to cancel the day, which is something I never ever would have done before. I felt terrible

about it, but there was just nothing I could do because there were times I couldn't leave the house because I was throwing up. (Therapist N)

One client was surprised at her own feelings when we therapist when into early labor, as is shown in the following quote,

When the covering therapist called to tell me my therapist had gone into early labor, I felt terribly for her and was worried about the baby, but at the same time, I was also like ugh, what about me? That is not familiar to me--that week was a particularly bad week, I felt not exactly angry at her but upset and kind of abandoned but not in a logical way.

(Client E)

The clients in this study didn't seem to express anger directly at the therapist, which is consistent with Katzman (1993) as are shown in the following patient accounts,

I felt angry but I wasn't so much angry at her. I was just upset because I had never seen someone regularly before and we were talking about medication, so it just felt like a bad time to leave because I was still going through a lot." (Client D)

I think the nature of our relationship has always been, I don't want to say close because that would indicate a friendship, but I think we've always had the type of therapist client relationship where it's pretty open and back and forth. That's one of the reasons why I was a little upset that she waited so long to tell me she was pregnant, because I knew for so long and I was like how can you just be so pregnant, you know, and not say anything.

(Client H)

If a client saw a covering therapist, whether because the maternity leave was too long, or a crisis arose, the client inevitably spent a good deal of energy comparing therapists, and there was also confusion over loyalties and the time elapsed.

I think we're finally at a point, or we've been at a point, where the covering therapist knows me better so I feel like it's just going backwards to switch back over. Honestly I've been thinking about this, whether I should switch back over, because I'm going to have to decide pretty soon. I feel like it would kind of hurt my feelings if I went on maternity leave and then all of my patients went to other people and none of them came back to me. (Client C)

From the therapist's perspective:

I think my anxiety, my guilt about leaving my patients made me more compelled to hook them up with coverage while I was away, when in reality, there were probably only two people that really needed to be seen in the interim. (Therapist H)

A critical clinical question for therapists to ask themselves and their clients is whether specific clients need actual coverage or just a covering number in case of a crisis. In some cases the therapist's impending leave seemed to trigger unexpected crises as described by one therapist:

A few patients requested emergency sessions because of whatever was going on with them and I think they might not have before, I don't know if that's because they knew I was leaving and they were trying to get more of me before I left. (Therapist N)

If the client can withstand the separation of a maternity leave, it seems it is ultimately less confusing for them, and may actually, as is shown in the following section, be clinically useful.

Revisiting Rapprochement

The dynamics found in this study between therapist and client resembled Mahler's rapprochement phase, and paralleled the individuation-separation struggles between mother and child, especially around the impending maternity leave. The following statement by Benjamin (1988) captures what a pregnant therapist may feel as she prepares to separate from her clients,

What the mother feels during rapprochement and how she works this out is colored by her ability to deal straightforwardly with aggression and dependence, her sense of herself as entitled to a separate existence, and her confidence in her child's wholeness and ability to survive conflict, loss, and imperfection (p. 34).

Just as Benjamin considers rapprochement as a crisis of parenting and a blow to her own narcissism, in the sense that they must identify with the disillusionment of their child, the pregnant therapist has no choice but to go through this crisis herself as a therapist. How the therapist negotiates the aforementioned dynamics will have a fateful impact on the treatment.

One therapist was surprised at her own fear of leaving her patients:

My fear was having to stop before I was ready (laughs) not before my patients were ready but before I was ready, I really though oh my gosh, that therapeutic alliance is going to be directly damaged. (Therapist N)

What emerged from the interviews is that in some cases, the pregnancy increased client agency, as well as the therapist's push for more agency and self-sufficiency on the part of the client:

Toward the end I noticed she would push me a little further than she normally would have which was funny to me. I even mentioned it to her. It's like she wanted to be able to leave and it would be clear for now. I think a lot of times I need that push and I also wanted her to leave knowing that I had done the things I said I was going to do and so it gave me the push to be accountable for myself. (Client F)

One therapist spoke in the following way about the patients who didn't see a covering therapist in the interim:

I have been so impressed, all of them have done a lot of work during the break, like they had time to really process some of the work we've done and to let it sink in and struggle with it a little on their own. (Therapist I)

Another therapist noticed a developing theme of object constancy as she interpreted a patient's dream about her pregnancy, "She potentially was going to keep a little part of me when I was on leave so there was some piece that was keeping her safe." Still another therapist discussed a patient's experience of holding her in mind while she was on maternity leave, "He found himself thinking about what I would say, and this seemed to offer him comfort." (Therapist I)

The struggle between dependence and independence is the natural result of a therapist's pregnancy. One client who had considered terminating with her long time therapist explained, "I needed someone to let me go in order to give myself license to take other steps in my relationship. I needed to feel like I would be allowed to leave." (Client A) One therapist said,

I feel like in a couple of cases knowing that I was leaving, people stepped up their self-improvement game, you know the same as some people became worse, other people were like I'm going to get my shit together before. (Therapist P)

Therapists admitted how difficult it was to let patients go.

It was really hard, but I allowed her to be angry with me and to go because I felt that's what she needed to do and to trust in the relationship that she would come back and that we would explore it, and she did. (Therapist N)

The way in which the therapists planned and handled their maternity leave seemed a critical piece for preserving the therapeutic alliance. The clients seemed to appreciate being

given different options, as is shown in the following client quote, “I like the way she planned for coverage. I thought that was helpful and appreciated that I knew that she was thinking about it, I really felt tended to.” (Client A) One therapist who was transparent about the tenuousness of her pregnancy observed, “Patients seemed quite appreciative of my giving them the choice to stop, cutback or continue, as well as the knowledge that things could shift quickly.” (Therapist I) It is, Benjamin (1990) says, “this appreciation of the other’s reality that completes the picture of separation and explains what there is beyond internalization—the establishment of shared reality” (p. 33).

For many, the reality of the therapist’s pregnancy can be a very painful process of which therapist’s need to be particularly attuned to. One therapist emphasized the care she took to match her patients with the right interim therapist, and how important it was when she was able to help them anticipate and work through “the feelings of a loss of me, of not being able to have all of me to themselves.” (Therapist N) Fallon et al. (2003) recognize the importance of this process when they observed, “When the therapist is present to assist the patient through these loss and identity formation experiences, the patient can learn that separation need not imply abandonment” (p. 29).

Almost all of the clients acknowledged expanding or using their outside support systems more when the therapist became pregnant, and in some cases, the pregnancy also seemed to stimulate an expansion of the client’s creative resourcefulness. Benjamin (1994) speaks about the importance of the therapist’s acknowledgement of such creative and independent capacity,

The analysand’s knowledge of her or his own creativity, her or his own ability to use the object and use the space, which begins to extend outward to experiences of communications and solitude, play and passion, beyond the couch. The analyst’s

recognition facilitates a developing confidence in the real feeling of freedom and aliveness (p. 174).

The following client captures what it can be like when all goes well:

My therapist's pregnancy was an enlightening experience; when someone you see weekly who is helping you through your stuff tells you they are leaving you it has negative connotations but it actually ended up being a positive thing that definitely helped me a lot, though I'm really excited for her to come back. (Client F)

Life vs. Loss: Desire vs. Regret

Most of the clients I interviewed spoke of feeling that their therapists were more human and became "more dimensional" as a result of the pregnancy. In a sense, the therapist became a real person with a life. However, as therapists became more alive to their clients, in some cases, this meant the patient feeling a loss of having the therapist all to themselves. Both vulnerability and fear of abandonment were palpable themes for both the clients and the therapists in this study. Ironically, it was as if the fear of loss on both sides, in some cases, further connected them.

Therapist vulnerability included feelings related to the pregnancy and anxiety about having a healthy baby, and in a few cases, this vulnerability was exacerbated by a personal history of miscarriages and a fear that they would suffer a similar loss as I shown in in the following:

The first trimester before I told them I was feeling exhausted, nauseous, and nervous that I would lose the pregnancy and all of that that was going on in my life and my psyche, and yet, I'm trying to present like everything is just the same. (Therapist E)

While clients were fearful that their therapist's would not return after they had their baby, many therapists seemed just as concerned that their patients would not come back. In some

cases, this shared, though often, unexpressed sense of vulnerability; made them seem to appreciate and perhaps tend to the relationship more.

In many cases, the pregnancy brought up topics relating to life and death; abortion, adoption, miscarriage, and illness were commonly contrasted with starting a family, or being afraid of not ever having a family. The therapist's pregnancy highlighted losses for some of the patients, in particular the patients who were struggling with fertility issues or those who had moved past their childbearing years and experienced regret as is shown in the following:

She had suffered so much loss; she said she couldn't be in a room with somebody who was sort of headed toward something so wonderful, that it was just too hard for her because her whole life was ruined in her eyes. (Therapist I)

Owning and expressing desire seemed to be another consequence of the therapist's pregnancy suggested by the following client example:

My therapist had always been very encouraging of me taking on expressing and owning my desires to be an independent, healthy professional woman who also wants to be a mother and that's ok and I can ask for that in my relationship and it allowed me in some ways, to be more forthcoming about that- so there was kind of a temporal relationship that around the time that she's becoming pregnant, I'm feeling more comfortable owning my own desires for that. (Client A)

Many clients expressed recognizing and feeling more of their own desires, while others felt the therapist's pregnancy was a catalyst for feeling regret.

She was now too old to have a baby and so my pregnancy allowed her to kind of, she sort of framed it as it was always in the back of her mind as a regret, but it wasn't a fully

formed regret until there was this pregnancy in the room with her and she was seeing me get bigger and bigger. (Therapist I)

Recall the therapist in this study who reported that she felt her pregnancy stimulated an erotic transference; that is one other possibility of of desire that can be triggered by a therapist's pregnancy.

Role Reversal: Manifest need to Nurture and Protect

“The sacred and liminal status accorded pregnant women acts in some respects to disempower the pregnant woman ... while empowering those who guide her through the rite of passage” (Balin, p. 300). In light of Balin's proposition, it is possible that some clients may at times feel empowered by their therapist's pregnancy, as if they are in some way taking a more active caretaking role in the relationship. The perceived role of caretaker can perhaps empower a client, contributing to that client feeling more connected to the therapist. On the other hand it can also be used by a client as a way to avoid discussing painful material as is demonstrated by the following client, “Her pregnancy was the one thing I could focus on, so I kept asking her about how she was feeling, sometimes it was kind of a way to avoid talking about myself.” (Client E) As suggested in the literature (Fallon et al. 2003, Fenster et al, 1986, and Grossman, 1990), many of the clients in this study reported a sense of role reversal or caretaking even though the motivations may have been different at different times as are expressed on the following accounts:

I think that there was sort of like a caring piece of just sort of me feeling like ‘oh she's pregnant’ and I want to be kind of go easy on her I guess, but I think that after seeing her for so long I trust that she's able to handle me, even if she's pregnant. (Client B)

I had kind of a surge of maternal and protective instincts toward her whereby I wanted to know the medical details of what was going on in a way that I don't think I would have anticipated. (Client A)

Knowing such personal details about your therapist is kind of an odd reversal of roles; it's this kind of a humanizing process. When someone tells you they are pregnant, it opens this window into their home life, to this huge emotional transition....I guess that's why it's sort of humanizing. (Client C)

I remember patients being quite displeased when they would see me walk up the stairs, it was sort of like the role got reversed for a minute and they were like the mother.

(Therapist I)

The role reversal that can happen when a therapist becomes pregnant can be used as a way of recognizing and empowering all clients to assert their natural caretaking capacities. "While you don't necessarily want the patient to take care of you" (Therapist N), when this happens, recognizing the power of real human connection is critical. Alfred Adler (1938) espoused, "We probably owe to the maternal sense of contact the largest part of human social feeling, and along with it the continuance of civilization" (p. 221). The therapist's pregnancy can be evocative of that need for a sense of the maternal in all people.

"How you never want to feel as a therapist." (Therapist N)

While pregnancy of the therapist is an undeniable into the treatment space, the way that a therapist handles this is critical and acknowledging the limitations the pregnancy can sometimes impose is part of that process,

I really did not like feeling like I was letting them down and that was undeniable.

Not that we are supposed to be superheroes but you know patients have their time and their day and the consistency of that is how trust is built and it becomes very special. (Therapist N).

Often the pregnant therapist is going to have to make sacrifices that challenge her identity as a professional. Katzman (1993) contends,

The task for the therapist is to assist the clients in constructing an image of womanhood that incorporates the power to produce as well as reproduce. To do this without subscribing to the superwoman ideal is difficult for both the client and practitioner. However, removing superwoman's cape is as critical to forming realistic images of women as it is to empowering motherhood (p.28).

The idea of removing superwoman's cape was directly supported by another client in this study who said:

Give the patient the benefit of the doubt, we understand that even though you're a therapist, we don't expect you to be a super human and you have just as much right to get pregnant and take maternity leave. I can't speak for all patients but I was okay. And most people probably are just fine. (Client B)

“Removing superwoman's cape” while necessary, may invoke in therapist's feelings of shame or inadequacy at not being able to do it all.

Much of the empirical literature explores themes of therapist guilt and feelings of inadequacy (Bassen, 1988, Baum, 2006, 2010, Grossman, 1990, Fenster et al., 1983, Fallon et al., 2003, Lyndon, 2013). A feeling that does not seem to be captured nearly as much by the literature is the feeling of shame. As pregnancy of the therapist has been relatively ignored or downplayed in the profession (Korol, 1996, McGarty, 1998) many therapists who become pregnant feel unprepared for the complex dynamics and sometimes painful feelings of being a pregnant therapist, and many face their pregnancies in what feels like isolation, and some perhaps are reticent to speak about it, especially among male colleagues. Lyndon (2013) in discussing the literature found, “McGarty links this silence on the part of the female analyst to her feelings of guilt and shame. Being unable to maintain her neutrality, her guilt for not being able to do so and her shame about the reason why silence her” (p. 37). The feeling of shame, as I understand it, is much more profound than guilt, and reflects the core of an individual, who they are or are not, versus. what they did or did not do (as in guilt). While none of the therapists in this study explicitly expressed feeling shame, they did use descriptive feelings such as feeling “bad, terrible, awful, shocked” indicating an amalgam of complex feelings can unexpectedly arise when a therapist become pregnant, especially for the first time. One therapist describes a client response that surprised her, and how this made her feel in the moment:

We had been working together for so many years and I was surprised by her reaction, she looked absolutely repulsed by me, and for me, my countertransference at that point was a feeling of, I don't know if I could say hurt, or simply just questioning, am I repulsive? It was kind of a momentary feeling, before being able to say what is this like for you.

(Therapist N).

Even though the therapists in this study did seem to be able to utilize supervision for support, pregnant therapists may still find their sense of themselves as professional women temporarily undermined, and they may feel isolated and unsure how to navigate all the levels of complexity. One therapist in this study admitted, “Part of the reason I wanted to participate in this study is because I was so disappointed at the dearth of information there is for pregnant therapists.” (Therapist Q) Taking off the cape is critical for acceptance of the dual nature/complexities of being a pregnant therapist and a woman, pushing through the feelings of guilt, shame and inadequacy is a critical message to impart to our clients. Acknowledging and modeling the complexity and limitations can even be for some a positive thing as is shown by the following client. “My therapist’s pregnancy helped me to realize what a work life balance looks like.” (Client F). While it is also necessary to acknowledge the life giving powers of womanhood, therapists, especially pregnant therapists, need to be cautious about overemphasizing the power of motherhood, or just as critically, reducing womanhood to the possibility to reproduce.

Supervision (especially in handling expressions of hostility)

The literature on the pregnancy of therapists supports the notion that pregnant therapists often avoid eliciting expressions of hostility and envy (Bassen, 1988, Baum, 2006, 2010, Imber, 1990, 1995, McGarty, 1988, Naperstak, 1976). This study suggest that while pregnant therapists were somewhat nervous about hostility, they actively used supervision as a way to tolerate and contain their patients real and potential hostility and anger as are shown in the following examples:

My supervisor kept telling me to get to her anger. And we were able to get to her anger and she was able to acknowledge it, because sometime she would be so angry screaming

at me in the session and not able to really recognize how angry she was until after.

(Therapist D)

I was glad to be in supervision and it was helpful to me just to process what it felt like for me to have someone I worked with for years storm out, just absolutely storm out of the office after I told him I was pregnant. (Therapist N)

Supervision was so important especially with the one patient who was just enraged at the pregnancy and sort of not wanting to continue and I really I didn't know how to handle that, I didn't know if I should just say ok fine I'll refer you, I didn't know if I should really try to explore it. (Therapist I)

I think I was worried about hostility or envy and I feel like that's what I particularly wanted to talk about in supervision-how would I handle it when it occurred. (Therapist Q)

While anticipating and imaging how to respond to anger and envy is important, it is equally important that the therapist not project these feelings on to the client as is shown in the following account:

I would never tell my therapist this, but it was really irritating because A) I would never begrudge anyone a pregnancy and B) because I just wasn't feeling that way so it was annoying. (Client E)

As will be shown in some of the quotes in the following section, it should be noted that each and every therapist in this study, recommended supervision while pregnant.

Advice for Pregnant Therapists

At the end of each interview, each therapist and most clients were asked if they had specific advice that they would give to a first time pregnant therapist. Some of the advice follows:

Knowing what your clients are struggling with, if they're struggling with fertility issues let them know early so they can process that. I think my therapist was very conscious of who her pregnancy could be a trigger for and helping her clients process that. (Client H)

Don't rush back from maternity leave but consider having your session scheduled for a particular date, maybe not leave it open-ended - have it on the calendar. (Therapist Q)

Spend a lot of time early in the pregnancy thinking about how and when you want to disclose. I mean there is something to sort of letting it happen organically but I think that if you really can spend time in supervision in particular sort of playing with that idea, imagining different scenarios, thinking about how and when you want to do that, thinking about how you'll respond when you get asked, for me there was a lot of anxiety about how to break the news and I think all the exploration around it was very helpful.

(Therapist I)

If you're not in supervision, get into supervision. It's a lot to hold one's own feelings about leaving patients as well as what it brings up for them. Even just struggling with the fact that you're more internally preoccupied. (Therapist B)

You don't have to tell the patient immediately when you become pregnant, but tell them with enough advance warning so they aren't left wondering. (Client C)

Give the patient the benefit of the doubt. I can't speak for all patients...but I was fine and probably most patients are fine. (Client B)

I think in some ways she was not as direct in exploring with me what my feelings were about her pregnancy. I never felt it wasn't allowed, I did feel there was space for me to explore it and I didn't feel as much conflict around it as perhaps some people might but I think it would have been interesting if she really just said to me 'what is it like to know that I'm pregnant and to like know that I'm nursing life here currently, you know that my attentions are divided in a sense' (Client A)

Schedule more breaks for yourself during the day so that you have more time to just take care of yourself, because it's hard to do self-care when you are back to back to back, that's really critical, The other piece of advice is to be in supervision and to figure out how much you want to disclose to your patient, how would you handle the range of responses that you could possibly get. I had some patients who really I think were maybe pushing the envelope in terms of asking me personal questions. (Therapist N)

Supervision is huge. If you hadn't been in supervision, make sure you get into it. Also, make sure you are honest with what you are able to do. Self-care is so crucial. I also wouldn't be so definitive about coming back unless you are absolutely sure (Therapist D)

If you want to ask me how I feel about your pregnancy, make it open ended...don't suggest ways I might be feeling. (Client E)

Be explicit about your plan from the beginning. My therapist told me her plan after she revealed she was pregnant, when she planned on taking her leave and when she planned on returning. This was very helpful to me. (Client F)

Don't be afraid to talk about it. I think I probably missed out on a lot of opportunities. (Therapist L).

Limitations to study

This study is limited because of its small sample size. In addition, while there is some diversity in this study with regard to race (19% non-caucasian) and sexual orientation (19% non-heterosexual), the majority of participants identified as “white or Caucasian” (81%) and “heterosexual” (81%). Since all of these cases were retrospective, there is potential for memory distortion. Due to sampling limitations, all of the client participants were well educated and would likely be considered high functioning intellectually. However, some of the therapists in this study were able to speak about clients they worked with who were more marginalized.

Future research should directly interview clients who are underrepresented minorities, lower functioning intellectually, severely traumatized and economically disadvantaged. The participants who volunteered for this study were all of child-bearing age, mean age 31. I was unable to recruit older women who might have been able to add a different perspective. Again, I

was able to get some of that perspective from the therapists in the study who worked with women beyond their childbearing years, but direct accounts would be preferable. While the therapists interviewed were first-time pregnant therapists, the clients' therapists may or may not have been pregnant for the first time and in some cases this variable was unknown. If possible, research conducted during the course of therapists' pregnancies would add yet another perspective. A male perspective is also absent from this study. Future studies should look at how the therapist's pregnancy specifically affects the therapeutic relationship between male and transgendered clients and their therapist. Other modalities of therapy such as cognitive behavioral therapy and dialectical behavioral therapy should also be researched. Research with patients in analysis is also likely to yield some rich material.

Implications for Clinical Practice

Therapeutic impasses during the time of a therapist's pregnancy can lead patients to prematurely terminate rather than work through their complicated feelings, thus minimizing or totally undoing any previous therapeutic gains. On the other hand, patients who stay in treatment and work through these feelings can make advances.

Therapists as well as clinical supervisors need to be better prepared for possible patient reactions to a therapist's pregnancy in order to appropriately handle the myriad of issues and crises that could arise. Social work graduate schools as well as training institutes should incorporate this rather common scenario into their curricula. Male practitioners as well as female practitioners who have never been pregnant should also be aware of these issues as they may cover for a therapist on maternity leave or act as a clinical supervisor. If these issues are handled optimally, the transition for both patient and therapist will be smoother. This study

suggests that communication and transparency are core ingredients of maintaining a healthy therapeutic relationship when a therapist becomes pregnant during treatment. Many clients/patients seemed to feel a greater sense of trust in their therapists when they were transparent about their pregnancies at an “early enough” state and showed thoughtful care in giving their clients different options regarding how to proceed. When the therapist openly acknowledged the pregnancy without pushing its potential meaning on the clients, but waited to unpack its meaning as it arose organically in the clients’ time, there seemed to be an authenticity and sense of trust that made the relationship and the work itself much more profound. “I think at the end of the day I have a really great therapist and her being pregnant is a positive thing in her life and it has effects but isn’t necessarily all positive or all negative.”

(Client B)

Paper Two

The Therapist's Pregnancy: Toward a Therapeutic Fourth

"Throughout the generations, each of us- male and female - has begun life inside a maternal body. Our first impressions were the walls of the womb, the taste of amniotic fluid, and the muffled sound of a female voice" (Raphael-Leff, 1993, p. 48).

A pregnancy is above all else, a reminder of where we all began. When a therapist becomes pregnant, this powerful reminder, even if unconscious, can transform the therapeutic process for both the therapist and the patient in a way that is mutative and beneficial. However, if not handled appropriately, this same idea can derail a treatment.

Psychotherapy is a profession dominated by women, many of whom are in their reproductive years and may well become pregnant and carry a child to term, while also practicing. Korol (1996) observed that during professional training, there is often pressure to deny the effects of pregnancy; this paper seeks to redress this repudiation.

While there have been some empirical studies that have captured the pregnant therapist's perspective (Bibring, 1959; Bassen, 1988; Baum, 2010; Baum & Itzhaky, 2006; Fallon & Brabender, 2003; Fenster, 1986; Wolfe, 2013, Lyndon, 2013), it is a sparse number in comparison to the vast number of women therapists who become pregnant. There have been to my knowledge, however, no studies that have actually interviewed patients/clients of pregnant therapists. In order to remedy that crucial missing perspective, this paper will include excerpts from a qualitative study in which I interviewed both the patients of pregnant therapists, as well as formerly pregnant therapists, though these excerpts do not represent any matched pairs.

While some may argue that any event in the therapist's life could alter the treatment (e.g. illness, a divorce, or a death in the family), I contend that a therapist's pregnancy falls into a

different category. Pregnancy is an event which is entirely visible, and undeniable. In addition, and perhaps even more importantly, there is a real other (sometimes more) in the treatment space, and it is reminiscent, even if only unconsciously, of the way each and every one of us of any gender began life, in our own mother's womb. The reality of the therapist's pregnancy is so powerful and consequential that, as Fenster, Phillips, and Rappaport (1986) suggest, "From the moment of recognition of the pregnancy, virtually all communication from the patient must be seen as potentially reflective of the meaning of the pregnancy and the breach in the setting" (p. 49). This paper will explore different theoretical perspectives in order to better understand and handle this potential breach in the therapeutic relationship. In particular, the contributions of D.W. Fairbairn, Jessica Benjamin and Christopher Bollas will be considered and excerpts from the aforementioned study, as well as my own personal experience as a formerly pregnant therapist, will be synthesized to better illustrate these concepts. I will also introduce a concept that I am calling "the fourth".

Raphael-Leff: Procreative Mysteries

Raphael-Leff (2004) has outlined procreative mysteries, or anxieties, that are deemed universal by women. She defines them as anxieties about formation, containment, preservation, transformation, and separation. Anxiety about formation includes ideas and/or fears of normality, destructiveness, and creativity; containment anxiety focuses on being known and occupied from within; preservation emphasizes sustaining, protecting and growing the baby within; transformation is the process through which the baby becomes real; and anxiety of separation centers on the fear of loss, miscarriage, internal depletion and a general apprehension related to the unknown of labor and birth. Pregnant therapists are not immune to these anxieties, and in many instances, may even feel them to a greater degree. It is critical that therapists are

aware of these feelings as they can be unconsciously shared with the patient, and, in some instances, may exacerbate anxieties already present in the patient.

Rationale for the Fourth

I have chosen to define what happens in the treatment space when a therapist becomes pregnant as a “fourth.” Why name it? Wedderkopp (1990) writes about the therapist’s pregnancy in the following way, “The multilayered, polymorphic nature of the experience between the pregnant therapist, her baby and her patient (which) is difficult to conceptualise and render intelligible”(39). In naming it, I am hoping to render this experience as more intelligible. Ingram (1996) sees naming as “knowledge management” and, by naming and specifying the experience of the patient, the therapist provides a context through which to organize and legitimize the patient’s experience in a way that can potentially liberate that patient from any internal conflict and confusion. In that same way, I am seeking to legitimize the experience of the pregnant therapist, and help assuage and normalize some of the anxiety that she may feel.

Why have I chosen to call this a “fourth” specifically? In part, it is to acknowledge the reality of an other in the treatment space. Multiple authors have written about the therapeutic relationship changing from dyadic to triadic when a therapist becomes pregnant (Balsam & Balsam, 1974, Chiamonte, 1986, Dyson & King, 2008, Stockman et al, 1994). As is shown in the following, “The therapeutic relationship shifts from being dyadic to triadic in which the baby may be perceived as an intruder or eavesdropper” (Dyson et al. 2008, p. 37). While it might make sense to call it a third, instead, I have decided to call it a fourth to both distinguish it from the multiply used meaning of the third in psychoanalytic literature (Benjamin, Britton, 2004; Green, 2004, Lacan, 1975; Ogden, 2004, Winnicott, 1965), while paradoxically retaining, building upon, and even highlighting the clinically useful concept of the third, particularly

Benjamin's thirdness.

The therapist's pregnancy is qualitatively different from any other event in a therapist's life in the fact that there is an "other" in the actual treatment space. I have personally experienced this sense of "other" when patients of mine were worried about confidentiality, or when one was startled when she actually saw my baby kick. While clients may or may not acknowledge an other, pregnant therapists themselves will likely be very attuned to the presence of an other. One participant in my study said she was surprised how much she enjoyed having her baby's "presence" in session with her; she explained, "I even enjoy saying to him now, you know these patients" (Therapist M). Another participant said, "If I was in session where somebody was really angry I would wonder, you know, hearing that anger-could the baby hear it and would that have an impact" (Therapist I). Some patients admitted to being more cautious because they didn't want to negatively affect their therapist's baby. One patient in my study, thought it would have been nice for the therapist to explicitly ask, "What's it like for you that I'm pregnant- that I'm nursing life currently, that my attentions are divided in a sense?" (Client A).

My hope is that the fourth will be a catalyst to connect pregnant therapists with Benjamin's concept of thirdness as I believe pregnant therapists can use the fourth as a way to highlight their own subjectivity and foster mutual recognition, the basis of thirdness. According to Benjamin, thirdness is the place needed for a therapist to soothe the patient, which, interestingly enough, might be most needed when the therapist is pregnant. "Thirdness is the quality of relatedness that is associated with two partners sharing an orientation to a third principle or perspective that lends the relationship a sense of mutual space and mutual accommodation" (Benjamin, 2005, p. 37). Benjamin sees thirdness as a process of building relational systems and developing intersubjective capacities that facilitate the co-creation of a

relationship that respects both partners' subjectivities (2004). As both therapy and pregnancy are processes, it is important to have a way of thinking about this somewhat unique merger of the two. Aron (2006) states, "Psychoanalysis has been plagued by its preoccupation with binaries. Conceptualizing the third is one attempt to move beyond such oppositions and to create a triangular space within which psychoanalysis can think more freely, open dialogue, grow and develop" (p. 366). The therapist's pregnancy could ideally serve as an impetus to create a triangular playpen in which the "multilayered, polymorphic" meaning of a therapist's pregnancy can be rendered meaningful, and where even the binaries of male and female are muted and instead that other is a kind of both real and symbolic stand-in for all human potential.

Defining the Fourth

The fourth, as I see it, is not only literally the therapist's pregnancy, but also the figurative, symbolic, conscious and unconscious meaning which the therapist and patient (of any gender) each individually attach to the pregnancy as well as to new motherhood, and their co-created meaning of each. As the client and therapist will in a sense experience three-trimesters of pregnancy together, in optimal circumstances they will also reunite for a metaphorical fourth "trimester" following the maternity leave with the knowledge that the therapist has a baby at home. The "fourth" is meant to be a brand of knowing and relating specific to pregnant therapists as a way to remind them of the aforementioned breach, and to inspire them to recognize and explore their own reactions and feelings as well as to utilize transference and countertransference issues in ways that thoughtfully elicit more meaningful material, and, in optimal circumstances, strengthen the therapeutic bond.

That all said, I am not trying to suggest that thirdness is the only concept that can be useful in thinking about the fourth. In this paper, I will also attempt to illustrate how Bollas's

concepts of the “unthought known”, “human aesthetic,” and “transformational object”, as well as Fairbairn’s endopsychic structure can be employed to better understand the multiple meanings and complex conscious and unconscious dynamics triggered by a therapist’s pregnancy.

Raphael-Leff (2004) contends that, "the analyst's pregnancy offers a window on bilateral processes of unconscious communication, often obscured in psychoanalytic theorizing" (p. 317).

In this paper, I hope to offer at least a glimpse into that window, as well as opening the door to more concrete ways in which pregnant therapists can be better prepared for the “intrusion in the analytic space” (Fenster, 1983) and to make “the fourth” in fact, therapeutic. My hope is that others will think about, contribute and share their own ideas about what can make the fourth, in fact, therapeutic.

Since my interest in this topic was inspired by my own fascinating experience as a formerly pregnant therapist, I have decided to open my discussion with a brief exchange between myself, and the source of my inspiration, my four-year-old daughter. While admittedly of dubious empirical value, it caused me to think more about what it must be like for a patient when she sees or senses that her own therapist is pregnant. I was laboriously musing on the meaning of pregnancy and this article, when my daughter walked in the room, and I spontaneously asked her: What do you think about when you see a woman who has a baby in her belly? Her immediate response was uncharacteristically short; she simply said, “Mama.” Her answer led me to revisit Christopher Bollas.

Why Bollas?

In the same way that Raphael-Leff speaks of the therapist’s pregnancy as a window for unconscious communication, or Wedderkopp’s (1990) observation that “there is something about the experience of living alongside the therapist and her-in-utero baby which viscerally and very

concretely throws the patient back into his own archaic, preverbal infant world” (p. 39) Bollas (1992), while not speaking directly to the pregnant therapist, supports both of these notions. He sees clinical work as work between two unconscious and separate subjectivities. “Object relations in the transference and the countertransference, will partly be preoccupied with the emergence into thought of early memories of being and relating” (Bollas, 1987, p. 3). The clinical task is to bring the wordless unconscious, or what he calls the “unthought known”, into symbolic awareness. The pregnant therapist is in the optimal position to do just that. Bollas even suggests that the ego structure begins in utero and after Winnicott (1956), his work highlights the clinical importance of the mother in any type of analytic work. He says,

The mother’s idiom of care and the infant’s experience of this handling is one of the first if not the earliest human aesthetic. It is the most profound occasion when the nature of the self is formed and transformed by the environment (Bollas, 1987, p. 32).

The pregnancy can remind the patient of their first human aesthetic. For example, one patient in my study, reported the following regarding her pregnant therapist:

It’s funny because I knew that she already had a child, so its not like, oh now she’s going to be a mother, she’s this maternal type, but for some reason when she became pregnant she became more nurturing and maternal in my mind. She didn’t necessarily act in any way that was different and she’s my age so it’s not as though her being pregnant should have that effect, but I think it did. (Client E)

In the inverse way, I contend that the pregnancy of the therapist can trigger in patients their own maternal instinct, maybe in some ways, a mirror of their own mother’s idiom of care. Consider the following:

I think I probably would have terminated when we had originally planned but when I found out she was pregnant, I had this kind of surge of maternal and protective instinct that I wanted to kind of see her through it. (Client A)

Bollas (1987) explains that his concept of the “unthought known” in the following way, “In part, [it] corresponds to the primary repressed unconscious, particularly when we take into account that the unconscious ego is itself a memory of ontogenesis” (p. 246). The parallel process of the therapist’s pregnancy in a dynamic therapy or an analysis could help the patient think thoughts about the self, previously repressed, in one sense, yet unborn. One therapist working with a group of teenage boys reported the following:

My pregnancy became really about who they were and their own...the story of their beginning, and you know, the meaning they had in their mother’s lives which is not necessarily something that comes up for boys, teenage boys ever. It was something that I never heard boys talk about before. (Therapist A)

Perhaps this group of teenagers was beginning to give voice to what Bollas’s “unthought known”, something inspired by their therapist’s pregnancy.

Many therapists, including myself, have reported experiences where their patients knew of their therapist’s pregnancy in the first few weeks. This was the case for one patient in my study whose knowledge surprised her therapist, she reported, “On the surface, maybe there was something in the way she got up because she definitely wasn’t showing, but I’m sure in part, it was also an unconscious fantasy.” (Client A)

Fenster, Phillips and Rappaport (1986) found that dreams were a most common expression of unconscious awareness regarding the therapist’s pregnancy. This led me to believe that there is a connection between a therapist’s pregnancy and the “unthought known”. The trace

of the past, or the “unthought known” leads us to search for that place of first transformation, and the therapist’s pregnant self might “cast its shadow” on the patient’s first object, providing, in some cases, what feels to the patient like a safer holding environment. Consider the experience of the following two therapists:

I don’t know if I have any evidence for this but my feeling is that I felt rightly or wrongly a deeper sense of trust from my patients. Like they felt, I don’t know whether it was seeing me struggling or something, I felt they were more comfortable around me-the feeling in the room was of being more relaxed. (Therapist, E)

I felt in both of these cases, like my pregnancy was a way of feeling closer to me or something, rather than a strained experience. I felt like we were more intimate.

(Therapist, G)

Bollas (1997) thinks that throughout life we are all in a constant state of transformational object seeking,

Not yet fully identified as an other, the mother is experienced as a process of transformation, and this feature of early existence lives on in certain forms of object-seeking in adult life, when the object is sought for its function as a signifier of transformation (Bollas, p. 14).

If a therapist can understand and tolerate this same role, she is in a unique place to help facilitate a transformation of the treatment process itself.

My pregnancy was a wonderful opportunity to work in that way, through traumatic material of her early childhood, that you know, we would have gotten there in another way over time, sure, but this was just so profoundly direct, the access was just so visceral

that it was really powerful. It allowed us to get to a much deeper place that she needed to get to. A week before I went on maternity leave, she found out she was pregnant herself, she has struggled with fertility issues for years and she said this baby it because of our work together, her son is 8 months younger than my daughter. (Therapist F)

I think my patient's expression of somatic symptoms, the feelings of butterflies in her stomach, after I became pregnant was about her allowing herself to finally feel. I think this was because she felt more comfortable, safer with me. There was also a way that I felt closer to her after telling her about my pregnancy. (Therapist B)

While the pregnancy can help facilitate treatment, it can just as easily have the opposite effect. "Aesthetic moments are not always beautiful or wonderful occasions- many are ugly and terrifying (...) because of the existential memory tapped" (Bollas, 1987, p. 29).

Consider the following:

I had a patient who needed to be transferred, because I think she knew I was pregnant and she became full-blown paranoid and psychotic. There was something about my pregnancy that I think triggered her. (Therapist, D)

A therapist's pregnancy definitely complicates one of Bollas's principle ideas, "News comes from within the self only on its own terms" (1987, p. 236). These terms necessarily must be negotiated when a therapist is pregnant. Bollas is speaking of the receptive capacity that is needed by the analyst to access the patient's unconscious life. The pregnancy itself is a kind of news from within, as Raphael-Leff (1993) illustrates, "Psychically, the baby is implanted in the soil of her unconscious inner world, gaining substance from her fantasies, influenced by and influencing the climate of her psychic reality" (p. 14). On the one hand, there could be a real

interference in the unconscious pathways; on the other hand, the pregnant therapist may be more receptive to both herself and the patient (Raphael-Leff, 2004, Cullen-Drill, 1994). “I actually think in some ways, I was more present for my patients. I was no longer preoccupied with finding a partner and starting a family.” (Therapist H). Keeping alive a receptive capacity is something that a pregnant therapist is in a special position to achieve; however, while she may be more keenly attuned to others’ deepest feelings, the therapist’s vulnerability might make her more prone to deny some of those same feelings, especially when it comes to hostility and envy (Imber, 1990). One therapist who worked primarily with patients who had experienced trauma, many of whom had hostile and sometimes psychotic reactions, admitted to being less present for her patients: “It definitely takes a toll. I think that it was really hard to deal with what I was dealing with feeling so vulnerable and not 100% physically well.” (Therapist D)

Themes of separation and loss and mother-infant relations, as well as conflicts like sibling rivalry that may not have emerged in the absence of the therapist’s pregnancy, can be usefully explored as a result of the opportunity presented by a therapist’s pregnancy (Kofman & Imber, 2005; Fenster et al, 1986).

One patient who had had an abortion didn't want to talk about it, but when I was pregnant her abortion came up a lot more. She started having dreams about it and being more open. I would say that my pregnancy helped her talk about it, whereas before that part of her was shut off. (Therapist, D)

Newman (2012) sees pregnancy as a process that unfolds in both positive and negative ways, sometimes both simultaneously. She contends while it is not only instinct or object exactly, and it is neither ‘me’ nor ‘not me’ completely, it can be understood as an extension of

Winnicott's intermediate space. The intermediate space, hopefully already operating in a therapy or analysis, is extended by the therapist's pregnancy and could be conceived of as the metaphorical playpen in which to safely explore meanings of life, creativity, symbiotic longings and dread, fears, both imagined and real, of abandonment, as well as themes of separation and individuation, and mortality. I contend that it is also an optimal space for which to let some "unthought known" be first thought.

Fairbairn's Object Relations

Fairbairn redefined the oedipal situation as the deprived and abandoned baby on the hillside (Scharff & Skolnick, 1998, xv). For Fairbairn, maternal deprivation is considered the root of both human suffering and psychopathology (Mitchell, 1998). As the therapist is often perceived as a maternal figure in the transference, her pregnancy can trigger unconscious feelings of this original deprivation. These feelings of abandonment can happen at any point in the treatment, often it is a feeling that occurs when the therapist discloses that she is pregnant:

They all thought I was going to leave, and they were all really upset and scared that I was gonna leave and not come back, all my kids, and I'm like I'm coming back, don't worry, but all of them were so sad about me leaving, it meant that you have a baby and you go away forever. (Therapist A)

The feelings of abandonment can also happen later in the pregnancy. Consider the following feelings of an adult patient whose therapist went into premature labor.

I was upset for my doctor and her child and worried about the baby, but I was also like, ugh, what about me, and that is not a familiar feeling to me, but it was a particularly bad week. I felt, not angry at her, but upset and kind of abandoned, but not in a logical way. (Client E).

Sometimes the abandonment is a reality as in the case of a patient whose therapist told her she was pregnant and not coming back. “She was the first person I had been seeing regularly, and it’s hard to start seeing someone new so I was really upset. I felt left out in the cold.” (Client D) Fairbairn’s idea of maternal deprivation can be used to understand his object relation’s theory, however, while some patients will retreat into an inner world of objects, it is also critical that the therapist acknowledge the reality of many of these feelings, as most will take a maternity leave, and at times may be less available to the patient, an emotional abandonment. That being said, familiarity with Fairbairn’s endopsychic world can help pregnant therapists to better understand and to tolerate the sometimes seemingly extreme reactions that their patients present upon learning of the pregnancy.

According to Fairbairn, the baby is born with a whole ego, albeit primitive; it is only when the baby perceives that the mother has failed him or her that the ego splits and the mother is internalized (Guntrip, 1961). Fairbairn contends that infants or children view any frustration with regard to their mothers from “a strictly affective standpoint (...) what he experiences is a sense of a lack of love, and indeed emotional rejection on his mother’s part” (Fairbairn, 1952, p.112). The child, in turn, internalizes the mother in order to control her, and to avoid an unsatisfactory, or even dangerous, relationship with the real external mother. This splitting of the self is universal according to Fairbairn, and only differs in the level of severity; thus the endopsychic structure in all of us is born. For Fairbairn, this closed system is a solution to a dangerous outer world, and is peopled with inner objects, closed off to outer reality (Grotstein & Rinsley, 1994). This metaphoric unconscious inner world has highly complex, ambivalent inner-relationships that have been created as a defense to control previously rejecting external objects; something the pregnant therapist could be perceived as. Fairbairn realized that people

retrospectively process personal experience based on the content of one's endopsychic world, and that these objects, good or bad, highly influence present perceptions of the world (Grotstein et al., 1994).

When a therapist becomes pregnant, a patient might feel like “the abandoned baby on the hillside” and retreat into an inner world, leaving little space for therapeutic work to be done. The literature on the pregnant therapist has shown that a common reaction of patients upon learning of the pregnancy is to regress or to act out (Balsam 1974, Bassen, 1988, Fenster, 1983, Katzman 1993, Napoli, 1999, Whyte, 1994).

We're not necessarily ever prepared for what comes out of people's mouths, and there is something about this very personal experience that you are having that somehow, depending on your theory of practice you can somewhat kind of control how you want to respond, things are gonna come up and your not going to be as prepared as you want to be and it can shock you. (Therapist A)

I am suggesting that being familiar with Fairbairn's object's relations' theory can help alleviate some level of shock the therapist may initially feel. Fairbairn's endopsychic structure can help us to work with the dynamic unconscious, particularly with patients who have been traumatized. The critically perceived crisis of a therapist's pregnancy, calls for an elaborate understanding, empathy, and entry into the patient's potentially fragile psyche so that there can be a rebuilding of ego strengths. Fairbairn felt the aim of psychotherapeutic treatment was to make a breach in the closed system and to introduce the outer reality as a way of opening the system. He believed, “it is necessary for the patient's relationship with the analyst to undergo a process of development in terms of which a relationship based on transference becomes replaced by a realistic relationship between two persons in the outer world” (Fairbairn, 1958, p. 380). The

pregnancy itself, if handled therapeutically, could be the breach needed to open the patient's inner world.

It's hard because I don't really do self-disclosure but here you're sitting there with a big distended belly and so people are like, 'How are you?' I don't believe that you want the patient to take care of you, at the same time you know it doesn't make sense to rebuff their advances and even though it is my training to say, 'What made you ask?' [laughs] you know, I really didn't feel like doing that because the thing was my ankles were huge, my belly was huge and I was sweating and looked horribly uncomfortable. (Therapist E)

The reality of the pregnancy should bring into clearer focus, the actual person of the therapist, including her real sexuality, not simply the therapist as a transference object.

Explicitly acknowledging the implications that the therapist's pregnancy will have on treatment will likely impact a patient's closed system. One patient reported,

In therapy it's difficult for me to just go on about myself and not get anything back, so when she was pregnant, it felt more of a two-sided relationship. I felt more connected like there was something given back which allowed me to open up in a less scary way.

(Client E)

Fairbairn felt that in order for psychological growth to occur, the patient must come to a place of self-awareness, self-acceptance, and, in turn, acceptance of real others in the outside world (Ogden, 2010). "This acceptance is achieved by means of the work of coming to terms with the full range of aspects of oneself, including one's disturbing, infantile, split-off identification with one's unloving, unaccepting mother" (Ogden, 2010, p. 218). This self-acceptance is something that is needed for both the patient and therapist. The literature on pregnancy has found that these infantile regressions are inherent in a pregnant woman's process

(Bibring, 1959, Raphael-Leff, 1994). It is critical that the pregnant therapist has the proper support structure in place during this time, whether it be through her own therapy, supervision or both.

Often pregnant therapists can be preoccupied, feel vulnerable, and be less available to the patient (Balsam, 1974; Bienen, 1990; Cullen Drill 1994, Imber,1990, 1995, Lax, 1969, Grossman 1990). Any lapse in the therapist's availability can evoke shame in the patient. According to Howell (2005), shame can be felt as an actual terror of psychic disintegration, and can lead to an even fiercer attachment to bad internal objects, and a further retreat into the closed system. The following is an example of how a therapist's being transparent about her pregnancy with a survivor of sexual trauma can actually be therapeutic and guard against the patient's a retreat into the inner world:

My patient was somebody I told I was pregnant and I made that decision to tell because she was somebody who had suffered, had a lot of sexual trauma and in her family one didn't speak about what was happening to one's body, they didn't speak about things related to sex so it felt important for me to say out loud that it was something that was happening in my body and to make it really transparent. I think it was also quite healing that I was wanting to be so transparent about it, so I think her feeling more comfortable telling me what was happening in her body was connected to her feeling safer with me.
(Therapist B)

Fairbairn posited that it is "infantile dependence" that causes pathology, and the resolution of this is actual "mature dependence." Notably, Grossman (1990) found one of the most consistent reactions of pregnant therapists was the wish to see their patients as less infantile and more adult (p.63). Perhaps, if therapists are aware of this dynamic ahead of time, they can

be better prepared to work with the infantile parts of their patients which will likely emerge. Pregnant therapists who might initially be overwhelmed by these infantile feelings, can find relief, understanding, and direction in supervision, as is shown in the following:

When I told my patient I was pregnant, he stormed out. It was so helpful for me to just process in supervision what it felt like for me to have someone I worked with for years, just storm out, just absolutely storm out of the office. (Therapist E)

The reality is that the pregnant therapist may have to go through the stage of infantile dependence with her patients if mature dependence is to eventually emerge as is alluded to in the example below:

Once he was through being pissed at me and all of that, we were really able to work on the loss, the abandonments he felt as a child, very directly. We were able to talk about his fears about me and how now this baby is going to get everything and he's going to get nothing. It was really powerful, really powerful, good work. (Therapist F)

Recognizing the other as a separate individual, not an inner object, is the outcome of mature dependence (Rubens, 1994). The following statement by Fairbairn (1958) can be directly applied to the situation between the patient and the pregnant therapist and offers a helpful way for the therapist to proceed:

Psycho-analytical treatment resolves itself into a struggle of the part of the patient to press-gang his relationship with the analyst into the closed system of the inner world through the agency of transference, and a determination on the part of the analyst to effect a breach in the closed system and to provide conditions under which, in the setting of a therapeutic relationship, the patient may be induced to accept the open system of outer reality (as cited in Ogden, 2010, p.91).

The pregnant therapist is in a better position to be perceived as more “more real” or “human” as was gleaned from many of the patients and therapists in my study.

It does really humanize you, and I feel that's ok, and that you shouldn't try to hide it, that you know you can't hide what's happening, it's one of the most in your face things that can happen. (Therapist G)

Its like you get this window into their home life and everything and something that's going to be this huge emotional transition for them so that's why I say its sort of humanizing in this strange way. (Patient C)

If the patient can come to accept the therapist as a real person with a separate subjectivity, not simply an object they have imagined, they are in a better position to achieve a state of health or “mature dependence.” Achieving a state of mature dependence is an important piece of Benjamin's concept of mutual recognition, the basis for thirdness.

Benjamin and Thirdness

In speaking about Stern's designation of intersubjectivity beginning at 8 or 9 months, Benjamin (1990) proposes conceptualizing the development of intersubjective capacity not as following a specific time phase per se, but rather to acknowledge that there are key transformational moments. This thinking seems to me to complement Bollas's concept of a transformational object. While the focus of this paper does not allow for a full discussion of the many conceptual differences between Benjamin and Bollas, this idea of transformation along with their shared emphasis on the importance of the early maternal process, can inspire us to

think about how the experience of therapy can be transformed in a way that explicitly utilizes the therapist's pregnancy.

Benjamin (1990) contends that in order to feel one's own subjectivity in another's presence, one must recognize that the other is also a subject; mutual recognition is only realized by both the need for recognition by the other, and a true capacity to recognize a subjective other in return. The other has a separate and equivalent center of self, and is not just an object of another's need to be used for its own purposes. If handled with clinical sophistication, the pregnancy of the therapist can potentially transform the development of the treatment and help foster mutual recognition. Diamond (2007) sees thirdness as a way of disentangling from the transference/countertransference trap.

My therapist's pregnancy and the fantasies that I had around her pregnant longings and all of that, really made me feel connected to her, and it also made me feel she understood me better. (Client A)

Benjamin (2004) notes, "Once we have deeply accepted our own contribution — and its inevitability - the fact of two-way participation becomes a vivid experience, something we can understand and use to feel less helpless and more effective" (p. 16). So how does mutual recognition and its necessary counterpart, breakdown of recognition, fit into the treatment process and the relationship between a pregnant therapist and her patient? Sometimes the reality of the therapist's pregnancy can initially seem like a breakdown of recognition as is seen in the following example:

My pregnancy was a shock and a blow to her. I think because of her identification with me, it was this sort of deep divergence from this symbiotic you know, twinship she

imagined and it meant all these things were now different. Somehow we got through it and are still working together years later. (Therapist A)

The breakdown, however, is in the therapist being an object onto which the patient can project her own desires and needs, becoming a subject in her own right. If the pregnant therapist is acquainted with Benjamin's concept of thirdness, and acknowledges the impact that her pregnancy will have on herself and the patient, she is in a better place to achieve a state of thirdness, the only place, according to Benjamin, where she can soothe the patient. Consider the following response from a patient on learning her therapist was pregnant:

I just felt like now there is no safe place, nobody to talk to, the one safe place that I had disappeared. That night I sobbed like I hadn't in so long. But we were actually able to talk that through the next week. It actually, was really good to realize all the reasons it was so sad. So I stayed with her because she was fabulous and she's wonderful and she gets it, and for her, it was always about what's best for me. (Patient G)

“The only usable third is, by definition, one that is potentially shareable, that is, one that supports a process that respects both partners' subjectivities rather than suppressing the needs and perspective of one” (Benjamin, 2006, p. 126). Thirdness incorporates accommodation and prevents one from getting stuck in one's own perspective and rightness, and shutting the other out or withdrawing from painful material; if a pregnant therapist can acknowledge the impact the fourth is having on both her and the patient, she is in a much better position to achieve a state of thirdness.

I felt it was more important for me to be uh authentic with them, not necessarily to shut down exploration but not to be so withholding either. (Therapist, E)

Knowing that she had been through something similar to me, whatever that was, made it easier to handle her pregnancy, it was helpful that she opened up a little about her background.” (Client, G)

In discussing Winnicott, Benjamin reminds us how satisfying it can be for a patient when a therapist survives their fantasies of destruction. This might be especially true when those fantasies of destruction involve a pregnant therapist. Balsam (1974) posits how mutative it can be when the therapist returns from a maternity leave. For me, and some of my own patients, much of the deeper work took place when I returned from maternity leave. One patient who had profound abandonment fears, remarked with surprise, that I was more present than I had been in all of our many years of work.

Another critical aspect of studying the pregnant therapist is recognizing the therapist as a desiring other, whether sexually desiring, or desiring a child, career or both. Too often women are seen as objects of desire, rather than owning their own desire (Benjamin, 1988, 2005). “The ‘real’ solution to the dilemma of woman’s desire must include a mother who is articulated as a sexual *subject*, one who expresses her own desire” (Benjamin, 1988, p. 113). Katzman’s (1993) study found that female patients expressed value in the therapist’s pregnancy in helping them to identify their own desires. Some patients in my study admitted to feeling this way, as is shown in the following:

She had always been very encouraging of me taking on expressing and owning my desires to be an independent, healthy professional woman who also wants to be a mother and that's ok and I can ask for that in my relationship and it allowed me in some ways, to be more forthcoming about that- so there was kind of a temporal relationship that around the time that she's becoming pregnant, I'm feeling more comfortable owning my own desires for that. (Patient A)

We talked a lot about relationships, what positive relationships would look like, which is not something that she and I had ever talked about before, just something I tended to be less focused on but I was more focused on when she was pregnant. (Patient F)

Benjamin identifies thirdness as beginning before verbal speech, in the shared pattern of recognition between infant and mother, what she calls the one in the third. "Thirdness begins in the mother-infant dyad (...) and develops through experiences in which the mother holds in tension her subjectivity/desire and the needs of the child, her awareness of the situation and empathic appreciation of the child's experience" (2005, p. 39). A pregnant therapist is in a similar position with her patient. Benjamin (1995) sees connection and separation not as opposites, but as a simultaneous tension, that along with parent-child affective exchange can redefine separation-individuation theory; that actual recognition by the mother is the cause of the child's sense of agency. In this same vein, a therapist's maternity leave can act as a kind of separation-individuation in which the therapist delicately works with the patient to find a balance between dependency and autonomy needs. Her actual leave, if handled appropriately, might inspire confidence in her patients to test their own sense of agency.

I think something I noticed in the last few sessions was that she wanted to see some of the things we had been talking about resolved, she would push me a little further than she might normally have. I think a lot of times I need that push and so I also wanted her to leave knowing that I had done the things I said I was going to do. (Client F)

I have been so impressed, all of them have done a lot of work during the break, like they had time to really process some of the work we've done and to let it sink in and struggle with it a little on their own. (Therapist I)

Case example of thirdness in the context of the fourth

While I was on maternity leave, I had coverage through the clinic where I was working at the time. One patient, who had initially chosen not to see a covering therapist, had an unexpected tragedy occur; his mother, to whom he had an extremely close relationship, died suddenly at a rather young age. I did not find out about this until about a month after when I contacted my supervisor. I felt terrible that I had not been available for him at this crucial time. I called him and expressed my sympathy and offered to see him before I officially returned. He was touched by my outreach and said that he didn't want to interrupt my maternity leave and that the covering therapist was helpful.

When we did meet after my leave, it was a very emotional session for both of us. I knew how devastating this loss was to him and I shared my regret at not having been available. This patient recently shared that he very vividly remembers that session when I came back from my leave and what it meant to him. He said that it was the first time he had seen me become emotional, and, more importantly, it was the first time he realized how much I cared for him, not just as a patient, but as a person. The reason I share this example is because of the meaning it

had for him. While I tend to imagine I would have been emotional and caring regardless of whether I had just had a baby, more to the point, he admitted to connecting my more human response to my new motherhood. His perception that my new role as a mother had perhaps changed me fundamentally, I do believe is astute and accurate, and I believe as a new mother, his loss took on new meaning for me as well, and I believe it has deepened our work together. His new ability to see me as a person and a mother, not just his therapist, and our mutual recognition of one another in this moment is a clinical example of thirdness. This state was fostered in my patient's mind at least, by a fourth, my new motherhood. The fact that he perceived my being a mother as being more available to him is an example of what can be therapeutic about the fourth. Since then, he has had his own child and feels even closer to me through his identification as a parent. While I clearly recognize that this particular example is full of complex dynamics based on my patient's profound loss, and there may be clearly other factors at play perhaps, (ie. his possible wish and need for a more maternal figure at such a crucial time, or his need to defend against any anger towards me for not being available); in any event, I do not believe his possible wish to see me as a mother negates the subjective reality and concur that "to refigure what it means to use one's subjectivity rather than accept polarity of subjectivity and objectivity is an important aim of contemporary analysis" (Mitchell, 1993; Gill, 1994 as cited in Benjamin, 1998, p. 22). While my capacity for thirdness may have begun, as Benjamin (2005) suggests with her concept of maternal thirdness, with my own mother; this I believe is an example of how it was reinforced by having my own child and my patient's knowledge of this event, and what can be therapeutic about the fourth.

If the pregnant therapist can be better prepared for what to expect in terms of both her own feelings about being pregnant, as well as some potential feelings and reactions of her

patients, she is in a better position to “surrender to the principle of mutual reciprocal influence in interaction” (Benjamin, 2004, p. 11), and the space of thirdness can remain open, allowing the discussion of the fourth; conversely, by discussing the fourth, a place of thirdness might be first achieved. Mutual recognition can be something to strive for as it can represent a more conscious attempt to connect (Gerhardt & Sweetham, 2001). Achieving a state of thirdness, can be facilitated by the process of supervision (Aron, 2006). Notably, each and every therapist I interviewed said they would definitely recommend supervision while pregnant.

Closing : Toward a Therapeutic Fourth

No matter what theoretical orientation the pregnant therapist adopts, she needs to acknowledge and realize the impact her pregnancy has on the treatment. In conceiving of and naming a fourth, we acknowledge that a pregnancy can create both opportunities and obstacles, as the fourth is not in and of itself therapeutic, as is shown in the following:

By the time she was like 6 or 7 months pregnant I was like oh she definitely is, and for a solid month it was an elephant in the room because I wasn't going to ask her, that would be impolite, and she wasn't going to say anything, but being a really analytic person and a feminist at that, I think it's very weird that we have these pregnancy taboos, especially between women of all things. (Client C)

The fourth can only be therapeutic if handled in a way that acknowledges the contribution of both the therapist and patient and the meaning the pregnancy and new motherhood has for both. Below are examples of what can be therapeutic:

Now, with hindsight being 20/20, I think in a way her pregnancy was really good for me, it was really, really hard but it also meant that a lot of things I was holding onto, a lot of things that I was afraid of, that I was needing to face, she and I talked about. (Client G)

It was affirming for me that she could understand the desire to be a mother and I had fantasies that she very much wanted to be a mother, I had fantasies that this was very much, I had never seen her as directly in a maternal position, I always looked at her as more of an older sister and it was really nice for me to see her as someone who was made for this and hence I could also be made for this. (Client A)

One of the patients I interviewed described learning about her therapist's pregnancy in the following way: "I think that there is sort of like a fourth wall coming down a bit" (Client B). After the interview I thought more about the theatrical concept of the fourth which Vincent Canby (1987) describes as "... that invisible screen that forever separates the audience from the stage." But rather than serving as a barrier, can a therapist's pregnancy actually invite the patient onto the stage in a way that can be mutative? Perhaps, by virtue of letting down part of that 'fourth wall,' a therapeutic fourth can take its place by bringing some verbal awareness to the bilateral unconscious communication between patient and therapist, uncovering and expressing some unthought known, fostering mutual recognition between the dyad, as well as creating a space in which to safely explore the multiple meanings of life. Benjamin (2005) says, "our current theorizing about the use of the analytic space as an extension of the maternal body container, which holds and gives coherence to the self, first makes symbolic thinking possible" (p. 25); can the therapist's pregnancy accelerate that same process, if so how? Future pregnant

therapists are in a very unique position to build on the idea of the fourth, and with the right support, they are also in the position to both glean and impart critical knowledge to therapeutic principles and theory in general.

Two-Paper Conclusion

Research focusing on the treatment environment and relationship when a therapist becomes pregnant is important for scholars, clinicians, and clients/patients. The preceding two-paper examination of this under researched aspect of practice within the context of a profession dominated by women is meant to be a step toward further opening this area for candid discussion. This dissertation is not intended to suggest that if someone has not been in treatment with a pregnant therapist they have missed out on an opportunity; rather, it is the intent of this study to demonstrate that for too long, women in the profession were made to feel that going through a pregnancy while practicing, was a disruptive intrusion rather than an opportunity to do some significant work. While every pregnant therapist-client dyad is different, for some, despite a therapist's best intentions and self-awareness, some clients may experience the treatment negatively. For others, however, it can be a catalyst for productive work and potential growth. (Imber, personal communication, February 20, 2015).

The aforementioned qualitative study included interviews with both previously first-time pregnant therapists and clients of previously pregnant therapists, and demonstrated the complexity of the challenges and opportunities that emerge when a therapist becomes pregnant. The first paper examined the coded results of this qualitative study and its emergent themes from the perspective of both the therapist and the client. The second paper, expanding on these findings, applied an object relations and intersubjective theoretical lens to better understand and work has been referred to as a particular "intrusion in the analytic space" (Fenster, 1983). The intersubjective system of reciprocal influence can be seen in the therapeutic concepts of transference and countertransference (Stolorow, 1994). As the pregnancy of the therapist has been shown to heighten the transference and countertransference dynamics (Raphael-Leff, 2004),

I argued that we must take advantage of the knowledge that can be gleaned from an acknowledgement and examination of the transference and countertransference.

I introduced a concept I am calling “the fourth” which represents not only the therapist’s pregnancy in a literal sense, but also the figurative, symbolic, conscious and unconscious meaning which the therapist and patient attach individually and together to the pregnancy as well as to new motherhood. My hope is that by naming it as such, I will in some way help to redress the relative historical neglect of this rich topic. We cannot be silent, nor should we feel shame about the impact a pregnancy has on the treatment process and relationship. Rather, we should use it as an occasion to learn something profound about ourselves personally and professionally. In the words of Benjamin (2009), “the analyst can change, can model the transformational process, and that revealing her struggle to do so also transforms the analytic process into one of mutual listening to multiple voices.” While Benjamin is not specifically speaking about an analyst’s pregnancy; I think when a therapist is pregnant, her point is amplified.

Ingram (1998) notes that psychoanalysis, “conceives a means to legitimately elaborate the languaging of who a person is, how the person came to be, and how the future is envisioned — all in endless complexity and specificity with countless visions and revisions” (p. 191). In a similar spirit, I am suggesting that the therapist’s pregnancy, in all its dynamic complexity, can be one unique opportunity to help clients put language to how they came to be and what they envision the future to look like. We are the instruments of our work, and when instruments change, we need to acknowledge and address those changes. Pregnancy is a powerful stimulus; Raphael-Leff maintains that universally, the emotional effects of pregnancy radiate beyond the pregnant matrix, and while interpretations may vary within different cultures, the pregnant belly galvanizes not only the expectant mother, but, those around her (2004). Recall that group of

teenage boys, whose pregnant therapist triggered thoughts of their own beginning and the meaning they had in their mothers' lives.

A therapist's pregnancy can be used as a means for helping our clients revise their own personal narratives in ways that enhance their understanding of themselves, and, optimally, serve to deepen the therapeutic relationship itself. As professionals, it is our responsibility to find clinically useful ways of using a therapist's pregnancy, to galvanize and illuminate the treatment space.

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