

## **On Becoming a Pregnant Therapist**

*by Rachel Somers*

I sat in a session with Sarah. Seven months pregnant, Sarah was speaking about her anxieties regarding her pregnancy and birth. She feared she would not be able to become attached to the child as she felt nothing for it now. While sitting in this space I became aware of a strange feeling. This feeling was one of anxiousness and excitement as I wondered could I possibly be pregnant too?

Following five pregnancy tests (not including the test by the doctor – upon which I insisted – just in case) it was confirmed. I was pregnant. I was overwhelmed with a wealth of different emotions; excitement, fear, anxiety, joy, stress, all consumed my body. My life was going to change. A baby, another person other than me. I was about to become a mother. Body changes, self image, fluctuating emotions and scattered thinking were all about to invade me over such a short period of time resulting in my having a huge responsibility to hold for the rest of my life.

This was a big enough ordeal personally but I was in no way prepared for the impact this would create in my work as a therapist. I was in for a further shock.

### **Practical Issues**

Within the therapy space I had to come to terms with this news and also discover a way to impart it to my clients. What would this mean for them? Of course it meant time out – a break in the sessions and premature endings. But for how long? I hadn't done this before and to the best of my knowledge there were no guidelines or rules on 'what to do.' Most of my colleagues and people I had trained with had already raised their own families prior to training and were flummoxed with my questions. My own supervisor's reactions were not what I had expected. I thought she would definitely be able to point me in the right direction. I was met with "you're pregnant? Oh my God...Oh my God...Oh my God". Once I had settled her and calmed her down from the shock, we sat and devised a plan. Questions hurled themselves at full force as I wondered 'how to say it?', 'When to say it?' and 'At what point in the session?' I wanted the answers right now in a

failing attempt to make this as easy an event as could be humanly possible. I was attempting the impossible.

We decided I would inform my clients four months into the pregnancy. From here onwards it would be appropriate to discuss the issues around this with the client. I would facilitate the client in exploring this news and what it was like for them to hear it. I would contract around dates to take a 'break in therapy', to discuss possible options for the client while away from therapy and also to discuss my plans regarding returning to work and when this would be likely to happen. Sounds good doesn't it? This was the easy part. What was next for me to face was the impact upon particular clients and the personal disclosure of private information, which I resisted in extending to them.

### **Disclosure of Personal Information**

I became aware of the difficulties I may face in informing individual clients that I was pregnant. Not only was I pregnant, I was about to leave them for another person whom I favoured over them. This also disclosed a relationship other than the one I had with my client. I was about to disclose a lot more information about myself and my life than I wanted to provide which conflicted with the concept of anonymity and boundaries of the therapist which had been drummed into me during and since my training. Now I was about to inform my clients about my sexuality, my relationships, and both my physical and internal processes by bringing my unborn child into the room. In essence I was inviting the uninvited. "*The analyst's pregnancy forcefully confronts the patient with the real aspects of the analyst as a person*" (Fenster et al. 1986).

Although all the literature spoke volumes regarding the 'genuine relationship' and the 'fertile ground' disclosure would create in terms of the clients' progress and process, I resisted and was in a firm state of reluctance to cross the line of self disclosure and expose these 'real aspects' of me. My conflict ensued.

Self-disclosure in my eyes would alter and threaten my attempts to create a safe space for the client. I became greatly aware that my attempts to create what Winnicott (1963) described as a "Holding Environment" was now to

become restricted and limited by what I was personally bringing into the therapy space.

Self-disclosure often came in the form of the non-verbal. As I grew bigger, my wardrobe changed. I sat in a different position and was often aware of trying to shift around in the chair in usually a failed attempt to get comfortable. My breathing, upon which I relied so much to assist and inform me as to how my clients were, now also altered as I found myself trying to catch a breath after climbing the stairs from waiting room to therapy room. *“Changes in the therapist create tension in an otherwise reliable and consistent structure”* (Fenster et al. 1986).

Clients reacted at times to these changes commenting on how I looked, asking how I felt, wanting to get the door for me and I was very aware of an element of minding me as the therapist. This was something, once highlighted, assisted the sessions and the client’s process in their seeing or experiencing me as fragile. Clients speculated a great deal about my life and me as a person. I received many comments on how good a mother I was going to be which was overwhelming to hear at times. This overwhelming emotion was elevated by my own raised emotional and hormonal state.

*“The obvious nature of a pregnancy, however, makes anonymity and neutrality impossible. The therapist is exposing a very real, very significant life event. Accordingly, she must negotiate a new image of herself, one that allows for disclosure and that can accommodate a human, changing, at times vulnerable, less than idealized view of self.”* (Fenster et al. 1986)

After six months my baby’s movements disclosed more information and became a more prominent feature in session. I noticed when I sat still, my child became more active. This would sometimes be quite visible as my tummy shuddered with the vibrations of an arm or a foot. I witnessed clients’ struggle whether they should say they had seen it, and my struggle to mention it and take the focus away from the verbal content of the session. Toward the end of my pregnancy as the movements became more pronounced, a leg or foot in my ribcage during a session created a discomfort and a distraction, which was difficult to hold in the space. My baby’s self-disclosure meant it was impossible not to focus on the dynamic and impact of its presence in therapy.

Now I was not about to be anonymous or neutral. I found that a fine balance had to be established between appropriate disclosure and what was obviously being disclosed by my changing self image. The further into my pregnancy, I saw the benefits in bringing in clients' comments about these changes into the therapeutic space.

### **Client Issues**

Nadelson et al (1974) points out that working through the conflicts around the therapist's pregnancy can be therapeutic for the client.

One such example was with John. As John commented and enquired as to how I was one session, it opened up a wealth of information and process regarding his longing to have children and become a father. He spoke about his sadness and pain about reaching his forties and not feeling as though he had enough time to form a relationship and have a child. This also highlighted his fears about being an elderly father as his own father had been. Pregnancy in my life encouraged John to explore his feelings of loss and betrayal at having had a father who had never been there for him coupled with the possibility that if he were to become a father, this could mean the same for him. This experience created a positive effect in John's therapy. My pregnancy presented an opportunity for him to mobilize ideation that lead to problem solving and resolution as well as disruption and regression.

For clients with children, a history of miscarriage, abortion, infertility problems, or sexual issues, pregnancy in their therapist may elicit strong responses of envy, loss, guilt, or identification (Clarkson 1980). Within supervision I explored the reactions of individual clients and was faced with the prospect of telling 2 clients who both presented with issues around not getting pregnant after years of IVF treatment.

Ann was referred to me eight months before my pregnancy. During this time she had worked on her experience of sexual abuse and had become aware of the family dysfunction, which had existed in facilitating her abuse as a child. Ann also processed a lot of her experiences involving her mother and her death. As I disclosed my pregnancy to her, this highlighted her experience of a series of failed IVF treatments within the

past ten years. Ann commented that she met the situations in her life which challenged her the most; working with men and her relationships with them, to now working with someone who reflected what she could never have, a child. Ann found this to be a very difficult experience. She spoke of believing she would never have addressed her emotions of loss and bereavement if I had not brought in the physical manifestation of having my child into the room. Through this Ann could mourn the loss of her children and plant an oak tree in memory of her and her husband's five embryos that didn't survive.

In 1969, Lax identified frequent reactions of clients, including themes of anger, rejection, sibling rivalry, oedipal strivings, and identification with the therapist or baby. Men and women reacted in different ways to their therapist's pregnancies. The men tended to use the defenses of denial and isolation and were hesitant to bring up the pregnancy while the women commented on the pregnancy earlier in the course and their reactions were more intense.

My experience regarding the differing reactions between male and female clients was quite marked. I noticed that my male clients didn't tend to comment or process the alterations in session other than the practicalities of when we would be finishing up or taking a break. My experience regarding female clients was in sharp contrast to this as it appeared that the process work became much more detailed and deeper emotionally. Out of eighteen clients, eight clients were female. Out of these, one, who had attended for a year, stopped therapy without notice, owing cancellation fees and not returning calls. One decided the time was right to terminate therapy after two years and another took a premature break in therapy, as she could now not make the appointment time. I experienced intense reactions from all my female clients including concerns around being abandoned, around my not returning, a fear that something might happen to me, and an increase in sexual content within the session. Only two of my female clients responded favorably with congratulations and elation at my news.

Initial reactions can be in keeping with the social conventions of congratulations and warm wishes; however clients may experience negative attitudes that are not typically expressed in our culture (Clarkson 1980).

One client was so pleased for me when I disclosed I was pregnant. Her excitement reached levels of enquiry as to my health, baby movement, touching my stomach on entrance to the session and bending down to say hello to my trousers. This I found difficult to contain. I felt resistant to even contemplating bringing this into the room again.

I discovered that socially acceptable feelings such as anger were often hidden, to emerge at unexpected times through acting out. This client was later to withdraw from therapy prematurely in favour of another therapist because I “wouldn’t be there”. As I was working predominantly with clients who had an experience of sexual abuse or violence, I was aware that this client’s history of abuse might have aroused transference feelings of being unprotected and neglected by me.

Other themes evoked in the therapy space included sibling rivalry, oedipal problems, separation anxiety, envy, sexuality, hostility, competition and fear of abandonment. I experienced that clients feared my fragility. One client who had been used to expressing her rage and anger by screaming when she needed commented, “You’ll have to give the baby loads of hugs after hearing me screaming; I wish someone had been there to give me that”.

### **My Countertransference**

My pregnancy was a personal matter involving a very blatant admission of my sexual activity. It was statement about my relationship to a man and to a family. This violated the rule of the therapist’s keeping her personal life out of the therapy space. Guilt was a predominant emotion I experienced around clients and I still do. I was emotionally torn when on terminating with one client she cried, “You are coming back aren’t you?” I felt like a mother leaving her child on her first day of school. I felt responsible for disrupting her process and sense of security by recreating the parent/child relationship.

I, as the holding environment was about to withdraw and abandon its holding. While some clients spoke openly about their satisfaction and feeling it was time to terminate or take a break, this did create a panic and anxiety in others. This impacted on my own countertransference as my guilt increased.

I dug deep to find research and knowledge around the subject and I was disheartened to find that only ten articles exist which address the subject of the therapist's internal state during her pregnancy. (Lax 1969; Paluszny and Poznanski, 1971; Benedek, 1973; Nadelson, Notman, Arons and Feldman, 1974; Balsam, 1975; Baum and Herring, 1975; Schwartz, 1975; Butts and Cavenar, 1979; Barbanel, 1980; Rubin, 1980).

Turkel noted that it is difficult but essential for the therapist to find balance in coping with the client's socially appropriate responses to the pregnancy and at the same time to be therapeutic in exploring uncomfortable issues the pregnancy arises (Turkel, 1993).

Anger was a dominating force, which I had to manage within the therapeutic space with one female client. This client sought to project her anger onto me by saying "You don't want me anymore". This was difficult to hold within session, as I was aware of my client's transference. I felt wounded by the projective identification within the room and my own personal guilt around 'Yes, I am leaving, Yes, I do have another relationship other than you, Yes, I am favouring my baby instead of you, Yes, I do have a life outside here, Yes, I have had sex, and No, I don't just spend my time waiting for you to come to see me every week'. Now I was going to be the good mother to another and reject and abandon my other child in the client. On working with this within the session the client began to process that she was responsible for herself. She said, "I have to do the work myself and I can't expect anyone else to save me". The client had become lodged in the fantasy of being saved and rescued. She had raged at me for not saving her but now commented that she wished she could have had the same care and mothering that I was about to give my child.

### **Natural Birth v Unnatural Ending**

Some of my clients who I had worked with for two or more years decided to terminate (Five in total) when I was leaving to go on maternity leave. For some I felt this was an appropriate decision however I wondered how the therapy might have terminated had I not perhaps provided the reason. "*For some patients their therapist's pregnancy makes treatment impossible, and they terminate*". (Fenster et al, 1986)

Often a patient's resistance increases during a therapist's pregnancy (Bassen 1988). The amount of cancellations of appointments, no shows and terminations of therapy increased after the time I had informed my clients that I was pregnant. Some clients reacted to this by saying "I'm sure you needed the break anyway" as a justification of minding me.

The situation of my pregnancy also brought up issues regarding consistency for two of my clients who were studying professional courses to become psychotherapists and as a consequence needed 40 hours per year of personal therapy to graduate each year. This created an anxiety and stress, which I'm aware, would not have had to be managed had I not become pregnant which created additional guilt.

It felt like the more I planned around informing my clients, the more obstacles I became faced with. The phrase 'keep it in the day' did not apply, as I had to work hard to make this less chaotic and stressful for my clients and myself while living with the uncertainty of nothing being certain. It was so difficult to even pinpoint when I might be returning to work as I did not know what I might be feeling at that time. This created an anxiety not only for myself but also for my clients. This increase in not knowing threatened the holding environment, which I struggled to maintain.

Bassen reported that pregnancy in therapists has the potential to both facilitate and disrupt treatment. She noted that the potential for premature termination seemed to be greatest in clients whose therapy was already tenuous (Bassen 1988; 8:280-298). This was also my experience in that those who terminated had on the whole, found it a struggle to connect into the relationship and remain in the therapeutic space.

## **Conclusion**

With the majority of therapists coming into the field of psychotherapy later in life the issue of the psychotherapist's pregnancy has not been a subject for much discussion up to now. However, as more and more people are coming into the training at an earlier age, as I had done, it is likely to be a pertinent subject for the future. It is therefore important to explore the impact both positive and negative upon the client and provide adequate training in this area for both the therapist and the supervisor.

Through my experience I became so aware of the impact of my presence in therapy, which I know I had at times taken for granted or chosen not to see or dismiss its significance. Through my baby's presence in therapy I became aware of how protected, individual and valuable the space is. This is again something which had temporarily left my awareness in the stream of clients who enter into it one after the other. Until I became pregnant I found I had renounced some the holding environment's qualities, securities and safeties. Once I had brought into it the threat of its potential destruction and fragility in the form of my self-disclosure with being pregnant, I became reminded of its true value to the individual in need of support.

This has been an unforgettable experience within my work and I value that this lesson has come to me so early in my career. I now look forward not only to my new arrival personally but also to the impact of this on the therapeutic space once I return to work. I wonder what this might bring?

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