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Patient into parent: The interplay of the psychological events of pregnancy and the therapeutic process

Fox, Berryl Caplan, Ph.D.

City University of New York, 1988

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PATIENT INTO PARENT: THE INTERPLAY OF THE PSYCHOLOGICAL EVENTS OF PREGNANCY AND THE THERAPEUTIC PROCESS

by

BERRYL FOX

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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Abstract

PATIENT INTO PARENT: THE INTERPLAY OF THE PSYCHOLOGICAL EVENTS OF PREGNANCY AND THE THERAPEUTIC PROCESS

By

Berryl Fox

Advisor: Professor Laurence J. Gould

This study examined therapists' experiences in treating pregnant women. The issues addressed concerned whether the pregnancy affected termination, whether it facilitated or disrupted the therapeutic process and what role the therapist's gender had.

61 clinicians were surveyed about their experiences in treating pregnant women. A majority of the therapists felt that the pregnancy had an impact on treatment. Some experienced the pregnancy as facilitating the treatment's progress and felt their patients acheived greater therapeutic gains relative to nonpregnant patients, while others indicated that the woman's gradual withdrawal from treatment and her increased introversion disrupted the process. In general, patients had a tendency to become less involved and committed to treatment and therapists tended to change to a more supportive approach during their patients' pregnancies.

Concerning termination, approximately half of the

therapists reported their patients had left treatment within fifteen months of becoming pregnant. Within this group most felt the termination was premature, while others felt the pregnancy marked the successful completion of the treatment's goals. It was also found that patients who were treated by psychologists, went to therapy more than once a week and were described as being very involved in their treatment before and after the pregnancy were more likely to remain in therapy.

A discriminant analysis revealed that male therapists who tended to be psychologists, worked more analytically with their pregnant patients than others, saw their patients relatively more times per week and did not get more supportive during their patients' pregnancies had patients who terminated significantly less than other patient/ therapist dyads.

No significant gender differences were found. However, female therapists, who tended to get more supportive with their patients, saw women who were felt to identify more with them than male therapists and saw patients who were described as more involved in treatment once they were pregnant.

This study considers the importance of the interaction of several patient, therapist and treatment variables that impact on the expectant mother's therapy. Specifically, it seems that patients who are in more analytically oriented treatments are more likely to remain in therapy during and immediately after their pregnancies.

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

In the past thirty years there has been a growing interest in the pregnant woman's psychological experience. Psychoanalytic theorists have come to recognize the importance of pregnancy in the emotional lives of women. It is no longer viewed as a static condition, a period in which the woman peacefully lives and calmly waits for her newborn. Rather, it has been distinguished as a critical phase in a woman's life involving profound psychological, physiological and social changes. There is now a greater understanding of pregnancy as time of reappraisal, redefinition and potential psychic growth.

Deutsch (1947) and Bibring (1959) were among the first to identify pregnancy as a normal transitional crisis; a crisis precipitated by the enormous endocrinological changes and psychological upheavals inherent in pregnancy. They suggested that this crisis is not a manifestation of disturbance in pathological women, but rather an essential and crucial occurrence that serves an integrative function. Throughout the literature it is stressed that a woman's ability to manage and resolve the crisis of pregnancy has far reaching implications. All agree that a woman's adjustment to pregnancy has a profound effect on her future stability, the welfare of the fetus and the earliest mother-infant relationship.

In addition, several researchers and clinicians have

pointed out the importance of therapy during this time of heightened psychological sensitivity and responsiveness (Bibring, 1959; Blitzer and Murray, 1964; Loewald, 1982; Raphael-Leff, 1980). It is widely believed that psychotherapy with pregnant women is a unique experience. Their capacity for insight seems heightened and their primitive fantasies are more accessible than ever before. However, the literature on pregnant women in treatment focuses on preventative measures and the expectant mother's need for therapy to assist her in managing her crisis. These women enter treatment because of difficulties that arise during the course of their pregnancies.

There is very little empirical or clinical data concerning the relationship between the events of pregnancy and the therapeutic process as it unfolds. The issue of how the crucial psychological event of pregnancy manifests itself in an ongoing treatment has been neglected. The few studies that have been documented express divergent views on the subject. On the one hand, Deutsch (1945) clearly admonishes against pregnant women being in psychoanalysis, suggesting that pregnancy is a condition that must "remain undisturbed in order to develop into a real experience" (p.161). Others feel that having a pregnant woman in treatment accelerates the movement of her therapy and that these patients achieve greater therapeutic gains relative to nonpregnant women (Leowald, 1982; Raphael-Leff, 1980).

The scarcity of literature concerning the impact of a patient's pregnancy on treatment is rather surprising in light

of the fact that recently there has been a great deal of interest in the significance of the therapist's pregnancy (e.g., Fenster et al., 1986). These studies suggest that the quality of the transference, the therapist's and patient's behavior and the treatment's outcome will be greatly affected by the therapist's pregnancy.

Similarly, the large body of anecdotal data from analysts and patients suggests that a patient's pregnancy will have an impact on her therapy. The aim of the present study is to examine what the nature and quality of that impact will be. In particular, how the pregnancy is manifested in the treatment specifically around termination issues will be examined in detail. Termination was chosen as an area to explore because many clinicians indicated that a number of their pregnant patients left treatment prematurely. In addition, termination provided, in some cases, a useful behavioral index of a patient's resistance to therapy and, in other cases, a measure of a successfully completed treatment. By focusing on termination, a clearer understanding can be achieved concerning whether the events of pregnancy have facilitated a woman's treatment or have created increased resistance to the therapeutic process.

This empirical study will attempt to investigate clinician's experiences with pregnant women in therapy, specifically around termination issues. While the study will mainly concern itself with the impact of pregnancy on the outcome of psychotherapy, several issues related to pregnant

patients, their therapists, their treatment and the interactions among these variables will also be examined.

The review of the literature is centered around the psychological processes of pregnancy. In order to fully understand how the events of a woman's pregnancy impact on her therapy, the motivations for and the developmental crises involved in pregnancy will be explored. Following this, research on psychotherapy with expectant mothers will be presented, highlighting how pregnancy may affect both the intensity of resistance in the treatment and the transference. The literature on the impact of the therapist's gender will also be examined, raising the question of whether the sex of the therapist will influence the clinician's perception of the pregnancy as well as the manner in which the pregnancy is manifested in the treatment. Finally, the literature on termination in psychotherapy will also be addressed briefly as it relates to this current study.

CHAPTER II

REVIEW OF THE LITERATURE

The Expectant Mother's Experience: Motivations for Pregnancy and the Three Trimesters

A number of authors have come to regard pregnancy as a period of crisis, involving profound endocrine and somatic as well as psychological changes. Bibring in her pioneering study of pregnant women at the Prenatal Clinic of a Boston hospital found in her interviews with mothers-to-be a predominance of severely disturbed patients. These women exhibited borderline features. The material they contributed contained magical thinking, premonitions, depressive reactions, primitive anxieties, paranoid thoughts and evidence of introjective and projective tendencies (Bibring, 1959). What was most striking, however, was that these women did not present pathological behavior prior to pregnancy. Thus, Bibring hypothesized that this profound emotional disequilibrium was a response to pregnancy and not necessarily a manifestation of the individual's specific problems.

Other researchers have supported Bibring's findings and have emphasized the pregnant woman's vulnerability to psychological disturbances. The following have been found to be common in normal prenatal clinic poplulations: anxiety (Klein et al., 1950); depression (Jarrahi-Zadeh et al., 1964); worry, mood lability, insomnia and impaired cognitive functioning (Colman et al., 1971; Jarrahi-Zadeh et al., 1964);

stress, emotional conflicts and severe disturbances of thought and behavior (Bibring, 1959); regressive shifts and emergence of earliest behavior patterns, attitudes, conflicts and increased dependency needs (Bibring et al., 1961; Kestenberg, 1976; Pines, 1972).

Despite the expectant mother's symptoms, authorities emphasize that the pregnant woman's psychological distress serves an integrative function. Regressions are necessary to facilitate the reorganization of the feminine ego into an adult maternal ego. The maturational crisis of pregnancy evokes a new and more adaptive intrapsychic organization. Thus, pregnancy heralds a truly integrative developmental stage that culminates in childbirth.

Bibring and others have also pointed out that therapeutic intervention provides rather immediate relief of pregnant women's symptoms (Loewald, 1982; Raphael-Leff, 1980, 1982; Turrini, 1980). It has been suggested that some expectant mothers are in need of supportive treatment to help prevent postpartum depression (Blitzer & Murray, 1964; Pines, 1972). Also, it has been hypothesized that the acute disequilibrium and consequent regressed state may be responsible for the pregnant woman's readiness to accept the help of a transference figure.

The apparent disequilibrium of these women can be attributed to various psychological, environmental and physiological factors. The pregnant woman, particularly the first-time expectant mother, is confronted with a series of new

adaptive tasks. There must be a redefinition of the woman's relationship to her sexual partner, to her self and to the growing fetus. In addition, temporary regressions are inevitable and old conflicts are revived that require new solutions. Early childhood identifications with the pregnant woman's mother are reawakened and conflicts related to the primagravida's struggle to separate from her mother are revived. The quality of the pregnant woman's own mother-child relationship is a critical factor in determining the future of the expectant woman's mothering. Therefore, pregnancy and motherhood encompasses three generations.

The commitment to motherhood is probably one of the most significant choices a woman can make in that it implies an unalterable, lifelong decision. With the extended knowledge and use of birth control, women now have greater control over when they choose to conceive. However, planned parenthood has not ameliorated the conscious and unconscious conflicts involved in the decision to bear a child. Researchers have begun to be more aware of the complexities of motives involved in childbearing.

The psychoanalytic perspective emphasizes the role a woman's psychosexual development plays in determining her wish for a baby. A daughter may consciously want to fulfill her parents desire for a grandchild, but this conventional motivation conceals the guilt laden Oedipal wish to be impregnated by the father. He possesses the penis which she lacks and can give her its equivalent in the form of a baby.

This has compensatory value since only women can have children. The fantasy serves the double function of fulfilling an infantile desire and resolving the initial inadequacy.

On a pre-Oedipal level, the desire for a child reflects the primacy of and longing for the original mother-infant relationship. In this situation, a woman wishes to relive, in her union with her future child, a reversal of the original mother-child symbiosis. The woman is both mother and by identification child. As Jacobson (1968) points out, in this situation, her fantasies are centered around the mother and the father is either uninvolved or experienced as a hated rival.

Kohut (1978) feels the woman's wish for a child is not necessarily motivated by Oedipal or pre-Oedipal strivings, but is a manifestation of her most central ambitions and ideals. He suggests that motherhood is the high point in a woman's development of her urge toward self-expression. Childbearing is both a creative and a self expanding process. A child, enhancing a woman's growth, may give her some sense of immortality or a link to the future. Deutsch comments further on a pregnant woman's sense of immortality: "the individual's will to self-preservation often falls into conflict with reproduction, but at the same time probably constitutes a powerful motive for it in both sexes. To have an heir of one's own ego, a carrier of one's own blood, a creature who springs from me, as fruit from a tree, and secures continuity, immortality, for my own transient existence--all these are psychologic motives in the desire for a child" (1945, p. 167).

At times the decision to become pregnant may also be motivated by the fantasy that the child will bring an otherwise estranged couple closer together. A woman may hope that a new baby will make up for the lack of a meaningful partnership. She may need to counteract feelings of loneliness, boredom and inner emptiness. The dissatisfied woman may develop an addiction to pregnancy. In addition, women may be motivated by the desire for prestige or the special status that motherhood promises. On the more positive side, a woman may want to create a family, to strengthen the bonds between and enrich an already satisfying relationship with her partner.

In addition to the more intrapsychic factors mentioned, Deutsch and others point out that the decision to have a child may be influenced by cultural demands. Historically, religion, tradition and public opinion have all glorified fertility. In many cultures, a childless woman is seen as inferior and damaged, whereas a woman who bears a child is acknowledged as worthy of recognition and praise. While a number of more recent trends have begun to challenge these notions, old prejudices still exist.

While positive motivations for pregnancy prevail in most cases, researchers caution that excitement over the news of pregnancy does not always indicate a woman is unambivalent about the prospect of parenthood. Exhilaration frequently compensates for concealed anxieties while initial dismay over an unplanned pregnancy may reveal itself as welcome in the course of pregnancy. There is also an important distinction to

be made between the wish to become pregnant and the wish to become a mother. The literature stresses that individual differences in the management and outcome of the woman's transitional crisis emerge because her disposition for parenthood depends on her social supports, including her current life situation, her past history, the specific structure of her personality and her prevailing defense mechanisms. While environmental factors significantly influence the outcome of a pregnancy, it is beyond the scope of this study to address this area fully.

The following literature review will focus primarily on first time mothers and the intrapsychic changes and tasks involved in their pregnancies. What follows are some of the more commonly shared experiences that characterize the three stages of pregnancy.

The First Trimester

The first trimester encompasses the time of conception until the first fetal movement (approximately the first four and a half months). During this initial stage, the pregnant woman's major task is accepting the reality of the conception. The belief in the pregnancy must be continually reaffirmed. The discovery of pregnancy involves an adjustment to a new and rapidly changing body ego and changes within a woman's body are usually the focus of her attention. The breasts swell, the womb enlarges, the blood vessels become fuller and the whole body increasingly adjusts itself to the task of sheltering the

embryo. The woman's body boundaries rapidly expand, reviving adolescent fantasies and feelings of body change.

The first stage also involves a regression to oral preoccupations as well as a revival of early magical ideas about conception arising out of eating or swallowing something (Freud, 1905). Food and the act of ingestion take on special meaning. Physically, the pregnant woman may experience weakness, vomiting, nausea and intense cravings. It is quite common for women to have ambivalent feelings about being pregnant. Conflicts over their wish to destroy the embryo and their wish to preserve it are often expressed orally. During this period physical symptoms may take on symbolic meanings. For example, oral expulsive tendencies such as nausea and vomiting may express a woman's hostility toward the pregnancy or the fetus. On the other hand, food cravings and the compulsive intake of food may represent an affirmation of fecundation (Deutsch, 1945). However, this greedy intake of food may be related to a wish for cannabalistic destruction of the fetus.

As Deutsch points out, a woman's ambivalent feelings toward the embryo often involve her feelings about being in the role of provider. The growing demands of the fetus may reactivate the expectant mother's infantile desire to receive. If she was deprived of love her willingness to love will be weakened. Consequently, the mother-to-be may become passive, dependent and intolerant of privations. Women commonly have fantasies of being sucked dry, used up or sapped by the fetus.

At this stage, there is a heightened concern over the pregnant woman's relationship with her mother. One of the more significant determinants of a woman's capacity for motherhood relates to how she manages the reactivation of her archaic relationship to her own mother. There may be a revival of childhood envies and jealousies, shame and guilt as well as fear of punishment for surpassing her own mother. She may fear her mother will steal her baby or, due to guilt, she may wish to give the baby to her mother. Deutsch emphasizes the need for the pregnant woman to accept and resolve her identification with her mother. "The ego of the pregnant woman must find a harmonious compromise between her deeply unconscious identification with the child, which is directed toward the future, and her identification with her own mother, which is directed toward the past " (Deutsch, 1945, p. 145). In order to become a well adjusted mother herself, she must engage in adaptive modifications of her often idealized or denigrated identifications with her early mother, thus enabling her to become a "good enough" mother (Winnicott, 1958).

Also, this stage is characterized by the pregnant woman's decreased interest in external reality and her increased turn inward. Instinctually, this introversion helps to preserve the species. During the first stage, biologically, the embryo is part of the mother's own self. On a psychic level, through identification, unity is also achieved. The libidinal concentration of the self increases and leads to the integration of and merging with the embryo. Thus, the pregnant

woman is in a state of heightened narcissism, surrounding her unborn child--an extension of her own ego--with narcissistic love.

While Deutsch offers a purely psychological view of the pregnant woman's turn inward, Benedek addresses the physiological aspects as well. High levels of progesterone increase the woman's libidinal energy leading to a state of heightened narcissism. Aided by the increased hormonal and metabolic processes the woman's vital energies are augmented. Her body abounds in libidinous feelings. "As metabolic and emotional processes replenish the libido reservoir of the pregnant woman, the supply of primary narcissism becomes a wellspring of her motherliness. Self-centered as it may appear, it increases her pleasure in bearing her child, stimulates her hopeful fantasies, diminishes her anxieties" (Benedek, 1970, p. 141).

The second trimester, heralded by the quickening, marks the expectant mother's need to face the reality of the baby as a separate being. As the baby begins to move, anxiety is awakened because of the growing realization that the baby will be a part of the external world. This feeling of the otherness within is a crucial experience of the second trimester. The fetus is felt as "part of the mother's body and yet foreign to it, a promise and at the same time a threat" (Chertok, 1969, p. 274).

For most women, the second trimester is characterized by a feeling of inner fulfillment and contentment. Though the woman

experiences a sense of triumphant plenitude, she continues to regard the pregnancy with ambivalence and at times resents the fetus. The intake of food is still ripe with conflict. The pregnant woman may feel that she is very hungry and eating for two, but obstetricians warn her about the dangers of gaining too much weight. Consequently, eating loses much of its spontaneous pleasure. Also, the woman's body now visibly loses its familiar shape. She must give up wearing her usual clothes and this change is often accompanied by feelings of loss of beauty and youth.

Anal regressive trends seem to dominate the second trimester. Often the fetus is not differentiated from the discardable contents of the woman's body. The fetus may be seen as something dirty or shameful that the mother needs to expel. "These themes combine with preoccupations with dirt, with scoptophilic wishes to look and reach inside the body and with anal-sadistic struggles with the mother, expressed in nagging and arguing" (Kestenberg, 1976, p. 238).

Once again, the pregnant woman's relationship with her own mother is of prime importance. During this stage, the woman usually feels more dependent on her mother. However, as motherhood becomes more imminent, the pregnant woman is now struggling with the decision to identify herself with her introjected mother or to rival her and succeed in becoming a better mother. Though the most relevant person to the pregnant woman is her own mother, there may also be a revival of feelings concerning other important figures from the woman's

past. She may have some difficulty in loosening ties with her introjected objects and feelings of anger or jealousy directed toward a former sibling rival may be displaced onto the future child.

The pregnant woman's relationship with her husband also changes. She may become more dependent on him and he may be seen in a supportive maternal role. However, more typically, he is regarded as an intruder capable of harming the baby. Women may refrain from sex during this period, having revived fantasies of sexual activities being harmful or damaging to their bodies.

A preoccupation common to all women during the second stage of pregnancy is whether or not the baby will be normal. Fantasies abound about the future child. For some women, the fetus may represent an internal penis, compensating for the original pain of the discovery of sexual differences. The child, in this situation, will be the ideal representation of the mother's masculinity and she will attribute heroic and messianic capabilities to her unborn baby. For others, oral fantasies may still be active, generating fantasies of a ravenous and greedy creature trying to eat up the mother. In these cases, the mother may harbor fears that her child, conceived of as a cancerous growth or a gnawing animal, will be born deformed.

These fantasies concerning her child are indicative of the woman's sense that she has no control over the growing fetus. However, alternating with this feeling is the concern that

whatever she engages in, ingests or even thinks will have a profound influence on her unborn baby. Women often take superstitious precautions to insure the physical and emotional health of their babies. The mother may eat certain foods that are believed to be of value to the child even though there is no rational proof of this. She may go to art galleries and gaze at beautiful paintings in order to produce a beautiful child. However irrational these acts are, they indicate the woman's increased turn toward the outer world and a decrease in her previous introversion. Throughout the pregnancy, the expectant mother is both more introverted and more concerned with external reality. This paradox is a unique aspect of pregnancy.

The third trimester coincides with the pregnant woman's belief in the viability of the real baby outside of her body (approximately twenty-eight to thirty-six weeks). It is marked by an increased concern about labor, fears of damage, exposure and separation. Delivery is anticipated with a polarity of feelings. Physically, the woman's body has become a burden. The pregnant woman is impatient to be rid of the baby, to be free of the physical dicomforts of pregnancy and to once again own her body. This tendency is countered by her fear that the baby, during delivery, will literally pull out everything after it, resulting in the loss of the woman's bodily contents. Also commmon are fears of dying in labor, being injured by the baby or damaging the baby during birth.

During this stage, it is necessary for the mother to see

the baby as separate so that "delivery does not have the effect of a painful separation from a part of the ego and a destructive psychic loss" (Deutsch, 1945, p. 154). Narcissistic libido shifts to object libido as the mother gradually recognizes the baby will be a separate and distinct entity. In order to prepare for separation, pregnant women often reorient themselves. Time now has a focus and they are living more in the future than in the present. They turn away from inward reflection and direct their thoughts to practical concerns. Often nesting behavior develops where the mother (and father) prepare the baby's room or become absorbed in domestic chores. This prepares the mother for relinquishing the internal baby and helps her redirect her motherliness to an external, unattached child.

Psychotherapy With Pregnant Women

What seems central then, to a pregnant woman's experience, is the significance of intrapsychic factors in determining her motivation for and response to her pregnancy. Studies indicate that because of the tremendous psychic upheaval that occurs during pregnancy expectant mothers have more immediate and direct access to their unconscious fantasies than others. Their dreams seem more vivid and are recalled with extreme clarity. Anxieties appear to surface readily. It is as if the pregnant woman is directly in touch with her unconscious.

Given her altered state of awareness and her heightened sensitivity to her own psychic processes, the pregnant woman

who is in therapy brings "a unique human and theoretical interest into the treatment....These women patients come for treatment of various problems of their own, often not primarily linked to their role as parents. They are the patients--not their children. But the events of pregnancy, childbirth and early infant care have a powerful magnetic effect on the directions of problem solving and the development of transference, in their treatment" (Loewald, 1982, p. 381).

Raphael-Leff discusses the ways in which pregnant women in therapy are unique. The unusual aspects of their treatment, created by their pregnancies, include:

1) Their retention of almost intact ego resources despite the apparent disintegration of boundaries. Also their powers of insight and interpretation of their own symbolism and primitive fantasies are at times remarkably astute.

2) Therapeutic intervention, clarification of the more cryptic messages or even just reassurance enabling the woman to examine her irrational feelings less fearfully achieve results reaching far beyond those normally achieved in therapy over a similar course of time. Women patients who become pregnant during an analysis also show an accelerated growth rate at this time.

3) The "baby self" of the patient, often referred to in the abstract form with other patients in therapy, is very much present in her identification with the tangible baby within her womb.

4) The sanctity of the one to one relationship within individual treatment is interrupted at times by the actual presence of a third and sometimes a fourth person; the fetus, and in it, the representation of the sexual partner (Raphael-Leff, 1980, p. 193).

It is apparent that the psychological situation of a pregnant woman in therapy is a special one. The literature on this subject mainly focuses on the psychotherapeutic needs of mothers-to-be. Raphael-Leff (1982) points out that some women

can not accomplish the preparation for motherhood alone and advocates timely therapeutic interventions in these cases. In a similar vien, Bibring (1959) suggests that therapy can be useful in helping the pregnant woman manage her crisis. These writers agree that expectant mothers can benefit more from supportive treatment than intensive psychotherapy. The therapies they describe are time limited and the expectation is that treatment will end before the due date.

The few studies that have been documented on women who become pregnant in an ongoing treatment suggest that the unborn child will have an impact on the treatment. It is generally believed that the impact will be favorable. Loewald (1982) suggests that the baby can act as the mediator or carrier of therapy at times. She discusses a case in which the mother-to-be was able to rediscover libidinal ties to her brother and father through new feelings about her future child. Other researchers support Loewald's notions and view pregnancy as a facilitator of treatment (Kestenberg, 1976; Raphael-Leff, 1980). However, some interesting questions regarding how pregnancy may interrupt the treatment remain unexplored.

In contrast to Raphael-Leff who believes that pregnant women are more accessible to treatment, Deutsch offers a different view: "I am opposed to psychoanalytic treatment of pregnant women unless there are indications that such treatment will have definite therapeutic results, just as I am opposed to analytic intervention in all life situations that must remain

undisturbed in order to develop into real experiences" (Deutsch, 1945, p.161). She believes that a pregnant woman will shy away from observing her own psychic life in order to avoid diminishing the intensity of the experience by subjecting it to scrutiny. She also feels that the pregnant woman's extreme introversion makes it difficult for her to share her internal state.

While Deutsch is referring specifically to psychoanalysis, her caution applies to all treatment modalities as well; difficulties may aries for both patient and therapist in a pregnant woman's treatment. Specifically, it has been suggested that pregnant women may terminate treatment prematurely. Given the findings on the psychological processes of pregnancy, it appears that expectant mothers would leave therapy because they feel they have achieved new solutions to conflicts and reached a new level of integration and growth. Women may also express practical reasons as to why termination would be appropriate. As the baby's arrival draws near, they may feel their priorities have changed and there is no longer time to pursue therapy since their time will be taken up with childcare. Kestenberg (1976) suggests that during the third trimester, when separating from the fetus is a central concern, the woman's ability to detach herself from the analyst goes hand in hand with the pregnant woman's readiness to detach herself from the fetus.

However, as in the case with any patient who wishes to terminate therapy, particularly when the decision is not mutually agreed upon, the unconscious motives involved in the

pregnant woman's decision to leave treatment must be considered. As noted earlier, the wish for a child may be stimulated by the desire to make up for deficiencies in a marriage and counteract a woman's feelings of inner emptiness. In these instances, the newborn may offer a temporary solution to the mother's difficulties while her underlying conflicts remain. The pregnancy becomes a grace period in which confronting disagreeable feelings and situations can be delayed. Perhaps these patients may also want to avoid dealing with the conflicts and strong feelings that treatment inevitably raises. This is not to suggest that the pregnancy should be understood as acting out behavior, but rather as an event that potentially creates a formidable resistance in the patient's treatment, resulting in a defensive flight from therapy.

Loewald (1982) raises the possibility that to undertake intensive therapy and plan a pregnancy at the same time might be a "suspect plan". She feels that the mother's revived and intensified libidinal and aggressive energies are directed toward her fetus, but that these energies need to flow between patient and therapist as well if therapy is to proceed. Therefore, therapy might divert the flow in one direction or another. While she is suggesting that the transference relationship might interfere with the mother-fetus relationship, what she does not state, but seems to imply, is that pregnancy may alter the therapist-patient relationship because the expectant mother must focus her energies on the

fetus and therefore, exclude the therapist.

Jackel (1966) suggests that pregnancy wishes and actual impregnation occur as reactions to object loss. He has observed that when therapy is about to be interrupted because of the analyst's impending vacation, some patients express the wish to have a baby. Though one could interpret this phenomenon as a desire for a baby from the analyst, he has found that the fantasy represents a way to exclude the therapist. The patient wishes to establish an early mother-child relationship where the patient is both mother and by identification child. Thus, the analyst is not involved or needed and the patient can protect herself from the pain, anxiety and feelings of helplessness associated with the imposed separation.

Loewald and Jackel's notions raise the question of whether pregnancy and the arrival of a child excludes the therapist and disrupts the dyadic relationship between analyst and patient. While this motivation may not prevail for most women who remain in treatment or even for those who terminate therapy, Loewald and Jackel's thoughts suggest that there are several unexplored areas concerning how, in fact, the pregnancy alters the patient-therapist relationship and what kinds of changes, if any, are experienced in the intensity of resistance to treatment.

Kestenberg and Deutsch both feel it may be an appropriate time to leave treatment when the patient is pregnant. Certainly pregnancy can be an indication of therapeutic

progress, a culmination of a woman's ideals and goals. However, in the past the ground rules of intensive psychotherapy and psychoanalysis admonished against any important changes in the life situation of the patient during treatment. This rule was established initially to promote verbalizaion before action, to insure that decisions were not based on the transference but on rational thought and to make sure that fundamental psychological problems would not escape examination (Langs, 1973; Kubie, 1950). The rule of abstinence implies that treatment will be facilitated and the patient will be protected if one adheres to its restrictions. While this ground rule is no longer strictly adhered to, mainly because treatments are so lengthy, the ramifications of making important life changes while in treatment must be given serious consideration.

The Therapist's Gender

The main focus of this study is to examine the impact of a woman's pregnancy on the outcome of her psychotherapy or psychoanalysis. However, by gathering data on the ways in which a pregnancy is manifested in treatment, a number of additional questions can be addressed. In particular, the issue of the impact of the therapist's gender on a pregnant woman's treatment has been ignored. This study will attempt to address whether a pregnant woman's therapy is differentially experienced by male and female therapists. Are there qualitative differences between these two groups in terms of

their response to and management of the pregnancy and their perception of the transference as it unfolds in the treatment?

In general, the question of how the therapist's gender affects the transference has received little attention, while the few studies that have been done have generated vague and inconclusive results. Traditional psychoanalytic theory maintains that the sex of the analyst or therapist, by and large, does not make a decisive difference (Glover, 1955; Greenacre, 1959; Kubie, 1950). According to classical theory, transference, described as a constellation of feelings and reactions repeating unresolved past relationships, will develop in a similar fashion during analysis regardless of the real qualities of the analyst. Glover (1955) supports this view, and surveyed a group of British psychoanalysts, finding that the majority believed the analyst's gender did not significantly influence the development of their patients' transferences. More recently Cavenar and Werman (1983) observed that while the issue of the therapist's gender may be important in supportive treatment, they found it to be an insignificant factor in insight oriented psychotherapy. They suggest that both patient and therapist's attention should be shifted away from the therapist's sex and back to defenses, transference reactions and resistance.

However, there have been notable exceptions to these points of view. Several writers have focused on the beginning stages of treatment and found that the therapist's gender may contribute to strong initial resistances to treatment. Kubie

(1950) felt the analyst's gender did not influence the ultimate success of a treatment, but felt it impacted on the patient's first reactions.

Bibring-Lehner (1936) noted that certain patients whose analyses were hopelessly stalemated with one analyst could become more accessible to treatment after a change of therapist, particularly when the sex of the second analyst was different. This suggestion was based on her observation that if the analyst's gender was the same as the sex of a parent with whom the patient had a very bad relationship, a severe negative transference would develop that could increase the patient's resistances and lead to a fixation and paralysis of the treatment. She believed that in these cases, the therapist's gender was an important factor and if there were too many similarities between the therapist and a person from the patient's past then this could "make a breach in the illusory quality proper to the transference" (Bibring-Lehner, 1936, p. 187).

Horney (1967) discusses how some women develop competitive transferences with female analysts. These patients have to defend against dependency needs and continually show the analyst that they are competent. Thus, all attempts at analysis are perceived as envy and invoke further competitiveness and wishes to control the relationship.

Several writers have emphasized the fact that the therapist's gender serves as an organizing point for maternal and paternal transferences. Freud was the first to suggest that a female analyst might stimulate material relating to the

mother more readily than a male analyst. In writing on eliciting material related to early mother-child attachments, he states: "It would in fact appear that women analysts...had been able to apprehend the facts with greater ease and clearness because they had the advantage of being suitable mother substitutes in the transference-situation with the patients whom they were studying" (Freud, 1931, p. 196). Stone (1954) concurs with Freud and emphasizes the organizing function of the real qualities of the analyst, stating that the transference requires some degree of resemblance to the remembered person and that maternal or paternal transferences will tend to be evoked by the respective gender of the therapist.

However, Karme (1979) offers an explanation as to why this viewpoint is not always supported by clinical observations. She explains why female analysts rarely experience father transferences while men regularly experience mother transferences. She distinguishes Oedipal from pre-Oedipal transferences and feels mother transferences with male analysts always fall into the latter category. Thus, early transferences can disregard gender. However, she feels Oedipal transferences are always related to the analyst's sex and that transferences of this sort can be facilitated by therapists of the same gender as the patient.

These contributions raise the question of whether the analyst's gender will have an impact on the pregnant woman's treatment. Those who advocate same-sex patients and

therapists, emphasize the value of shared experiences for the development of empathy. Gender linked biological events such as pregnancy can only be experienced by members of the same sex. Goz (1973) discusses how her own experience with pregnancy and motherhood facilitated her work with women in similar circumstances.

Similarly, Kaplan (1985) suggests that the psychological gender differences between men and women may have an effect in therapy. She and others (Gilligan, Surrey, Jordan and Miller) from the Stone Center present a different view of female development from that of the traditional psychoanalytic theorists. In describing the way in which a person becomes related to others, they argue:

> Early in life, daughters and mothers experience a process of mutual identification whereby each responds to the feelings and experience of the other in a mutually affirming way. This process ...focuses on connectedness as a path to growth....With increasing age, girls continue to gain in their sensitivity to the affective states of others and to the value for self-development of maintaining relational bonds. Such qualities, in turn, are validated and supported by others and become the cornerstone of women's self-image and sense of self. Thus, the core self in women is best described as the self-in-relation (Kaplan, 1985, p. 115).

This theory has implications for women in psychotherapy. Treatment becomes one specific example of a woman's pattern of the self-in-relation. A female patient will need and look for a therapist who can validate her own experience by responding to the patient appropriately. Kaplan suggests that a woman therapist, by virtue of her following a similar developmental course (a self which grows and develops as a relational being) as her female patients, may be better able to validate the

patient's own experience. Kaplan is not suggesting that a male therapist is incapable of empathically listening and responding to female patients, but feels women therapists have an initial advantage in this respect.

She notes that male therapists will have a more difficult time in confirming their female patients' experiences by direct reference to their own lives. Women patients may present material with which men can not resonate. "This could lead to difficulties in therapists' drawing on their own affective lives as a basis for intervention. At one level, male therapists may approach unfamiliar affect or experience warily, curiously-perhaps seeking to draw it out but without a direct connection to the patient's state. At worst, they may judge the patient's response in terms of their own experience and thereby translate a viable reaction into something pathological" (Kaplan, 1985, p. 116).

It would seem that Kaplan's notions have implications for the treatment of a pregnant patient. Not only would pregnant women experience male and female therapists differently, but also perhaps different sex therapists would differentially react to and interact with their pregnant patients. Goz and Kaplan raise the possibility that a female therapist will have a greater capacity to confirm a pregnant woman's experience and enable her to feel understood. Conversely, male therapists will have a less empathic connection to the psychological state of pregnancy creating a situation in which their patients may feel misunderstood and distant from their therapists. These

feelings may have a negative impact on treatment outcome and lead to higher termination rates for pregnant women who are in treatment with male therapists than with female therapists.

What Goz and Kaplan fail to account for are the numerous other factors affecting the patient therapist dyad. For example, Orlinsky and Howard (1976) found that the therapist's level of experience was a more salient predictor of patient satisfaction and therapy outcome than the therapist's gender. Certainly dozens of other variables have been identified which influence the process of therapy. However, what seems germane to this study is whether, while controlling for a number of different patient and therapist variables, a gender effect is observable in relation to the process and outcome of a pregnant woman's treatment.

Though the literature suggests that the therapist's gender has some impact, no consistent findings have been documented. It is generally believed, though not substantiated, that the therapist's gender is more important at the beginning of treatment, will affect the content and order of presentation of psychic material, can create formidable resistances, facilitate certain transferences, and make certain contents more available in therapy. Specifically, the issue of how the therapist's gender interacts with a pregnant woman's treatment remains to be explored.

Termination Studies

One aspect of the present study concerns itself with whether pregnant women tend to terminate treatment and if so what factors contribute to this outcome. In order to evaluate the data obtained in this study, termination must be examined within a larger context. There is a vast amount of literature addressing outcomes in psychotherapy and psychoanalysis. Examining patient drop out rates and the factors associated with termination is of interest both theoretically and practically. Clinicians, in particular, are interested in improving patient success rates not only because of economic realities but also because of their concern over the painful and disappointing feelings often associated with the process of termination.

There has been a great deal of interest in identifying and alerting therapists to the warning signs that might help predict untimely termination. Therapists could then be better informed and would have the option of utilizing preventative measures sooner. In addition, these factors would be helpful in creating criteria for selecting patients who are suitable for psychoanalysis or exploratory therapy. The emphasis of these studies has been on examining the patient and therapist factors that might be useful in predicting outcome and not merely on reporting termination rates. Studies have examined several kinds of treatment modalities, patient populations and therapeutic orientations.

In general, the factors that have been found to be

important in contributing to premature termination in analysis include: patient's ego strength and initial level of anxiety (Kernberg et al., 1972); diagnosis (Zetzel, 1968; Knapp et al., 1960); age (Knapp et al., 1960) and patient's past history and quality of object relationships (Sashin et al.,1975). Factors involved in termination in psychotherapy include: age, race, quality of therapy insurance and source of referral (Greenspan & Kulish, 1985); education, income and motivation for treatment (Brandt, 1965); the patient's chronic personality characteristics (Levinson et al., 1978); therapist's level of experience (Reder & Tyson, 1980); countertransference (Fielding, 1972; Levinson et al., 1978); level of professional training and therapist's involvement in their own personal therapy (Greenspan & Kulish, 1985) and factors based on the dynamic interaction of therapy and patients' anxieties and conflicts (Levinson et al., 1978). Most studies have not identified the therapist's gender as a pertinent factor in predicting termination.

The above mentioned variables represent just some of the factors that have been examined. However, of particular relevance to this study, are those inquiries that speak to a circumscribed population and concern themselves with long term psychoanalytically oriented psychotherapy and psychoanalysis. Levinson et al. (1978) looked at thirty prematurely terminating patients from selected private practices. These patients had been in treatment for at least three months, termination was unilateral and abrupt and the therapists felt that the

treatment's main goals remained unaccomplished.

They found that the most salient causes for dropping out of treatment were based on factors associated with the interaction of the therapy process with the patient's conflicts. Items in this category included transference, fear of dependence, fear of aggression and fear of loss of defenses. They also found that premature termination was generally multidetermined with an average of three contributing factors for each patient. The other commonly mentioned influences on termination were the therapist's countertransference and interpersonal factors such as family or spouse interference. "Interestingly, reality factors, which are often offered to rationalize leaving therapy, caused premature interruption in only one case" (p. 828).

Reder and Tyson (1980) in their extensive review of the literature on unilateral termination found that overall, treatment dropout rate, though initially high, increased over time. Lower termination rates were associated with patients in psychoanalysis than those in brief psychotherapy. The highest figures were for those patients in long term psychotherapy. They suggest these results are indicative of the deliberate selection of patients with higher degrees of psychopathology for this treatment modality. In addition, in noting the negative correlation between therapist's level of experience and patient drop out rate, they surmised that the intensive supervision of analytic cases could possibly account for the lower termination rates of patients in psychoanalysis.

In addition to assessing the qualitative factors that contribute to premature termination, several studies have taken a statistical approach and reported termination rates. Figures have ranged from a high of 63% to a low of 15%. Hendrick (1967) citing statistics from the Berlin Psychoanalytic Institute reported a drop out rate of 40% for analytic cases that encompassed all diagnoses and a 34% rate for the psychoneurotic disorders. Hamburg (1967) reporting on the results of a study conducted by the American Psychoanalytic Association found that 43% of patients in analysis and 63% in psychotherapy terminated. Sashin (1975) found that 15% of those patients in psychoanalysis at the Boston Psychoanalytic Institute left treatment prematurely. Aronson and Weintraub (1969) reported that the drop out rate per year in analysis was about 10% and that at the end of a five year period an analyst could expect about 50% of his or her cases to have terminated. Greenspan and Kulish (1985) found in their study of patients in psychotherapy in a private clinic that about 38% terminated prematurely.

As Reder and Tyson remark in their study there are many difficulties in assessing therapy drop out rates. Therapists often have different criteria of what constitutes termination. Several treatment modalities, types of patients and therapists are addressed simultaneously. Distinctions are often not made between clinic, community mental health center and private practice patients. Also, there may be a lack of clarity between mutually agreed upon terminations, forced (initiated by

the therapist) and unilateral terminations (initiated by the patient).

While no consensus has been reached as to what contributes to premature termination or even how many people drop out of treatment, some trends are notable. Patients will tend to stay longer in a more analytically oriented treatment than in other modes of treatment (Reder & Tyson, 1980). The reasons for this are multidetermined and not clearly delineated. It also seems that researchers have had a great deal of difficulty in agreeing on what factors influence termination. The problem does not seem to lie in identifying more variables but seems to stem from the fact that most studies limit themselves to looking at factors that can be objectively measured and fail to take into account the dynamic interaction among patient, therapist and treatment variables.

Of relevance to the present study is the realization that there is no norm or average rate of patient termination. It seems there are as many statistics and variables generated relating to drop out rates as there are patients. While it has been demonstrated that a number of factors should be considered in assessing therapy outcome, no studies have specifically addressed how major life changes contribute to termination. It appears that this oversight is the result of too narrow a focus on what quantifiable variables affect outcome. To study how pregnancy impacts on treatment requires a consideration of the more subtle interaction between psychodynamic variables and objectifiable factors.

Aim of the Study

It is apparent from the review of the literature on pregnancy that expectant mothers share a complex and unique psychological state. While the psychological processes have been well documented, there is very little empirical or clinical data available concerning the relationship between pregnancy and the therapeutic process.

The few studies that have been documented offer contrasting theories regarding the pregnant woman's psychological availability while in therapy. On the one hand, pregnancy is seen as a facilitator of treatment. During the pregnancy, therapeutic movement is accelerated and issues are brought up more readily and resolved more quickly. On the other hand, pregnancy is regarded as a time when few therapeutic gains can be achieved. The pregnant woman's extreme introversion and her desire to leave the experience undisturbed make it difficult for her to utilize treatment.

Though the literature has attempted to document some aspects of a pregnant woman's therapy, these studies are limited in a number of different ways. Some focus on the pregnant woman's subjective experience of her psychological state and ignore the impact of therapy. Others that address the therapist's experience in treating pregnant women tend to be single case studies that suggest therapy can be helpful in adverting a potential crisis such as postpartum depression. These studies focus on preventative measures and due to the

small sample size can say little about the larger population of pregnant women. Still others focus on the experiences of pregnant women who come to treatment because they have difficulties associated with their pregnancies. These studies are limited to examining a population in crisis and do not address what happens when a women becomes pregnant during a treatment that is in progress.

The objective of this study is to investigate a number of different aspects of treatment with pregnant women. Examining therapists' experiences in treating pregnant women will provide a context in which to assess how pregnancy may be manifested in an already established treatment. Specifically, termination issues will provide the focus for this inquiry. This study is exploratory in nature and not designed to test specific hypotheses, but rather to generate ideas related to therapists' experiences when they have had the opportunity to treat pregnant women.

CHAPTER III

METHOD

This study utilized both a semi-structured questionnaire and an in-depth interview. These measures were designed to obtain information from therapists about their experiences in treating pregnant women. The questionnaire and interview were intended to be open-ended, allowing for as much flexibility and depth as possible in terms of responses. The instruments that were used attempted to allow for statistical treatment of the data as well as a more qualitative and descriptive analysis of the responses.

Given the lack of empirical studies on pregnant women in therapy, this study represents an initial attempt to address specific treatment issues and to generate hypotheses for future research in this area.

SUBJECTS:

The Questionnaire

The propositions that were considered in the previous section were examined by distributing a questionnaire, devised for this study, to candidates, staff therapists and analysts at psychoanalytic institutes. These questionnaires were given to analysts-in-training and therapists associated with selected psychoanalytic institutes in the New York metropolitan area. Subjects eligible for this study included any psychotherapist,

psychoanalyst or analytic candidate who had treated a pregnant woman.

Ideally, the patients to whom the clinicians were referring would have been married, first time mothers, had full-term pregnancies and would have been in treatment at least six months prior to becoming pregnant. The six month time frame was chosen to ensure that some relationship had developed between therapist and patient prior to the pregnancy and allow for comparisons between aspects of the treatment before pregnancy and after. In addition, this excluded women from the study who specifically started treatment because of issues associated with their pregnancies.

Of the 950 questionnaires that were distributed, 61 or 6% were returned completed. Forty (66%) female and twenty-one (44%) male therapists responded. The therapists ranged in age from 21 to 68 and the mean age was 40. In this sample, 25 (41%) people were psychoanalysts, 17 (28%) were dynamic psychotherapists and 19 (31%) were analytic candidates. In addition, 29 subjects were psychologists, 25 were social workers and the remaining group was comprised of 3 psychiatrists, 2 nurses, 1 teacher and a lay analyst. Other demographic data assigned to categories based on gender are presented in the Results section in Table 1.

Therapists were asked to respond to the questionnaire with only one case in mind. Since all responses focused on a single patient, the 61 therapists generated data related to 61 pregnant women in treatment. The average age range of the

women in therapy was 31-35 years old. 53 (87%) of these women were pregnant with their first child. Additional data related specifically to the pregnant patients is presented in the Results section in Table 2.

The Follow-Up Interview

The respondents were asked if they would participate in a follow-up interview. Of those that agreed, seven were selected for interviews. This sample consisted of two male therapists and five female therapists, ranging in age from 28 years to 51 years. The patients on whom the therapists were reporting were all married, pregnant with their first child, and in treatment at least 2 years before becoming pregnant.

These respondents were chosen because the cases they were considering appeared to be representative of a number of therapists' experiences. Their cases were typical in the sense that the therapists did not report any special or unusual circumstances related to the pregnancies, the women or the therapy beyond the fact that treating a pregnant woman was in itself atypical.

In addition, after the questionnaires were returned, it became clear that the cases could be divided into four categories. The respondents included in the follow-up interview were a representative sampling of these four categories. They are: 1) Those who felt the pregnancy facilitated treatment and the patient stayed in therapy; 2) those who felt the pregnancy facilitated treatment and the

patient terminated; 3) clinicians who felt the pregnancy created increased resistance to treatment and the patient stayed in therapy and 4) clinicians who felt the pregnancy created increased resistance to treatment and the patient terminated. Both male and female therapists were chosen in order to assess possible sex differences.

MATERIALS:

The Questionnaire

A combination of an open-ended and partially structured questionnaire was utilized in order to determine the ways in which a woman's pregnancy may impact on her psychotherapy or psychoanalysis. The questions were formulated on the basis of the themes that were described in the literature on pregnancy and women in treatment. They also were based on discussions with therapists who had treated pregnant women and additionally with women who had been pregnant while they were in therapy. A pilot study was conducted and several questions were revised and added based on the therapists' responses.

The data obtained from the questionnaire was entirely from the therapist's point of view and the patient's perceptions were not pursued. This was also a retrospective study and therapists were asked to comment on a case in which the patient had already given birth. This enabled therapists to reflect on aspects of the treatment both before and after the pregnancy. Also, it was felt that if clinicians responded to the questionnaire while they were seeing a pregnant patient,

the study could have altered the ways in which they acted or thought about the pregnancy and served as an uncalled for intervention in the treatment.

The questionnaire invited the subjects to reflect on their experiences as therapists when they have had the opportunity to treat pregnant women. They were requested to focus on the woman that best met the criteria previously described (see subjects section). The questionaire included three parts. The following is an overall description of each section:

Background Information This section was designed to obtain descriptive information about the therapists including their level of training, professional affiliations and their range of experience treating pregnant women. Therapists were also asked to provide background information concerning their patients (e.g., age, number of children, treatment history, etc.).

The Pregnancy and the Course of Treatment This section was designed to assess the therapist's experience of treating a pregnant woman including: 1) the degree to which the patient brought the pregnancy into the treatment (e.g., how often she discussed her pregnancy; when she told the therapist she was pregnant); 2) the degree to which the patient-therapist relationship was affected by the pregnancy (e.g., whether the therapist experienced any change in the extent to which he or she was included in the treatment once the patient was pregnant); 3) the degree to which the pregnancy facilitated or

impeded aspects of the treatment (e.g., whether the therapist experienced any change in the patient's involvement in treatment once she was pregnant); 4) the degree to which the pregnancy impacted on the therapist if at all; and 5) the degree to which the pregnancy impacted on the patient if at all.

Termination Issues This section was designed to ascertain whether the patient terminated treatment or not, and if so why. Additionally, subjects were asked to comment on their response to the termination. Also included in this section were two open-ended questions designed to provide more qualitative information. Therapists were invited to discuss their countertransference responses to their pregnant patient and to give any thoughts they had that might not have been sufficiently emphasized in the questionnaire concerning what the impact of the patient's pregnancy was on the nature and course of the treatment.

The questionnaire is presented in Appendix A.

Follow-Up Interview

A follow-up open-ended interview, designed to provide descriptive information, was conducted with seven respondents. The content of the interview was based on information they had previously provided in the questionnaire. Respondents were asked to discuss the case more fully, provide more background information, think about their behavior and the patient's and discuss the pregnancy in more depth. An effort was made to

allow for as much flexibility as possible during the interview. Respondents were also invited to join in generating hypotheses that could become the basis of future research.

PROCEDURE:

Directors of fifteen psychoanalytic institutes were contacted in order to obtain permission to distribute the questionnaires to their candidates and, if possible, to their staff therapists and faculty. 10 institutes agreed to participate in the study. The questionnaires were either mailed directly to the subjects or brought to the institute and distributed there. A cover letter informing subjects of the nature of the study as well as a self-addressed stamped envelope accompanied each questionnaire. Subjects had the opportunity to include their names and addresses so that an in-depth follow-up interview might be possible, and to permit them to receive an abstract of the study. All subjects were informed their responses would remain confidential.

Follow-Up Interview

Seven respondents were contacted by telephone and all agreed to participate in the follow-up interview. All interviews were conducted in the respondents' offices and lasted approximately one hour. The interview sessions were recorded and subsequently the tapes were transcribed.

TREATMENT OF THE DATA:

The data analysis served to explore several relationships and issues associated with a pregnant woman's treatment. The analysis of the data was guided by several objectives: 1) to identify salient themes related to the treatment of pregnant women; 2) to examine whether therapist's felt the pregnancy had an impact on the treatment and if so what the nature and quality of that impact was; 3) to assess how many pregnant women terminated treatment and of those that did what the relationship between the termination, the therapy and the pregnancy was; and 4) to examine whether any gender differences existed in the therapists' experiences with pregnant women.

First, frequencies were generated on all the responses. Then several relationships were explored using the chi square. Finally, discriminant analysis was used to explore whether significant differences existed among groups of terminators and nonterminators in terms of several demographic and treatment variables.

Discriminant analysis was the appropriate measure to determine whether group differences existed between terminators and nonterminators, explain them in terms of smaller numbers of underlying factors and help predict in which group a patient in the future would most likely be classified.

In addition to the statistical analysis of the data, other themes and issues were presented more descriptively. Both the questionnaires and the follow-up interviews generated a great deal of information that merited qualitative analysis.

CHAPTER IV

RESULTS

Sixty-one subjects responded to over 50 questions. To aid in the organization of the data, the results will be presented in four sections: discussion of the sample as a whole, termination issues, additional questions answerable by the data, and description of the follow-up interview data. Since the subjects often gave more than one response per question, in some cases, the number of responses may exceed the total N.

I The Sample

First, data will be presented related to the therapist's overall experience in treating a pregnant woman. Frequencies of selected responses are presented in Tables 1-5. The questions and their responses were organized into five categories: variables related specifically to the therapist, variables related to the pregnant patients, variables related to the quality of the treatment, pregnancy related treatment variables and termination related variables.

Table 1

Therapist Variables

VARIABLE	NUMBER OF RESPONSES MALE	FEMALE	% OF TOTAL SAMPLE
Gender:Male	21	--	34.4%
Female	--	40	65.6%
Slant:Psychoanalyst	13	12	41.0%
Dynamic Therapist	3	14	27.9%
Analytic Candidate	5	14	31.1%
Profession: Psychiatrist	3	--	4.9%
Psychologist	13	16	47.5%
Social Worker	4	21	41.0%
Nurse,Teacher,Lay Analyst	1	3	6.5%
Age Group:28-35	8	13	34.4%
36-40	4	13	27.9%
41-50	3	11	23.0%
51-HIGH	6	3	14.8%
# Pregnant Women Treated:1	7	20	44.3%
2	7	7	23.0%
3	4	5	14.8%
4+	3	8	18.0%
Supervisor Gender For This Case: Male	2	10	19.7%
Female	--	6	9.8%
Male & Female	2	2	6.6%
Not Applicable	17	22	64.0%
Level Of Experience:Experienced	12	19	50.8%
Inexperienced	9	21	49.1%
Was Therapist Pregnant While Treating This Patient: Yes	--	5	8.2%
No	21	35	91.8%
Does Therapist Have Children:Yes	11	25	59.0%
No	10	15	41.0%

Table 2

Patient Variables

VARIABLE	NUMBER OF RESPONSES MALE	FEMALE	% OF TOTAL SAMPLE
Patient's Age:22-30	11	19	49.2%
31-35	9	14	37.7%
36-HIGH	1	7	13.1%
# Of Children At Time Of Pregnancy: None	19	34	86.9%
One or More	2	6	13.1%
What Year In Tx Patient Got Pregnant: 6 Months	--	6	9.8%
1 Year	2	4	9.8%
Within 1 1/2 Years	6	7	13.0%
Within 2 Years	5	9	23.0%
3 Years	7	4	18.0%
4 Or More Years	1	10	18.0%
Marital Status:Married	19	35	88.5%
Single	1	4	8.2%
Divorced Or Separated	1	1	3.3%
Patient's Mother:Living	20	37	93.4%
Deceased	1	3	6.5%
Prior Treatment:Yes	9	23	52.5%
No	12	17	47.5%
Presenting Problem:Depression	13	24	60.7%
Anxiety	10	19	47.5%
Marital Difficulties	6	8	23.0%
Interpersonal Difficulties	7	12	31.1%
Career Difficulties	7	8	24.6%
Other	--	4	6.6%
Was Patient An Analytic Candidate: Yes	2	--	3.3%
No	19	40	96.7%
Diagnosis: Hysterical	4	3	11.5%
Obsessive Compulsive	5	7	19.7%
Mixed Neurosis	4	17	34.4%
Narcissistic	5	8	21.3%
Paranoid	1	1	3.3%
Borderline	4	4	13.1%
Was Pregnancy:Planned	18	27	73.8%
Accidental	2	11	21.3%
Both	1	2	2.9%

Table 3

Treatment Variables

VARIABLE	NUMBER OF RESPONSES MALE	FEMALE	% OF TOTAL SAMPLE
Type of Treatment:			
Psychoanalysis	6	3	14.8%
Dynamic Psychotherapy	13	30	70.5%
Supportive Therapy	1	4	8.2%
Other Combinations	1	3	6.6%
Treatment Rate:			
One Time Per Week	9	22	50.8%
Two Times Per Week	7	14	34.4%
Three Times Per Week	5	4	14.8%

Table 4

Pregnancy Related Treatment Variables

VARIABLE	NUMBER OF RESPONSES MALE	FEMALE	% OF TOTAL SAMPLE
Defensive Functioning Change: Yes	9	15	39.3%
No	10	23	54.1%
Talked About Becoming Pregnant:			
Never or Rarely	5	8	21.3%
Occasionally	9	13	36.1%
Frequently or Always	7	19	42.6%
Talked About Pregnancy While Pregnant: Never or Rarely	2	2	6.6%
Occasionally	9	10	31.1%
Frequently or Every Session	10	28	62.3%
Patient's Manifest Behavior Did Not Change When Pregnant	8	20	45.9%
Patient's Behavior Changed:			
Missed More Sessions	3	6	14.8%
Came Earlier To Sessions	--	2	3.3%
Came Later To Sessions	1	1	3.3%
Was More Talkative	2	4	9.8%
Was More Silent	1	1	3.3%
Had Trouble Paying Bill	1	2	4.9%
Other Changes	5	8	21.3%
Involvement In Tx Prior To Pregnancy: Very Involved	15	29	72.2%
Somewhat Involved	2	8	16.4%
Somewhat & Very Uninvolved	2	3	8.2%
Involvement In Tx While Pregnant:			
More Involved +/or Committed	5	15	32.8%
Less Involved +/or Committed	8	13	34.4%
No Change	6	11	27.9%
Shift In Identifications: To Mom	9	17	42.6%
To Husband or Father	3	5	13.1%
To Therapist	2	15	27.9%
Pregnant Patient: More Sensitive re: Therapist's Comments&Behavior	6	15	34.4%
Less Sensitive	1	1	3.3%
Neither More Nor Less Sensitive	14	22	59.0%
Was Therapist: More Directly In Tx	6	17	37.7%
Less Directly In The Tx	2	4	9.8%
Neither More Nor Less In The Tx	13	19	52.5%

Table 4 Continued

Pregnancy Related Treatment Variables

VARIABLE	NUMBER OF RESPONSES MALE	FEMALE	% OF TOTAL SAMPLE
Therapist's Approach Changed When Patient Pregnant:No	11	12	37.7%
Yes, More Active	5	19	39.3%
Yes, More Supportive	9	21	49.2%
Yes, More Flexible	3	9	19.7%
Other:More Awareness&Empathy	1	1	3.2%
Other:Less Supportive	1	--	1.6%
Extent Therapist Felt Included In Pregnancy:Not Included	2	2	6.6%
Somewhat Included	6	11	27.9%
Very Much&Completely Included	13	27	65.6%
Countertransference: Positive	10	18	45.9%
Negative	6	10	26.2%
None Stated	10	15	41.0%

Table 5

Termination Variables

VARIABLE	NUMBER OF RESPONSES MALE	FEMALE	% OF TOTAL SAMPLE
Did Patient Terminate: No	11	19	49.2%
Yes, During Pregnancy	6	5	18.0%
Yes, Around The Due Date	--	2	3.3%
Yes,Within 6 Months of Birth	3	10	21.3%
Yes, Within a Year Or More	1	4	8.2%
Therapist's Understanding Of Why Pt. Terminated:Resistance And/Or Defensive Maneuver	3	11	23.0%
Adaptive Refocusing Of Energy	4	2	9.8%
Successful Completion Of Tx	2	3	8.2%
Other Combinations	1	5	9.8%
Pt.'s Reasons For Terminating: Resolved Issues Via Pregnancy	2	1	4.9%
Time And/Or Energy	7	7	23.0%
Money	4	5	14.8%
Got What She Wanted From Tx	5	10	24.6%
Other: Moved	--	2	3.3%
Total # Of Pts. That Left Tx Around Due Date: None	7	13	32.8%
One	9	17	42.6%
Two	5	6	18.0%
Three Or More	--	1	1.6%

The results indicate that overall, the majority of therapists felt that the pregnancy had an impact on the treatment. Almost all patients talked about their pregnancies in sessions once they were pregnant. Thus, the manifest content of sessions changed. In addition, a majority of patients talked about becoming pregnant before they made the decision to do so, heralding the changes to come.

Once pregnant, several changes were noted in the patient's behavior as well as in the therapist's style of working with his or her patient. Of the 54% of the therapists who felt their patients exhibited behavioral changes, patients missing more sessions was the most frequently cited manifest change. Patients' changes in behavior were further assessed by creating two summary statistics: positive changes (e.g., paid bill more conscientiously, came earlier to sessions) and negative changes (e.g., missed more sessions, came later to sessions). Of those patients who changed, 21 or 57% exhibited negative changes and 16 or 43% exhibited positive changes, suggesting that in this particular area the pregnancy was felt to create increased difficulties in the treatment.

Similarly, pregnant women were felt to be slightly less involved and/or committed to therapy when they were pregnant. However, the majority of women were starting with a baseline of intense involvement in their treatment prior to pregnancy. A minority of therapists felt there was no change in commitment and involvement in treatment.

In terms of technical changes in the therapist's mode of

working with their patients, 62% felt they had changed their style in a variety of ways. Of these therapists, the majority believed they had become more active and more supportive. With the exception of one therapist, all felt that their approach had become more flexible, suggesting that the pregnancy gave rise to a situation in which either consciously or unconsciously the therapist felt compelled to soften his or her approach.

Therapists also discussed their countertransference responses to their pregnant patients. The majority of therapists acknowledged positive countertransferential feelings that seemed to be related to the pregnancy (e.g., felt more maternal, more protective, had positive feelings for her). Some expressed negative feelings such as being angry, resentful and envious. Jealousy was expressed by four female therapists while no males acknowledged this feeling. 41% of the respondents did not answer this question indicating they were not aware of any countertransference responses or they chose not to disclose this highly personal information.

The patient's reaction to the therapist was also noted. The majority of therapists felt their patients did not become any more or less sensitive to their comments than before nor did the patients exhibit any change in the amount of references they made to the therapists. However, most therapists did feel their patients tried to actively share the experience of the pregnancy with them. Consistent with the notion that the patients wanted to include the therapist in the process was the

finding that all patients told their therapists they were pregnant immediately or within a few weeks of the pregnancy.

Therapists did experience a shift in their patients' significant identifications. Consistent with the literature on the psychological processes of pregnancy, most therapists felt patients began to identify more with their mothers. However, a large group of therapists felt their patients began to identify more with them. About four times as many female therapists as male therapists noted this phenomenon, suggesting gender differences may have had some impact on the patient's ability to identify with her therapist.

Termination frequencies were also examined. About 49% of the patients remained in treatment. While this indicates a majority of the patients did terminate treatment, only 43% terminated within six months of the baby's birth. In terms of looking at the impact of the pregnancy on termination, those patients who terminated after the six month period were not considered pregnancy related terminations. It was felt that too many other variables could have influenced the termination if treatment ended a year or so after the birth. While it is possible that treatments which ended within the chosen time period still could have been influenced by factors other than the pregnancy, all therapists did feel these terminations were pregnancy related.

Therapists most frequently felt that the termination was a manifestation of resistance or a defensive maneuver. Conversely, most patients stated they left treatment because

they had gotten what they wanted from the therapy. This statistic dramatically highlights the differing perceptions of patients and therapists within the same treatment. In terms of therapists' overall experience with pregnant women, most therapists had treated an average of one pregnant woman in their career and had an average of one pregnant patient terminate. Termination issues will be discussed more thoroughly in the next section.

Some interesting data related to the patient's characteristics was also generated. As stated in the methods section, most women were married, first time mothers whose own mothers were living. The most frequently occurring diagnosis was mixed neurosis. No patients carried the diagnosis of schizoid nor were any women in this sample psychotic. Patients were described as exhibiting a variety of defenses, most notably denial, repression and isolation of affect. In categorizing these defenses into higher and lower level defenses, it appeared both categories were represented almost equally. Patients tended to be described as using higher level defenses a bit more frequently, but not to a degree which would indicate a trend.

In terms of therapists' characteristics, approximately 34% were male respondents and 66% were female. The fact that there were about twice as many female respondents as male may be a reflection of several factors: The current trend toward a greater number of females in practice, the possibility that females treat more pregnant women or that females tend to respond to questionnaires more readily. In contrast, the

majority of therapists who were in supervision had male supervisors for their cases. However, 64% received no supervision.

The majority of respondents were psychoanalysts (41%) and the second largest group (31%) was composed of analytic candidates in training. About 48% of the sample had a Ph.D. in Psychology, 41% were Social Workers and 5% had M.Ds. Their level of experience was assessed by creating a variable which included a combination of their age and whether or not they were an analytic candidate. Using these criteria, 51% of the respondents were categorized as experienced and 49% as relatively inexperienced.

It should be noted that while there was an attempt to look at a "typical" pregnant woman in treatment--one who did not present any unusual circumstances--two special situations were uncovered. Two male therapists had treated pregnant women who were analytic candidates in their training analyses. It would seem both of these women would be particularly invested in their treatment and would not terminate regardless of the dynamics of their pregnancies. In fact, both these women did remain in treatment. Secondly, five female therapists were pregnant at the time they treated their pregnant patients. While it is very probable that the dual pregnancies had a profound influence on both patient and therapist, examining the nuances of this special situation was beyond the scope of this study.

In addition, there were two questions in particular that

presented some difficulty. While the literature suggests that a pregnant woman's dreams are more prevalent and vivid, only 16% of the therapists reported this finding. It appeared that many therapists could not remember details related to dreams. Thus, this small percentage may be a reflection of the therapist's failure to remember and not a reflection of the patient's quality of dreams or her failure to bring these dreams into the treatment. About 20% of the therapists did feel there was a shift in the content of their patients' dreams and that the therapists were more prominently in the dreams in either a disguised or undisguised form.

Therapist were also asked if they had children of their own. While 59% said that they did, it was not known whether they had children at the time they were treating these cases. Therefore, it was impossible to say whether or not parenthood could have had an impact on their responses to their pregnant patients.

Finally, these frequencies do not reveal the qualitative aspects of the therapist's experience in treating a pregnant woman. Many therapists discussed their feelings about the impact their patient's pregnancy had on the treatment. Some examples of these responses are described below:

> Case 1. The pregnancy has added a dimension to the relationship and the transference. It has evoked issues that the patient had dealt with before, but now were brought into focus in a more intense and in a much clearer way.

Case 2. Pregnancy and motherhood issues are very delicate to explore and problems with maintaining appropriate neutrality while still addressing them are difficult. In this case, the pregnancy made some contribution to deepening the analytic process. It brought up a range of concerns that previously hadn't been touched on and also provided an opportunity for more personal, spontaneous exchange and sharing of a major, mostly positive, life event- all of which was quite helpful to the treatment.

Case 3. This particular patient's pregnancy became a reason for termination. The patient re-entered treatment after the birth of her second baby. She had indeed become absorbed in raising the kids and felt that she and her marriage were suffering as a result. It was this use of the pregnancy/infants as a refuge that brought the original course of treatment to a close.

Case 4. During the pregnancy, issues of her mother and the kind of childcare she provided arose in treatment. The patient felt she was feeling closer to me during her pregnancy and her perceptions of me changed. During much of the treatment, prior to her pregnancy, she had felt that I was single and not involved in a relationship. When she became pregnant, her perception in this regard changed so she began to assume that I was married and a mother. The birth of her child has resulted in her being less involved in treatment partially because she comes to treatment less frequently, but also because she has great difficulty being able to deal with commitment and involvement with more than one person. She's repeating the pattern of her relationship with her parents where she was able to be close with only one parent to the exclusion of the other. She has referred to people being seen as two dimensional cardboard creatures by her and while the lack of involvement in treatment is not to that extent there is some repetition of this pattern.

In addition, frequencies of selected responses, categorized by the therapist's gender and whether or not the patient terminated treatment, are presented in Appendix B.

II Termination Issues
The Chi Square

The relationships between termination and 36 selected variables were explored using chi square. The following relationships were found to be significant: (Strength of relationship in parentheses)

Table 6

Relationships Between Termination And:

Profession X^2 =6.3 p.= .03 (Cramer's Φ = .32)

Treatment Rate X^2 =15.9 p.=.000 (Cramer's Φ = .51)

Pt. Involvement In Tx Before Pregnancy X^2 =5.5 p.= .01 (r= -.37)

Pt. Involvement In Tx While Pregnant X^2 =11.5 p.= .003 (Cramer's Φ =.44)

Termination and profession were significantly related in that psychologists' patients tended to terminate less than social workers', psychiatrists', nurses' and teachers'. In other words, social workers and other groups had significantly more pregnant women who terminated therapy. This relationship was weak to moderate.

Also termination and the number of times per week that a patient went to therapy were found to be related. Patients who went once a week terminated significantly more than those who attended biweekly or triweekly. Patients who went to therapy twice per week terminated significantly less than expected as well as patients who were in therapy three times per week. This relationship was moderate.

In addition, the patient's level of involvement in

treatment before and during her pregnancy was found to be significantly related to termination. Patients who were seen as having a high level of involvement in their treatment before they became pregnant tended to remain in treatment and those who had been somewhat or very univolved in their therapy terminated.

Similarly, patients whose therapists felt they were more involved and committed to their treatment during their pregnancy stayed in treatment and those who became less involved and committed to treatment once they were pregnant tended to terminate. However, patients who were felt to exhibit no change in their level of commitment and involvement once they were pregnant also terminated significantly less than expected. This relationship is consistent with the frequency data that indicated most women were very involved and committed to their treatment prior to the pregnancy. Therefore no change in level of commitment during the pregnancy suggests these women are still functioning on a level of intense involvement in their treatment. The relationships dicussed above were found to be moderate.

No significant relationship was found between the therapist's gender and termination. In addition, a nonsignificant relationship was found between a therapist's level of training (e.g., psychoanalyst, dynamic psychotherapist and analytic candidate) and termination. The finding suggested that patients treated by psychoanalysts were more likely to remain in treatment than patients seen by psychodynamically

oriented psychotherapists and analytic candidates. This relationship, as noted above, did not reach statistical significance, but did suggest a moderate association between these variables (p. = .062).

Termination Issues
Discriminant Analysis

An additional measure was utilized to determine which variables if any could predict therapy outcome. Using discriminant analysis, a set of 11 variables related to patient, therapist and treatment characteristics were used to predict termination. The independent variables or predictors were: gender, profession, level of experience, change in therapist's behavior, change in patient's behavior, patient's age, when she got pregnant, whether pregnancy was planned, her diagnosis, type of treatment, and treatment rate. The dependent variable was whether or not the patient terminated treatment.

Profession, Treatment Rate and When the Patient Became Pregnant were found to predict membership in the nonterminator group. In other words, patients who most likely did not terminate their therapy during or immediately after the pregnancy became pregnant relatively later in the treatment (more than 2 years), were treated by psychologists and were seen more than one time per week.

Discriminant analysis was also performed using 10 of the same predictor variables, but 4 outcome groups were delineated: male therapists whose patients had terminated (MT), male therapists whose patients did not terminate (MNT), female therapists whose patients left treatment (FT), and female

therapists whose patients remained in treatment (FNT). Thus, gender was removed from the list of predictor variables and utilized as a dependent variable.

This discriminant analysis revealed that the male nonterminator group could be discriminated from the three others. Members of this former group were more likely to be psychologists, work more analytically than those in other groups, see their patients relatively more times per week and not become more supportive or flexible once their patients were pregnant; i.e., therapists did not change their behavior. Once again, no gender differences were noted in relation to termination. This measure does not suggest that patients who remained in therapy were more likely treated by males, but rather indicates that the other three groups, (FT, FNT, MT) were more similar in composition and the group means of the male nonterminators were significantly different from the other group means.

The results of the second discriminant analysis were consistent with the original one. It seems that when treatment was more classical or analytic--measured by type of treatment, treatment rate, professional orientation and disinclination to become more supportive--then the more likely it was that a pregnant patient would remain in treatment.

III Other Questions Answerable By The Data

Given the large number of variables, not surprisingly, many other relationships were uncovered. Some of the more relevant relationships are presented in Table 7.

Table 7

Significant Relationships Among Several Patient,Therapist & Treatment Variables (Chi Square- All p. Values $<.05$)

	THERAPIST'S LEVEL OF TRAINING	PROFESSION	EXPERIENCE	POSITIVE CHANGE
Therapist's Gender	X	X		
Patient's Age			X	
Pregnancy Was Planned		X		
Degree To Which Pt. Discussed Becoming Pregnant	X			
Degree To Which Pt. Was Involved In Tx Prior To Pregnancy	X	X		
Degree To Which Pt. Was Involved In Tx During Pregnancy			X	X
Therapist's Negative Countertransference		X		

Table 7 reveals that there was a significant relationship between the therapist's level of training (analyst, dynamic psychotherapist or analytic candidate) and the following variables: therapist's gender, extent to which patient talked about becoming pregnant and the extent of the patient's involvement in treatment prior to the pregnancy.

Specifically, more analysts were men and significantly more dynamic therapists and candidates were women. More analysts had patients who spoke frequently about becoming pregnant and significantly more dynamic therapists had patients who rarely discussed their plans regarding pregnancy. Psychoanalysts and psychotherapists treated patients who were seen as very involved in their treatment prior to the pregnancy and candidates' patients were felt to be more uninvolved in their treatment.

Profession (psychologist, psychiatrist/other and social worker) was found to be significantly related to the therapist's gender, whether the pregnancy was planned or unplanned, the extent of involvement in the treatment prior to the pregnancy and the therapist's experienced negative counter-transference. These relationships suggested that more psychologists and psychiatrists/others were men and more social workers were female. In addition, social workers treated patients who described their pregnancies as unplanned. Psychologists had patients who were felt to be quite involved in their treatment prior to the pregnancy and significantly

more social workers and psychiartists/others had patients who were felt to be somewhat uninvolved in treatment. Finally, psychiatrists/others and social workers expressed significantly more negative countertransference and psychologists experienced significantly less.

In terms of a therapist's level of experience, inexperienced therapists treated more younger patients (22-30 years old) and experienced therapists tended to treat older pregnant patients (31-40 years old). Experienced therapists also treated patients who either were seen as more committed and involved in therapy or exhibited no change in involvement or commitment once they were pregnant. Conversely, inexperienced therapists treated more pregnant patients who were felt to be less involved and committed to therapy.

The last relationship examined concerned the association between patients whose manifest behavior changed in a positive way (e.g., came to sessions more often, paid bills more conscientiously) and their degree of involvement in therapy during their pregnancy. Those who changed in what was perceived as a more positive direction were seen as exhibiting a greater degree of commitment and involvement in treatment during their pregnancy. Those patients whose behavior did not demonstrate positive changes tended to be either less committed and involved in treatment or exhibited no change during the pregnancy. All the relationships discussed in this section were moderately strong.

In addition to these significant relationships, it was

found that psychodynamically oriented psychotherapists tended to become more flexible and supportive while treating pregnant women, while analysts and candidates did not ($p. < .10$). This relationship did not reach statistical significance, but was noteworthy particularly in light of the fact that it was previously reported that psychodynamically oriented therapists had patients who tended to terminate treatment. It is also consistent with the discriminant analysis which revealed that the group of male nonterminators were not likely to get more supportive with regard to their pregnant patients.

Outlining these relationships serves to enrich the discussion of therapists' experiences in treating pregnant women and to augment the data already obtained on termination. In putting several of these relationships together some profiles emerge. First, there are social workers whose patients tended to terminate treatment, who described more of their patients' pregnancies as unplanned relative to the other groups, whose patients seemed somewhat uninvolved in treatment prior to their pregnancies, and who as therapists saw themselves as experiencing negative countertransference.

The group labeled psychiatrists and other professionals were similar to social workers with respect to the variables described above except that this group tended to have more male members and treat more women whose pregnancies were seen as planned.

Psychologists, who were likely to be men, had patients who tended to terminate less often, whose patients were felt to be

quite involved in the treatment prior to their pregnancies, and who as therapists tended to see themselves as experiencing little negative countertransference relative to other groups.

IV Follow-Up Interviews

Seven brief vignettes are presented to highlight some of the themes associated with pregnant women's treatment and to describe clinical phenomena related to therapists' experiences with their pregnant patients.

Case A. Mrs. A was in biweekly psychoanalysis with a male social worker/analyst. She stated she began treatment because she felt angry with her husband. The patient was described as verbal, bright, well defended, terribly frightened of abandonment and someone who "personified a lot of women today who have a strong conviction in their own independence and at the same time want to have a love life, a marriage which in turn creates conflicts and problems based upon dependency."

She was the fourth of six children from a middle class Orthodox Jewish family. The patient felt her father was the nurturer in the family, while mother was depressed, very needy and dependent. Ms. A said she identified more with her father, particularly his strong work ethic. The patient married a man who was seen as similar to her mother, very dependent, depressed and prone to hysterical outbursts.

The patient became pregnant approximatley 2 and a half years into the treatment when she was 28 years old. She had no children at the time. "I had cautioned her to talk about any major changes in the course of her analysis, so she talked about her wish to have a baby for a year. Having a baby could be seen, on one level, as an Oedipal wish to have a child with me. It came out in a dream where she and I and the baby were in a bathtub together. She never connected that to wanting to have a baby with me and I never interpreted that to her because what she was doing was trying to resolve getting closer to her father."

Over the course of the year, the discussion centered on her wanting to have a baby "for the wrong reasons." She realized that she hoped for a child to distance herself from

her husband, knowing she would focus all her attention on the newborn and exclude her husband. She also wanted to create a child to nurture in a way she had never been. She understood that these were not appropriate reasons for her to have a child because it would put undue pressure on the newborn. As she resolved some of these issues, she became pregnant and worked on what it meant to be "a mother, a real mother and raise a child that would be part of a triangle."

Before she became pregnant, in the course of working on her need to distance herself from her husband, she became aware of her resistance to getting closer to her analyst. However, once she was pregnant, "the patient's love feelings toward me became more manifest and in general, the transference heated up. Early in the treatment I had felt put off by her defenses, but during the pregnancy the patient started to involve me directly without disguise." Though the analyst believes in encouragement, his approach did not change once his patient was pregnant. Mrs. A has remained in treatment.

"One thing that appears to be fairly common is that dependency wishes are extrememly stirred up by pregnancy, the fear that once they have a child they're going to lose their dependency. Their dependency wishes are punctuated by the pregnancy. This patient had worked long enough in her analysis, for 2, 3 years realizing she had dependency wishes. If the mother has been working long enough to get to her unconscious dependency wishes then she can have a child which will be totally dependent on her and she doesn't have to feel she will be left all alone."

Case B. Mrs. B was in biweekly psychodynamically oriented psychotherapy with a female psychologist/psychotherapist. She began treatment because of depression and a long standing pattern of becoming involved with unavailable men.

She was the second of four children and the only girl. She remembers her parents were constantly fighting. Her father drank a great deal and the family moved every two years because father was in the Navy. The patient felt she was a parentified child and took care of her depressed and passive mother. In later years she tended to form attachments to people who needed her, but did not give much back in return. She had a history of getting involved with men who were married or involved with someone else. She went through several relationships that were self-defeating.

After several years of treatment, she married a man who was seen as very suitable for her and her relationship with him was described as extremely open and affectionate.

The patient became pregnant, in her early thirties, after approximately ten years of therapy. She had no children at the time. The pregnancy was described as "part of this whole new development in her life that she was going to be less devoted to taking care of other people's interests and more nurturing and considerate of herself, not in a selfish way, but in a healthy way. In a sense getting married, becoming pregnant and having a family of her own was the goal of her treatment--one of the goals of her treatment in terms of changes of circumstances as opposed to changes in internal structures. It was to both of us a sign of her growing health, success in life and greater happiness. The pregnancy exemplified the patient's success in working out her problems, both Oedipal and pre-Oedipal, with her parents and her own self-image."

During the pregnancy, the transference was affected in that there was a greater identification with the therapist. She knew the therapist had children and grandchildren and the therapist had a sense that Mrs. B was in need of being able to see that role as a strong, satisfying and nonmasochistic one. The patient also had revived fears of following in her mother's footsteps and while her identification with her own mother was strengthened during this period, it was problemmatic for her because of her conflictual feelings about her mother.

The pregnancy was seen as a generally happy and contented time for the patient. The baby was very welcome and therefore the therapist felt "it probably came out less in the whole treatment because it wasn't conflictual beyond the inevitable anxieties that come up such as what kind of mother will I be? My patient was probably in an ideal state. She was married to someone she loved a great deal and she had been looking forward to having children her whole life."

The therapist felt she did not modify her stance with her pregnant patient because the therapist saw the patient as a very capable, high functioning woman. The therapist did feel the patient exhibited greater dependency and though Mrs. B was a bit conflicted about this, it was perceived to be an important experience for her to feel she could lean on her husband.

Overall the patient seemed more involved in her treatment when she was pregnant. Since the pregnancy was a culmination of a great deal of work, the patient was working toward termination. However, the ending was postponed because her brother became seriously ill and died. The patient is currently still in treatment.

In terms of treating pregnant women, "you would want to know the fantasies about the baby. Sometimes the baby represents someone to love you, for example, which isn't realistic because infants need you to love them. I think you have to consider the individual and what kinds of issues she

has around femininity, motherhood and dependency. In a way you have a whole continuum of neurotic versus healthy motivations for getting pregnant and I would say my patient was pretty far over toward the healthy end of the spectrum."

Case C. Mrs. C was in triweekly psychoanalysis with a female psychologist/ analytic candidate. The patient's presenting problems included anxiety and career conflicts.

The patient was the oldest of four children. Mrs. C felt she did not receive enough attention from her mother who was a professional woman, always in the limelight. The patient felt she could not outshine her mother and was second best in comparison to mom whom the patient conceived of as a "star."

The patient became pregnant when she was in her late thirties, 3 years after she began analysis. The patient had no children at the time. The patient became pregnant about three months after the therapist adopted a child. Dr. C had alerted the patient that a child was coming and the patient began to express many feelings and fantasies associated with the adoption. "She thought it was so wonderful that she wanted to adopt. That was before she got pregnant. She never thought that there could be anything wrong with me. I was still glorified. I was mother earth who was going to take over and rescue a child."

The flavor of the treatment both before and after the patient's pregnancy was described as a power struggle. Initially, the transference took the form of the patient acting as if the therapist was the successful, adequate mother and the patient was the cheated victimized child. Once Mrs. C was pregnant, the therapist felt the patient "was trying to create something. She couldn't create in her field. She was an actress and this was going to be her production. She was going to get the accolades. She could do something I couldn't. I couldn't be included. There was that quality to it."

The patient's difficulty in including the therapist heralded some problems in the treatment. The patient began missing sessions, coming late and not paying her bill. There was also an avoidance of talking about any substantial issues. In part the therapist felt this was something that had to be tolerated. "I think it's hard to be able to stay connected to your analyst. It's such a symbiotic stage of involvement. It's almost as though it's exclusively yours with the baby and anybody else, I think, is an intrusion. An analyst can be a disruptive other in that you don't want to deal with conflicts. I don't know the terminology, but it's like some sort of semi-psychotic reverie. You're not here. You're in a state of euphoria that has been legitimized to you because you're having a baby."

The therapist continued raising issues regarding the pregnancy. Did the patient feel the therapist would be envious of Mrs. C's pregnancy? Was she trying to provoke envy in the therapist? Was the patient retaliating? Never the less, the patient remained withdrawn, had retreated, but did not

terminate treatment. When the baby was born the patient continued in much the same manner. The therapist cut down sessions to two times per week. "I was flexible with time. I was accomodating to her because I understood what it was about. There was a tendency to use the treatment as more supportive. To talk about the baby, to stay with the baby world as opposed to getting into issues about your mother or father for those three or four months until you sort of hatch. You might need to focus the treatment on supportive issues and deal with diapers and sleeping and bottles. It's a suspension of other things until you can hatch and move away and it takes time to move away. It's a very gradual separation. As you begin to separate you start to recathect to the treatment, but the period is touch and go. The therapist has to be able to be relegated to a place which is not part of that union."

The patient's response to the therapist's modifications was "an abuse of them." After 6 months the therapist said she was no longer going to tolerate it. "I don't feel it's in the interest of the baby or you. You're acting out and you're using it as a cover up." After this period the patient returned to discussing career conflicts and issues concerning being a new mother.

The period of the pregnancy and several months following the birth was seen as a time when the treatment did not progress. The therapist felt this case may be representative of other pregnant women in treatment in that "It's no time to want to work on other issues that can evoke sadness, pain and conflict. It's a perfect opportunity to get out of treatment, perfect. If a blend develops between mother and baby then everyone else is other."

In terms of gender issues, "I think there is an issue of a male or female analyst and the age of the therapist. It might be difficult for pregnant patients who have women analysts who are childless. It's something the patient might want to share and yet perhaps there is a sense that you might create envy or provoke hostility and retaliation. It doesn't feel O.K. It's like you're the patient and you're more beautiful than your analyst or you're the patient who has the money. If the analyst had children, the patient might feel more understood. With a male analyst I don't know what they would be up against. I know it would be different."

Case D. Mrs. D was in biweekly psychodynamically oriented psychotherapy with a female social worker/analyst. She began treatment because she was feeling depressed and was trying to decided whether or not to marry.

The patient came from a lower middle class Jewish family. Her mother was described as simple, unsophisticated and intrusive woman. The patient had a strong attachment to her mother. Father was described as an alcoholic who was very volitile. Later, the patient married a man with whom she had many conflicts. Both husband and wife were artists and had great difficulties with money and keeping jobs.

During her fourth year of treatment when the patient was in her late twenties she became pregnant. The patient had no children at the time. However, the patient had not intended to get pregnant, but her doctor advised her that she could not have any more abortions if she wanted to have children in the future.

Initially, the patient was depressed about the pregnancy. She had recently started school and didn't know if she could continue. She also was not sure if she wanted to stay with her husband. "While it might have been an unconscious and purposeful accident it may well have been a decision to stay with her husband. She was really returning to the kind of depression she had when she had started treatment."

During the pregnancy the patient became much less involved in her treatment. "When she got pregnant we were in the middle of, for the first time, struggling with her ambivalance about her dependency. I think this was another aspect of her wanting to be pregnant whether she tried to or not. What really happened was once she hit the second trimester, she got out of the depression and really stoppped struggling with everything. It was like she was happy and pleased that she was pregnant. There wasn't any major work going on in terms of dependency issues or separation issues. It wasn't available."

The therapist felt she used the pregnancy to avoid cerain basic, very disturbing issues in her treatment. "I don't think that she merged with this baby. There wasn't much symbiotic sort of pleasure. To recognize any of the qualitities that the baby might have had would have meant to talk about the problems she was having with her husband. The baby was half the husband's. I guess at that point in her development merger fantasies would have been too threatening."

The therapist saw herself as becoming more supportive with her pregnant patient. "Not because she was pregnant, but because she was in a state of denial I changed my approach. If I hadn't she would have gotten more defensive." About two months after the baby was born, Mrs. D terminated treatment. She resumed treatment after an eight month time period, but

then ended treatment within approximately another eight months. Regarding the first termination, "We were both very clear that we were back in the place at which she had gotten pregnant. We were looking at issues which she had not wanted to look at 12 months before. She made a choice that she was not going to work at it. She made money the manifest reason, but she was as clear as I was that there was an underlying conflict that we just couldn't get to."

"In terms of her treatment, I saw the pregnancy as a block of time that essentially took her away from the work she had been doing. I think a lot of issues came up for her in the experience of being a mother, but they weren't available to her in the treatment."

Case E. Mrs. E was in weekly psychodynamically oriented psychotherapy with a female psychologist/psychotherapist. She came to treatment because she was having diffiuclties with her relationship with her mother and she was fighting with her a great deal. She was also troubled about her close relationship with another man who was not her husband. It was not a sexual relationship, but it bothered her because it diverted her attention away from her marriage. The patient was seen as a verbal, bright and very competent professional woman.

The patient's mother was described as intensely competitive with her daughter, very demanding and inclined to act more like a sibling than a mother. She was in graduate school at the same time the patient was. The patient's grandmother was sick and deteriorating throughout the patient's pregnancy. So mother was going through leaving grandmother at the same time that the patient was also trying to separate from her mother. Thus, the patient's mother was making demands on her daughter for care when it was the patient who needed nurturing.

The patient became pregnant when she was in her late twenties after 2 years of treatment. She had no children. The patient became more emotionally available as the pregnancy progressed and she began to deal with issues related to her mother. "I think the pregnancy raised certain issues that hadn't been raised and highlighted cerain issues about relationships in the family and her place in the world. Her grandmother had just died and she was having a baby so the whole shift in the generations came to the fore in a way that people don't usually think about them--life cycle issues."

The therapist felt the patient became more involved in the treatment once Mrs. E was pregnant. The patient brought in more dreams related to issues of motherhood and her relationships with other women. During the pregnancy the therapist felt she was experienced as a role model who could

guide the patient through the process in a way her mother could not. The therapist felt a pull toward behaving more maternally and providing more concrete information about health concerns. "There was something compelling about the practical area. I think I was more active and more directive. This is a woman who is high functioning. There was also a shift because she was going through a termination process so it felt more comfortable to be more active."

The termination was mutually agreed upon. "What happened was that the diminishing of her attraction to this other man and the increasing investment in herself and her baby kind of balanced each other. She transferred a lot of her intense emotions on to this baby so when one ended the other began. The issue she came to treatment for was abating which made it possible for her to become pregnant. I think the treatment kind of facilitated that transition. I think that the termination was an appropriate one in terms of the timing. Essentially, she was making an emotional commitment to her husband and the marriage."

Case F. Mrs. F was in biweekly psychodynamically oriented psychotherapy with a female social worker/ psychotherapist. Her presenting problems were severe depression due to the recent death of her grandmother and her inability to function well as a result of this loss.

The patient was brought up in a household where the mother was apparently very inadequate and helpless. The father was described as remote. Both parents did not speak English and the patient spent her childhood navigating for them. She was very close with her grandmother who was the matriarch of the household. Later, the patient acquired an important position in the filmmaking field and married somewhat of a celebrity.

The patient became pregnant in her second year of treatment when she was in her early thirties. She had no children at the time. The pregnancy was planned in that she always understood that when she got married she would get pregnant. The therapist felt that during the course of the pregnancy the patient became more withdrawn. She was consciously unambivalent about the pregnancy, but within a short period of time she became sick and was vomiting so severely that she required hospitalization to be rehydrated. "It seems that she had such strong issues relating to merger. There was something terrifying about having another thing parasitic to her and she had a distinct feeling about the fetus inside of her."

Throughout the pregnancy the patient was frustrated that she could not identify with her mother, but her idealization of

her husband intensified. The therapist did not feel particularly included in the process, and did modify her stance. She also cut down to one session a week at the patient's request. "I probably had a tendency to act more maternal. As a woman you have certain feelings for other women who are pregnant. She did use me for information in a motherly way and I referred her to an obstetrician."

Basically, the therapist felt that "this had been a difficult and intense therapy with the patient needing to avoid her dependency and to act out her childhood ambivalence. She became much more withdrawn and dependent on her husband. I think it's a classic thing. She wanted to make her nest and deny any problems. It seems that in other cases too that until a year of two after the birth there is a reprieve, a wanting to take some time off. This case had very much that feeling. They don't want all those introjects floating in their heads."

The patient left treatment around the time of her due date. "She left treatment with the intent of returning, but felt too busy after the child was born. Generally, she utilized the pregnancy in the service of resistance that was already very strong, but had previously been a dynamic force in her treatment."

Case G. Mrs. G was in biweekly psychodynamically oriented psychotherapy with a male psychiatrist/ analyst. The patient came to treatment because she was depressed about her career. She had finished Law School, but did not feel she was getting interesting job offers. She was also upset about her marriage and felt ambivalent about her husband.

The patient perceived of her mother as a competent, dynamic and powerful woman. Her mother was also critical of the patient and she often felt her mother wanted her to act in a prescribed way. The patient was close to her mother and it seemed that as an adult she was having trouble separating from her. The father was seen as less critical and seemed to accept the patient more unequivocally. She also saw the father as more fragile and in need of her protection. The patient's relationship with her husband was described as infantile and they were like "two children playing in an adult world."

The patient became pregnant in her late twenties after three years of treatment. The patient had no children at the time. Very early on in the pregnancy it became apparent that she was jealous of the baby. "She saw the baby as a rival and that the mother was more interested in the baby than in her. She was losing what little sense of an identity she had. She was angry that she was becoming less and less significant."

The therapist felt the pregnancy was, in part, a way to preserve the marriage and her relationship with her mother. Her husband and her mother wanted the baby very much. "The therapy was beginning to threaten the status quo. I think the treatment was designed to help her grow up and I think one of the ways to avoid growing up was to get pregnant and sort of be taken out of commission. She then became her mother's darling and could be close to her mother again around this baby. She also was not going to get into a competitive struggle with her husband in any way and was going to be the dutiful wife."

During the pregnancy the patient retreated from the treatment in a number of ways. She began missing more session and talking less. She also became increasingly infantile in dress and behavior, "dressing like a little girl and being less assertive at work." The pregnancy allowed her to "retreat from an ongoing process of increased independence and assertion."

In terms of her relationship with the therapist, "I think the baby was designed to come between us, create a wall between us. It was a running away from being too close to me and from being more involved and getting closer. I would say that the baby was a way to reduce her intensity about the treatment and to pull out of it to some extent."

The therapist, while initially feeling he did not change his approach to his pregnant patient, thinks, in retrospect, "I accepted the pregnancy as a given and it limited the interpretive work we did. If I had felt more free, I might have questioned or brought up more issues of why now and what the baby was about. I think I might have been more aggressive in interpreting that sort of thing now. I felt nervous about interpreting this wonderful event of having a baby as an acting out of the treatment. I believe having my own baby has changed my view and made me more courageous about dealing with some of these issues." He also believes he was angry that the patient was withdrawing from him and the treatment.

In terms of her response to the therapist modifying his stance, "She might have been disappointed that I didn't go after her in some way. It might not have changed the outcome, but she may have felt my interest was in her and not the baby. Perhaps the way she felt about her mother was the way she was feeling about me, that I was more interested in the baby than her. The baby was not really the one in treatment; She was in treatment. I abandoned her and her healthy ego in some way." On the other hand, the therapist also felt the patient was probably relieved that he "left her alone and took her out of danger and let her stay out of danger."

The patient terminated treatment about 6 months after the birth of her baby. The patient moved, though she was still close enough to commute to sessions. She also started to work

part time near her new home. "Those things pushed it. I think the other thing was that there was a sense that a new balance had formed in her family, the baby, her husband, her mother and her. She didn't want to disturb that balance. I think she stopped and it was a continuation of having the baby. It was sort of a program she had for herself that I wasn't privy to, but it was the plan. Another way to look at this is that the treatment was designed to help her have a baby, but I didn't see it that way."

"They've said that a woman who's pregnant can't be analyzed because she's too wrapped up in the baby and she's not available. I don't think that's true. I think a lot of it has to do with the babies. A newborn is incredibly demanding and you'd think a woman would want a therapist to be on her side to deal with her in a grown-up mature way. I think there must be something that goes on between mothers and babies that the mother doesn't want any intrusion on that dyad from the outside."

These cases illustrate the range of experiences of therapists treating pregnant women from those who saw the pregnancy as a culmination of the work of therapy to those who perceived the pregnancy as disrupting the dyadic relationship and impeding the therapeutic movement. While it is clear that there were individual differences in these treatments, there were also some common themes expressed. All the therapists recognized the importance of this major life event and felt it had an impact on the transference, the content of sessions and the progression of the treatment.

CHAPTER V

DISCUSSION

Prinicipal Findings
The Therapist's Experience

The purpose of this study was to explore therapists' experiences in treating pregnant women. Therapists and analytic candidates' responses to a questionnaire provided a context in which to examine how a pregnancy may be manifested in treatment. The degree to which therapists felt the pregnancy had an impact on treatment was assessed by considering various aspects of treatment including the content of sessions, the transference, the patient's and the therapist's response to the pregnancy and the treatment's outcome.

Specific questions were formulated regarding a pregnant woman's psychotherapy or psychoanalysis. These questions addressed whether or not pregnant women tended to terminate treatment within 15 months of becoming pregnant and whether the therapist's gender had any impact on the pregnant woman's therapy. Questions regarding whether the pregnancy was seen to have facilitated the therapeutic process or created increased resistance were also raised.

The results of this study indicate that the majority of therapists felt that the patient's pregnancy did have an impact on her treatment. Most respondents noted a change in the

content of therapy sessions once the patient was pregnant. Issues related to the patient's own mother were discussed more frequently and vividly and most therapists noted a shift in the woman's identification toward her own mother.

It has been consistently documented in the literature on the psychological processes of pregnancy that a woman's sense of her own mother is an important aspect in her successful adjustment to pregnancy. Deutsch (1945), in particular, suggested a woman must come to terms with her negative feelings toward her mother if she is to develop a sense of herself as a mother and her sense of her child as a person. The therapists' responses to both the questionnaire and the interviews support this notion. Even for those women who became more withdrawn during therapy, there was a general sense that they were actively grappling with their conflicts with their mothers.

Other themes that emerged in the pregnant woman's treatment were also consistent with the literature concerning the expectant mother's subjective experience of pregnancy. Bibring (1961) observed that pregnant women often experienced increased dependency needs. Deutsch (1945) discussed the primagravida's increased conflicts around being in the role of provider and Chertok (1969) noted that pregnant women often sense they have no control over the growing fetus yet also feel they are completely responsible for the health and welfare of the baby.

The women in this sample expressed conflicts over the

their need to depend on someone while having a baby that would be completely dependent on them. Therapists felt that some patients exhibited greater dependency on their mothers and/or their husbands and some defended against their dependency needs, while others experienced dependency less conflictually. Themes of control and dependency were also manifested in the transference.

Most frequently control issues were expressed in competitive struggles with the therapist: "She was going to get the accolades. She could do something I couldn't" (Case C). In addition, patients' dependency issues were expressed in feelings of anger and disappointment directed toward the therapist. These feelings were evoked because the patients believed they were either not adequately being cared for, protected or supported.

Therapists had a sense that these issues, in particular, were a reflection of the patients' struggles with their own mothers. Thus, the therapists' reports of the content changes in sessions and the transferential shifts reflected the dynamic issues that pregnancy evoked.

Changes in the Patient's Behavior

As noted in the review of the literature on psychotherapy with pregnant women there is a sense that the expectant mother's emotional lability, proneness to regression, augmented sensitivity to her psychological processes and her increased insight all contribute to an emotional state that is favorable

to psychotherapy. Raphael-Leff (1980) believes that women, by virtue of their unique psychological state, will be able to resolve certain conflicts more quickly and will be more invested in their treatment because of its capacity to aid them in their transition to motherhood.

The results of this study indicate that for the most part therapist's did not experience the pregnancy as having a favorable impact on treatment. Since the degree to which the pregnancy was seen to have facilitated the treatment was not a singular concept it was measured by a number of different variables. The majority of therapists felt that their patients' behavior changed in a way that made them less available in treatment. These patients missed more sessions, were more withdrawn while in treatment and generally became less involved and/or committed to therapy during the pregnancy.

This notable shift toward being less involved in treatment lends support to Deutsch's notion that the pregnant woman's increased introversion makes it difficult for her to be available to therapy. It appeared that the therapist was experienced as an unwelcome intrusion on the mother-unborn child dyad. Deutsch (1945) also holds the opinion that "a normal woman, in life situations that hold for her the greatest positive value, is not inclined to grant another person, especially a psychoanalyst, insight into her psychic life, and rightly so" (p. 125). However, in contrast to her views, the therapists in this sample did not think it was in the patient's best interest to leave the experience undisturbed. The

majority of therapists felt the patients' introversion helped them deny and avoid dealing with crucial conflicts that ideally should have been resolved in treatment. In these cases there was a sense that the work of treatment had been disrupted.

Interestingly enough, the majority of therapists felt their patients actively tried to share the experience with the therapists regardless of whether the pregnancy was felt to have facilitated the process or not. This finding suggests that the women enjoyed talking with their therapists about their pregnancy and their feelings of contentment, but did not necessarily want to examine conflicts and more troublesome feelings related to the pregnancy.

It should be noted that while a majority of therapist felt the pregnancy disrupted the treatment's progression, many also felt that it facilitated the process. These patients appeared to be more committed to treatment, more involved and generally more available in that issues were brought up more readily and with greater intensity.

These findings taken together indicate that therapists experienced the impact of the pregnancy in diametrically opposed ways. While determining what contributed to these different experiences is open to speculation, it does appear that therapists who felt the pregnancy facilitated the treatment, frequently saw the pregnancy as a culmination of a great deal of work that had been accomplished in treatment. This viewpoint was best represented by one therapist's comments: "The pregnancy was a consumation of her achieved

freedom of choice and creativity. It was a statement of faith on her part about her ability to love and be loved. Her pregnancy certainly seemed like the appropriate culmination of her work. It seemed to be an expression of a true resolution of her problems with her mother."

On the other hand, those who experienced the pregnancy as disrupting the treatment felt the woman's pregnancy created a situation in which she could seek refuge from the therapy and "for the most part could short circuit a threatening treatment." It seems these therapists felt that prior to the pregnancy the patient had not resolved important issues.

Termination

The question of whether a pregnant women tends to terminate treatment during her pregnancy or around the time of the baby's birth was raised. In addition, it was considered whether the therapist thought the termination was premature and a defensive flight from treatment or whether the therapist and patient agreed that the termination was appropriate and the patient had successfully completed her treatment.

The results of this present study indicate that almost half of the patients terminated treatment within fifteen months of becoming pregnant. Of this group the majority of therapists felt the termination was a manifestation of resistance and/or a defensive maneuver, suggesting that for this group of therapists the termination was considered premature. This trend was also highlighted in the follow up interviews in which four therapists felt the termination was premature.

A minority of therapists felt that the termination was appropriate and the pregnancy marked the successful completion of the goals of treatment. Thus, just as there were two views represented regarding whether the pregnancy facilitated or impeded the therapeutic movement, there were two conceptualizations of termination.

Among the group of patients who left treatment there were several significant relationships uncovered. Patients who terminated were more likely to be in once a week therapy, to be fairly uninvolved in their treatment prior to their pregnancy and become less involved and/or committed to treatment once they were pregnant. In addition, they were more likely to be treated by social workers and psychiatrists. There was also a tendency for these therapists to be analytic candidates and psychodynamically oriented psychotherapists as opposed to psychoanalysts.

Conversely, the profile of the nonterminator group included patients who were very involved in their treatment prior to the pregnancy, exhibited no change in their behavior or became more involved and/or committed to treatment once they were pregnant, went to treatment at least two times per week and tended to get pregnant relatively later in treatment (after 2 years). In addition, these patients were more likely to be treated by psychologists. There was also a tendency for patients seen by psychoanalysts to remain in treatment.

While these relationships differentiated terminators from nonterminators, a smaller subset of male therapists whose

patients did not terminate was also identified. These patients' characteristics were similar to the nonterminator group except that they were also more likely to be in psychoanalysis or exploratory treatment rather than therapies that were described as supportive. In addition, therapists in this group did not change their approach with the patient once she got pregnant. Since, within the whole sample, therapists only changed toward a more flexible, supportive approach, a finding which suggests that therapists with nonterminating patients didn't change their behavior indicates they did not get more supportive with their pregnant patients.

It is not surprising that patients who were quite involved and committed to their treatment before and after their pregnancy remained in therapy. However, in examining the other variables that differentiated the nonterminator group, there was a distinct tendency for those patients who were in treatments described as analytic--conducted more than once a week, treatment's orientation was not supportive and the therapists did not modify their stance--to remain in treatment.

One explanation of this may be that the more the treatment is focused on an examination of the resistance the more likely it is a patient will remain in therapy. Certainly when termination is seen as a manifestation of resistance or a defensive flight from treatment then an approach that attempts to understand the resistance may contribute to the treatment's favorable outcome.

The fact that there was a tendency for psychoanalysts to

treat patients who terminated less frequently than psychodynamically oriented psychotherapists and analytic candidates may also lend support to this argument. Psychoanalysts, by virtue of their training, are more likely than other clinicians to have an approach that is geared to analyzing the resistance particularly as it is manifested in the transference. Clearly this group is specifically trained to conduct analytic treatment and this treatment approach may be more conducive to patients remaining in therapy.

It is also possible that the therapist's stance may have had an impact on the treatment's outcome. Changing one's style of working with a patient when she is pregnant and moving toward a more supportive stance could be conceptualized as colluding with the patient's resistance. As one therapist said, in discussing his tendency to be less interpretive when his patient was pregnant, "I abandoned her in some way. I abandoned the patient's healthy ego."

However, while it seems that maintaining an analytic stance may be important to a pregnant woman's treatment, an attempt to zealously interpret the patient's increased resistance may also have drawbacks. Given the pregnant woman's increased introversion and heightened sensitvity to others outside the mother-fetus dyad, a therapist who is aggressively analyzing the resistance when the patient is not available to participate may be experienced as a threatening and potentially damaging outsider. Similarly, a supportive stance might be experienced as equally intrusive and overwhelming. Thus, both approaches have implications for the transference. At best,

the pregnant woman may be weary of intrusions in the mother-fetus dyad regardless of the therapist's behavior. Therefore, it seems very likely that any modifications that are perceived of as impinging or threatening are particularly apt to create increased resistance to the process and to the patient-therapist relationship. It seems a distinction must be made between the therapist maintaining an inquiring analytic attitude and acting in either an overly aggressive or overly supportive manner.

It appears that many therapists felt the pregnancy disrupted the therapeutic process, but not all of their respective patients left therapy. Therefore, the pregnancy could be viewed as impeding the treatment's progress, but did not necessarily result in termination. This finding suggests that these pregnant women were less available in treatment as a result of their pregnancies. However, one factor that may have contributed to their remaining in treatment might have been the therapist's respect for and tolerance of this shift. It is possible these therapists found a balance and did not collude with the patient's resistance nor did they impinge on the patient's desire to leave the experience undisturbed.

In addition to issues related to the therapist's stance, it was found that patients in the nonterminating group tended to get pregnant later in treatment relative to the terminating group. Perhaps women who were in a lengthy treatment before their pregnancies utilized that time to discuss their decision to have a baby and work out conflicts associated with

motherhood. Therefore, once they were pregnant they had already had an opportunity to resolve important issues around their pregnancies and treatment did not seem as threatening so they did not need to flee the therapy. This notion is supported by the follow up interviews, particularly the first two cases, in which one patient discussed her decision to become pregnant over the course of a year of treatment and in the other case where she became pregnant in the tenth year of treatment. Neither of these patients left therapy.

There are several possibilities as to why the subgroup of male therapists whose patients did not terminate treatment could be differentiated from the other groups. As noted before, this finding does not suggest a relationship between sex of therapist and termination. It does, however, indicate that this group was significantly different from groups of terminators and female therapists whose patients did not terminate treatment.

Drawing on other relationships that were uncovered, it was found that psychotherapists tended to get more supportive while psychoanalysts did not. It was also discovered that analysts were more likely to be men and psychotherapists were more likely to be women. Further, the responses indicated that men were more likely to conduct therapy that was not supportive and the frequency data suggested a greater percentage of men did not change their stance once their patients became pregnant. Thus, there was a relationship between the variables most associated with nonterminating patients--psychoanalysts who

maintained their analytic stance in a treatment that was more analytically oriented--and male therapists.

Since there was no control group of nonpregnant women in this study, it was impossible to determine if a significant number of pregnant women terminated treatment in comparison to a sample of women who were not pregnant. However, the findings of this research are consistent with some of the trends discussed in the literature on termination. Reder and Tyson (1980) found that lower termination rates were associated with patients in psychoanalysis than those in brief psychotherapy. Hamburg (1967) found a similar trend, indicating the more the treatment's orientation resembled psychoanalysis the lower the rate of premature termination would be.

It is difficult to assess whether the termination rate in this study is significantly different from termination rates cited in other studies. However, it is clear from the responses of therapists that the pregnancy was seen to have contributed to the termination and contrary to Deutsch's notions, most therapists felt these patients would have benefited from remaining in treatment. It was further suggested that although there was a sense that the psychological state of these pregnant women may have predisposed them to excluding the therapist, the interaction of the pregnancy, the parameters of the treatment and the therapist's behavior also contributed to premature termination. Therefore, the present results strongly suggest that it was not merely the pregnant woman's increased introversion that made it

difficult for her to stay in treatment, but a combination of the above mentioned factors.

Gender Issues

There was no significant difference found between the rates of termination for male and female therapists. Thus, the therapist's gender did not seem to influence the ultimate success of the therapy. However, it appeared that the sex of the therapist did have an impact on the therapeutic process. Significant gender differences were found for the therapist's profession and level of training. In this sample, psychoanalysts, psychologists and psychiatrists were more likely to be men, and psychodynamically oriented psychotherapists, analytic candidates and social workers were more likely to be women.

These findings may suggest that while women are entering the field in greater numbers, more men have achieved an advanced level of training and a higher level of professional status. However, the greater number of women in analytic training indicates that this trend may be changing. These frequencies may be representative of shifts in the mental health field, or may simply reflect sampling bias.

In terms of the therapist's response to the pregnancy, female therapists seemed to shift to a more supportive and less interpretive stance when their patients became pregnant. In comparison to the male therapists, they also had a greater number of patients who were seen as more committed and involved in treatment during the pregnancy and there was a tendency for

their pregnant patients to identify with them.

These findings are consistent with the work of Goz (1973) and Kaplan (1985) who suggest that a woman therapist may have a greater capacity to empathize with a female patient because of the therapist's ability to confirm the patient's experience by direct reference to her own life. Kaplan's view implies that a female therapist does not have to be a mother to empathize with a pregnant patient, but the fact that the patient and therapist share a similar developmental course enhances the therapist's ability to validate the patient's experience. It seems that the female therapists in this study were more flexible and supportive in response to the patient's pregnancy. Perhaps drawing on their own experiences, they believed that their patients needed more support during this time of increased stress and psychological disequilibrium.

It follows then that these patients also felt more committed and involved in treatment when they were pregnant. It may be that the patients withdrew less from the process and stayed very involved in their treatment because they felt temporarily more connected and better understood. In fact, more women therapists had patients who did not change their manifest behavior when they were pregnant.

Similarly, it was more frequently reported by female therapists than by male clinicians that their patients identified with them. Given the pregnant woman's proclivity to reviving and resolving past conflicts with her own mother, it is not suprising to find that patients, particularly those that

were making a successful adaptation to pregnancy, tended to identify with their female therapists. As Freud (1931) observed, female therapists are more likely to draw maternal transferences.

The findings reported above suggest there was a tendency for pregnant patients to be more involved in therapy when they were treated by female therapists. However, it is interesting to consider that this apparent connectedness between the patient and her therapist might have created a situation in which the female therapist modified her stance. However, as it was previously reported, this change to a more supportive approach may have actually contributed to premature termination. It did seem that women therapists more frequently saw termination as a manifestation of resistance and male therapists more frequently saw the termination as adaptive and/or the successful completion of treatment.

It is possible that the patients who were treated by female therapists experienced this shift to a more supportive stance as a loss of neutrality. Perhaps, this loss of distance would frighten the patient because it could further stimulate infantile merger fantasies and wishes for "absolute dependence" (Winnicott, 1963). This situation would inevitably be frustrating as the therapist remained in her professional role and set limits on gratifying the patient.

Implications Of This Study

The results of this study suggest several important implications for for the treatment of pregnant women. Several writers have suggested that pregnant patients share a unique psychological state. Issues concerning their own mothers surface readily, the quality of the transference changes and the dyadic relationship between patient and therapist shifts. While these findings have been supported by the current research, several issues that had previously been ignored concerning the parameters of treatment and the therapist's technique have also been addressed in this study.

The pregnant woman's therapy offers her an important opportunity to resolve issues related to impending motherhood. Therefore, it is crucial for therapists who treat expectant mothers to have a better understanding of what may disrupt the therapeutic process, particularly in light of the fact that unresolved conflicts and an interrupted treatment may have serious consequences for the psychological health of the mother and her child.

The results of this study indicate that a treatment approach which appears to respond to the pregnant patient's need for increased support may in fact have an unfavorable impact on the therapy. A more beneficial approach should include maintaining an analytic stance, being sensitive to the changes in the intensity of the resistance, and closely examining potential countertransference reactions in response to the pregnancy.

While Deutsch suggests that pregnant women can not and should not be analyzed, it appears that this does not necessarily have to be true. It seems that during pregnancy both therapist and patient are inclined to shy away from examining the process. The pregnancy appears to create a situation in which it is easy for the therapist to be drawn into treating the baby in the patient and not the patient. However, by cutting down the number of sessions, becoming more supportive or moving away from an exploratory approach, it seems likely that the therapist may be colluding with the patient's resistance.

However, it must also be emphasized that an approach that includes aggressively pursuing and interpreting the patient's resistance without being sensitive to the special circumstances of pregnancy may also disrupt the treatment and create a defensive flight from therapy. The pregnant woman's increased introversion is protective and adaptive as well as defensive. A therapist's move away from a neutral stance toward a more confrontational approach may be experienced by the patient as an impingement, whereas a more supportive approach that may initially be welcomed with relief, may impede the emergence of important conflicts that need to be addressed.

While a treatment approach that is geared to exploring issues, focusing on conflicts and sensitively analyzing the resistance may be beneficial with a variety of patients, it seems to particularly true for pregnant patients. The events of pregnancy appear to exert a powerful pull on both patient

and therapist. The pregnant patient would like to leave the experience undisturbed and the therapist may feel he or she should give the patient more leeway because of her physical and psychological condition. It seems that male therapists are more likely to feel that pregnant women are fragile and thus should be treated more gently or they may approach her with trepidation. Female therapists may draw on their own feelings related to motherhood and in an effort to be empathic may lose distance from the experience.

On the other hand, it also seems that therapists may be frustrated by their patients withdrawing from the treatment and respond with increased efforts to address the resistance without being sensitive to or respecting the pregnant woman's augmented fears of intrusion. It seems the pregnant woman's treatment may best be served by maintaining the treatment's analytic frame and the therapist's analytic attitude without creating undue impingments.

While the treatment approach suggested above may be helpful in keeping the pregnant woman connected to therapy and may ultimately influence whether she remains in treatment or not, these recommendations do not speak to the patients whose pregnancies facilitated the process or to those who did not necessarily need to remain in treatment. Certainly an interesting clinical question concerns itself with how to differentiate patients whose termination represents an appropriate end to a successful treatment from those whose termination is premature and represents a defensive flight.

The follow up interviews have suggested some possible answers. A pregnant woman's therapy could benefit from the therapist's consideration of the woman's history, the time in her life when she makes the decision for motherhood, whether the pregnancy was planned or not, what her motivations for the pregnancy were and how well she has worked out issues related to her mother, dependency and control. However, this question has not been systematically addressed and could prove to be a fruitful area for future research.

Limitations Of This Study
Recommendations For Future Research

This study represents a preliminary effort to explore therapist's experiences in treating pregnant women. The data reflects the therapists' perceptions, and the patients' experiences were not elicited. Thus, there is an inherent bias in the responses and the findings of this research must be interpreted in light of the fact that the patients may have had very different perceptions of their own treatment. Certainly it would have added another dimension to this work if the questionnaire had also been given to the patients who were in treatment with the respondents. This would have provided important information about the pregnant woman's subjective experience of therapy and possibly may have illustrated the differing perceptions of therapists and pregnant patients within the same treatment.

Analytic candidates were specifically chosen to participate in this study because it was believed that they

would more likely be in supervision, be required to have process notes and perhaps be in a better position to remember details about their cases. However, in an effort to obtain more precise and in depth responses, this study lacked a random sampling procedure which compromised its generalizability.

In terms of the methodology, the instrument utilized was specifically designed for this study. The questionnaire was constructed based on careful consideration of the trends discussed in the literature, conversations with therapists and patients and was revised several times in the hope that it accurately and thoroughly addressed therapists experiences in treating pregnant women. However, because this research addressed questions that had not been previously examined, there was no opportunity to test the questionnaire for reliability and validity.

However, the questionnaire, designed to provide as much information as possible, did generate a great deal of data, while the follow up interviews provided information that could be analyzed more descriptively. Thus, general trends as well as individual differences could be examined. However, the study's small sample size limited some of the analysis that could have been done. Had there been more respondents, there would have been a greater effort to only include patients in this study that presented a similar profile. It would have been advantageous to control for more variables and for example, have only included women who were in psychoanalysis or who were first time mothers. Ideally, this research could be

replicated with a larger sample and then the criteria for selection in the study could be more rigorous.

While a great many aspects of therapists' experiences were explored, a few significant areas were not addressed. Several demographic variables related to the patients and therapists such as their ethnicity and socio-economic status were ignored. These factors may have had an impact on a pregnant woman's treatment and future studies may benefit from addressing these issues.

This research raises many questions concerning the relationship between pregnancy and the therapeutic process. The findings suggest that the management of the pregnant patient's therapy and the therapist's response to the expectant mother may have important implications for the success of her treatment and perhaps, more critically, her adaptation and adjustment to motherhood. Since therapy may provide the single most important arena for the pregnant woman to resolve her conflicts regarding motherhood, it seems imperative for clinicians to have a greater appreciation and understanding of the factors that may affect the expectant mother's treatment.

APPENDICES

APPENDIX A

QUESTIONNAIRE

This study will explore how a woman's pregnancy may affect her psychotherapy or psychoanalysis. I would like you to reflect on your experience as a therapist when you have had the opportunity to treat a pregnant woman. I am particularly interested in your patients who were married, expecting their first child, in treatment at least 6 months prior to getting pregnant and had full-term pregnancies. If you have treated more than one pregnant woman, please focus on the case that best meets the above criteria. If you treated a woman who does not meet the above criteria, but she is the only pregnant woman you have treated, please respond to the items below based on that case. Circle all the answers that apply. All responses will remain confidential.

I) Background Information

1) Are you a a)psychoanalyst b)a psychoanalytically oriented psychotherapist c)a non-psychoanalytically oriented psychotherapist d)analytic candidate.

2) If you are an analyst-in-training, how far along are you in your training? _____

3) If applicable, what is the name of the psychoanalytic institute you are attending? _____

4) Are you a a)psychologist b)psychiatrist c)social worker d)other:____

5) Are you a)male b)female.

6) Have you ever treated any pregnant women? If so, how many a)one b)two c)three d)four e)five or more.

7) If you have treated more than one pregnant woman, please focus on one in particular. If you are an analytic candidate, at what point in your training did you begin to treat this woman?_____

8) How old were you when you began treating this woman?_____

9) If you had supervision on this case, what was the gender of your supervisor? a)male b)female

10) How old was the patient when she became pregnant? a)18-21 b)22-25 c)26-30 d)31-35 e)36-40 f)41 or older.

11) At the time of this pregnancy, how many children did the patient have? a)none b) one c)two d)three e)four or more.

12) How would you best describe the kind of therapy you conducted with this patient? a)psychoanalysis b)psychodynamically oriented psychotherapy c) supportive therapy d)other:_____

13) During her pregnancy, how often was she in therapy? a) one day per week b)two days per week c) three days per week d)four days per week e)five days per week.

14) How long after your patient started treatment did she become pregnant? a)she was already pregnant when she started treatment b)she became pregnant within 6 months of starting treatment c)within approximately one year d)within 1 1/2 years e)two years f)three years g)four years or more.

15) Was this woman a)single b)married c)divorced or separated d)widowed?

16) At the time of her pregnancy was her mother a) living b)deceased. If her mother was deceased, when had she died? a)during the pregnant woman's childhood b)during her adolescence c)during her early adulthood d)just prior to the pregnancy e)during the pregnancy.

17) Had your patient been in therapy prior to you treating her? a)yes b)no.

18) What was your patient's presenting problem when she came to you for treatment? a) depression b) anxiety c)maritial difficulties d)interpersonal difficulties with someone other than spouse e) career or occupational difficulties e)other:_____

19) Was this pregnant woman an analytic candidate who was in her training analysis with you?_____

20) How would you describe the patient's major characterological/ diagnostic orientation? a)hysterical b)obsessive-compulsive c)narcissistic d)schizoid e)mixed neurosis f)paranoid g)borderline h)other:_____

21) What do you think were your patient's characteristic defenses prior to her pregnancy? (Circle all that apply) a) repression b)denial c)undoing d)projection e)reaction formation f)isolation of affect g)withdrawal h)intellectualization i)externalization of blame j)splitting k)projective identification l)other:_____

22) How did the patient's characterological/diagnostic orientation manifest itself in the pregnancy. That is, how was it displayed in treatment (e.g., fantasies, themes discussed, aspects of the transference). Please comment.

23) Do you feel that the patient's defensive functioning changed during her pregnancy? a)yes b)no. If yes, would you please comment on what you think the changes were and why they occurred.

II) The Pregnancy and the Course of Treatment

1) Was the patient's pregnancy a)planned b)accidental?

2) If this pregnancy was an accident, had your patient expressed a desire to have a child around the time of the pregnancy? a)yes b)no

3) If this pregnancy was an accident, did the pregnancy deviate from her life plans of when she wanted to get pregnant? a)yes b)no

4) Before the patient was pregnant, while in treatment, how often did she talk about becoming pregnant? a)she never talked about it b) she rarely discussed it c)she occasionally discussed it d)she frequently discussed it e)it was the main focus of treatment.

5) How often was the pregnancy a manifest concern for your patient while she was in treatment? a)she never discussed the pregnancy b)she rarely discussed the pregnancy c)she occasionally discussed it d)she frequently discussed the pregnancy e) she brought it up almost every session.

6) Do you remember any manifest changes in your patient's behavior when she was pregnant in relation to treatment? (Please circle all that apply) a)no change b)she missed more sessions c)she missed fewer sessions d)she came to sessions earlier e)she came to sessions later f)she was more talkative g)she was more silent h)she paid her therapy bills more conscientiously i)she had more difficulty paying her bill j)other:_____

7) Do you feel your patient experienced a consistently negative transference in the treatment within the period of 6 months prior to her pregnancy? a)yes b)no.

8) How involved in therapy did the patient seem prior to her pregnancy? a)intensely involved b)quite involved c)somewhat involved d)somewhat uninvolved e)very uninvolved and detached.

9) When the patient was pregnant did she seem a)more involved in therapy b)less involved in therapy c)more committed to therapy d)less committed to therapy e)no change.

10) Did your patient report that her dreams were more prevalent? a)yes b)no.

11) Do you feel there was a shift in the content of your patient's dreams? a)yes b)no. If yes, could you give an example?

12) Do you feel you were in the patient's dreams a)more frequently and in a disguised form b) more frequently in an undisguised form c)neither.

13) During your patient's pregnancy, did you notice any shift in her significant identifications? a)no b)yes, patient became more identified with mother c)with father d)with husband e)with you f)other:

14) Do you think there was a shift in the patient's identifications toward someone she experienced as more maternal? a) yes b) no. If yes, why do you think this shift occured?_____

15) If your patient's pregnancy was planned, did you know when she was actively trying to become pregnant? a)yes b)no.

16) At what point in the pregnancy did your patient tell you she was pregnant? a)immediately b)within the first trimester c)within the second trimester c)during the third trimester d) she never told you.

17) Do you feel your patient was a)more sensitive about your comments or behavior than before b) less sensitive c)neither of the above.

18) Do you feel you were a)more directly in the treatment (i.e., there were more references to you made) b) less directly in the treatment c)neither more nor less.

19) Do you think your approach to the patient changed as a result of her being pregnant? a) yes b) no c) maybe. If yes or maybe, in what ways? (Circle all that apply) a)more active b)less active c)more supportive d)less supportive e)more flexible about appointments, etc. f)less flexible g) other:_____

20) To what extent did you feel included in the process of your patient's pregnancy? (The patient tried to actively share the experience with you.) a)not at all included b)somewhat included c)very much included d)completely included.

III) Termination Issues

1) Has your patient terminated treatment? a)yes b)no. If yes, when did this occur? a)during the pregnancy b)around the time of her due date c)immediately after giving birth d)3-6 months later e)1 year later f)1 1/2 or more years later.

2) If your patient terminated, did you see this as a) a manifestation of resistance b)a defensive maneuver c)an adaptive refocusing of her energy d)she had "successfully" completed her therapy e)other:_____

3) If your patient left therapy, what did she say about leaving? a)she no longer needed therapy because her pregnancy had allowed her to resolve the issues she needed to work through b) she needed more time to spend with her infant c)when the baby arrived it would no longer be financially feasible to continue therapy d) she had reached a chronic impasse in the treatment e)she felt she had gotten what she wanted from treatment f)other:_____

4) If your patient left treatment because she felt she had gotten what she wanted from it, what was your response? a)you agreed with her b)you disagreed with her and urged her to remain in treatment c)other: _____

5) If your patient was working when she terminated treatment, did she, as far as you know, leave her job? a)no, she did not leave her job b)yes, during the pregnancy c)around the time of her due date d)immediately after giving birth e)6 months later f)1 year later g)1 1/2 or more years later h)she stayed at work but reduced her work schedule i)don't know j)other:_____

6) In general, how many pregnant women have you treated that have terminated before or around the time of their babies' births? a)none b)one c)two d)three e)four f)five or more.

7) Do you have any children? a)no b)yes.

8) Where you pregnant at the time you treated this patient? a)not applicable b)no c)yes.

9) At the time you were treating your patient did you notice any countertransference responses to your pregnant patient that you could identify? Would you please comment briefly.

10) I would appreciate it if you would take a few moments to briefly comment on the impact of your patient's pregnancy on the nature and course of the treatment, giving any ideas, thoughts or impressions you have that may not have been touched upon or emphasized sufficiently in this questionnaire. It would also be useful if you have any explicit hypotheses on how the pregnancy affected or influenced the nature and course of your patient's treatment.

NAME:

ADDRESS:

PHONE:

Would you like an abstract of this study mailed to you? _____

APPENDIX B

Frequencies of Selected Responses Categorized by Therapist's Gender and Treatment Outcome

	FEMALE THERAPISTS		MALE THERAPISTS	
	Terminated	Nonterm	Terminated	Nonterm
Psychoanalyst	2	10	5	8
Dynamic Psychotherapist	8	6	2	1
Analytic Candidate	7	7	2	1
Psychiatrist	--	--	3	--
Psychologist	5	11	3	10
Social Worker	11	10	2	2
Other	1	2	1	--
Year in Treatment Patient Became Pregnant:6 Months	3	3	--	--
1 Year	3	1	1	1
Within 2 Years	7	9	4	7
Within 3 or More Years	4	10	4	4
Was Pregnancy: Planned	10	17	6	12
Accidental	6	5	2	--
Both	1	1	1	--
Type of Tx: Psychoanalysis	1	2	--	6
Dynamic Psychotherapy	13	17	7	6
Supportive Therapy	3	1	1	--
Other Combinations	--	3	1	--
Tx Rate: Once Per Week	13	9	7	2
Twice Per Week	2	12	1	6
Three Times Per Week	2	2	1	4
Pt.'s Manifest Behavior Changed When Pregnant: No	7	13	4	4
Pt.'s Behavior Changed: Yes: Positively*	5	6	--	2
No: Negatively	5	3	3	4
Therapist's Approach Changed When Pt. Was Pregnant:No	7	18	3	8
Yes**	10	5	6	4
Shift In Identifications: To Mother	8	9	4	5
To Husband or Father	--	5	2	1
To Therapist	4	11	--	2

* Positive changes in patients' behavior included coming to sessions earlier, being more talkative and paying their bills more conscientiously. Negative changes included coming later to sessions, becoming more withdrawn, missing more sessions and having more difficultly paying bills.

** Changes in the therapist's approach included his or her moving toward a more supportive, flexible or active stance.

References

Aronson, H. & Weintraub, W. Certain initial variables as predictors of change with classical psychoanalysis. Journal of Abnormal Psychology, 1969, 74, 490-497.

Benedek, T. Sexual functions in women and their disturbances. In S. Arieti (Ed.), American handbook of psychiatry. New York: Basic Books, 1959.

Benedek, T. The psychobiology of pregnancy. In E.J. Anthony and T. Benedek (Eds.), Parenthood: its psychology and psychopathology. Boston: Little, Brown and Company, 1970.

Bibring, G.L. Some considerations of the psychological processes in pregnancy. The Psychoanalytic Study of the Child, 1959, 14, 113-121.

Bibring, G.L. et al. A study of the psychological processes in pregnancy and the earliest mother-child relationship. The Psychoanalytic Study of the Child, 1961, 16, 9-72.

Bibring-Lehner, G. A contribution to the subject of transference resistance. International Journal of Psychoanalysis, 1936,17, 181-189.

Blitzer, J. & Murray, J. On the transformation of early narcissism during pregnancy. International Journal of Psychoanalysis, 1964, 45, 89-97.

Brandt, L.W. Studies of "dropout" patients in psychotherapy: a review of findings. Psychotherapy: Theory, Research and Practice,1965, 2, 6-13.

Cavenar, J. & Werman, D. The sex of the psychotherapist. American Journal of Psychiatry, 1983, 140, 85-87.

Chertok, L. Motherhood and personality: psychosomatic aspects of childbirth. London: Tavistock Publications, 1969.

Colman, A.D. and Colman, L.L. Pregnancy: the psychological experience. New York: Herder and Herder, 1971.

Deutsch, H. The psychology of women, motherhood. (Vol. 2). New York: Grune and Stratton, 1945.

Fenster, S., Phillips, S. & Rapoport, E. The therapist's pregnancy: intrusion in the analytic space. Hillsdale: Analytic Press, 1986.

Fielding, B. Aspects affecting premature termination. American Journal of Psychotherapy, 1972, 26(2), 270-275.

Firestein, S. Termination of psychoanalysis: theoretical, clinical and pedagogic considerations. Psychoanalytic Inquiry, 1982 2(3), 473-497.

Fox, H. Narcissistic defenses during pregnancy. Pychoanalytic Quarterly, 1958, 27, 340-358.

Freud, S. Three essays on the theory of sexuality. Standard Edition,1905, 7, 125-248. London: Hogarth Press, 1953.

Freud, S. Some psychological consequences of the anantomical differences between the sexes. International Journal of Psychoanalysis,1927,8, 133-142.

Freud, S. Female sexuality. Standard Edition, 1931, 21, 223-243. London: Hogarth Press, 1961.

Freud, S. New introductory lectures on psychoanalysis: femininity. Standard Edition, 1933, 22, 3-182. London: Hogarth Press, 1964.

Galinsky, E. Between generations: the six stages of parenthood. New York: Times Books, 1981.

Glover, E. The technique of psychoanalysis. New York: International Universities Press, 1955.

Goz, R. Women patients and women therapists: some issues that come up in psychotherapy. International Journal of Psychoanalytic Psychotherapy, 1973,2, 298-319.

Greenacre, P. Certain technical problems in the transference relationship. Journal of the American Psychoanalytic Association, 1959, 7, 484-502.

Greenacre, P. Symposium. the psychoanalytic process, transference and acting out. International Journal of Psychoanalysis, 1968, 49, 211-218.

Greenson, R. special technical problems in handling transference during analysis. Bulletin of the Philadelphia Association of Psychoanalysis, 1962, 12, 47-49.

Greenspan, M. & Kulish, N. Factors in premature termination in long-term psychotherapy. Psychotherapy,1985, 22(1), 75-82.

Hamburg, D. et al. Central fact gathering committee report. Journal of the American Psychoanalytic Association, 1967, 15, 841-861.

Hendrick, I. Facts and theories of psychoanalysis (3rd ed.). New York: Knopf, 1967.

Horney, K. Feminine psychology. New York: Norton, 1967.

Ivey, E. P. Significance of the sex of the psychiatrist. A.M.A. Archives of General Psychiatry, 1960, 2, 622-631.

Jackel, M. Interruptions during psychoanalytic treatment and the wish for a child. Journal of the American Psychoanalytic Association, 1966, 14, 730-735.

Jacobson, E. On the development of the girl's wish for a child. Psychoanalytic Quarterly, 1968, 37(4), 523-538.

Jarrahi-Zadeh, A. et al. Emotional and cognitive changes in pregnancy and early puerperium. British Journal of Psychiatry, 1969,115, 797-806.

Jessner, L., Weigert, E. and Foy, J.L. The development of parental attitudes during pregnancy. In E.J. Anthony & T. Benedek (Eds.), Parenthood: its psychology and psychopathology. Boston: Little, Brown and Company, 1970.

Kaplan, A. Female or male therapists for women patients: new formulations. Psychiatry, 1985, 48, 111-120.

Karme, L. The analysis of a male patient by a female analyst: the problem of the negative oedipal transference. International Journal of Psychoanalysis, 1979, 60, 253-261.

Kestenberg, J.S. Regression and reintegration in pregnancy. Journal of the American Psychoanalytic Association, 1976, 24, 213-250.

Knapp. P.H., Levin, S., McCarter, R.H., Wermer, H. & Zetzel, E. Suitability for psychoanalysis: a review of one hundred supervised analytic cases. Psychoanalytic Quarterly, 1960, 29, 459-477.

Kohut, H. The search for the self (Vol. 2). New York: International Universities Press, 1978.

Kubie, L. Practical and theoretical aspects of psychoanalysis. New York: International Universities Press, 1950.

Kulish, N.M. The effect of the sex of the analyst on transference. Bulletin of the Menninger Clinic,1984,48,95-110.

Langs, R. The technique of psychoanalytic psychotherapy (Vol.1). New York: Jason Aronson, 1973.

Leifer, M. Psychological effects of motherhood: the first pregnancy. New York: Prager Books, 1976.

Levinson, P., McMurray, L., Podell, P. & Weiner, H. Causes for premature interruption of psychotherapy by private pracitice patients. American Journal of Psychiatry, 1978, 135(7), 826-830.

Loewald, E. The baby in mother's therapy. Psychoanalytic Study of the Child, 1982,37, 381-404.

Mogul, K. Overview: the sex of the therapist. American Journal of Psychiatry,1982,139, 1-11.

Novick, J. Termination: themes and issues. Psychoanalytic Inquiry, 1982, 2(3), 329-363.

Orlinsky, D. & Howard, K. The effects of sex of therapist on the therapeutic experiences of women. Psychotherapy: Theory, Research and Practice, 1976, 13(1), 882-888.

Pines, D. Pregnancy and motherhood: interaction between fantasy and reality. British Journal of Medical Psychology, 1972,45, 333-342.

Pines, D. The relevance of early psychic development to pregnancy and abortion. International Journal of Psychoanalysis, 1982, 63, 311-319.

Raphael-Leff, J. Psychotherapy with pregnant women. In B.L. Blum (Ed.), Psychological aspects of pregnancy, birthing and bonding. New York: Human Sciences Press, 1980.

Raphael-Leff, J. Psychotherapeutic needs of mothers-to-be. Journal of Child Psychotherapy, 1982, 8, 3-13.

Raphael-Leff, J. Facilitators and regulators: conscious and uncounscious processes in pregnancy and early motherhood. British Journal of Medical Psychology, 1986, 59, 43-55.

Reder, P. & Tyson, R. Patient dropout from individual psychotherapy. Bulletin of the Menninger Clinic, 1980, 44(3), 229-249.

Sashin, J., Eldred, S. & van Amerongen, S. A search for predictive factors in institute supervised cases: a retrospective study of 183 cases from 1959-1966 at the boston psychoanalytic society and institute. International Journal of Psychoanalysis, 1975, 56, 343-359.

Shainess, N. Significance of match in sex of analyst and patient. American Journal of Psychoanalysis, 1983, 43, 205-217.

Stone, L. Transference and its context. New York: Jason Aronson, 1984.

Turrini, P. Psychological crises in normal pregnancy. In B.L. Blum (Ed.), Psychological aspects of pregnancy, birthing and bonding. New York: Human Sciences Press, 1980.

Vanggaard, T. Symposium. Contribution to symposium on acting out. International Journal of Psychoanalysis, 1968, 49, 206-210.

Winnicott, D.W. Through paediatrics to psychoanalysis. New York: Basic Books, 1956.

Winnicott, D.W. From dependence towards independence in the development of the individual. In The maturational processes and the facilitating environment. New York: International Universities Press, 1965.