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**The therapist's emotional experience during pregnancy and
miscarriage: Thoughts on countertransference, empathy and
reality**

Desheh, Yael, Ph.D.

City University of New York, 1987

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THE THERAPIST'S EMOTIONAL EXPERIENCE

DURING PREGNANCY AND MISCARRIAGE

Thoughts on Countertransference, Empathy and Reality

by

Yael Desheh

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.

1987

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Abstract

THE THERAPIST'S EMOTIONAL EXPERIENCE
DURING PREGNANCY AND MISCARRIAGE

Thoughts on Countertransference, Empathy and Reality

by

Yael Desheh

Advisor: Dr. Arietta Slade

A clinical study explored therapists' unique internal experience during pregnancy, early motherhood and miscarriage and its impact on the therapeutic process.

Eleven psychodynamically-oriented therapists were interviewed during and following their pregnancies. Three were interviewed regarding their experience of a miscarriage or a problematic pregnancy. Ongoing and retrospective data was provided regarding therapists' changing internal state and sense of self at various stages, and its impact on their professional identity, relationships with patients and colleagues and alterations in the treatment setting.

A major area of focus related to the intensification of countertransference phenomena at this time. These were examined in relation to impact on therapeutic effectiveness, capacity for empathy and choices of technical handling of practical problems introduced by the pregnancy or miscarriage.

The findings confirm the hypothesis that alongside intensification of real and transferential aspects of the therapeutic relationship there is an equally profound intensification of countertransferential feelings as well as concerns regarding reality based obstacles. Whether these will facilitate therapeutic gains or increase negative effects depends on the manner in which they are handled.

Regarding pregnancy, alongside self absorption and withdrawal from patients, an increase in maternal nurturance and empathic attunement was noted. These observations were discussed in light of parallel processes between therapy and parenting. Distinct alterations in professional role and therapeutic style were observed after delivery. These were evaluated in the context of therapists' redefinition of boundaries and sense of self.

The effects of a therapist's sudden miscarriage or a complicated pregnancy on the therapeutic process were described and explanations regarding the almost total neglect of the topic were offered. A prolonged and ubiquitous process of mourning which was insufficiently acknowledged was noted. Its contribution to countertransferential and realistic difficulties was evaluated in relation to issues of omnipotence, narcissistic injury and loss.

The crucial significance of adequate forums for therapists' expression of their own needs and frustrations at a time of personal or developmental crisis was underscored.

Finally, therapeutic implications regarding technical handling of practical and logistical issues were reviewed and some recommendations were offered.

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To the patients who accompanied me during two pregnancies and whose trust and sharing of feelings and thoughts provided me with a unique and rich therapeutic experience, I extend by gratitude and respect.

Special acknowledgment is due to the therapists who participated in this study. I am indebted to them for their investment of time and effort and for their astounding honesty in sharing their most personal experiences during pregnancy, early motherhood and miscarriage. In particular, I'm appreciative of their courage in discussing conflicts, difficulties, vulnerabilities and pain and the consequent effects on their therapeutic functioning. Their feedback has been invaluable in providing rich clinical material and in illuminating the significant impact of the therapist's pregnancy or miscarriage on herself and on the therapeutic process.

I thank my family, friends and mentors who believed in me and in the possibility of completion of this endeavor. Above all, I give my deepest gratitude to my husband and friend, Eyal, whose love, tireless dedication and faith in me have been a constant source of strength and hope. Without him and our children Hila and Eran, who endured with patience the juggling of my dual roles, none of this work would have been possible.

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CHAPTER I

REVIEW OF THE LITERATURE

Introduction

Several years ago while I was pregnant with my second child, and treating patients at a university clinic, I became intrigued by the profound impact my pregnancy had on intensification of transference and countertransference reactions, and was fascinated by the unique dimensions this event in my life introduced into the treatment.

I reflected on my first pregnancy (nine years earlier), when I was a beginning therapist, also at a university clinic. I was absolutely amazed in realizing the extent to which the effects of this pregnancy had gone unnoticed and undiscussed both in my direct therapeutic work as well as in my supervision (which was otherwise very rich and focused on transference and countertransference manifestations within a psychoanalytic context). It was almost as if the pregnancy did not exist and had no relevance for the therapeutic relationship.

The above insight into what was probably meaningful denial and avoidance by all involved (myself, patients, supervisors) led me to further pursue this topic in both clinical and theoretical domains.

In reviewing the literature, I discovered to my surprise that although there has been a small and recently growing number of articles

on the pregnant therapist, over the past fifteen years, the literature is relatively scattered and incomplete. Such "silence" in the usually rich psychoanalytic literature, which has recently focused increasing attention on the psychological processes of pregnancy, is peculiar. It leads one to wonder why women therapists, many of whom must have been pregnant while practicing, have not shared their experiences as they related to their work. This paucity of accounts is even more surprising in light of the increasing number of women combining their professional role as therapists with motherhood.

A related topic, even more absent in the literature despite its high incidence in real life, is that of a therapist's miscarriage. It is striking to note that there is only one article dealing directly with a therapist's miscarriage and its implications for treatment (Hannett, 1949), and a few others who mention it in passing (Barbanel, 1980; Ballou, 1978). While there is some attempt at delineating patients' reactions, there is a total absence of discussion of the therapist's personal experience of loss and grief and its impact on her work.

Several authors have commented on this lack of attention to such crucial topics as not being accidental. Barbanel (1980) discussed factors supporting denial of a therapist's pregnancy in the literature as well as in the therapeutic process (by both patients and therapists). Some of these factors relate to psychological and social taboos associated with pregnancy and its disclosure, including superstitions of ominous outcome of discussion of one's own pregnancy: i.e., miscarriage (Klein, Potter & Dyk, 1950; Klein, 1957). Other taboos of discussion

relate to pregnancy as one aspect of human sexuality and to conflicts regarding personal exposure.

Barbanel's contention is that this state of affairs reflects "certain notions about pregnancy, therapists and the combination of the two," i.e., a therapist's pregnancy is an event unique to female therapists and it is viewed by many (both male and female) as an intrusion of the therapist's female functions into her work, possibly limiting her capacity to "mother" her patients. It follows, that if the pregnancy has to occur, it is best to keep it out of the consulting room as much as possible (Barbanel, 1980).

One could question the extent of legitimacy female therapists have felt in exploring and discussing this personal event in their life as a valid topic for professional interest.

On the other hand, the above mentioned "silence," could be only one extreme example of a general tendency of both male and female therapists to defensively minimize and avoid discussion of the impact of life stresses on themselves and on their work.

Reports such as those of Aaron (1974), Dewald (1980), Abend (1980) and Lindner (1984), confirm that any life event which exerts a profound emotional and/or physical effect on the therapist (such as marriage, divorce, or serious and life threatening illness), serves as fertile ground for denial, blocking, avoidance and the cultivation of countertransference difficulties. Such events, often threaten therapists' omnipotent fantasies and ego ideal while at the same time painfully confront them with their own humanness, and narcissistic vulnerabilities

as well as the realistic limitations on their capacity for productive work. Additional forces at work relate to conflicts regarding disclosure of personal needs and gratifications at a time of crisis, especially if these interfere with the adherence to rigorous principles of psychotherapeutic technique. Therapists may fear a blurring of boundaries between what they perceive as an intact and effective "professional self," intruded upon by a distraught or excited "personal self." Attending to countertransference difficulties or to intense personal reactions entering the therapeutic relationship, threatens to destroy the myth of the consistent and immune supertherapist.

Thus, the stage is set for resistance to honest exploration of one's personal experience during a poignant life event, and for denial of the emotional and realistic consequences for oneself, one's patients and the therapeutic process.

A therapist's pregnancy is a unique event which has profound implications for both patient and therapist. It intrudes into the therapeutic process as a concrete visual and undeniable reality, exposing highly personal aspects of the therapist's life. Thus it violates her relative anonymity and introduces her as a real person with a separate life apart from her work, a sexual woman intimately involved with others and soon to become a mother.

The unfolding of this highly charged process stimulates intense transference and countertransference reactions although the latter have been insufficiently explored. The therapist who is going through a developmental life crisis, facing major changes and adjustive tasks, has

her own emotional reactions to the pregnancy and its impact on her work. Considering her increased vulnerability, her changing sense of self and her exposure within the therapeutic setting it is logical to assume she will be more sensitive to patients' intense reactions as they relate to her own unresolved conflicts and ambivalences. How these may unfold and the manner in which they are dealt with, will significantly impact the course and effectiveness of the therapeutic process.

Statement of Purpose

The purpose of this presentation is to shed some light on the unique internal experience of the pregnant therapist at a time when she is both a woman going through a profound stage of personal development, and a professional engaged in a psychotherapeutic process.

I will describe the sequence of transformations, emotional and adjustive tasks, anxieties and conflicts which affect her psychic life during the different stages of pregnancy, delivery and the early postpartum period. The pregnant therapist's changing sense of self and others, in both her internal world and external reality, will be examined in relation to the multifaceted effect on her professional identity, and her relationship with her patients, colleagues and supervisors.

A major focus of attention will be dedicated to one of the least explored but most crucial aspects of a therapist's pregnancy: the development and intensification of specific countertransference phenomena and their impact on the therapeutic process. These phenomena, will be examined in relation to their potential origins, as they are influ-

enced both by the therapist's unresolved conflicts as well as by her patients' real and transferentially determined responses to the pregnancy. Special consideration will be given to the relationship between these countertransference phenomena and the therapist's capacity for empathy.

Overall, I will attempt to assess the unique role and impact of countertransference phenomena as they relate to a personal event in the therapist's life in general, and to a pregnancy or miscarriage in particular. I will evaluate the potential gains as well as the burdens and difficulties introduced into the treatment at this time. This will be presented in light of different theoretical approaches regarding countertransference and its technical handling -- whether viewing it as a noxious development deleterious to treatment or as a sensitive and valuable tool.

Last, but not least, special notice will be given to practical and logistical problems arising as a result of a therapist's pregnancy or miscarriage, and the contribution of countertransference issues to specific choices of their technical handling. The consequent alterations in the therapeutic relationship and the implications for modification of technique will be reviewed and discussed.

The current study evolved out of the author's personal experience as a pregnant therapist and through a unique meeting with 10 other therapists who were interviewed both during and following their pregnancies or miscarriages regarding the complex impact of these experiences on themselves and on their work.

Literature Review

The theoretical framework which serves as a basis for this presentation within a psychoanalytic perspective, regards pregnancy as a life event involving profound psychological, physiological and social changes. It is perceived as a maturational crisis creating upheaval in the psychic balance of all women, regardless of their psychic health. (This pertains to women who happen to be therapists -- as well.)

Within this context, investigations such as Bibring's (1959, 1961) influenced by Deutsch (1944, 1945), Benedek (1952, 1959, 1970) and Erikson (1950), regard pregnancy as a developmental "point of no return," just like puberty and menopause. Bibring found that the maturational crisis of pregnancy creates a psychological disturbance in all expectant mothers, which reflects something characteristic of the process of pregnancy itself, and its inherent stress. This is beyond considerations of the specific women's emotional makeup, or the degree of unresolved conflict she brings into the pregnancy (Bibring, 1961). Particularly for the primigravida (first time mother-to-be) this stage in the life cycle entails a significant degree of disequilibrium of previously attained psychological organization. This process is necessary in order to allow for a corresponding recomposition towards new maturational functions and a new level of integrated identity.

Pregnancy and childbirth, is a universal theme which has stimulated many fantasies, wishes, superstitions and fears. It is a powerful event which has evoked a mixture of awe, fascination and distrust in a variety of cultures over time and has been unconsciously and consciously asso-

ciated with danger and death, as mysterious, uncontrollable and unpredictable.

As such, it is consistent with psychoanalytic theory to assume that the pregnancy, a unique time limited event, has profound implications for both patient and therapist engaged in a therapeutic relationship. The pregnancy, is physically obvious, cannot realistically be ignored,* and becomes a "highly charged stimulus evoking deep seated childhood conflicts and wishes" (Lax, 1969). It will inevitably affect the course of the treatment by leading to interruption or termination. The impending separation within a defined sequence of time, whether temporary or permanent (loss) is of crucial significance to all involved.

Viewing pregnancy in the context of a maturational crisis, it is very likely that this process will stir in the therapist (as in other women) echoes of her childhood conflicts and ambivalence in her object relations. She must work through her changing identity, and take the developmental step towards motherhood, integrating the roles of wife, mother and therapist, and deal with her divided loyalties. Moving towards parenthood, implies a struggle between identification and differentiation from her own parents (especially her mother), or their image embedded in her ego ideal (Bibring, 1961). This will necessitate

* Many a time, despite it's powerful visibility, the pregnancy is defensively denied and avoided by both patient and therapist. The motivations for this denial will be discussed at a later point in this presentation.

a re-examination and a consolidation of her previous identifications, and often a search for new ones. Vascillation between guilt, anger or withdrawal on the one hand and elation and a heightened sense of personal fulfillment on the other, may accompany this process of internal change (Fenster, et al., 1986).

Consequently, these fluctuations in her identifications in the context of her past and future relationship to herself and significant others, render the pregnant therapist more sensitive to the "onslaught of conflict manifestations presented in her patient's material" (Lax, 1969). Thus it follows, that the pregnant therapist may be more vulnerable than usual, to her patient's transference reactions, and that these in turn will evoke in her a variety of conscious and unconscious reactions. These reactions may increase countertransference phenomena on the one hand, or enhance attunement to primitive material on the other.

Anonymity and Neutrality

There are few life changes (with the exception of severe or terminal illness), where the therapist has so little control over revealing her personal life, as during pregnancy. While it is true that patients undoubtedly become aware of personal events and details about the therapist's life, in the course of treatment (a marriage, a divorce, a child's voice where the living quarters are adjacent to the office), the pregnancy's self revelation disregards the therapist's wishes vis a vis self disclosure, as well as patient's interests and concerns. In the eyes of most patients, a therapist does not seem to change much during the course of therapy. They view the therapist as a static person, a

timeless grown-up, a perception which contributes to the experience of a consistent "holding environment" (Winnicott, 1957) and to the fostering of transference reactions. At the same time it aids the patients in denying some "real" aspects of the therapist's existence (Lax, 1969; Nadelson et al., 1974).

Not so during a therapist's pregnancy. The usually sheltering and stable quality of the relationship is shaken upon recognition of this concrete reality. This is one life event that cannot be hidden or kept outside the consulting room, even in the face of arduous attempts to do so. The pregnancy impinges on the therapeutic process, interfering with the so-called anonymity and neutrality of the therapist. The patient, witnessing the unfolding of this process of change, is provided with direct, visual evidence that the therapist has a separate, private life, apart from her work, and that one intimate aspect of this life is her sexuality and sexual identity.

The therapist, on the other hand, has to come to terms with this exposure as well as with her increased physical and emotional vulnerabilities and the consequent limitations on her capacity for work. She must also confront the shifts in her relationships with colleagues and supervisors, who in turn will have a variety of conscious and unconscious reactions to her pregnancy. It is crucial that these will be articulated and acknowledged as affecting the therapeutic process. Thus for many patients as well as therapists, this is the first time that the pregnant therapist is confronted as a "real" person, for better or for worse.

A theoretical and technical point evolves from these unique circumstances. This pertains to the so-called anonymity and neutrality of the therapist, interfered with or even "uncontrollably destroyed" (Underwood & Underwood, 1976) by the "intrusion of the pregnancy into the analytic space" (Fenster, 1983).

The traditional view of psychoanalysis (and its derived therapies) construes the essence of the therapeutic process as the analysis of transference and resistance in bringing unconscious material into consciousness, striving for change through self knowledge (Freud, 1914). Within this context, certain external criteria (such as free association, frequent sessions, use of the couch and anonymity and neutrality) evolved to facilitate this process.

One of the underlying assumptions regarding anonymity and neutrality of the therapist is based on the observation that a person interprets and responds to situations in terms of his or her past and present conflicts and life experiences. The more "neutral" the situation, the greater the possibility for projection, which will foster the development of transference. The preservation of the therapist's anonymity and neutrality is perceived as essential for achieving analytic understanding through "objective inquiry," and thus the therapist attempts to limit his or her personal influence in favor of consistently neutral formulation of interpretations. It follows, that in terms of classical concepts of analysis, it is impossible to speak of the pregnant therapist as a "blank projective screen." There is no doubt that it is beneficial to the treatment process if the therapist's private life does

not impinge upon her patients or interfere with the unfolding of their transference patterns and the exploration of their subjective inner world. The question to be raised, is to what extent this is possible, and as to the procedure to follow when it is not. Obviously, pregnancy is not the only condition patients inevitably become aware of. There are many life instances where the therapist presents to the patient a specific reality stimulus rather than a "blank mirror." Lax (1969), in reviewing her patients reactions to her pregnancy, raised the question as to the extent one can speak of the therapist as an "optimal projective screen" if she enables patients to respond to the given reality situation (here, pregnancy) in a manner determined by their unique psychic constellation.

— What are the circumstances under which this option becomes a viable one and what are the obstacles? Does modification of this external criteria (of anonymity and neutrality) necessarily preclude sustaining of the internal integrity of the therapeutic process?

A satisfactory discussion of these issues requires highlighting some of the major forces operating within the consulting room, examining the therapist's internal experience and it's inevitable influence on all participants in the therapeutic drama.

In the regular course of psychoanalytic work, even when one is not affected by powerful life events, it is impossible to maintain an optimal analytic stance indefinitely. This stems from the fact that a psychotherapeutic endeavor can only be carried out by two human beings, the therapist being no less human than the patient. If the therapist is

indeed immersed in the intense emotional interchange that the analytic setting provokes, she is subjected to powerful pressures to abandon her analytic neutrality (Silverman, 1985). Witenberg (1983) has noted that once one starts to formulate a theory of treatment, one begins to realize that man taken in isolation is a fiction. He commented on the fundamental attitude necessary for analytic work, a special mode of attention labeled by E. Schachtel as the "Allocentric Attitude." This unique form of attention presupposes the therapist has the capacity to "become interested in the totality of any object without interference from one's own needs," thus temporarily suspending their gratification and disregarding their influence on one's perceptions of the world. Others have referred to this capacity as a "freely hovering attentive state" in which the therapist is receptive emotionally and intellectually to the patient's utterances and non-verbal behavior "in such a way that he is free to grasp their unconscious as well as their conscious import without filtering, distinguishing, rejecting or utilizing them for his own personal gains" (Silverman, 1985). Witenberg (1983) contends that in either case there is absence of neutrality. Fenster, et al. (1986) also noted that any stance, even a neutral one, is a mode of participation that tells the patient something about the analyst. They quote Gill's expanded version of the traditional notion of transference, which includes the "inadvertent influences" of the analyst on ongoing interaction with the patient, by his/her personality, what he/she attends to, how intervenes and how responds. All of the above exert an undeniable but subtle influence on the interpersonal interaction and by

extension on the transference. He considers the notion of an "uncontaminated transference" a myth (Gill, 1984). Issacharoff (1983) commented on the need for anonymity and neutrality, not arguing for neutrality of affect or of value judgments but rather as a process of ego control. This prevents dissociated reactions lacking an observing ego which eliminate the distance necessary for psychological awareness. Issacharoff defines the preservation of the therapist's neutrality as the refraining from identification with any particular aspect of the patient; thus objectivity is maintained enabling the therapist to respond, without bias, if and when he chooses to do so. If the therapist's bias arises from countertransference responses and the reasons remain dissociated, his response ceases to be neutral and prevents the patient from recognizing and exploring the conflictual aspects of his ambivalence (Issacharoff, 1983). A bias introduced as a result of countertransference difficulties implies the therapist's needs have entered the field where they now command attention, and thus the therapist does more than "hover" and "receive" and is beyond the role of a commenting spectator.

It is inherent in the analytic process that the patient relentlessly attempts to draw the analyst into complicity with him in gratifying his neurotic needs rather than understanding their infantile roots (Calef & Weinshel, 1983). In doing so patients masterfully probe for the analyst's vulnerabilities and attempt to exploit them in the above fashion. Since the analytic work is replete with stresses and strains, and since the analyst is no less human than his patients, he/she is also under constant danger of slipping from "analytic empathy" to counter-

transferential (including counter-identificatory) acting out of his own unconscious conflicts, using the patient as an object for gratification (Silverman, 1985). Thus as analysts and therapists, we are constantly at the mercy of the pull and push of our patients as well as our own inner anxieties and tensions.

Empathy and Countertransference

At this point, it becomes necessary to describe and distinguish between what is considered analytic empathy and countertransference. Regarding the therapist's empathic ability, it is assumed that as the therapist permits himself/herself to drift freely in response to patients' free associations, a regressive emotional reaction occurs. This regressions, in the service of the ego, produces via utilization of projective and introjective processes a "trial identification" with the patient (Fleiss, 1942), which provides valuable clues in understanding of the patient's inner world as it is manifested in the transference. In the regular course of events, this trial identification is transient, broken off and the analyst separates from the patient and reflects from a distance, bringing his cognitive abilities to bear on the emotional stirrings within him (Beres & Arlow, 1974; Arlow, 1985). This is in congruence with Freud's recommendation from 1912 that "the analyst must turn to his own unconscious like a receptive organ towards the transmitting unconscious of the patient . . . So the Doctor's unconscious is able . . . to reconstruct [the patient's] unconscious" (Freud, 1912, pp. 115-116). Thus during the trial identification phase there is a tempo-

rary sharing of the patient's unconscious wishes and responses to internalized objects in order to facilitate understanding of the transference. When the trial identifications break down or do not occur, there is danger of countertransference interference, and the therapist may remain fixed at the point of identification with the patient and utilize him/her for gratification of his/her own needs.

Regarding countertransference, there has been considerable difference of opinion and disagreement as to what should be included under this heading since Freud first introduced his discovery in 1910: "We have become aware of the countertransference which arises in the physician as a result of the patient's influence on his unconscious feelings" There the requirement is made that "the analyst begin his activity with self-analysis and continually carry it deeper while he is making his observations on his patients" (Freud, 1910, pp. 144-145).

Epstein and Feiner (1983) noted the fact that two themes have been intertwined in the historical development of the concept of countertransference. Countertransference as a hindrance to treatment alongside indications of the therapist's use of his/her unconscious to understand the patient and enhance the therapeutic process.

Various definitions evolved regarding the content of countertransference, its development and its technical and theoretical place in the therapeutic process. Some of the different conceptualizations include: (1) Countertransference as a noxious development emanating from the analyst's unresolved unconscious conflicts and contaminating his/her understanding and technique (the Classical Approach -- Reich, 1951); (2)

Countertransference as a natural and necessary counterpart to the patient's transference with useful and deleterious effects (Bird, 1972), including a "reflexive role response," a "compromise formation between the therapist's tendencies and reflexive acceptance of the role the patient is forcing on him" (Sandler, 1976); (3) Considering all the therapist's attitudes and feelings towards his patient as countertransference, an essential and sensitive tool in enhancing the understanding and integration of the patient (Heimann, 1950; Little, 1950 -- the Totalistic Approach).

It is beyond the scope of this presentation to review in detail the various countertransference definitions.

For the purpose of this study I shall focus on countertransference as the pregnant therapist's response to her patients and their transference stemming from her own issues, unresolved conflicts, personal history and defenses (defined as "countertransference disposition" -- Racker, 1967), and will comment on how these relate to aspects of the "real relationship" and to the therapist's reactions evoked by the analytic situation as such (Racker, 1968; Greenson, 1972; Arlow, 1985).

Beyond the specific definitions and the assessment of the potential value or danger inherent in countertransference phenomena, it is undeniable that countertransference is an inevitable and ubiquitous phenomenon in the therapeutic process. Analysis and self analysis are interminable (Freud, 1937) and even a training analysis will not immunize any therapist against the possibility of countertransference interference. Those who believe that they are so "well analyzed" that they are imper-

vious to these powerful influences, may be the most vulnerable to their development to the detriment of the therapeutic process (Silverman, 1985; Bird, 1972).

How does a life event or crisis such as pregnancy affect this delicate balance of forces and the therapist's attention, empathic ability and availability?

When one takes into consideration the emotional dislocations and realistic obstacles of pregnancy, one can assume the therapist will be confronted with greater intrapsychic pressures and intensification of conflict which may lead to countertransference interference. This is most likely to occur in the trial identification phase (Baum, 1974; Witenberg, 1983). To the extent that the pregnant therapist is unable to accept her human frailty and examine her own feelings and reactions to the pregnancy, she will be threatened by her patients' infantile responses and is likely to encounter anxiety and depletion. These may interfere with the working alliance, and lead to breaks in empathy and errors in interpretations. There is often a tendency to develop an undue need for the patient in order to deny personal distress. Thus the therapist's regression will be more like that of the patient and she will be unable to sustain fluidity of empathic identification and reflection, or help her patients overcome the problems that prevent them from realizing their potential in life (Lax, 1969; Baum, 1974; Arlow, 1979; Greenson, 1974; Witenberg, 1983).

The Psychological Processes of Pregnancy

In order to gain a better understanding of the therapist's internal experience as a pregnant woman, or as a woman subjected to the experience of miscarriage, I shall review some of the major themes, issues and conflicts which emerge as these processes unfold. Since the focus of this presentation is on the impact of these internal shifts on the therapist's work, I shall be selective and not attempt a comprehensive review.

In former decades, the investigation of the psychological processes of pregnancy proceeded with some reservation, and avoidance of intrusion into this period of constant psychophysiological change and upheaval. H. Deutsch (1945) explained this by pointing to the pregnant woman's shying away from observing her own psychic processes during pregnancy. The relative neglect of inquiry into pregnancy despite its centrality, was also influenced by the social biases and taboos prevailing. Within the theoretical framework of psychoanalysis, there was a neglect of pregnancy's crucial psychic significance, stemming from the assumption that the pregnant woman is not in need nor accessible to analysis, since she lives in the bliss of her basic wish being gratified: i.e., the symbolic substitution of the child for the missing penis. Freud never abandoned this position despite his subsequent insights on the importance of the girl's pre-oedipal attachment to her mother. In the patriarchal society in which he worked and lived, there was no room for focusing on woman's primary role in reproduction and her subjective experience in pregnancy, childbirth and motherhood.

During the last decades, there has been increasing interest in the psychological processes of pregnancy, and a growing recognition of a need for counseling both in preparation of and during pregnancy has emerged.

Much of the literature originally focused on pregnancy as a hurdle to overcome with a hoped return to the pre-pregnant state of equilibrium (Breen, 1975). Attention has been given to the emotional and psychological upheaval during pregnancy and its relation to pathological developments in the pregnancy itself, and in the future mother-child relationship. Factors such as increased depression (Tobin, 1957) or pathological post-partum depression (Zilboorg, 1929, 1938; Rochlin, 1959, 1961), psychological tension (Grimm, 1961; Light & Fenster, 1974), anxiety in the first and third trimesters (Lubin, Gardner & Roth, 1975), mood lability (Jarrahi-Zadeh, et al., 1969), diminished cognitive acuity in the first trimester (Murai & Murai, 1975), and altered perceptual processes (Davids, DeVault & Talmadge, 1966; Colman, 1969) have been noted. Other studies, however, have shifted their emphasis to consider pregnancy as a normal developmental phase. Thus an understanding of specific and typical conflicts and anxieties in normal pregnancy has gained importance for the future healthy development of both parent and child, and in shedding light on the linkages of three generations in the psychology of parenthood.

Within this context and in conjunction with clinical and theoretical reformulations of the hypotheses re the woman's wish for a child and motherhood, the work of H. Deutsch (1944-1945), T. Benedek (1952, 1959,

1970) and E. Erikson (1950, 1953, 1968), influenced investigations such as Bibring, et al. (1959, 1961) and led to a developmental point of view of pregnancy as a maturational crisis requiring physiological adjustments and psychological adaptations, ultimately calling into question old solutions and leading to new levels of intra-psychic equilibrium and organization (Bibring, 1959, 1961; Breen, 1975).

Bibring, et al. (1961), who interviewed and tested primiparous women (first time mothers to be), at different stages of pregnancy and early post-partum, observed a picture of serious disturbance in these women (without proportional degree of disturbance in their pre-pregnant history, and with a surprising favorable response to simple therapeutic interventions). They concluded that pregnancy, like puberty and menopause, is a normal maturational crisis, affecting all expectant mothers regardless of their psychic health. In fact, Zilboorg (1929, 1938), who focused on pathological post-partum reactions noted that women who develop psychotic symptomatology after childbirth, have had "unusually happy and symptom free pregnancies, in contrast to neurotic problems often present during pregnancies of normal and mildly neurotic women" (Zilboorg, 1929). Thus, the psychological disturbance observed in pregnant women by Bibring and others reflects something characteristic of pregnancy itself, and its inherent stress (be it psychological, physiological or social). As such, this crisis introduces an accelerated rate of psychological change, entailing regression, a general loosening of defenses (with the appearance of more primitive content material and

major shifts in significant relations to people and activities" (Bibring, 1961, p. 26).

The dissolution of previous organization of self concept and identifications is seen as an essential developmental step in allowing for recomposition to a new level of intrapsychic integration and functioning.

Bibring, et al. (1961), defined the unique developmental process of pregnancy and motherhood in terms of the woman's relationship to her sexual partner, herself and her child, as expressed in shifts of the level and distribution of narcissistic libido and object libido. This is manifested throughout pregnancy in the pregnant woman's negotiation of two opposing major adjustive tasks: 1) accepting and incorporating the intrusion of impregnation by turning the child (representing the love object) into part of the self, and 2) accepting the separateness of the baby as an object.

All those who have written about pregnancy agree that narcissism increases during normal pregnancy (Zilboorg, 1929, 1938; Deutsch, 1944, 1945; Benedek, 1952; Bibring, 1959, 1961). This increase makes all pregnant women more vulnerable to regressive psychopathology and reactivation of partially resolved conflicts, which had been relatively dormant prior to the pregnancy. Deutsch (1944) describes the process of introversion as a disturbance of psychic balance taking place as the woman deals with her changing self image. Regression, in the service of the ego, allows her to begin empathizing with the unborn child and prepare for motherhood. Deutsch also noted that a major emotional task

of pregnancy is the development of a positive identification with the fetus, which helps overcome the unconscious wish of almost all women to terminate the pregnancy. This is achieved through enhanced narcissism. Once the pregnant woman has identified with the unborn child, it is surrounded by boundless narcissistic love, as a gratifying extension of her own ego. Thus, the narcissism of pregnancy erases the boundaries between mother and child, as preparation for future selfless love of the child.

In line with Deutsch's conception of the typical heightened narcissism in pregnancy and its socially valuable results, Murray (1960) calls attention to the relationship of narcissism to the ego ideal. The act of giving birth to a new life, is in a sense the highest fulfillment of creativeness and of the normal unconscious forces in the ego which are focused on the healthy ego ideal. Severe pathological disturbance arises when this social and idealistic orientation is lost, and the meaning of pregnancy regresses to fulfillment of primitive narcissistic needs (Zilboorg, 1929; Blitzer & Murray, 1964).

Bibring, et al. (1961) concluded that if the relationship with the future offspring fulfills its maturational requirement it will have a "freely changeable fusion of narcissistic and object libidinal strivings," so the child will always remain part of the pregnant woman but at the same time will have to remain an object that is part of the outside world as well as of the sexual partner (p. 16). Inherent in the view of parenthood as a developmental stage in the life cycle (Erikson, 1950; Benedek, 1959), is a struggle between identification and differen-

tiation in relation to the parents or their representation embedded in the ego ideal of the younger generation.

All authors who have written about the psychological processes of pregnancy have focused on the pregnant woman's relationship to her own mother, and coming to terms with resurgence of ambivalent feelings towards her, as the core of the adjustive task (Deutsch, 1945; Benedek, 1956, 1970; Bibring et al., 1959, 1961; Pines, 1972, 1982; Jessner, 1970; Galinsky, 1981). Prospective parenthood touches off in the pregnant woman a nostalgia for her mother, to relive in her union with the future child a reversal of the original mother-child symbiosis. Mahler (1968), postulated that the longing for the symbiotic "good mother" (who was once part of the self), is an existential aspect of human life, and remains with us throughout the life cycle. Benedek (1956, 1970) noted the pregnant woman's heightened dependency needs, which evoke feelings and memories of her early sense of her own mother and of herself as a child. Benedek relates this process to the influence of hormonal stimulation.

Pines (1972, 1982), describes a first pregnancy as "an important developmental phase in a woman's lifelong task of separation and individuation from her own mother" (p. 318). She notes the primitive anxieties and conflicts aroused during the inevitable regression of pregnancy. Pines distinguishes between the wish to become pregnant and the wish to become a mother and bring a live child into the world. She discusses the unique opportunities the pregnancy affords for further emotional identification -- with the omnipotent, life giving pre-oedipal

mother (now based on a biological foundation), as well as a narcissistic identification with the fetus, as if it were herself. The possibilities for differentiation and growth vs. difficulties complicating separation are reviewed.

Galinsky (1978), describes the reactivation of unconscious memories relating to identification and conflict with the mother as an "image forming process" during which the pregnant woman prepares for the unknown. Deutsch (1945), warns that ambivalent feelings towards the pregnant woman's mother may lead to guilt and an unreasonable fear of loss of the child, while Friday (1970) and Ballou (1978) discuss the longing for emotional reconciliation with the mother related to open ambivalence and issues of dependency. Through this process, solutions of childhood may be abandoned and replaced by new identifications with the mother.

The degree of freedom from complete psychological dependence of the pregnant woman upon her mother will determine her ability to attain successful motherhood. If the pregnant woman is unable to emulate the "good mother" of her childhood and perceives motherhood as an unreachable perfection or as martyrdom, conflict will increase and might interfere with motherliness. The pregnant woman's ego must find a compromise between her deeply unconscious identification with her child (future) and with her mother (the past). If she rejects the latter, it may weaken her capacity for motherhood.

Consistent with the above, Ballou (1978) suggested a relationship between the pregnant woman's ability to reconcile her sense of her mother and her ability to establish a sense of her child, as a person.

In addition, Ballou discusses changes in identity and femininity as they relate to the marital relationship as well. The pregnant woman faces another task in her object relations that relates to the acceptance of the physical and mental representation of her sexual partner. This is in relation to her own development as a mature sexual woman confronting the fact that the pregnancy is a "visible manifestation to the outside world that she has had a sexual relationship" (Pines, 1972, p. 334). Pines stresses the difference between a mature identification with the mother's adult and sexual body and a sexual act that unconsciously represents a return to the infantile omnipotence of the baby in order to satisfy unfulfilled pre-oedipal longings for being mothered.

Overall, most of the above writers stress that the turmoil of pregnancy may indeed facilitate the transition to motherhood, rather than merely being a peripheral symptom of the pregnant state.

Miscarriage

Spontaneous abortion (miscarriage) is by definition, the termination by natural causes of a previable pregnancy. The majority of miscarriages occur in the first trimester of pregnancy, referred to in the literature as the "narcissistic stage of pregnancy," when the woman experiences the fetus as an integral part of herself (Bibring, et al., 1961; Deutsch, 1945).

Because the process of spontaneous abortion has the dynamic characteristic of a loss, the woman who experiences a miscarriage is subject to a grieving process and is vulnerable to the occurrence of prolonged pathological and unresolved grief reactions. Many physicians as well as

clinicians have not acknowledged this grieving, following a miscarriage. The experience of loss at a personal and intrapsychic level is often minimized by family and friends as well as by the woman herself.

Despite the fact that nearly ten percent of all pregnancies end in spontaneous abortion of random and non-recurring causes (Malpas, 1938), a review of the literature reveals that there has been insufficient focus on the psychological effects of a miscarriage. There is some discussion of the psychological factors in habitual abortion and of the benefit of psychotherapy in assisting the habitual aborter to carry a baby to term (Dunbar, 1963; Mann, 1972; Mann & Rumstead, 1975).

Deutsch (1945) observed that many spontaneous abortions studied were unmistakably so much influenced by psychogenic factors that these could be held responsible for the process. While she noted that almost in every woman there seems to be an active tendency to interrupt the harmony of pregnancy, it is only in extreme cases that the unconscious conflicts and hostile emotions succeed in inducing a significant physiological disturbance in the pregnancy that leads to early labor or miscarriage.

Benedek (1970) also commented on the possibility that extreme rage may lead to spontaneous abortion, especially in the first trimester of pregnancy. "Unrelieved frustration and the accompanying helpless, hopeless anger interrupt the well being of the physiologic symbiosis" (p. 144). The frustrated pregnant woman cannot find gratification in her pregnancy. She feels unable to satisfy her unborn child and this activates her anxiety. The rejection of the pregnancy goes hand in hand

with the hostility towards the unborn child, as well as towards the rejected self (Benedek, 1970). Kaij, et al., (1969) observed evidence of poor postpartum mental health in women with a history of spontaneous abortion. They suggested that these patients were more likely than control patients to have lost a father and suffered early neurotic symptoms combined with bereavement. The authors suggested unsuccessful identification with the mother and an absent, detached or dead father as common psychological factors among women with a history of miscarriage. Stack (1984) commented that while these authors focused on causation of miscarriage by the above mentioned factors, they did not consider the possibility that unresolved loss as well as incomplete grieving of the miscarriage itself may have contributed to their poor mental health. Many obstetricians observe a higher incidence of a second spontaneous abortion in the first six months following a miscarriage, but do not link this observation with the fact that six months are often the normal grief period (Stack, 1984).

While it is recognized that attachment and affective bonding to the fetus begin during pregnancy (mourning usually follows the death of a still-born), it is suggested that this attachment does not begin until after quickening, as the mother begins to identify with the fetus as a separate person (Klaus & Kennell, 1976; Ballou, 1978). Klaus and Kennell (1976), who observed maternal mourning of infants, explained the psychological process in terms of the damaged narcissism or the annihilation of the fantasies about motherhood and the baby, accompanied by sudden loneliness and lowered self-esteem. They concluded from these

observations that women can develop an intense emotional investment during pregnancy.

Galinsky (1981) commented on the process of loss of an anticipated image stimulating depression, especially in extreme cases where fantasy collides with reality. Thus, when there are medical problems in pregnancy (even without the end result of a spontaneous abortion), the dreamed for radiant pregnancy and healthy child fades as the parents are left with worry or loss. When a miscarriage does occur, the loss is profound and it may take a while to recover and to alter the image that pregnancy means birth and not death. Solnit and Stark (1961) also commented on the depression reflecting the loss of the wishes and image of the child as expressed in cases of birth of a defective or a dead child. Peppers and Knapp (1980), who studied a hundred couples who experienced early miscarriage, later stillbirth and neonatal death, found no difference in intensity of maternal mourning related to gestational age at which the loss occurred. Horowitz (1979) observed that some teenagers whose pregnancies ended in a miscarriage, have tried to relieve the grief and mourning by becoming pregnant again, soon. One might wonder, if pregnant therapists who experience a miscarriage are susceptible to the same pull and if they might attempt compensation of their loss through their work. Rochlin (1961), indicated that pathologically heightened narcissism makes one especially vulnerable to severe failure in self-esteem, when a loss is suffered. The loss itself leads to further heightened narcissism and a pathological reaction ensues if

there is an identification with what is lost in instances of changes in body image (Rochlin, 1959).

There is evidence that some women do not completely resolve their grief following a miscarriage. Peppers and Knapp (1980) described a "shadow grief" ranging from eight to twenty-one years after a miscarriage. Stack (1980) also reported persistence of unresolved grief and flooding of emotion during subsequent interviews 10 to 21 years after the miscarriage. Corney (1974) reported a case of pathological grief reaction to a miscarriage and the neglect of the topic in the literature, and Stack (1980) reported a case of a delayed grief reaction that resulted in organic illness and was only resolved after intensive working through of the loss.

The literature on miscarriage and emotional reactions by both women and men provides various case histories (Dunbar, 1963; Horowitz, 1979; Mann & Aumstead, 1979; Peppers & Knapp, 1980). While there is disagreement regarding psychological factors as a cause of miscarriage, there is a consensus that the emotional response can be psychologically devastating. Descriptions such as uncertainty, powerlessness, helplessness, guilt, sadness, disbelief, anger, frustration, blame and disappointment, recur throughout these works (Stack, 1986). In addressing the psychological sequelae of miscarriage, one would hope to gain a better understanding of the contributing factors to a normal, grieving process or a pathological unresolved grief reaction.

Some general characteristics in a normal grieving process include: somatic distress, preoccupation with the image of the lost person, guilt

for things said (or not said) and done (or not done), prior to the loss; a sense of blame for the loss with self recrimination. Anger and hostility towards the self as survivor and the lost person and change in normal conduct. If the loss is acknowledged by self and others, a normal process of mourning can ensue. Friends and caregivers give permission to experience and express a sense of loss by allowing the grieving one to assume a dependent role, cry, be held and be cared for. Thus through a period of relative disorganization, resolution usually occurs (Clayton, et al., 1968; Lindemann, 1944; Parks, 1972).

Relatives and friends often fail to respond to parents who have experienced a seemingly obvious loss of a stillborn or a neonate. In case of miscarriage there is even less of an adequate response. Thus, the unique characteristics of such a loss may contribute to the development of delayed, prolonged or pathological grief reactions. Stack (1984) describes these factors: people frequently don't even know the woman was pregnant and are thus unaware of her loss. A woman who has miscarried is often reticent to mention that she has been, but is no longer pregnant. Often, she has not resolved the typical ambivalence of the narcissistic stage of pregnancy and has not yet identified the fetus as a new person who was part of herself. One should wonder then, what the consequences are to grieve a loss of one's self or part of self rather than of an external love object. If the woman had experienced quickening, the assumption is that she at least was able to acknowledge through fetal movement some "otherness within" (Bibring, et al., 1961). Socially, there is no funeral or religious rituals that attempt to deal

with the psychological components of loss and grief. Since the woman who miscarries rarely sees or knows what she has lost, she can only fantasize as to the sex or personality of the child she will never have. Caregivers, family and friends often encourage denial of the loss through intellectualization or perception of a pregnancy that "didn't take" and wasn't meant to be. They rarely allow or encourage the woman to assume a bereaved role and openly discuss her loss. A miscarriage is usually sudden and doesn't allow any preparation or anticipatory grieving. Explanations regarding cause are often inadequate and non-existent thus leading the woman to feel she may have done something (or not done enough) to cause the miscarriage. Guilt is a nearly universal feeling of the woman who has experienced a miscarriage. As many survivors do, she may feel she did not care enough or even consciously wished not to be pregnant, and thus got her wish (Kaij, et al., 1969; Horowitz, 1979). In addition, a major factor contributing to development of pathological grief is the sense of helplessness and loss of control in the face of the woman's bleeding and cramping. No one can stop the process, and thus helplessness may precipitate despair and depression (Stack, 1984). The threat to the body's intactness further enhances narcissistic vulnerability and the accompanying fears of injury, mutilation, loss of part of the body and death.

The Pregnant Therapist: Patients' Reactions and Transference Themes

When one considers the psychological processes of pregnancy, one can assume that the pregnant therapist experiences many of the intra-

psychic, interpersonal, emotional and developmental changes attributed to the majority of normal pregnant women (Fenster, et al., 1986).

In addition, the pregnant therapist will have to confront and respond to her patients' myriad conscious and unconscious reactions stimulated by the blatant introduction of the pregnancy into the treatment. In this context, the therapist's pregnancy may be considered as "a special event" which alters and intrudes upon the basic analytic situation (Weiss, 1975). Several authors who have addressed special events such as a chance meeting with the therapist, late arrival of the therapist or a therapist's illness, have found that these events strengthen transference responses (Tarnower, 1966; Weiss, 1975; Katz, 1978). Rather than distorting the analytic work these events allow glimpses into intense feelings and fantasies about the therapist, that were previously unconscious. These authors note that especially for patients who keep the transference pale, these events crystalize the intrapsychic clash between the therapist as a real person and as a transference figure.

Since the therapist's pregnancy intrudes on the analytic barrier and becomes an ever-present reality in the therapeutic experience, and since pregnancy in itself is a major event with profound psychological meaning, it follows that patients must respond to this event whether in fantasy, affect, defense or behavior. In order to gain a better understanding of the therapist's internal experience and the unique interchange with her patients during this time (including specific countertransference phenomena), some of the predominant transference themes and

reactions to the pregnancy, and their impact on the therapist and the therapeutic process, will be reviewed.

Several authors have written about patients' intense emotional reactions, of a primitive and infantile nature elicited by the pregnancy (Lax, 1969; Aaron, 1974; Nadelson, 1974; Cole, 1980). Lax (1969) wrote about the "deep-seated childhood conflicts, fantasies and wishes" evoked (p. 362), and noted the "transference storm" evolving particularly with her female patients. In reporting about six adult patients' reactions to her pregnancy, she noted that each patient responded with reactivation of the infantile conflict most significant to their pathology, recreating in the transference the childhood situation where "she was cast in the role in which the patient originally experienced the mother" (p. 364).

Nadelson, et al., (1974) in discussing the implications of a therapist's pregnancy, stated that the pregnancy brings up issues of parenthood and sexual identity for both male and female patients. These authors and many others (Hannet, 1949; Ulanov, 1973; Cole, 1980; Rubin, 1980; Ashway, 1984) pointed to the intensification of the maternal transference as one of the major processes enhanced by the pregnancy. This allows a re-examination of the patient's relationship with his or her mother on both a pre-oedipal and oedipal level. The presence of a "real" expectant mother, can revive a host of early memories about maternal care, longing, deprivation, identification, sibling rivalry and rejection. In reviewing patients' responses, Nadelson, et al. (1974) concluded that this intensified maternal transference facilitated work-

ing through of ambivalent mother-child relationships. Rubin (1980) exemplifies this theme in presenting a case in which her pregnancy provided an opportunity for a graduate student to work through ambivalent feelings towards her mother by enabling her to re-experience and express painful rage at and rejection in the presence of a non-judgmental non-retaliating "mother."

Several authors (Lax, 1969; Paluszny & Poznansky, 1971; Berman, 1974; Clarkson, 1980; Barbanel, 1980; Cole, 1980) attempted evaluation of positive and negative impact of the therapist's pregnancy. They explored on the one hand the opportunity for greater integration and on the other hand, for greater disruption and disorganization, for some patients.

Paluszny and Poznansky (1971) suggested that the reconciliation seen between women and their mothers late in pregnancy (Ballou, 1978) may be provoked indirectly in patients, as the therapist progresses towards delivery. Clarkson (1980) exemplified the process in a case of a young borderline patient who was able during the last months of pregnancy to reconcile her intense maternal transference and powerful yearnings, with the reality and limitation of the actual therapeutic relationship. Ulanov (1973) described the impact of her pregnancy on three female patients who had a particularly intense response. She described how in each case there was an intensification of the mother-daughter complex already present, leading to a "rebirth" of the patient to a new self-image and a capacity to relate to others as separate beings. The confrontation with the therapist's pregnancy (a real biological mother-

child relationship), heightened these women's awareness of their involvement with the fantasy mother they had projected onto the therapist, as well as their identification with the baby. Relinquishing the daughter-baby role and the insistence that the therapist play the mother counterpart moved them towards a more mature and integrated perception of themselves as well as others.

The majority of the above stated authors agree that the degree of pathology and level of ego strength is a major determinant of the patient's reactions. Lax (1969) noted the most striking differences between her neurotic and borderline patients. The latter became aware of the pregnancy much earlier than others, and responded with much greater intensity (including acting out behavior). Lax felt that these patients found it much more difficult to distinguish between the transference and reality aspects of their reactions. Fenster (1983) who interviewed 22 pregnant therapists, also noted the early recognition of the pregnancy by borderline patients (long before obvious physical clues were apparent), as opposed to later recognition of both neurotics and psychotics. Fenster, et al. (1986) speculated on these patients' heightened sensitivity to the therapist's emotional stance, particularly in the first trimester, and these patients' attunement to any situation precipitating abandonment and loss.

It is a fairly consistent observation that patients integrate their responses to the therapist's pregnancy according to their personal histories and conflicts (Lax, 1969; Bender, 1975; Schwartz, 1975; Cole, 1980; Barbanel, 1980). Significant factors contributing to the pa-

tients' reactions relate to whether the patient was an only child or had siblings, the pregnancy history of the patient's mother, and whether or not the patient is a parent or not.

Regarding initial recognition of the pregnancy, Goodwin (1980) reports that women tended to "recognize" the pregnancy sooner than men, a finding corroborated by Bender (1975). Goodwin also found that the more intensely involved patients also "recognize" the pregnancy early. These may also be the ones who will make the most therapeutic gain from the experience within a libidinal vs. a defensive transference relationship (Hannet, 1949). Recognition may be expressed through acting out (missed appointments, rage, outbursts at family members, stealing, pregnancy, abortion), or associative material and dreams of babies and pregnancies. Questions regarding confidentiality, statements about "something queer in the room" (Benedek, 1973) and sexual concerns are viewed as signs of undisclosed recognition of the pregnancy. Different levels of "knowing" are represented in an area where the irrational abounds. Subliminal awareness of the therapist's pregnancy may be regarded as a kind of primitive identification with her and the pregnancy. In addition, Barbanel (1980) discussed the enormous amounts of denial in acknowledging the pregnancy. She found patients felt more comfortable assuming the therapist was fat because she was without a man, or homosexual, rather than contemplating the possibility of her pregnancy. Many patients notice some "change" in physical appearance -- haircuts, style of dress or jewelry, but refuse to attribute it to pregnancy.

Beyond the idiosyncratic determinants of response for each patient, the unconscious meaning of the pregnancy, the therapist's inevitable absence, the intrusion of the growing baby and the element of danger in childbirth, introduce recurrent themes of separation and loss, sibling rivalry and envy, and anxiety that hostile fantasies may actually injure the vulnerable therapist and/or baby.

Separation and Loss. A therapist's pregnancy means there is going to be an unavoidable interruption in or termination of the treatment. Whether this will be a maternity leave or a termination of a job, patients are confronted with their feelings about the impending loss. Many of these reactions will be similar to those expected in any termination or interruption including denial, anger, regression, increased dependence, crisis and acting out. These reactions take on a special meaning when patients fantasize about the therapist enjoying taking care of her baby. Patients are saddened by the inevitable separation and often feel abandoned just in its anticipation. Rubin (1980) noted about one of her male patients: "As he watched my body grow progressively larger, he felt he was losing his space not only in my life but in the very room in which we were sitting" (p. 210).

The pregnancy and the impending separation stir up feelings of loss related to other events and circumstances in the patient's life. Nadelson (1974) commented on some female patients' envy of the therapist for her apparent personal fulfillment, the pregnancy being a constant reminder of what they have lost or will never experience. Patients go through mourning of past losses, such as abortions, children given up or

wished for, but never conceived. At times patients will go through a grief reaction with stages of denial, anger and guilt, and hopefully eventual resolution. Female patients may react to the anticipated loss by acting out and getting pregnant, expressing a hostile replacement of the therapist. Naperstack (1972) who interviewed 32 pregnant therapists reported that the two main themes mentioned in their adult patients' reactions were fear of abandonment and loss, as well as painful recognition of dependency on the therapist. Titus-Maxfield and Maxfield (1979) noted patients wanting to leave treatment upon learning of the therapist's pregnancy. They interpreted this withdrawal as masking powerful unconscious dependency. Underwood and Underwood (1976), pinpointed patient themes at different pregnancy stages. Separation and termination themes predominated in both the first and final trimesters. Often, the anticipated termination precipitated crisis in an attempt to dissuade the therapist from leaving.

Sibling Rivalry. A birth of a sibling may have been experienced in the patient's childhood as the loss of mother's exclusive attention. Many patients relive this abandonment in the transference and are convinced (despite reassurances) that the therapist will no longer be available to care for them, or may not return at all. They feel rejected in favor of the therapist's unborn child who is a deadly competitor threatening to cause the patient's desertion (Clarkson, 1980; Nadelson, et al., 1974).

In comparing transference themes and reactions to pregnancy in an individual and a group setting, Breen (1977) reported that intrusion, envy of the baby and the therapist, exclusion, competition and impingement of the outside world, were predominant in the individual setting (but not in the group). In the individual context, patients had to deal with the reality of the third person (baby, father) intruding into the therapeutic dyad, whereas the group might have represented a later family-child experience, where the pregnancy was only yet another sharing. In addition Breen noted that the group setting allowed for more denial and splitting and the "good" therapist's loss was not as catastrophic. Group themes focused more on sexuality.

Nadelson, et al. (1974) noted that one way of dealing with issues of sibling rivalry is through identification with the baby. This identification may be defended against and appear in a guise of identifying with the therapist: "I want to have a child," but really meaning "I want to be the child" (who had a mother). Paluszny and Poznanski (1971) also described the central themes of sibling rivalry, oedipal strivings and identification with both therapist and baby, observed in their adult and child patients.

Anger, Hostility and Death Wishes. Many authors have referred to patients' hostility towards the therapist's unborn child, and envy of the therapist as a mother and fertile woman (Nadelson, et al., 1974; Aaron, 1974; Naperstack, 1976; Ashway, 1980; Rubin, 1980). These hostile feelings evoke substantial conflict and guilt, expressed in the fantasy that "words can kill" and in fears of retaliation. Psychotic patients may

experience this as a concrete belief that their hostility will damage the fetus or therapist. Neurotics and borderline patients may express their hostile fantasies in a variety of more direct or indirect ways. Several authors (Benedek, 1973; Barbanel, 1980; Clarkson, 1980) have commented on the social factors and taboos discouraging examination of pregnancy and particularly the "pronatalism" of our culture prohibiting expression of negative attitudes. Aaron (1974) commented on the feelings of sibling rivalry and guilt over destructive fantasies when there is a negative transference to the child in utero. Some of the common fantasies and wishes expressed in dreams relate to the baby dying, an accident or a miscarriage.

These feelings take on a special meaning if the therapist actually experiences a spontaneous abortion or complications in the course of the pregnancy. Barbanel (1980) cited an example of a patient who disrupted treatment in response to her late miscarriage because he could not tolerate his feelings of anger and hostility towards the therapist, coupled with the guilt over the fetus's death. Therapist and baby were hated objects whom he wished to kill. There is a multitude of ways in which patients cope with this anger. Some deny it, project it or use reaction formation and become oversolicitous, and overprotective of the therapist. Others threaten and warn of impending crisis, as tactics to keep the therapist "faithful." Still others cannot contain their anger, act it out, or leave treatment. Schwartz (1975) cited an example of an adolescent who approached her with a knitting needle, threatening to kill her "rival." These kinds of reactions have multiple ramifications

for the therapist's experience and response, and will be addressed separately.

Envy and Jealousy. The pregnant therapist projects an image of traditional norms, stability and respectability. Patients who perceive themselves as lacking these attributes will feel envious. Balsam and Balsam (1974) reported of a patient who felt like a "slut" in the presence of her "too virtuous" therapist. Envy is generally expressed in the feeling that the therapist has "everything -- a profession, a man and now a baby," while the patient has nothing. This is accompanied by feelings of resentment, emptiness and despair (Fenster, et al., 1983). Jealousy (viewed as less primitive and malevolent than envy [Segal, 1964]), is often directed at the therapist's relationship with her partner and baby, and patients' feelings of being replaced in importance by the real baby. Envy and jealousy can be aroused in both male and female patients. For men, envy of the female sex and her child-bearing function: "pregnancy envy." van Leeuwen (1966) discussed the analysis of a male patient from the point of view of pregnancy envy and woman envy. A progression from regressive longings to be the analyst's baby to replace her husband and, later, the patient's facing his deeply repressed envy of women was described. The therapist was seen as a complete person "with creative strength derived from her bisexual role as professional woman and mother" (p. 323). Titus-Maxfield and Maxfield (1979) described men's responses that "ran the gamut from wishing to be the baby's father,

to wishing to be the baby and, finally, wishing to be a pregnant woman, capable of becoming a mother" (p. 11).

Nadelson, et al. (1974) noted the threat of anticipating the therapist's commitment to her future family rather than to them, and stimulation of fantasies and dreams of the therapist's domestic life. For some female patients, oedipal rivalry is revived as they watch the therapist become a mother. For others, the therapist becomes the quintessentially productive person: her pregnancy an indication of her apparent success with both private and professional matters. This may contribute to feelings of envy, rage and competition on one hand, or to identification furthering integration on the other hand (Naperstack, 1976). Fenster (1983) also noted envy, competition and identification in female patients' responses. Identification reflects different dynamics: a need to view the therapist as a role-model and idealize her, seeking commonality to enhance intimacy and mother the therapist, avoiding negative feelings or acting out through a pregnancy which may involve a wish to compete, to convey a counterdependent message or to ward off her loss.

Other predominant themes relate to sexuality and sexual identity brought to the fore by the visible proof that the therapist is a sexual person involved in a sexual life. Depending on the patient's age, sex, sexual preference and psychological make-up different concerns will be expressed. Nadelson, et al., (1974) discussed several reactions of male patients including a re-awakening of fears about their sexual competence, increased awareness of sexual feelings towards the therapist, and competition with her husband. Naperstack (1976) observed increased

openness around sexual issues particularly from the men, hypothesizing that the pregnancy "de-virginized" the therapist, allowing discussion of taboo issues. Other therapists noted that for some patients the pregnancy "desexualized" them, making them a safer sounding board. Raphael-Leff (1980) and Breen (1977) suggest that the pregnancy precipitates for males sexual identity conflicts, involving the wish to bear a child. They respond at times, with a flight into "homosexual themes and interests." Blum (1980) speculated that this may also be a response to the "potent, sexual woman," now embodied by the pregnant therapist" (p. 201). Breen also noted that in the group setting she was rejected by the group as representing the sexual woman and bad sexual mother.

Balsam and Balsam (1974) noted that female patients may find it reassuring to discuss sexual concerns with a pregnant therapist and especially adolescents may call upon her as a "teacher" of sexual matters. Breen (1977) also noted the centrality of sexual themes and permission to compete with the therapist, particularly in the group setting.

For some homosexual patients, the therapist's pregnancy may be inhibiting and frustrating. Balsam (1974) described a male homosexual's repelled reaction to the "graphic demonstration of her femininity" (p. 278). Lesbian patients may experience a particular sense of betrayal related to the rejection of their transference wish (that the therapist is also a homosexual). They may interpret the pregnancy as an implicit criticism of their "depreciated" choice, and envy the baby's intimacy with the therapist (Nadelson, et al., 1974).

Male and Female Responses. Almost most authors who have written about a therapist's pregnancy have addressed patients recognition and reactions as a function of their sex. Lax (1969) noted that the pregnancy was much more of an "exciting stimulus for her female patients . . . evoking a profound transference storm . . . ," while her male patients showed a relative "paucity of responses" (p. 370). Several authors (van Leewen, 1966; Lax, 1969; Breen, 1977; Fenster, 1983) have commented that male patients react to the therapist's pregnancy with some degree of denial, isolation of affect and suppression of thoughts and feelings. Male patients were less willing to entertain transference issues related to the pregnancy, insisted it does not affect them and focused on concrete details of scheduling. Many authors have noted female patients' earlier acknowledgment and confronting of the pregnancy. This was so especially for those who were mothers or wanted to have children. Male patients tended to wait longer and rather than inquiring directly, responded in dreams or derivatives of themes aroused by the pregnancy (Fenster, 1983). These authors suggest that while both male and female patients may "notice" changes in the therapist, the female patients might have more of a frame of reference evoking recognition. Some explain the male's relative failure to directly confront the pregnancy as stemming from the different psychosexual development of girls and boys and the conflicting aspects of the wish to identify with the mother. Lax (1969) noted that regardless of conflict, all her female patients employed identification as the main mechanism of defense while the male patients resorted more to isolation and suppression. She related this observation

to the opportunity for narcissistic gratification and compensation this mechanism offered the females but not the males. While for females identification with the mother augments a sense of self as a female, later on, the male has to disidentify from a maternal female identification in order to achieve a sense of himself as a male (Greenson, 1968; Stoller, 1974). Thus the defensive aspects of the male patient's reaction to the therapist's pregnancy is generally seen as related to sexual conflicts regarding the therapist, sexual identity conflicts regarding male identifications and underlying wishes to be female and pregnant. Few authors (Lax, 1969; Philips, 1982) have addressed this recalcitrance as also reflecting the therapist's own discomfort in dealing with her pregnancy with the male patients. Thus it is particularly important to consider the therapist's role in the underlying dynamics of a patient's response. This point will be elaborated in detail from a countertransference perspective.

Acting Out and Risks. Not all patients are able to deal successfully with the impact of the therapist's pregnancy and with the impending separation. Some tend to abruptly terminate the treatment and leave before they are abandoned. Others denigrate the therapy or therapist, find another one or attempt to replace her through a relationship or sudden life changes including becoming pregnant. Berman (1975) who investigated acting out tendencies during a therapist's pregnancy concluded that there is a definite increase in reported frequency of acting out, the most common of which is abrupt, unplanned termination.

Nevertheless, she stated that not the personal history of losses but rather other factors were better predictors. Berman noted borderline patients to be most likely candidates for acting out, but also stressed that the more comfortable and unambivalent the therapist was, the less acting out occurred. Cole (1980) also reported on one of her patients who fled upon notification of her pregnancy and who lacked a sufficiently healthy ego to integrate the unconscious fears and anger provoked by the pregnancy.

Fenster (1983) noted that despite observed terminations, 95% of the therapists interviewed felt that overall the issues that emerged as the result of the pregnancy enhanced the treatment progress. They noted that the intensification of turbulent angry or negative reactions did not seem to preclude treatment gains, especially if the therapist was able to confront, interpret and handle these developments in a therapeutically sound manner. Thus some patients who seemed initially to be the most disturbed by the pregnancy, made the most significant progress as a result of the pregnancy. In line with the above, Paluszny and Posnansky (1971) stated that while they saw temporary regressions in some patients, they did not feel there were any permanent setbacks. Berman (1975) concluded that despite some negative effects, there was not enough justification for the occasional proposal that pregnant therapists cease working while pregnant. These negative effects are counterbalanced by integrative and positive effects, and should be further explored and specified (Berman, 1975; Cole, 1980; Rubin, 1980; Fenster, 1983).

Children. Despite relatively scarce literature on the effect of the therapist's pregnancy on child patients, a few authors (Paluszny & Posnanski, 1971; Browning, 1974; Nadelson, et al., 1974; Ashway, 1984) report of specific patterns of response. These include denial (despite early initial unconscious recognition manifested in play and drawings), displacement onto other parts of the body, reaction-formation, use of magical thinking to "make the pregnancy go away." And lastly, acknowledgment resulting in fear of abandonment, anger and temporary regression. Later on, separation concerns, sibling rivalry and sexual issues surface. Some children may act out their hostile wishes and may need help in limit setting. Nadelson, et al. (1974) pointed out that for the child patient the therapist's pregnancy may seem more like an actual event, a combination of transference issues with the developmental experience of relating to the therapist as a real object (Scharfman, 1978).

Staff and Colleagues -- Professional Relationships. Butts and Cavenar (1979) suggest that the intrapsychic conflicts felt by many pregnant therapists are unwittingly created by supervisors and peers. The pregnant therapist may in turn react differently towards them. She may, by her own feelings of guilt and anxiety, provoke reactions of jealousy, hostility and anxiety in her peers and supervisors (Baum & Herring, 1975). Butts and Cavenar (1979) illustrated how negative reactions from colleagues may mobilize ambivalence, identity conflicts, guilt and self defeating behavior in the therapist. Benedek (1973) has written about reactions of inpatient staff to her pregnancy, paralleling patients

reactions. In discussing her future plans and expectations, she enabled staff to recognize their own feelings about her pregnancy including hostility, anxiety and resentment. She noted that this facilitated helping the child patients deal with the implications of her pregnancy. Thus an open dialogue with supervisors and staff facilitated empathy with patients.

Nadelson, et al. (1974) addressed the issue of professional relationships regarding special arrangements during a therapist's pregnancy and maternity leave. If the staff encourages a "heroic" attitude and does not provide support, they may push the pregnant therapist into counterphobic overwork. Both male and female colleagues may feel envious and resentful at assuming extra work. Some of the resentment stems from reactivation of their own conflicts around parenthood and juggling of a family and a career. Some colleagues (especially men) were noted to focus increasing attention on physical changes, expressing both caring and hostility. The authors cited, above all stressed the importance of supervisors and colleagues confronting their own reactions to the therapist's pregnancy, and coming to grips with her anticipated separation.

Fenster (1983) who interviewed pregnant therapists in supervision, discussed noticeable changes in the supervisory relationship. These included increased dependence on the supervisor, increased vulnerability to criticism, feeling that the supervisor had become closer and more "real," preferring female supervisors or supervisors who are parents, as well as negative changes such as withdrawal from and by supervisors.

Fenster, et al. (1986) discussed these changes in terms of a parallel process between patient-therapist and therapist-supervisor (colleague) and noted the unique relationship between the therapist, supervisor, patient and baby and its possible implications for both the supervisory as well as the therapeutic process.

Miscarriage. A therapist's miscarriage or reports of the impact of a problematic pregnancy, are topics which are even more absent in the literature. Cain, et al. (1974) show the neglect of the topic in standard textbooks of obstetrics and psychiatry despite the high incidence of miscarriage. In the analytic literature there is only one article (Hannet, 1949) referring to an analyst's miscarriage. While there is some attempt to delineate patient's reactions, there is no discussion of the therapist's internal experience during this time. The therapist did not tell her patients the reason for her absence was her miscarriage. She left it for them to surmise or not. Cain, et al. (1974) discussed children's reactions to their mother's miscarriage, which are similar to patients' reactions to a therapist's miscarriage. An initial puzzlement followed by guilt over the hostile thoughts towards the fetus, that magically came true. Guilt over envy of the therapist and blame of the therapist for having actively "killed" her baby. Surely, if the therapist could not carry a fetus to birth, she could not be an adequate mother to the patient. Along with the above were noted fears of child-bearing that tend to be exaggerated by female patients and for males -- all the discomfort, fear, awe and disgust they feel towards woman's insides get stirred up. For some there is little deep meaning, for

others, deep transferential issues leading to chaos and hopefully resolution.

Barbanel (1980) who experienced four pregnancies in five years, two resulting in miscarriage, commented on the importance of addressing this issue. To deny or avoid discussion, where the therapist has clearly experienced a miscarriage, is to deny the patient's experience and prevent opportunity for exploration of rich material evoked by this event.

The therapist herself is subject to a process of grief and loss, presented earlier in detail. Her own feelings of guilt, helplessness, loss of control, injury, anger and vulnerability will affect her functioning. The sudden and unexpected interruption in the treatment as well as the stage in which the miscarriage occurs, will profoundly affect the possibility of interference from countertransference phenomena.

The Pregnant Therapist's Inner World:
Reaction to Patients and Countertransference

When one considers the psychic upheaval evoked in every pregnant woman, and the distinct emotional intrapsychic and physical transformations inherent in this process, one can expect the pregnant therapist to share the majority of these experiences.

Pregnancy immediately confronts the therapist with basic issues involving her changing identity and sense of self (both physical and mental). She is faced with major adjustive tasks regarding role integration, re-examination and consolidation of past and present identifi-

cations and ambivalences in her object relations. In addition, the situation is compounded by a parallel alteration in the therapist's sense of her "professional self." The intrusion of the pregnancy into the therapeutic situation as an undeniable reality, confronts her with violation of her previously maintained relative anonymity and with the disclosure of a significant event in her personal life. The therapist needs to come to grips with her physical and emotional vulnerabilities and their consequent limitations on her capacity for work, as well as with the exposure of her sexuality. Thus she must negotiate a new image which will accommodate a human, changing, less than idealized view of self as a therapist.

Numerous authors have discussed the critical necessity for the pregnant therapist to be aware of her own emotional state during this developmental crisis (Lax, 1969; Paluszny & Poznanski, 1971; Benedek, 1973; Nadelson, et al., 1974; Aaron, 1974; Balsam, 1975; Baum & Herring, 1975; Schwartz, 1975; Barbanel, 1980; Rubin, 1980; Fenster, 1983). In general, these writers confirm the presence of disruptive feeling states in the therapist during her pregnancy, and discuss their ramifications within the therapeutic relationship.

Lax (1969) noted that various transference reactions specifically directed at the therapist's pregnancy must affect her unconscious infantile conflicts, and increase the possibility for countertransference reactions. These will depend on the specific conflicts evoked for each therapist. It follows, that considering the pregnant therapist' counter-

transference is critical if one is to sustain successful work with patients.

The authors addressing countertransference in this context defined it first and foremost as the therapist's reactions (images, impulses, defenses, behavior) to her patients and their transference, stemming specifically from her own unresolved infantile conflicts. Some refer to her reactions to her patients and the analytic situation as such, and examine these reactions in relation to aspects of the "real relationship" (Racker, 1968; Lax, 1969; Greenson, 1972; Aaron, 1974; Fenster, et al., 1986).

Following, I will review some of the major themes and countertransference reactions which emerge as the therapist's pregnancy unfolds.

Acknowledgment and Denial. Many factors support denial of the therapist's pregnancy by both patients and therapists. Several authors have noted some of the social factors involved such as avoidance of pregnancy as a sexual taboo (Benedek, 1973), historical trends to hide or not discuss the pregnancy, related to the feared outcome of miscarriage (Barbanel, 1980), and the pronatalism of our culture prohibiting expression of negative attitudes (Clarkson, 1980).

Several authors have noted the tendency to be "blind and deaf" to veiled allusions to their conditions made by their patients, and the avoiding or delaying of patients' verbalizations regarding the pregnancy. Some therapists explained this as a result of the fact that in their case the "patients didn't really know they were pregnant, because it didn't show" (Lax, 1969, p. 365). Other authors have commented on

the stance of "business as usual" common to therapists during pregnancy (Lax, 1969; Benedek, 1973; Baum & Herring, 1975; Schwarz, 1975; Titus-Maxfield & Maxfield, 1979; Phillips, 1982). By adopting this attitude, therapists are often seen as colluding with the patients in denying the impact of the pregnancy on their work. Titus-Maxfield and Maxfield explained this "denial" as the therapist's effort to minimize the anxiety by treating the baby's birth as calmly and routinely as if it had been a trip to a professional meeting or a summer vacation" (p. 5).

The First Trimester (from first awareness of pregnancy to approximately the fourth month). Conception introduces major upheaval in the woman's body affecting her emotional experience. An object relation has led to impregnation by which a significant representation of the love object becomes part of the self (Bibring, et al., 1961). To accept the reality of this intrusion and to incorporate it successfully is the first ajustive task facing the pregnant therapist. This stage of pregnancy is characterized by strong mixed emotions: excitement coupled with anxiety and fear. Lack of overt manifestation of the baby and unconscious conflicts regarding destruction vs. preservation of the embryo contribute to intensification of concern for the baby's well being and, at times perceiving it as an enemy exploiting the pregnant woman's body, an obstacle to her personal growth (Deutsch, 1944). These reactions are often exacerbated by physical discomfort and lack of validation of the pregnancy by others. Enhanced narcissism enables merger with the fetus which becomes an integral part of the self. The counterpart to the physical

symbiosis is often subjectively experienced as loneliness, self absorption, and distraction accompanied by a strong wish to be protected. Adding to the therapist's feelings of distance is her experience of carrying a "secret" weighing as a hidden agenda (Fenster, et al., 1986). Many women are struck as early as this stage by the idea of being a link between generations, and by wishes to prove their womanhood. This is where many of the early identifications previously mentioned branch off.

The countertransference anxieties that emerge involve fears that the pregnancy will disrupt treatment as well as fears that patients angry reactions will negatively affect both therapist and baby.

Lax (1969) reported that many therapists anticipated with discomfort patients' discovering of the pregnancy, fearing their hostility. Upon self-exploration, these therapists discovered that their discomfort regarding the patients' expected attack, was related to their childhood rage and disappointment when a younger sibling was born. Other "blind spots" in observing male patients' allusions to the pregnancy revealed re-arousal of conflicts regarding self-image and femininity in the therapist.

Reference to recognition of the pregnancy in its early phases when there is no external visibility, has been made by many authors. They have noted particularly the borderline patient's sensitivity and early perception of the pregnancy through primitive identifications (Barbanel, 1980). If the therapist feels well concealed, the patient's direct allusion to the pregnancy may shock her. If she is feeling exposed, she may prematurely force the patient to talk about the pregnancy. If she

is flooded with one particular emotion as elation or excitement, she may read similar feelings in her patients and avoid hostile reactions (Balsam & Balsam, 1974).

Lax (1969), Benedek (1973) and Barbanel (1980), among others, stressed the avoidance of discussion of the pregnancy as denial of the patient's perceptions. If the therapist's pregnancy is not openly dealt with, a parent-child situation in which the bedroom secrets are not discussed is recreated. But the children always "know" on some level. To respond with silence to a patient's correct observation about the therapist's life situation, and to collude in denial because of some notion of anonymity, would be carrying that notion to an extreme. Patients may perceive this as a parental prohibition, which would intensify the transference, rather than lead to its resolution.

Benedek (1973) noted that ignoring one's own reactions towards the pregnancy, as well as those of patients and staff, is in itself a manifestation of countertransference problems.

If patients continue to deny the therapist's pregnancy into the second trimester, it is absolutely necessary to explore the therapist's countertransference contribution. This is often salient with male patients. Lax (1969), van Leeuwen (1974), Fenster (1983), all noted "blind spots" regarding their male patients' recognition of the pregnancy and expression of full gamut of feelings. The countertransference issues related to ambivalence about femininity and the therapist's need to maintain a "narcissistically masculine identification" expressed in the wish to be "flat like a man." The pregnancy's physical changes shatter

this unconscious self-image. Fenster, et al. (1986) noted the therapist's need to deny her sexuality and involvement with (a man, resulting from apprehension of male disapproval and rejection, symbolizing loss of paternal approval. These countertransference positions interfere with exploring the full range of male patients reactions to the pregnancy. Thus, therapists focusing on their female patients reactions as more exciting and enhancing treatment-gains, might relate to the therapist's being more attuned to female patients (who may in fact be more disturbed by the pregnancy) and less sensitive to her male patients' cues.

Baum and Herring (1975) pointed out several feelings encountered in pregnant therapists and possibly relating to countertransference. These include anxiety, helplessness, fear and fantasies of harm to baby or self, withdrawal of libido from work and guilt for leaving patients. They cautioned against turning to patients for emotional support and suggested alternative routes via therapy, spouse, supervision, or colleagues.

Van Leeuwen (1966) noted the difficulties in exposing her countertransference reactions during her pregnancy. She stated that alongside objectivity, neutrality, warmth and confidence of being helpful, there is irritation when patients cancel, don't pay or act out. Suicidal impulses and violence scare the therapist, while sexual seductiveness can cause discomfort. Boredom, flattery, gratification and frustration, all enter into the gamut of the therapist's emotions. Denying their existence is not without cost!

The Pregnant Therapist: Alterations in Self. A process of introversion, self absorption and withdrawal from patients has been noted during the therapist's pregnancy (Paluszny & Poznanski, 1971; Balsam, 1975; Baum & Herring, 1975; Schwartz, 1975; Barbanel, 1980; Rubin, 1980). A hyperawareness of physical changes, the presence of daydreams and thoughts about the baby and a decrease in intellectual curiosity, are facts that seem to make this a more difficult time for therapists to fully attend to their patients. The heightened awareness of the maternal state seems to serve as an unconscious stimulus for further patient discussion of children. Balsam (1975) noted the emergence of fantasies of the fetus as a draining parasite in the early stages, combined with narcissistic absorption as influencing the therapist's attunement to symbiotic desires.

Paluszny and Poznanski (1971) described feelings of existing in two worlds simultaneously as a therapist with her patients and a mother with her child. While most authors viewed this self-absorption as generally distracting from the treatment process, Nadelson, et al. (1974) asserted that therapists often experience a simultaneous and paradoxical increase in acuity and sensitivity towards patients at this time. Barbanel (1980) noted the lack of attention to positive countertransference manifestations evoked by the pregnancy: while the therapist withdraws and focuses on her body, she may also find that her emphatic and intuitive resonance with her patients is heightened as she becomes more sensitized to her body. The emotional primitive aspect of this process

may make her more available to the irrational and primitive in her patient's material.

Several authors point to the therapist's heightened vulnerability, mood swings, fatigue and emotional ability at this time (Lax, 1969; Baum & Herring, 1975; Nadelson, et al., 1974; Titus-Maxfield & Maxfield, 1979). A common arena of conflict was seen in the therapist's feeling of inadequacy about her abilities to be a helping person, resulting from fears concerning physical limitations. Nadelson, et al. (1974), explained this in terms of the threat to the therapist's fantasies of omnipotence and cautioned against the use of counterdependent mechanisms. Other authors related this to difficulties in integrating the dual roles of a career and motherhood (Schwartz, 1975; Butts & Cavenar, 1979). Schwartz noted therapists' concentrating on their professional role competence, partially as a distraction from the physical discomfort and uncertainty of their maternal competence. Fenster, et al. (1986), also noted the anxiety evoked by integration of a new self-image in conjunction with anticipating patients negative reactions. Lack of sufficient role modeling for a dual role of mother and therapist enhances anxiety and the therapist's need to be the all available idealized mother (to patients and her future child). If the pregnant therapist is unaware of these needs and anxieties, she may unwittingly slip into what Racker (1968) described as "complementary countertransference," identifying with patients idealized introject and experiencing anger and guilt for being unable to be the idealized parent.

Second Trimester (usually ushered in by quickening and lasts 3-4 months). The second trimester accents the beginning of the life long task of accepting the separateness of the baby. A sudden shift with quickening disrupts the narcissistic process by introducing otherness within, thus introducing the child as an undeniable and tangible reality and relieving some of the fears of losing it. The developing boundaries of the child within her facilitate further self differentiation of the pregnant woman from her own mother, and allow the emergence of motherliness -- the wish and pleasure in caring for the infant. Thus alongside the wish to be taken care of emerge feelings of maturity and responsibility for the baby. The visibility of the pregnancy is powerful and allows for validation and support from the outside world (Deutsch, 1945; Bibring et al., 1961; Lester and Notman, 1980). An additional task at this stage is the beginning of attachment to the unborn child through a process of imaging (Liefer, 1979). The fantasies regarding content of the womb shift in focus from self to sexual partner, to child. They include idealized fantasies of birth of the future hero alongside painful fears of having a deformed child.

For most women, this is a time of fulfillment and delight in experiencing "the productive interior" (Erikson, 1968) despite the significant alterations in body image.

Balsam (1975), Fenster et al. (1986) and others noted there is a time in middle pregnancy that is internally serene. Despite the fact that the pregnant woman may wonder at times whether she is mother or baby, this stage is characterized by a decrease in anxiety and increase

in empathy and interest in understanding patients reactions. This parallels the shift from introversion to reality.

Many authors address therapists difficulties in dealing with patients' hostile and aggressive reactions. Naperstack (1976) stressed the importance of the therapist's ability to hear her patients' feelings, especially anger. The fear of attack and injury, feelings of entitlement and specialness less deserving of aggression, resentment of lack of control and personal exposure, all contribute to countertransference difficulties. These may be affected by the general fluctuations at this stage between being at the mercy of the unborn or feeling overpowerful in affecting the fetus. Folklore's influence regarding possible harmful effects of anxiety and sorrow may make it more difficult for the pregnant therapist to be attuned to her patients hostile reactions.

Third Trimester (last period of pregnancy 2-3 months leading to delivery). The major adjustive task in the third trimester is preparing for birth and separation, physically as well as mentally. The reactivation of old anxieties in conjunction with new fears and the physical discomfort, make this phase one of relative stress. The fetus is no longer tender in its movement and sensations of bursting prevail (Jessner, et al., 1970). These final weeks often contain feelings of nostalgia about the pregnancy and impatience. The extreme disfigurement of the body becomes a source of concern related to primitive fears of threat to bodily intactness. Related to these are fears of delivery alongside reactivation of infantile fantasies of childbirth (Lester &

Notman, 1986; Murray & Blitzler, 1964). There is an apparent conflict between real acceptance of the child as a future love object and an inner unwillingness to give up the gratifying union. The fear of death connected with childbirth is expressed in the fear of losing both the object and the self, thus the giving of life turns in fantasy to the losing of life. Fears for the integrity of the child and concerns about deformity and stillbirth are very common at this stage. This may be accompanied or replaced by the dread of being left and feeling empty after delivery (Deutsch, 1945).

Balsam and Balsam (1974) noted that particularly in the Third Trimester the pregnant therapist may fail to hear her patients anxious concerns about her well-being, since she herself is preoccupied with issues of life, death and danger. She may also over-react by quick reassurance thus preventing full expression of patients concerns. Dewald (1980) also noted countertransference difficulties in tolerating patients' aggression when therapists are vulnerable and uncertain of their own strength and capacities. He suggested that the therapists may unconsciously invite caring and sympathetic reactions from their patients.

Rafael-Leff (1980) noted the common fear of death during or following delivery while Zuckerberg (1980) described a concern for "self survival" related to the pregnant therapist's concern about her inner resources and ability to survive the demands of both motherhood and her patients.

During this final stage the pregnant woman's fantasies about the child become more complete and concrete and include visualizing external wished for presentation and the preparation of names. Many women feel the inevitability of what is about to occur: conception cannot be undone and they will forever be the parents of this future child (Lester & Notman, 1980).

In the treatment there is also a process of preparation. Fenster et al. (1986) noted a parallel in "nesting behavior" towards the baby as well as patients and therapists' attempts to achieve closure with their patients prior to delivery.

During this stage, there is resurgence of patients' attunement to the reality of the baby in the room, and some express genuine concern and caring. Barbanel (1980) noted that while some therapists found it difficult to tolerate patients stormy and hostile feelings, others had more difficulty with the expression of tender, protective feelings. Some of these difficulties stemmed from conflicts around gratifying intense longing for kindness and support at the expense of professional integrity.

A related issue addressed by several authors (Schwartz, 1975; Dewald, 1980) relates to "role reversal" and the therapist as "patient." The visibility of the pregnancy may subtly produce a partial role reversal where therapist (and baby) are major topics of interest. This may increase personal inquiry and stimulate advice giving, especially by patients who are parents. For some of these patients, this sharing provides an experience of competence, for others it may mask hostile and

competitive feelings. During this last and final stage of pregnancy, the therapist is ultimately faced with issues of separation and loss in both her personal as well as her professional life.

Regarding termination, a few authors noted the reality aspect to some of patients ubiquitous concerns of abandonment, rejection in favor of the baby or loss (Balsam, 1975; Schwartz, 1975; Barbanel, 1980; Rubin, 1980; Fenster, et al., 1986). Rubin (1980) noted her guilt for being responsible for interruption of productive treatment and thus put off termination. At a time when she was obviously withdrawing from her patients, she tried to stay as involved as possible.

Several authors have commented on the relative neglect of issues of termination in the literature, despite its centrality in the treatment process (Schwartz, 1975; Weddington, et al., 1979). They related this to therapists' avoidance of and denial of their own issues of rejection, loss and abandonment. Weddington, et al. (1979) discussed the "countertransference storm" in cases where the therapist initiates termination because of his own reasons rather than patients' concerns. They noted that therapists were often threatened by discovering how vulnerable and similar they were to their patients. Consequently, they responded to symptom recurrence prior to termination, with countertransference guilt, therapeutic undoing, overresponsibility and despair.

Fenster, et al. (1986) noted that the countertransference anxiety regarding separation from patients relates to both the actual loss of patients but also to the fear of emotional loss of definition of self, of a crucial part of their identity, that of a therapist. Commenting on therapists' narcissism and termination, Goldberg (1975) noted that as the therapist ceases to function as a needed object for the patient, the therapist experiences mourning. Many authors have commented on the advantage of setting a final date in advance which will provide a frame for exploration of both transference and countertransference (Balsam, 1975; Barbanel, 1980; Fenster, 1983).

It is crucial for the pregnant therapist to understand her feelings about leaving. Patients who sense her ambivalence may manipulate her guilt as she becomes the abandoning figure. The manner in which the separation will be dealt with, will greatly influence the maintenance and continuation of therapeutic gains (Hiatt, 1965). While this period has potential for countertransference acting out, it also promises an opportunity for mastery and growth for patient as well as therapist (Weddington, et al., 1979).

Post Partum: Separation and Attachment. Hearing the baby's cry and seeing him/her for the first time introduces the parents to the new task of forming an attachment with the child and reconciling its image with reality. This process of reconciliation and the discrepancy between fantasy and reality will determine the patients' emotional

reaction. For some mothers, the love of the newborn may well up immediately, for others, there is an emotional lag, creating surprise, disappointment and guilt for their estrangement or resentment (Benedek, 1970). The "depression" often noted in post-partum women is influenced by hormonal changes (Benedek, 1970), type of delivery, immediacy of reunion with the child, each woman's regressive tendencies and own need for mothering, as well as the cultural and familial environment. The emotional lag is usually overcome within a couple of days by the emotional symbiosis brought about by caring for the infant. In this context it is relevant to describe the phenomenon of "primary maternal pre-occupation." Winnicott (1958, 1960, 1970) described this as a unique process of the pregnant woman initiated during pregnancy continuing several weeks after delivery. He referred to a sophisticated capacity of projective identification with the growing baby, through which the mother achieves a powerful sense of its needs. Stemming from this capacity to respond, mutuality later develops. The mother's capacity to let go of this identification through "individuation" and a regaining sense of herself, free from the reproductive cycle (but secure in her ability to care for her child), will determine the course of events as healthy or pathological. If the mother tends to remain merged with the infant beyond the symbiotic stage of her motherliness, normal functioning of mothering will be disturbed (Winnicott, 1960; Benedek, 1970). During this post-partum period, despite the mother's joy over the child, her orientation is still

extremely narcissistic. For some time the world is still identical with her own ego, she is at the center of loving attention, and the child is her achievement. She will need to reconstruct her relationship with the environment and once again emotionally occupy a place in the outside world (Deutsch, 1945).

The Therapist as New Mother (some major themes in returning to work). The therapist as every woman, changes dramatically after giving birth. It is worth noting that the crisis inaugurated by pregnancy does not come to completion with the arrival of the baby, and maturational integration of "parenthood" into her self image, occurs gradually.

Returning to work evokes mixed feelings of excitement and dread. This is a time of peak emotional openness in which the therapist may find herself more sensitive but also more vulnerable to her patients' reactions. Some of the stresses inherent in the initial stages of returning to work relate to the struggle of integrating her mothering with her professional role. The therapist may fear she has traded her ability to be a therapist as a result of her choice to become a mother or fear her choice to recommit to her patients may damage her child's emotional development.

Some countertransference themes have been noted by several authors. Taking into consideration the symbiotic tie with the infant, the therapist might feel a need to protect this exclusive bond from all impingements and resent her having to move beyond the symbiotic orbit

in order to reconnect with her patients. She might feel the patient's presence as an intrusion, while other therapists may "fill the gap" of loss of the baby from their body, with the patient as a symbolic substitute. This may lead to aggressively pushing patients away prematurely, or holding on to them and opposing appropriate independence. Difficulties with divided loyalties between patient and baby may result in treating the patient almost as an extension of the baby (Balsam, 1975). Other countertransference difficulties emerge through annoyance with patients for being involved with old issues, or resurgence of conflicts with the therapist's mother which are expressed in inappropriate negative and triumphant feelings, especially with older female patients.

Despite the above, it is only the actual return to work and contact with patients that provides the therapist with a sense of relief and validation of her continuing professional capacities, and enables her to actively begin negotiating the integration of her dual roles (Fenster et al., 1986).

Practical and Logistical Considerations. The majority of authors who have addressed the therapist's pregnancy have commented on logistical and practical implications of the pregnancy and the countertransference issues involved in making reality-based decisions (Nadelson, et al., 1974; Balsam & Balsam, 1974; Naperstack, 1976; Barbanel, 1980; Fenster, et al., 1986).

The first of these has to do with introducing, or not introducing the pregnancy. This may be complicated particularly if the therapist is still uncomfortable about her pregnancy, and gains salience during middle pregnancy when the reality of the pregnancy becomes visible. Timing and interpretation depends on patients' history as well as on resistance through the therapist's avoidance. In any event, all the authors note the absolute necessity of acknowledgment and discussion. Where the patient persists in denying, the therapist should introduce the pregnancy to allow enough time for working through its implications. Where this is not done, it is a manifestation of countertransference difficulties that will be to the detriment of all involved in the therapeutic process.

Other practical issues relate to setting a leave date and a realistic return date. Naperstack (1976) reported that therapists who did not set a leave date, felt in retrospect it put a huge burden of anxiety on their patients. Others noted therapists not considering possibilities of early delivery or lack of energy in the last weeks of pregnancy. Some therapists were unrealistic in over-estimating their willingness to return to work while others found ways of graduating their return. Some authors (Balsam, 1975) raised the issue of appropriateness of treating suicidal and impulsive patients at a time when therapists' resources are limited.

An additional area of concern reviewed in the literature, relates to self disclosure and exposure within the therapeutic setting. Considerations of how much, when and what to share with the patient have

been raised. Barbanel (1980) feels the decision depends on patients' developmental level and whether they have siblings or children. Browning (1974) acknowledges the difficulties in knowing how much to reveal to child patients. Titus-Maxfield and Maxfield (1979) suggest that the focus on genetic determinants of the patient's reaction masks the therapist's resistance to dealing with these difficult interpersonal issues. The therapist's heightened relatedness to some patients (mothers) and increased difficulty with others (abortion and infertility consultations), have also been considered as determining level of self disclosure. Fenster, et al. (1986) stated that the therapist's sharing of information about the child's birth is a very subjective decision depending on who she is as a therapist and person, and how she feels. Naperstack (1976) reported that patients who received birth announcements containing information on baby and next appointment, experienced this as an act of courtesy, including them in the end result of a process which they shared and impacted them heavily. In addition, they were reassured that both therapist and baby survived and treatment will continue. These therapists were better able to take longer, less disruptive leaves. A relevant question for exploration is raised: does sharing of information impede the transference development and prevent patients from producing meaningful fantasy material?

Gifts are another issue for consideration. Is their acceptance a transference gratification or sensitivity to social mores while still acting ethically? Clarkson (1980) noted that given our pronatalist society, gifts are not as inappropriate in this context. Benedek

(1973) suggests that gifts may be examined for underlying ambivalence. The pregnant therapist will have to resolve the above dilemmas while negotiating her patients' interest in her as a "real person" as well as a transference figure. She will have to take into consideration each patient's history and needs as well as her own conflicts contributing to countertransference phenomena.

CHAPTER II

METHODOLOGY

The general methodological approach is exploratory, descriptive and hypothesis-generating rather than hypothesis-testing. This strategy is particularly useful in studying the topic of the pregnant therapist, since a large body of data, upon which to test specific hypotheses does not as yet exist. Premature hypothesis-testing without a sufficient clinical and theoretical frame of reference may limit inquiry to a few variables, and lead to distorted results or neglect of meaningful information. Thus, in order to define and describe clinical phenomena related to the therapist's pregnancy and its impact on herself and on her work, a phenomenological approach is used. It is hoped that this kind of descriptive research will provide important information which will help produce a richer base of data, out of which meaningful hypotheses will develop and be tested in the future.

The current study evolved out of this author's clinical experience as a pregnant therapist, and through a unique meeting with nine other therapists in the context of a clinical and theoretical seminar on "The Pregnant Therapist -- Transference and Countertransference Implications." This seminar was conducted by Dr. Roni Cohen and given through New York University Postdoctoral Training Program in Psychoanalysis and Psychotherapy, during May and June of 1984. A follow-up meeting in the

same group forum took place in January of 1985. Additional follow-up interviews were conducted within a year-and-a-half to two years post-partum. These interviews were conducted on an individual basis. Thus, the clinical data was provided from both a current-ongoing as well as a retrospective point of view. This study is unique and unconventional, as it was not planned as a research project per-se. Thus, the group of therapists was not pre-selected according to strict research criteria. Nevertheless, the therapists' motivation to join the workshop while pregnant provided a self selection of sorts.

Subjects

This particular group of women consisted of ten therapists. They ranged in age from 30 to 41, and were all Caucasian and married. All were in good health and were practicing in or around the New York metropolitan area. With the exception of the author (who had delivered her second child two weeks prior to the workshop), and the consultant, who was a mother of one child, all other therapists were first-time mothers-to-be. One woman was not as yet pregnant but was attempting to conceive. The rest of the women were more or less evenly distributed between the various stages of pregnancy. This provided a variability of experience and a unique interchange between fantasy and reality, which was enriching. Thus, the women in the group represented the full continuum from pre-conception (but after a decision to become pregnant had been made), through various stages of pregnancy, delivery and post-partum.

All women in the group had completed their basic training in the respective professions (clinical psychology, clinical counseling, social work) and some were in the midst or had completed advanced training. Six of the women were clinical psychologists, three were social workers, and one had an undergraduate degree in nursing and a graduate degree in clinical counseling. All women were working for a minimum of five years, mostly in outpatient facilities (one also worked on an inpatient unit), and six of the women had a private practice. A third of the group were seeing children, adolescents and families, in addition to adults, and there was a wide variety of patient populations (mostly non-psychotic but exhibiting a wide range of pathology). Several therapists were also in supervisory positions. Thus, these women had established some stable sense of a professional identity prior to their becoming pregnant. Most of them had delayed motherhood in order to complete professional training. Overall, the therapists acknowledged utilizing dynamic, insight-oriented psychotherapy with some also utilizing family therapy, theory and technique. All were seeing patients in varying degrees of intensity from once-a-week to five times a week and were planning to resume work after their respective maternity leaves, while taking into consideration possible modifications. This was important in order to distinguish between transference and countertransference reactions that were compounded by termination issues (and actual loss) from those that were directly related to the pregnancy and its implications for the ongoing therapeutic relationship.

All women had previously been or were still involved in their own psychotherapy or analysis. This was an important factor which had bearing on their ability to be more attuned to their own issues and conflicts, and express their ambivalence and concerns more freely.

Another noteworthy observation about this group was their high degree of participation, curiosity and enthusiasm in sharing their experiences on both the personal and the professional levels. They were responsive and eager both during the initial sessions as well as in the later individual follow-up, despite the time and investment it required.

One can understand the high level of participation and enthusiasm as related to the unique opportunity this forum provided the therapists for in-depth exploration of their own and others' experiences as pregnant therapists. It enabled them to overcome isolation, air concerns and share conflicts in an atmosphere that was accepting as well as clinically and theoretically thought-provoking. Thus, the study afforded a unique opportunity to focus on professional issues that interfaced sharply with personal ones.

Of the nine therapists who came to the workshop, two were unavailable for the retrospective follow-up (one relocated and one left the workshop following a miscarriage). Another therapist had a miscarriage and one therapist had an additional complicated pregnancy within the first year post partum.

An additional subject, who was not part of the original group, was interviewed regarding her experience of a miscarriage at an advanced stage of her second pregnancy. She was also Caucasian, married, and in

the midst of her training as a psychiatric resident. She was somewhat less experienced as a therapist but was under close supervision.

A Few Remarks on the Sample

Eleven therapists. Undoubtedly a small number. What kind of universe does this small group of women represent? Can one generalize from the experiences of such a small and specific sample?

The rationale of use of such a sample parallels that used in case studies in which a particular example is not necessarily a random one but an example with explanatory power (Ballou, 1978). In a hypothesis generating study such as this, the aim was not to select a sample that was necessarily representative of the population at large, but to utilize a sample that would provide an opportunity to learn something significant about a therapist's pregnancy and her internal experience. In dealing with this unique sample, consideration was given to the pregnant therapists' ability to introspect and articulate their experiences on both a personal and a professional level. Taking into account their motivation to confront the issues and their integrity and experience, it was assumed the therapists' reports would be relatively valid and reliable.

Procedure and Measures

This study consisted of two stages. 1) In the first stage (the seminar), the women took part in six consecutive group sessions, each

lasting between an hour-and-a-half to two hours. The sessions were semistructured and focused around central themes, yet at the same time were somewhat free-associative, in order to encourage spontaneity as well as complexity of response. The sessions tapped information in the following areas: the pregnant therapist's internal experience and changing sense of self and significant others, her relationship to her future child, patients, supervisors and colleagues. Special attention was also given to transference and countertransference themes emerging in relation to the pregnancy and to the conflicts and technical handling related to practical issues. The sessions were tape recorded and transcribed. 2) In the second stage the women participated in an individual interview that was conducted within a year to two years after childbirth or miscarriage. In line with the pattern followed in the original sessions, the individual interviews were conducted in a manner that attempted to achieve a balance between structure and range of spontaneous response. Central themes addressed in the original sessions were repeated in order to provide continuity between the first set of data and the retrospective information. In addition, an attempt was made to update the women's experiences regarding delivery, maternity leave, return to work and the consequent transference and countertransference difficulties. These interviews were also tape recorded and transcribed. All the participants gave their written consent to make use of the data, with the understanding of preserving confidentiality regarding identifying data of both patients and therapists.

The structure of this group and the nature of the sessions as well as the follow-up interviews, allowed focus on development of individual themes over time, as well as exploring these themes at similar stages of pregnancy and comparing among the women. Thus this dual approach took into consideration individual idiosyncracies related to each therapist's history and psychic constellation, as well as shared themes, stimulated by the pregnancy and the analytic situation as such. Contribution from both these sources to the development of conflicts and countertransference difficulties was evaluated, within a psychoanalytic theoretical framework.

Some difficulties with these types of measures are well recognized. Respondents may wish to present themselves in a positive and competent light, and may unwittingly or wittingly edit events and reactions in present or past. One may wonder whether in a group forum such as the one described, the women were not affected by some unspoken expectations regarding appropriateness of reactions, and whether latent competition affected the therapist's self presentation.

It was my impression that although one cannot eliminate the above tendencies completely, the therapists in this group responded with unusual candor regarding their experiences, and in particular their concerns and insecurities. When one takes into consideration these therapists' level of training, security in their professional identity and their viewing the group as providing an opportunity for sharing and support, in addition to enhancing knowledge and understanding, it is

unlikely the above factors played a major role in distorting self presentation.

Another consideration often raised with this type of study relates to the question of how much the procedure itself (the initial six sessions in particular) influences the response and the phenomena observed (for example, altering the therapist's handling of technical issues). While I am aware that the mere participation in the study may influence the phenomena observed, these effects are inevitable if one is to gain access to the kind of content and subjective experiences explored.

Treatment of the Data

All data obtained from the original sessions and subsequent interviews was recorded and transcribed. In order to define and describe phenomenological accounts of the therapists' experiences as pregnant women involved in a psychotherapeutic process, a qualitative analysis of the content was conducted. The results will be presented along thematic lines focusing on two parallel processes and their mutual impact on each other: 1) the therapist's inner experience, emotional transformations and changing sense of self and others during pregnancy, delivery and early motherhood; 2) the therapist's consequent changing sense of her professional identity and relationships with patients, supervisors and colleagues. Special focus will be given to countertransference manifestations in reacting to patients intensified transference and "real" reactions to the pregnancy, and to the alterations in the therapeutic process.

Other focuses of interest: contribution of countertransference and conflict to technical handling of practical considerations; similarities and differences in therapists responses to particular themes and issues; the unique implications and handling of a therapist's miscarriage or unexpected complications of the pregnancy.

CHAPTER III

RESULTS

In the following sections I will present data from clinical interviews conducted with pregnant therapists both during and following their pregnancies. I will describe the internal experiences of these women in the different stages of pregnancy, delivery and the early post partum period, as they relate to their work as therapists. Central themes, conflicts, countertransferential difficulties and practical considerations will be highlighted, as these therapists evaluate the impact of this personal event in their life on themselves and on their patients.

The first section will focus on the therapist's emotional experience during pregnancy. The second section will describe the early post partum period, maternity leave and return to work: The therapist's experiences while attempting to integrate her dual role and new sense of self. The third section will describe the therapists experience of distress, loss and grief in the event of a problematic pregnancy or miscarriage, and the implications of such circumstances on the therapeutic process.

Section I:

On Being A Pregnant Therapist

In reviewing the pregnant therapist's internal experience, one observes that alongside common themes and difficulties inherent in the process, therapists vary in their feelings about themselves, the pregnancy and its impact on their work. These variations are colored by the therapist's physical well being as well as by her personal history and the degree of ambivalence, discomfort and conflict aroused by the pregnancy.

Several reactions were described by the various therapists regarding the initial stages of pregnancy (prior to patients' acknowledgment): At one end of the continuum were the therapists who experienced the initial stages of pregnancy as particularly energizing and exciting. They reported feeling "healthy," "content," "in tune with myself and my body." Lack of physical symptoms enhanced their glowing omnipotence: "I can do it all, this is a breeze;" "I felt like I could conquer the world;" "I'm going to go through this like superwoman!" While these therapists described an increased awareness of their changing self, they felt it did not interfere with their attending to their patients' needs. One of them reflected: "If anything, I think it sharpened my ability to be more in tune with my patients." It was only during later stages in the pregnancy that they noted the impact of the internal emotional turmoil on their interactions with their patients.

Other therapists reported a more mixed experience: alongside excitement and joy at anticipating parenthood and feeling creative and

productive, were anxiety and fear in apprehending complications or even a miscarriage. Several therapists noted their self-consciousness and discomfort with their changing bodies. One therapist noted the total loss of control over her body and her feeling sexually unattractive. This reactivated for her the upheaval of adolescence, when "nothing about my body was right." Another therapist noted that despite her wish to have a child, she wished she could, "in some magical way stay the same." She was distressed by her enlarged breasts and noted "spending hours discussing my body in therapy." Other therapists, were struggling with maintaining a "professional presentation" in the face of their bodily changes complicated by the lack of external validation of the pregnancy. They felt awkward in their regular clothes and not yet ready for maternity clothes, and were relieved as soon as they were perceived as "pregnant" vs. "just fat."

The therapists who experienced extreme fatigue and nausea in the early stages of pregnancy, were faced immediately with the limitations on their "less than omnipotent" capacity for work. One therapist noted her preoccupation with the embarrassing fantasy that she would have to leave the session precipitously to run to the bathroom. Others felt they could not stay awake and were relieved when the last patient had left. In some cases the physical difficulties necessitated adjustments such as changes in schedule or bringing in a drink. Yet, for the most part, all therapists struggled at this early phase to maintain the status quo, of "business as usual." Other therapists noted their discomfort and anxiety in realizing the future inevitable exposure of their

sexual activity in a professional setting: "I felt unprepared to reveal so much of myself. I felt I had no control. They were going to find out anyway and I couldn't be as anonymous as I would like to." Thus, the pregnancy had a life of its own, and some therapists felt unprepared to deal with its exposure. They therefore attempted to hide it as long as possible. "I didn't get up as much as I might have . . . ;" "I held my stomach in and tried not to stand or dress in a way that was too obvious, until I was ready." Other therapists noted being self-conscious and anxious in anticipating their patients' rageful and disappointed reactions upon noting their pregnancy. One therapist stated: "I'm aware of wanting to put it off, because I don't want to deal with my patients' aggression towards the baby and me." While for many therapists this was a concern in the early stages, there were variations in the degree to which this interfered with their attention and their empathic ability. In one extreme case, the therapist described herself as "petrified" and unprepared emotionally, and technically to deal with her patients' anticipated attacks. In retrospect, she noted that her extreme preoccupation with her anxiety and guilt interfered with her ability to attend to her patients' subtle cues as they were manifested in the clinical material. Overwhelmed by her then unconscious counter-transference feelings she colluded with her patients in denial of the pregnancy even beyond the initial stages, and avoided any topic that could stimulate negative reactions. While this is an extreme example, other therapists recalled that in the very initial stages of pregnancy they found themselves steering away from exploring painful topics such

as miscarriages, abortions, infertility and children given up for adoption because of the conflict and guilt it aroused for them. All therapists were concerned to some degree that their pregnancy would negatively affect their patients by disrupting their treatment. They felt guilty that their good fortune would be a stimulus for their patients' pain and rage. Nevertheless, to the extent that the therapist was aware of her feelings and was able to distinguish between the reality based vs. the countertransferentially determined aspects of her concerns, she was able to guard against acting out her own reactivated conflicts of the past and be attuned to her patients' needs and feelings. At a time of uncertainty and vulnerability, this was not an easy task!

Almost all the therapists interviewed commented on the very poignant experience of existing in "two worlds simultaneously" in the initial stages of pregnancy. Despite their acute awareness of their changing bodies, they were not yet visibly "showing" and had no external validation for what they knew was evolving within. The pregnancy was a secret, a hidden agenda of sorts. One therapist described it thus: "You walk around with a secret. You are dealing with one thing, but going along as if everything was normal when it's not. It creates an emotional distance between yourself and others . . . It's like you're in this balloon, the world is out there, and they have no idea what's going on with you, and you're trying to be in both places at the same time."

For some therapists this secret was a burden. They felt an urge to share and disclose it to their patients but were conflicted as they wanted to allow the patients their own recognition without imposing

their issues on them prematurely. One therapist noted: "I felt like I was keeping something from them. Like I was being deceitful. How can you be in such an intimate relationship and not share this." For other therapists although the experience was vivid, they felt relatively comfortable and curious to follow their patient's unique responses. All therapists without exception noted an incredible relief once the pregnancy was openly addressed (mostly in the second and third trimesters): "Once my pregnancy was openly acknowledged, I felt a great burden had been lifted. I could move freely in the session, put my hands on my stomach and turn to fully explore the positive and negative ramifications. Although my fantasies about my patients' hostile reactions were well founded, they were much worse than the actual process of confronting and dealing with them." Another therapist recalled the physical and emotional relief upon bringing up her pregnancy: "When I told my last patient, I remember the relief I felt. I could walk freely without worrying who I would run into, I could walk my patients to the door. I was so liberated and so much more there as a therapist when I didn't worry about it anymore."

During the second trimester, many therapists described their excitement and thrill in relation to the sonogram or amniocentesis. One therapist noted: "I could see the baby's arms and legs. I could actually see her moving and sucking her thumb. I felt a sense of symbiosis and closeness forming." Other therapists noted that once they knew the baby's sex, they could give it a name and identity and felt closer and more attached. "Prior to that she was just an anonymous fetus. But

with a name I felt like I was carrying a person." Unanimous reports of excitement and thrill related to the experience of "quickenings" and first fetal movements. All therapists commented on the distraction introduced by these movements during sessions. Some expressed frustration at not being able to follow the baby's movements with their hands, others resented patients' presence as they wanted to focus on their own body. Still others, reported smiling with the patient at witnessing the "swift kicker." Despite the above distractions, most therapists reported feeling more secure and at peace during this stage. Some noted being gratified by the special attention shown by friends, family and colleagues. They reported feeling attractive and sexually appealing. The pregnancy and baby had been validated, some of their initial concerns alleviated. They could now relax and turn to fully explore the impact of this experience on their patients.

Most therapists noted that at this stage, they were better able to confront patients who persisted in denial or deal with painful issues avoided previously. One therapist reflected on her avoidance of exploring a patient's abortion which coincided with the very early stages of her pregnancy. The patient, who had entered treatment a few months earlier, reacted in a rage to a summer break, became pregnant and aborted upon the therapist's return. The therapist felt guilty for this acting out, as well as for her having a planned and wanted child, in the face of her patient's ordeal. In addition, the therapist herself had had experience with abortion. In retrospect she believed that facing her feelings of loss and guilt about her own abortion, was too threaten-

ing in the initial and insecure stages of her pregnancy. It was only as the pregnancy progressed that the therapist felt secure enough to confront her own issues, and to allow the patient to mourn her loss and fully express her envy and rage.

Several therapists noted that as their pregnancy progressed they felt an increase in maternal and nurturant feelings towards their patients, and felt intensely involved in their treatment. At times they needed to remind themselves to curb this nurturance. In reflecting on a possible blurring of boundaries between their "personal self" and "professional self" one therapist reported: "At times I felt overly maternal, giving and controlling. I worked on not nurturing so much and allowing the patients to nurture themselves more." It is not surprising that almost all therapist's described during this time their attempt at adjusting their self concept: "I'm trying to integrate the professional side of me, and the side which is preparing to be a mother. I'm trying to imagine doing both. I go back and forth wondering, will my professional life suffer? Will my commitment to a professional life interfere with my being a good mother?" Another therapist noted: "My fear is to get mixed up with the roles, that I won't keep them separate in a way that I'd like to; that I'll be too maternal with my patients" One therapist noted her shock at initially being unable to imagine herself in a totally different role. She described daydreams about her future child in which her husband was home during the day, and would take the baby out. "Something was wrong with this picture. I was going to be the one who would give up a full time job and be home with the

baby." As the pregnancy progressed she became more comfortable with the new images and notions about her future life. Each therapist was going through an evaluative process of her own mothering. Each of them was struggling to define for herself what kind of a mother she wanted to be and how she could possibly negotiate caretaking and being available to her future child as well as her patients.

S., a 37 year old clinical psychologist, described several cases in which she found herself being overly maternal. One female patient was stimulated by S.'s pregnancy to discuss her own conflict about becoming a mother. S. was feeling harmonious and bonded with her growing baby. She felt a strong urge to help her patient adopt her positive view of pregnancy and motherhood, and keep her from discussing the negative aspects of birth.

In retrospect, S. stated that other factors might have also contributed to her motivation: She had received some distressing news from the amniocentesis. A genetic problem had been identified and there was some chance that the baby would be learning disabled or retarded. (S. has retarded relatives.) Considering the risks, S. decided not to follow a suggestion to discontinue the pregnancy. It is understandable why in the face of these grave concerns she wished to avoid her patient's negative ideation regarding pregnancy and birth.

A common experience noted by several of the therapists interviewed, related to their guilt feelings over their good fortune, and their belief that their pregnancy would be a stimulus for their patients' pain. One therapist reported a female patient's accusation: "You have

everything, a career, a husband and now you'll have a baby. I have nothing!" For this patient the therapist's pregnancy almost meant she took from her. While exploring the patient's intense feelings of competition with a younger sister, which were reactivated by the therapist's pregnancy, the therapist became strikingly aware of her own reasons for accepting the patient's accusation. While it was true the pregnancy would inevitably disrupt the treatment, the therapist became aware that the patient represented her own older sister who was single and childless. Facing her competitive as well as guilty feelings for having what her sister did not, relieved the therapist of some of her guilt, and enabled her to allow the patient to express and explore the full extent of her envy, resentment and greed.

In the final stages of pregnancy all therapists reported the salience of termination and separation issues as well as preoccupation with life, loss and death. Therapists were confronting these issues in their personal life as well as in their therapeutic work. Many reported feeling exhausted and preoccupied with concerns for the baby's and their own well being during delivery. Increase in physical discomfort contributed to a drop in energy level and to the therapist's becoming more aware of her own neediness. Some therapists struggled to maintain a heroic position, not even allowing themselves the use of the bathroom despite great urgency. Others were painfully confronted with further physical limitations and loss of control. One therapist noted her helplessness and frustration with a urine leak she could not control. All therapists acknowledged confronting the emotional limitations on

their empathic ability and availability to their patients. Several therapists experienced a lower tolerance for their patients' increased demands and neediness at a time when they felt more vulnerable and seeking their own nurturance. One therapist noted the conflict aroused in continuously listening to a needy patient: "I resented having to give so much. Who wants to listen to this stuff, I'd rather go off with myself and take a bubble bath, or eat, or see someone else." Another therapist who was working with abused children and their mothers felt that during the last stages of the pregnancy she became less tolerant of the negative interactions reported by the mothers with their abused children.

Several therapists reported incidents of increased acting out in these final stages of pregnancy mostly in the form of suicidal attempts and demanding the therapist's limitless availability at all hours. One therapist reflected on a depressed male inpatient's successful suicide during her last trimester of pregnancy. Although she acknowledged multiple factors contributing to his desperate act, she initially felt guilty and wondered if her fatigue and own neediness rendered her less tolerant and less attuned to the patient's suicidal ideation. The therapist noted she gratified the patient's requests for passes and privileges rather than exploring them. The patient was angered and felt misunderstood, despaired and hopeless. Although the therapist noted that her pregnancy helped the patient reach out to his estranged child prior to his suicide, she wondered if her preoccupation with the crea-

tion of life had in some way interfered with her listening to her patient's preoccupation with death.

Another therapist noted her guilt at wanting to leave and withdraw from a very disturbed chronically suicidal patient who had made several life threatening attempts prior to and during the pregnancy. The therapist felt terrorized by this patient who intruded into her life at all hours of the day and night. Her guilt for abandoning her and taking a six month maternity leave interfered with setting sufficient limits. The therapist felt disappointed at her own resentment and feelings of what appeared to her as insufficient commitment to the patient. "The patient felt she could not manage without me, but I felt I couldn't manage with her."

Regarding their reactions to hostile and aggressive wishes expressed towards themselves and the baby, most therapists noted that despite the discomfort aroused by some of these fantasies (wishes for a miscarriage, a stillbirth, wanting to stab the therapist, tar her stomach or throw her off the top of the roof to watch her "splatter in a bloody mess") they were relieved that patients were able to express their anger rather than act it out. Occasionally some therapists found themselves momentarily joining their patients' magical thinking that their hostile wishes may cause some harm. Those who felt more vulnerable and threatened acknowledged their fostering a more positive transference. Some of these therapists were able to identify countertransference sources for their anxiety relating to childhood rage and disappointment at a sibling's birth.

While some therapists experienced extreme discomfort with patients' aggression, others were conflicted when they were confronted with patients' tender protective feelings and solicitous behavior particularly in the final stages. A few therapists acknowledged their wish to be treated kindly by their patients and enjoyed receiving helpful "tips" from those patients who were parents. One therapist, who worked with a population of addicts and child abuse families, was astonished at the degree of insight, and sound advice some of her prostitute and abusive mothers were able to offer. While acknowledging her own gratification at being nurtured and coached, the therapist stated that there was a positive aspect: she was pleased to witness that these child abusers, could get in touch with a more tender and protective side of themselves and wished they could apply their understanding to their own lives.

Other therapists noted that their patients' oversolicitous and caring behavior was masking their guilt and fear in relation to their unexpressed hostile and enraged reactions. Most therapists did not accept these reactions at face value.

One therapist noted that she was very much conflicted regarding a patient's expression of an intense erotic fantasy of being breast fed by her. This was a 39 year old female single patient who was enmeshed in a symbiotic relationship with her mother. The therapist noted that the intensity of the patient's wish and her overwhelming neediness aroused more discomfort for her than the patient's graphic hostile wishes. The patient's aggression was characteristic and familiar, but this was new: the patient "wanted to be mushed up with me and made me feel like I

wanted to distance myself from her. She wanted to take something that was going to be the baby's, she wanted too much closeness." The therapist's awareness of her feelings prevented her from acting on them. In reflecting on her own discomfort she identified a countertransference contribution: the therapist described a stormy relationship with her own mother who throughout her life was extremely critical and accused her of being "greedy." After the therapist's birth, her mother became ill for approximately eight or nine months. At this time the therapist's older brother was taken care of by her maternal grandmother, while her mother took care of her. At around nine months as her mother started to feel better, she resumed taking care of both children. The therapist was very jealous of her brother. The mother subsequently used this example as an indication for the patient's greed -- "here I had had her all along, and what was my problem!" The therapist's strong feelings regarding "greed" were reactivated by her patient's intense wishes for merger. Her conflict was exacerbated as she was making plans for delivery and leaving the patient in order to care for her child. She wanted to be a very different mother from her own.

Several therapists noted the salience of the inevitable impending separation from their patients. Most of them reported some degree of guilt concerning the realistic aspects of their upcoming "abandonment" of their patients. This guilt prompted some to work until the very last minute or be more available, despite their awareness of their wish to withdraw and be less involved.

Other therapists commented on their anticipation of losing their professional role (and part of their definition of self) with the upcoming separation from patients. One therapist noted her increase of professional activity in the last few weeks prior to her delivery: "I suddenly noticed that I was getting on more and more committees, it was crazy. I realized I wanted to leave my mark there, to know that I will have something to come back to." Other therapists reported a wish to arrive at some kind of closure with their patients prior to their separation. Both patients and therapists were struggling with the uncertainty and unpredictability of the future.

Some Further Notes on the Impact of a
Therapist's Past On Conflict During Pregnancy

I will now present two therapist's accounts of how their life experiences with abandonment and loss affected their work during pregnancy.

N. is a 36-year-old clinical social worker, married and working in an outpatient clinic with children, families and adults. She is the eldest of three children, with two brothers (4 years and 11 years younger). N.'s mother committed suicide by strangulation when N. was 15, following a manic-depressive illness and numerous attempts at unsuccessful treatments.

N. describes her father as a very steady, functional and solid man, emotionally awkward and constricted, but caring very much about his children. He remarried two years after his wife's suicide. N. followed her father's example of "keeping a stiff upper lip" after her mother's

death, returned to school and functioned with no "dramatic problems" that necessitated treatment at the time. Going into treatment was a loaded issue. It had not helped her mother much.

The following events and dynamics in N.'s life were pertinent to her later experience of pregnancy.

N.'s mother became pregnant with N. unexpectedly when she was 20, just prior to her marriage. N. reported that when she was 20, she unconsciously allowed herself to become pregnant and had an abortion. Only after this occurred did she realize that this had to do with her mother, and made note of the identical stage in life. While N. remembered some good times with her mother during her childhood, she recalled many difficulties in her mother's relationship with her younger brother, who was somewhat hyperactive. N. became the "good girl" of the family while her brother had the role of the "bad boy." N. reported feeling guilty for this situation, particularly when her brother was sent away to boarding school as a result of her mother's inability to cope with him. He later returned to "no mother!" He was too late. N.'s mother's third pregnancy was also unplanned. N. noted her mother's difficulty in adjusting to the pregnancy and recalled one vivid event in which her mother had "lost it." She had a sudden and rageful reaction to N.'s sharing the news of the pregnancy with her friends. It was then that she chose to tell N. (then 10 years old) that her maternal grandmother had died by committing suicide. N. recalled this as a terrifying experience and her vowing not to be like her mother. At this time pregnancy, suicide and "going off the deep end" all become interrelated.

Although N. did not enter treatment following her mother's death, she was aware of many unresolved issues. During college she sought counseling when she noticed her keeping her mother's suicide a secret from her friends. She sought some additional help after the abortion, but never completely worked through its meaning or implications.

A year prior to N.'s pregnancy, she thought she had conceived and she was then faced with the anxiety connected with the loss of her mother. Her husband went on a prolonged business trip and N. was alone. Although she functioned at work, she felt "this thing just erupted inside me" and she became increasingly upset and depressed. She knew then that pregnancy for her was going to be "serious treatment time." When N. became pregnant after careful planning and decision making, she entered treatment with a female therapist with great anxiety. For her, entering treatment meant possibly being like her mother. N. had a physically "ideal" pregnancy in which she felt healthy and omnipotent, gratified by others' admiration. The omnipotence was capped off by a 4 1/2 week early and complicated delivery.

N. recalled that during the early stages of her labor, through many hours of waiting, she obsessed about "what shape I would be in, if I could call my patients" expecting herself to be able to deal with work right after delivery. In retrospect, N. thought that her omnipotent expectation was an attempt to also deny her fear that some harm would come to her in childbirth, and that she would be unable to be there to deal with her patients. This was an experience she knew, and did not want to repeat. N. decided to take a five month maternity leave, and

later returned to a very partial work schedule for another six months. "It was a strong urge, a feeling without words. I found myself wondering how a small and dependent child would feel and react to being left in someone else's hands. Abandonment was there for me."

N. made some interesting observations regarding the impact of her past experience on her work, during and following her pregnancy. She realized throughout her pregnancy that most of her adult patients were being particularly "nice, protective and happy for me." Not enough anger was coming out despite the fact that N. was terminating with some of her patients prior to her maternity leave and transferring others. She was aware that the child patients were more direct and expressed angry reactions. N. became particularly aware of her fostering a positive transference when one female patient wanted to leave treatment upon finding out about her pregnancy. N. was able to reach out to her patient and work through her conflict. In retrospect, N. acknowledged she did not want her patients to be angry at her for leaving them. For her, abandonment was a very big issue: "If they got angry at me, I might get upset and that might disrupt my forming attachment with the baby." N. felt that with all her patients she was much more attuned and willing to interpret loss, mourning and abandonment rather than anger.

In reflecting on possible countertransference or irregular technical handling, N. reported an interesting interaction with a male homosexual patient. She reported feeling particularly nurturing towards him. At one point N. noted "going out of her way" to help him in a procedural issue at the clinic, without his awareness. The patient had

accumulated an outstanding balance to the point where the clinic was considering stopping his treatment. N. noted that, despite some real difficulties in the patient's financial situation, she intervened and advocated to reduce his fee. She did not want the treatment to stop because of the financial issue. But the crucial factor was that the patient's plan was to stop treatment if necessary and then return. N. knew that she would not be there upon his return, or that he would be coming back to a "very pregnant therapist who was about ready to leave." She debated if to let him leave without telling him of her pregnancy. This felt uncomfortable. Yet she did not wish to bring up the pregnancy; she preferred to allow him his own pattern of recognition. N. resolved this conflict by arranging for his reduced fee and continuation of treatment. She noted she acted on a "gut feeling" and was aware she had gone out of her way. It was only in the retrospective interview two years later that N. made the connection to her own experience with her younger brother: she had been feeling guilty for his being sent away and coming back to find no mother. She would protect her patient from what she knew was a devastating experience. She could now act, protect, and prevent in a way she was unable to do as a young child.

N. noted the anxiety provoked in her by a child patient she had been seeing for several years. The little girl (11 years old at the time -- the same age N. was when her mother gave birth to her youngest brother) did not conceal her anger at N.'s leaving and believed N. would never come back. This girl was abandoned by her mother in the first year of life and after a custody fight was given to the father, a very

disturbed man. The patient was a very oppositional child, impulse-ridden and inappropriately obsessed and confused regarding sexual and aggressive impulses. N. noted feeling guilty for "abandoning" this patient for five months. Although she had arranged for intermediate care, she was the one patient for whom she came back early from maternity leave. Treatment resumed and N. felt this had been a particularly gratifying and special experience. She was able to be a different kind of mother both from her own and from the patient's.

N. reported of discomfort aroused for her by a father of an adolescent patient she was seeing in family therapy. The father was simultaneously comparing N. to his daughter-in-law who was also pregnant, and to his wife. He was flirtatious and sought contact with N. outside the family sessions. N. felt embarrassed and uncomfortable by this man's addressing her as the competent woman while treating his wife as the incompetent one. One might wonder about the contribution of N.'s unresolved oedipal issues to her discomfort. Her being in treatment and being aware of these feelings allowed her to adhere to strict limits and deal with these dynamics within the family sessions.

One additional observation: N. described a very unique and unusual relationship she developed with an older female staff member who was diagnosed as having terminal cancer in the initial stages of N.'s pregnancy. In reflecting, N. described a very intense and close relationship with this older woman who was dying. Despite her condition the staff member was very maternal towards N. and sensitive to her needs. She was unaware of N.'s history but was unusually supportive and in-

vested. N. described a deep empathic understanding that did not need a friendship as a basis. Despite the fact that N. was creating a new life and the staff member was dying, a bond was formed. N. was able to work through some of her feelings about her own mother and her death prior to the delivery. She utilized her own treatment and reached out to her father to "mother" her at this crucial time. This helped her in putting some of her trauma to rest. She could now become a mother, who has faced her own mothering and its disillusionment. One who could separate and be different for both her child and her patients.

L. is a 36-year-old clinical psychologist, married and working both privately and in an outpatient clinic. She too lucidly described how her own experience with death and loss affected her work with one particular patient.

L. is the second of two siblings (has a brother 9 years her senior). Her mother never worked outside the house, although contemplated it many times. L. reported losing her father, a very meaningful figure in her life, through a sudden heart attack at the young age of 8. Her mother was 38 years old at the time. L. described a treatment of a 38-year-old professional woman who lost her husband suddenly during L.'s pregnancy. The patient had a very strained and conflicted relationship with her own mother. As a child she spent a year and a half (between ages 1.5-3) with both parents but, following her parents' divorce, was disconnected from her father and never heard from him again until she was 30. At that time, she sought him out but he did not want to see her. During the course of treatment after her husband died, she renewed

her relationship with her father, very much at L.'s urging. L.'s patient did not acknowledge her pregnancy until the seventh month. The patient's husband had suddenly died when L. was in her fifth month of pregnancy. The patient, shocked and grief-stricken at this untimely death, was devastated as she and her husband were attempting to conceive a baby. They had bought many infant clothes in Europe. Later on, the patient would speak of her fantasy to give L. some of those outfits as a gift. At the time of the patient's loss L. felt very pained and guilty. She realized the patient had lost her husband at the exact same age her mother was when her father died. L. noted feeling guilty for having a husband, a career and a child in the face of the patient's loss. She acted on this guilt by allowing the patient to pay a lower fee than she normally charges. L. noted her need to make the patient equal to her. She described her as brilliant, attractive and talented and often had a hard time empathizing with her problems: she idealized her in the same way she had idealized her older brother. Even prior to the patient's loss, L. felt guilty and inadequate about treating this woman. She felt guilty for being in the position she was in vis-a-vis the patient (i.e. more successful and accomplished). Despite the patient's having three Master's degrees she failed to pursue a focused career. In reflecting on the countertransference source of this guilt, L. noted that the patient represented her own mother. She had always felt guilty about the fact that she had so much more in life than her mother did. The primitive fantasy was that she stole it from her mother. In addition, L. noted other "less charitable" smug feelings evoked by this patient.

At times she felt that maybe she deserved what she was getting. L.'s feelings of guilt and sadness were exacerbated during her pregnancy in the face of her patient's loss. L. did not wish to confront her patient with her own success and achievements at a time of such loss. She reflected on her investment in reuniting the patient with her father. The patient's loss reactivated L.'s experience of her own loss of her father. The fact that the patient had a father who was alive and with whom she could have a relationship prompted L. to encourage her patient to make that choice. Thus, in addition to considering the patient's needs, L. would not feel so guilty about having what her patient so badly wanted. L. noted that, despite the complexity of countertransferential feelings evoked by this patient, she was able to utilize her own reactivated experiences with death and loss and be very much there for her patient throughout her crisis. Her genuine sadness and empathy for this patient enabled her to confront the issue of the pregnancy and help the patient express and explore the full gamut of her reactions to it.

Practical Considerations

To Tell or Not To Tell. The first technical quandary facing the pregnant therapist is whether to announce her pregnancy to her patients, whether to wait for them to notice, or whether to bring it up at all.

Among the pregnant therapists interviewed there was an unanimous consensus that the pregnancy has to definitely be addressed and openly acknowledged. As to how and when this should be done there were varia-

tions stemming from theoretical consideration of patient's needs, as well as from specific countertransference conflicts evoked for each therapist. Overall, most therapists contended that it is preferable to allow the patients their unique characteristic pattern of response in acknowledging the pregnancy.

All therapists felt it was much more meaningful to address the pregnancy when there was sufficient accumulation of evidence in the clinical material or transference of the patient's acknowledgement, even if on an unconscious level. In the face of uncertainty, therapists described the flourishing of rich fantasy material that might have been lost if the pregnancy was announced prematurely. The decision to initially wait rather than to announce was perceived as allowing the patients some degree of control over their psychological readiness to deal with the pregnancy. Premature announcement would prevent patients from exhibiting their unique style of reaction and utilization of their characteristic defenses. It would not allow an adequate evaluation of the degree of denial or avoidance a particular patient needed to utilize. (A patient's denial at 8 weeks has a very different meaning than at 7 months!)

Alongside the above considerations, many therapists noted their discomfort at having a "hidden agenda," a secret they were not sharing with their patients, despite the direct impact their pregnancy would have on their patients' treatment. At the same time they were very cautious regarding announcement as they did not wish to prematurely impose their own preoccupation on their patients. Aware of their in-

creased self-involvement, they wanted to make sure they were addressing the patient's issues and not their own.

All therapists felt that if a patient persisted in denial of the pregnancy beyond a certain point (for some it was after they began wearing maternity clothes, for others the cut-off point was the beginning of the seventh month), it was incumbent upon them to bring up the issue. Failing to do so was perceived as an indication of the therapist's acting out and collusion in denial. All therapists felt that it was crucial to have at least three months to discuss the patient's reactions to the pregnancy and the impending interruption in treatment.

In particular, it was felt that a sufficient span of time was needed to work through patients' negative reactions which were usually more difficult to elicit. Patients were responding to cultural norms of a pronatalist society as well as to covert messages from the therapists to inhibit expression of their hostility, destructive fantasies and rage.

Special Considerations. While most therapists preferred to wait, some noted specific circumstances under which they chose to tell their patients of their pregnancy. These circumstances related to individual dynamics of a particular patient or complications aroused as a result of a specific therapeutic setting.

One therapist reported deciding to bring up her pregnancy fairly early with a particular female patient. During her childhood, the patient had always been "kept in the dark" regarding important events that affected her life. The therapist decided not to repeat that exper-

ience, and this decision had a profound impact on the patient, generating very rich material.

Another therapist stated she decided to bring up her pregnancy earlier with two very disturbed patients. She felt they needed a much longer period to work through their reactions. Unlike most patients, they instantly reacted with hostility and rage. One might wonder if the early announcement contributed to this reaction. Other considerations for announcing earlier related to therapist's evaluation of patients at high risk for suicidal acting out. It was believed that direct confrontation would reduce the probability of extreme acting out and danger to the patient. Other special considerations related to working in a group, family or hospital setting when one member found out about the pregnancy. The therapists usually preferred to directly inform their patients (especially children and adolescents) rather than their finding out through rumors. When sibling rivalry issues arose in a group setting, the therapist believed that direct confrontation would minimize acting out.

All therapists noted that "waiting" or "announcing" was not always "purely motivated" by the patient's needs. Several therapists noted their own conflict about exposure of the pregnancy. Some needed more time to plan practicalities such as a leave date and length of maternity leave before they confronted their patients. Others feared for themselves and their unborn child as they anticipated patients' angry reactions. Still others were extremely uncomfortable about the exposure of their sexuality and personal life in the therapeutic setting. They

wondered to what extent their own countertransference difficulties contributed at times to their patients' denial.

New Referrals. Most of the therapists interviewed decided not to accept new patients at this time and reduce their usual workload as pregnancy progressed. They felt they did not want to over-extend themselves and take on responsibility they would later find out was "too much." One therapist noted: "It isn't fair to the patient. For someone just starting there isn't enough of a working alliance to deal with a prolonged interruption."

Of those who decided to take on new patients, they felt it necessary to inform the patient of the pregnancy immediately. It was felt that this would reduce the patient's experience of being deceived or betrayed and give them the opportunity to choose whether they wanted to enter treatment under these circumstances or not. Some therapists who were not planning to return to a full time clinic job did take on new cases early in the pregnancy but did not inform them since they were concerned about miscarrying at the early stages.

One therapist reported taking on a new patient in the beginning of her pregnancy and feeling that, as the pregnancy progressed, she was too stressed to carry both her child and the additional patient. The patient was transferred without being informed of the pregnancy and felt extremely disappointed and rejected. The therapist felt guilty and deceitful and regretted following a supervisor's advice not to discuss the pregnancy.

The question was raised regarding what type of patient (if any at all) should be taken on. A few therapists stated that taking into consideration the heightened vulnerability during pregnancy and the yet undeveloped working alliance and trust, it might be inappropriate to take on severely hostile, suicidal, extremely dependent or borderline patients. Others noted their difficulty in working with specific populations such as sexually abused children or women who had had multiple abortions.

Therapists felt that there were no contraindications to taking on short term referrals or conducting brief evaluations. One therapist reported taking on a short term referral for 12 sessions early on in her pregnancy. After taking on the patient, she became concerned that this would turn into a long term referral, and felt uncomfortable about the upcoming interruptions of a 4 week vacation as well as the anticipated maternity leave. Her discomfort was exacerbated by the fact that the patient, an adolescent girl, had worked with a female therapist for six months at which time the therapist "up and left abruptly telling the patient she had a family emergency." This was the end of treatment. Issues of trust, dependency and coping with interruptions were salient.

Setting A Leave Date. There were individual variations regarding the decision when to stop work, and setting the leave date. Many therapists felt that setting a specific leave date provided a framework for working through patients' feelings regarding the interruption and separation. A few therapists who did not set a leave date regretted doing so. They felt it imposed an unnecessary burden of anxiety on their patients

and did not allow themselves time for preparation prior to delivery.

Some therapists noted their changing perspective regarding their leave date throughout the pregnancy. While in the initial stages they felt they would want to work "until the last hour," as their pregnancy progressed, they felt an increase in fatigue and a drop in energy, and began to evaluate their own needs for an earlier leave date.

Several therapists set their leave date for their due date. In reflecting on their need to work as long as possible, they discussed their guilt for leaving their patients and their attempts to establish their devotion and investment in their treatment in the face of their wish to withdraw.

Others who chose to work until delivery felt comfortable with that decision. They stated they wanted to work as long as possible until delivery, so they could spend all their maternity leave with their newborn baby. This was particularly relevant to those taking shorter maternity leaves (between four and eight weeks duration). In addition, a few therapists stated that if they delivered early and still took the same length of maternity leave, they would stay away from work longer. They had some concerns as to how their patients (especially the more dependent and borderline) would cope with such circumstances.

Preparing Patients for the Interruption in Treatment. Depending on the therapist's plans for maternity leave and on her evaluation of each patients' specific needs, preparations were made regarding the interruption in treatment. To the extent that the therapist was planning a

prolonged maternity leave (5 or 6 months), she and the patients considered transferring to another therapist. In some cases it would be an intermediate therapist, in others the treatment was terminated. Some therapists noted letting their patients choose between waiting or transferring. Regardless of the length of maternity leave planned, the decision of coverage was primarily determined by the therapist's evaluation (sometimes with patient's input) of the patient's capacity to endure the separation. For patients considered more disturbed or for children, coverage was prearranged. One therapist noted: "Some of my child patients and my borderline patients I know will have intense reactions. I've arranged for coverage because I don't want to be in the position of handling intense reactions over the phone during maternity leave. I need to protect myself." Most therapists who had a private practice noted that, in most cases, they did not arrange for coverage for their patients unless they anticipated extreme acting out that would endanger the patient. They also reported planning to return to their private practice within 4-8 weeks, but to take longer leaves in their clinic jobs (5-6 months). The availability of other staff members and support of a clinic enabled them to do so. One therapist noted the fact that, since she was seeing her patients in a clinic, she could relieve her guilt at abandoning them by rationalizing that they were not without therapy and were being taken care of. While there was some reality to this, the therapist acknowledged her conflict: "I could dump my abandonment on the whole staff and clinic. I could let them handle the aftermath of my leaving."

Section II:

The Therapist's Experience of Early Motherhood:

Dual Role Integration and a Changing Sense of Self

In the following section I will describe the therapist's emotional experiences in the early post-partum period, during maternity leave and upon returning to work.

Despite the therapist's careful planning of a leave date, many were faced with the unpredictability of childbirth. Several therapists delivered early (up to 4 1/2 weeks) and had to leave precipitously, while others were late and continued working several weeks beyond their due date. They noted the anxiety, hostility and discomfort this aroused for both patients and colleagues. On more than one occasion the therapist shared others' concerns that she would give birth at any moment.

Whether early, on time or late, delivery finally became a reality. Each therapist had now taken the irreversible step into motherhood. All therapists (except two who miscarried early on in the pregnancy) delivered healthy babies with no complications. Despite the variations in the experience of labor and different types of deliveries, all reported the poignant emotional experience of witnessing "the miracle of this new life." They noted feelings of thrill, joy and exhilaration alongside fear, exhaustion and great relief.

Maternity Leave

Initial Experiences. All therapists who were interviewed described a combination of intense gratification and concerns during the initial post-partum period. Alongside guilt feelings for leaving their patients and being unavailable for them, most therapists described a withdrawal and detachment from their patients at this time. The focus of their life had changed dramatically. They were totally consumed and preoccupied with their newborn infant, with the symbiotic relationship forming between them and with the major adjustments they were facing in their marriages and their lives. Their child and their family was the number one priority. For some therapists this was an immediate experience, for others a more gradual process.

Some therapists noted missing being pregnant and the "loss" of the child from their body. They missed feeling "special, proud, competent, powerful, fulfilled" and missed the baby's movements. In thinking about future separation in order to return to work, one therapist noted: "Pregnancy was easy. I did not need to feel conflicted or bad about leaving my child or worry about his care, that someone [the babysitter] would take him away from me." Other therapists were relieved that the pregnancy was over, but all agreed early motherhood was a totally new and perplexing experience. Most therapists enjoyed the regression and symbiotic relationship with the baby. One therapist noted her gratification at seeing herself reflected in her child and reliving through her, her own childhood. Those who were successfully nursing reported the unique satisfaction in this exclusive bond. They described this as

a very special, serene time of physical and emotional closeness and nurturance. Other therapists had more mixed experiences with nursing. When things went less smoothly than they had imagined or wished, concerns regarding maternal adequacy surfaced. Therapists noted feeling frustrated, disappointed and guilty. "I was worried that I wouldn't have enough milk or that my milk wasn't good enough. I wish I could have been more relaxed; I felt that I was doing something wrong." Some therapists felt tired, drained and burdened by the total responsibility of breastfeeding. Some felt that it was somewhat an infringement on their sense of self. One therapist noted: "Only after I stopped nursing I felt that through that distance I had myself back. I felt like a whole person again."

Another therapist noted her neediness and regression during the early post-partum period. She described how she followed her mother's advice regarding nursing, while not trusting her own instincts: "Although my greatest fear was to be like my mother, this was a remnant of the past. She had to be right! Anything different was wrong, so I gave in and listened to her. After my second child was born, I was determined to do things my own way, and I did."

Many therapists described their vulnerability and emotional lability during this sensitive time. One therapist noted: "I felt emotionally agitated and depressed. I was scared that I could not cope with all the changes in my life. I was concerned about giving up my autonomy and part of my career, and that I would later regret it. I yearned for stability again." Another therapist described being "high" for the

first few weeks and then occasionally bursting into tears, inexplicably. These new mothers were struggling with their own dependency and neediness, as well as that of their infants and spouses.

Whether internally or in actual life, all therapists continued during the early post-partum period to work through their relationship with their mothers. On the one hand, they described a resurgence of conflict (oedipal and preoedipal). One therapist reported: "After giving birth I felt more a sense of power vis-a-vis my mother. As I had the only grandchildren, I knew she wouldn't mess around with me anymore. She wanted to be on good terms with me." Another therapist noted her initial disappointment and disillusionment as her mother told her she did not feel she could help her with the baby, but would pay for an infant nurse. "This was a source of sadness for me, that after raising two kids my mother didn't feel she could help me know how to become a mother. She was nervous about living up to my expectations. I saw during those first few months how frightened she must have been of me as an infant. In the same way, I felt inadequate with my son. I was concerned that I would overstimulate him on the one hand, or not be able to read his subtle cues. I worried that if this happened, he would be understimulated. Just like my mother was with me, I was afraid that he wouldn't know me, wouldn't love me. I felt I needed him to make a specific and strong attachment to me immediately. I was angry at my mother for feeling this way but could now understand more." So, despite the above, this therapist further stated: "After the first few months, my relationship with my mother started to improve. I felt closer to her

than I had in a long time. She supported my return to work and I feel appreciative and respectful of her efforts and intense involvement."

Thus, alongside the reactivation of early conflicts, most therapists noted a process of reconciliation with their mothers during the first year post-partum. One therapist lucidly described her ambivalence in accepting her mother's help after her delivery: "Initially I thought -- 'Who wants her?' But as the pregnancy progressed, I said -- 'Maybe it would be nice to have her.' I've heard this from many women who've had problematic relationships with their mothers, that when 'push comes to shove,' it's nice to have your mother there." The therapist described how she came to appreciate her mother's help, particularly her availability during crises. She noted her changing perspective: "Becoming a mother has made me more aware and appreciative of how hard it is to be a good parent. I have more sympathy for my mother as well as my patients' parents. I understand more now about her situation then, when we were growing up. As a kid, you never think of your parents as having anything at all upsetting in their life." Other therapists confirmed this process of reconciliation with their mothers. They noted not being as angry at their mothers and seeing them as more human rather than idealized. One therapist felt less afraid and reassured that she could be separate, and did not have to be the same. "Although I couldn't change my mother, I could change my perception. I had a choice as to how much to go along with her view of me, to evaluate what was valid and what was not. I could appreciate the things she did well, but also decide how I wanted to be as a mother. I could be different!"

It is worth noting that the above processes of reconciliation and differentiation were described as gradual, and susceptible to regression. In contrast to the therapist's relatively stable professional identity, her newly acquired sense of herself as a mature and competent mother was hard won and easily lost, particularly in the initial post partum phases.

Maternity Leave and Return to Work. Although most therapists reached some decision regarding the length of their maternity leave prior to delivery, some of them discovered the reality of life after giving birth was at times incongruent with their original expectations.

The decision regarding the length of leave was determined by a variety of factors: Whether the therapist was working in private practice or in a clinic or hospital setting, the kind of coverage that was pre-arranged for the period of interruption, the specific characteristics of the patient population, financial concerns and, most of all, the therapist's estimation of her own needs and readiness to return to work.

The therapists interviewed took maternity leaves ranging from four weeks to six months. Almost all therapists were planning to return to a partial schedule. Nevertheless, several therapists needed to adjust the length of their leave and some had mixed feelings about their decisions.

A few therapists who anticipated returning to work several weeks after delivery needed to extend their leave. They reported that they had not anticipated the degree of attachment they would feel to their infant, and their reluctance to leave and resume work. In addition, their guilt about leaving their patients prompted them to make omnipo-

tent, unrealistic plans. Another therapist who returned to partial work (five weeks after delivery) regretted not giving herself enough time to stay home with her son and get to know him better. She explained her predicament thus: "In the early months it was very difficult. I felt very inadequate, felt I couldn't get him to relate to me. I was anxious and afraid that I would be depressed and I was. I felt lonely and didn't know what to do with myself, especially in the mornings, after my husband went off to work. Work was something I knew: I knew my patients longer and they had a specific relationship with me. The self-esteem I derived from work was very important to me in the early months when I felt inadequate as a mother." Another therapist (N. -- see previous chapter), felt a need to adjust her original plans. While she returned a month early from her 6 month planned leave to see an 11-year-old child, she felt a need to work only one day a week for an additional 6 months. At the time, N. felt unprepared to resume the full extent of her responsibilities noting: "I was unwilling to stay away from my child that many days a week [three]. I imagined how it would be for him to be left in someone else's hands while I was at work expending energy I didn't feel I had to offer. I tried to imagine how a small, dependent child would react to these changes." In reflecting on her change of plans, N. noted she returned to see her child patient earlier as a result of her guilt for abandoning her. Nevertheless, she felt unprepared to pick up too many new cases, and felt she had gotten attached to the "infant stage" much more than she had anticipated. N. stated that if she had a private practice, she might have returned part-time after

two months or so. In reflecting on her own history (her mother committed suicide when N. was 15), N. wondered if her "gut feeling" of needing to stay longer with her child had to do with her attempts at reparation. She noted: "Abandonment was there for me." Thus, she was determined to be a very available and a different mother from her own.

One therapist adjusted her leave in the opposite direction. She shortened a 6-month planned leave at an inpatient facility to 4 months (while resuming treatment with her private patients after several weeks). She recalled: "At first I didn't miss my patients, but after several weeks I felt agitated and depressed. I missed work and adult company. I yearned for stability again, and work could give me this. I was looking forward to returning to the adult world where I could get mature feedback and be challenged at a different level." Other therapists noted missing a certain kind of intellectual stimulation and had some difficulty with timelessness at home and the sense of unpredictability. Still others noted they missed having a structure and engaging their minds, but did not particularly miss their patients as people. Particularly with more disturbed and demanding patients, there was a sense of relief at not seeing them during this time.

Several therapists had minimal conflict regarding the length of their maternity leave. Those who returned on a part-time basis, 4-6 weeks after delivery, were relatively pleased with this arrangement despite the inherent stress in the first few weeks. They felt it was refreshing to leave but they also welcomed "running back home." One therapist stated: "Going out into the 'real world' exhilarated me. I

found that coming back home, I was energized and had all the patience and will to be with my baby and attend to his needs. I felt more balanced and complete." Another therapist noted: "I felt like I was almost renewing myself."

Some Initial Concerns and Gratifications In Returning To Work

Irrespective of the length of maternity leave, the return to work does not occur without some degree of conflict and ambivalence. All the therapists interviewed noted the complex "juggling act" of being a new mother, a wife and a therapist and wanting to be totally available to all, at all times. Therapists felt they were constantly attending to others' needs and demands whether at home or at work. They noted their own neediness and longing for nurturance. One therapist noted her fatigue and difficulties attending to some patients, especially the angrier and more demanding ones. She felt she constantly needed to explore her own dependency and neediness to prevent stifling her patients' expression of their feelings. Therapy provided some therapists with their own forum of expression. One therapist reported feeling grateful she was in analysis at the time: "It was the only hour in the day that was just for me. Someone was listening to me and to what I needed."

Reality considerations entered the scene: questions regarding the quality and stability of childcare were raised. Some therapists noted their jealousy of their child's attachment to the babysitter: "Will he know I'm his mother?" Others felt reassured that the child was secure

and happy. The more comfortable the therapists felt with their child-care arrangements, the less distraught they were at work. Positive feelings regarding the return to work were being voiced alongside difficulties in initial separation from the baby. One therapist stated: "I was very happy and relieved to be working again but anxious about leaving him with the babysitter. I had missed the intellectual stimulation, and was happy to get out of the symbiosis with the baby and be an adult. I felt concern for my patients and guilt for being so happy to return, for wanting to leave my child."

All therapists returned to work gradually, on a part-time basis. The initial weeks of transition and separation from their infants were the most stressful. Each of them was trying to find the comfortable balance between motherhood and professional life. Some noted difficulties in the initial sessions. One therapist noted: "It was crazy. There were days when I would go back and forth to the office three times. I was a wreck." Others noted some difficulties in concentrating in the beginning. Others noted that once they were in the office they could sharply focus on their patients. They felt that working in the early post-partum period was very restoring and exciting. It relieved them of their fears of loss of professional capacity because of their choice to become mothers. They could still be competent professionals, even if on a part-time basis.

Nevertheless several therapists expressed concerns: that their patients wouldn't want to stay in treatment with them, now that they had the baby; that their having the baby interfered with their treatment,

and possibly damaged them. A few therapists noted their "bending backwards" to accommodate their patients. One therapist observed that on the first session back she went overtime with one of her patients: "I guess I needed to pay back, and make up for leaving. So she would really know I was back and there for her."

In anticipating their return to work with dread and excitement, some therapists noted their expectation that their patients would be very curious and inquisitive about the baby and their experiences. Some felt uncomfortable with the fact that their life reality was still the focus of attention, while others wanted very much to share their experiences and anticipated having to restrain their self disclosure. One therapist who saw her private patients in her home, expected them to ask to see the baby. She did not want her on display. Regarding anticipation of requests for pictures, the therapist noted that particularly with male inpatients who tended to be angrier and needier she felt a stronger urge to "protect" her daughter. Another therapist reported making an exception and sending an adolescent girl who was intellectually limited, a picture of her baby, when this was requested. She felt the patient needed something concrete to hold on to during the interruption, and did not see this gesture as motivated by her own narcissistic needs. The surprising element for several therapists was that preoccupation with the baby was not the patients' issue. The patients asked much less than the therapist anticipated. They were eager to get back to "their own thing." A few therapists wondered if this expectation was

a projection of their own preoccupation and their wish to share their glowing pride as new mothers.

The Impact of Motherhood on Definition of Boundaries

In resuming work, all the therapists-mothers had to grapple with the constant movement from merger with their infants to a working alliance and an empathic reconnection with their patients. In reflecting on this process of fluctuation between two worlds, most therapists noted that having the baby immediately clarified priorities and boundaries and changed the quality of the emotional investment in work.

Several therapists noted a dramatic shift in the focus of their life. Their child and family became undoubtedly the first priority. Consequently some therapists reported "being less invested than before" in their work, but paradoxically "more focused and seriously involved when working."

How can one become less invested and more focused and involved? The answer lies in a process of changing perspective regarding the therapist's relationship to her patients. Almost all therapists stated that prior to becoming mothers they were at times overinvested emotionally in their patients' treatment: It was almost as if the patients were their surrogate children. One therapist noted: "I can see very clearly the differences in how I relate to my baby and how I am with my patients. I now feel that I don't need to be so important to my patients, and in fact don't want to be, as I used to want or need. I have a baby and another major interest in my life. I am much more active in sending them out to make other relationships." Another therapist noted

that prior to her becoming a mother she felt at times overly maternal, giving and controlling. Becoming a mother helped her evaluate her role vis-a-vis her patients. While she felt experiencing the primitive states of her infant enhanced her ability to tolerate her patients' regressions, she noted that she could also see them as adults. She did not want to be in a maternal-infantilizing and controlling role. "I did not need to nurture them as concretely. I could respect their own ability and allow them to grow and move along."

In reflecting on the issue of patients as "surrogate children" one therapist (L.) described her experience with a suicidal adolescent who terminated treatment following a life-threatening suicide attempt, when L. was in her seventh month of pregnancy. L. described how her difficulties in setting sufficient therapeutic limits with this patient contributed to a negative therapeutic effect. She also illuminated through her discussion of the case some salient countertransferential motivations for being enmeshed with one's patients.

L. had been seeing this suicidal adolescent for several years. She noted: "This patient was really my surrogate child. At one point in the treatment prior to the pregnancy I even held her, she was so depressed, yearning, longing. I hadn't set good limits, I felt I had led her on. While I was in the process of pulling back things got escalated as a result of the pregnancy." The patient made her most severe suicidal attempt six weeks after she was notified of the therapist's pregnancy. During that time, she persisted in acting out her rage by increasing

demands and calling the therapist at all hours of the day and night. L. was unable to set sufficient limits.

In reflecting on this case, L. noted two countertransferential contributions: She spoke of a rescue fantasy, in which she would conduct one of those treatments where through the therapist's ministrations, a very sick patient would find a new road. She stated that her collusion with her patient in resisting more family work (which was therapeutically called for) stemmed from her identification with her patient: Both did not want the symbiotic bond to be broken. Their relationship was exclusive. The pregnancy shattered this illusion. In summarizing, L. noted that becoming a mother helped her clearly define her role as mother vs. her role as therapist: "I would never do this again. I am only the therapist."

Moving away from overinvestment in the patient as the therapy-child helped therapists to become more confrontational with their patients and adhere more closely to limit-setting upon returning to work. Almost all the therapists interviewed noted that they were much less flexible about schedule changes, phone contact outside the session, fees and tolerance of abusive behaviors. Some noted that the reality of their time constraints and hectic schedule at home, with the new baby, forced them to set firmer limits. In addition, they felt they did not have the time or patience to deal with their patients extensively on the phone. Others noted feeling much less threatened by patients' anger and acting out and more daring and confident in confronting them. They were less likely to act on guilt that was countertransferentially determined. Setting

limits did not mean they could not be available for their patients. On the contrary, the therapists felt they expanded the use of themselves in the treatment and were much more productive. They did not need to overindulge their patients. Paradoxically, the decrease in emotional overinvolvement with their patients was viewed by all therapists as enabling them to enhance their understanding of their patients' issues, be more focused and more sensitive to their patients' needs.

Regarding therapists' overall evaluation of the impact of motherhood on their functioning as therapists, all noted a profound effect. "Having a child has been the most important event in my life that has affected my work, more than supervision or anything else I've experienced. It's made all the difference. The greatest pleasure in becoming a parent is the profound sense of connection I've felt with the world. I feel more grounded, full, deeply rooted because I have a child. I feel more loving and loved. I suddenly have all this information and emotional reservoir about an infant's experience and the song and dance between a mother and child. I've felt it helped me understand and better deal with the dilemmas of limit-setting versus permitting, belonging versus autonomy, with my patients."

Other therapists noted the increase in understanding of their patients through their own emotional experiences as mothers. They noted they were much more sensitive to struggles of separation-individuation and to patients' needs for dependency, symbiosis and autonomy. Many therapists felt that by witnessing their child's primitive states, they became more tolerant of patient's regressions and less frustrated when

those occurred. They felt that they could use their experience of motherhood as a frame of reference for understanding their patients' needs. In addition, working through their relationship with their own mothers provided therapists with a new perspective and empathic ability regarding the complexities of being a parent. "Becoming a mother has made me more aware of what each child (and patient) brings into a relationship with the parents, whether in temperament or other unique ways. It is not only the parent who molds the child. I have also come to appreciate how hard it is to be a good parent and have more sympathy for my own mother as well as patients' parents." Other therapists noted that working through their relationship with their mothers helped them help their patients put their mothers into a more human versus idealized perspective. Therapists felt more confident and at ease with their own humanness and less than idealized self-image. They felt more permission to be themselves with their patients and felt they could separate from their mothers and not necessarily be the same. This helped them in expanding their flexibility in the context of their work. Both therapist and patients had a choice. They had an option to accept their parents' view of them or attempt at making an independent evaluation of what was valid and what was not. The therapists' fluctuating between the child and parent position enhanced their ability to empathize with both and to appreciate the complexities of a parent-child relationship.

Some therapists stated that their experiences as therapists contributed to their functioning as parents. Although most therapists noted the difficulty to observe or be objective while being intensely involved

in the interaction with their children, some therapists felt that there is much training for motherhood through the experience of a therapist. These therapists felt that they received important exposure to different and meaningful ways of listening to others. They were confronted with issues of frustration-tolerance and limit-setting and became aware of prominent themes in development such as separation-individuation. In their interactions with their children they described their attempt to intermittently step back and reflect, rather than respond indiscriminately. However, many therapists noted that it was often easier to be effective in coping with conflict at work versus in "real life."

In reviewing the overall impact of their pregnancy on their work, all therapists agreed that, despite the trials and tribulations, the disruption and turmoil introduced into the treatment, the pregnancy was a stimulus for a very "intense, rich and meaningful therapeutic experience." They perceived it for the most part as providing opportunities for healing, conflict resolution and growth for both their patients and themselves.

Most therapists had at least one patient who terminated treatment during or after the pregnancy. Others reported patients acting out through pregnancies, abortions and suicide threats and attempts. While for some patients the termination was clearly related to their intolerance of the pregnancy and its consequences, other terminations were used as a resistance to treatment or were not clearly related to the pregnancy. Interestingly enough, several therapists reported that the intensification of negative transference reactions, although anxiety producing,

did not preclude therapeutic gains. In fact, some patients who had been the most disrupted by the pregnancy were those who also made significant therapeutic gains. Many therapists stated that they believed that with sound therapeutic handling of technical issues, acting out behaviors and awareness of countertransference contributions, negative effects could be minimized, although not eliminated.

While often intense and intimidating for both patients and therapists the exploration of patients' reactions to the pregnancy and the heightened focus on the real and transference aspects of the therapeutic relationship was invaluable. For the therapist, becoming more aware of her own countertransference difficulties expanded her ability to be more effective, confident and empathic.

Practical Considerations

Notification of Childbirth. Among the therapists interviewed there were variations in handling the issue of notifying patients of the delivery, and in the amount of information disclosed.

Overall, most therapists contended that patients should be notified of the delivery. Most therapists preferred calling their patients personally, some only a few hours after delivery, others waited several days until they returned home. One therapist's husband called her patients and was instructed as to the information to be disclosed. Other therapists who had set a leave date prior to their delivery had arranged to call their patients within a month to discuss future appointments. They did not inform their patients of their delivery but

responded to questions when they were asked later on. Still other therapists sent their patients birth announcements or a letter.

The nature of the message and the amount of information provided varied from therapist to therapist. Most therapists who notified their patients, told them they had delivered, and reassured them that both the baby and they were fine. The majority of therapists also shared the baby's sex, name and weight. Some disclosed this information spontaneously while others shared information in response to patient's questions. In general the therapists answered questions without intimate details or prolonged descriptions of the delivery, etc. Each therapist responded according to her own degree of comfort.

Regarding the rationale for sharing the information of the baby's birth, one therapist responded thus: "Although I was aware that this was kind of a switch in role, that I was giving some information, I felt that since patients had been part of the pregnancy for months, in a sense not to tell them about the outcome was as if to say that nothing had happened." This same therapist notified her patients two hours after her delivery. She noted that they were gratified by being called so soon, and greatly reassured. In particular the patients who had been extremely angry and expressed hostile wishes towards both therapist and baby were relieved that none of their wishes had hurt the child and that both mother and child were doing fine.

Other therapists noted that patients experienced the announcement as an act of courtesy, including them in the end result of a process which they shared, and impacted them heavily. They felt important to

the therapist and respected by her. The therapist's utilizing this opportunity to verify the next contact reassured patients that treatment would resume.

Some therapists felt conflicted about sharing information about their newborn babies. They feared they would burden their patients or prevent them from producing meaningful fantasy material. One therapist felt that if she was a good enough analyst, she would have been able to analyze patient's wishes to know the baby's sex. Another therapist stated: "I was conflicted as to what was therapeutic and what was ethical and human. I regretted following a strict instruction of a male supervisor to disclose nothing. In retrospect I felt that not sharing some of the basic information with my patients, did not contribute to a fuller examination of their fantasies but to their fleeing the topic almost completely. One patient, in anticipating the discontinuity of her participation in the baby's and my life outside the treatment, felt 'shut off like a child locked out of their own house.' I wondered if patients' not asking was a result of my communicating to them that to do so was inappropriate and unacceptable."

Referrals to Other Therapists. The issue of referring patients to colleagues for coverage or transferring them (particularly, in the case of an extended leave) is a complex one. While in most cases coverage was arranged according to the patient's needs and level of tolerance of separation, other factors often contributed. Several therapists noted their temptation to rid themselves of very demanding and difficult

patients. Others discussed the anticipated complications of referral. Is the referral temporary or permanent? Will the new relationship be an extension of the old one? Will the patient prefer the other therapist? A combination of mixed feelings of competition, omnipotence, possessiveness, relief and concern for patients complicated these decisions. Most private practice patients did not warrant a referral but a few therapists noted they overestimated their ability for being "all available" and resented patients' hostile intrusion during their maternity leave. They found that, at times, brief contact and redirecting patients to express themselves in the upcoming sessions was helpful.

Contact With Patients During Maternity Leave. The issue of contact with patients during maternity leave was handled in a variety of ways. The first kind of contact related to therapists' notifying patients of the delivery and reassuring them that both mother and child survived, and of their plans for resuming work. Most therapists who decided to notify their patients called them personally. Some sent a note or an announcement.

The second type of contact with patients had to do with patients' need to reach the therapist as a result of a crisis or if there was no coverage. Most of the therapists who worked in clinic settings had made arrangements for therapeutic coverage and therefore did not have contact with their patients during their leave (except for the initial notification). With private practice patients the situation was more varied. One therapist noted speaking to two of her patients on the phone on the morning of her delivery. This same therapist conducted regular weekly

phone sessions with these two patients starting 10 days after her delivery. In retrospect, she felt that, despite her patients' great needs, it was not as necessary and her difficulty with setting sufficient limits stemmed from her countertransference irritation and guilt. She "bent over backwards" to accommodate them and prove her availability. Other therapists reported having sporadic contact around crises. Some felt comfortable with their decision to have contact while others felt it was a "terrible mistake" not to tell patients that they would be unavailable during their maternity leave. One therapist reported on her contact with a borderline patient which, in retrospect, she felt was an example of countertransference interference to the detriment of treatment. The patient, a very demeaning and rageful borderline woman, was having a very difficult time prior to the interruption and told the therapist that not speaking to her would be intolerable. Although the therapist made it clear that she would be unable to answer her messages promptly, she discovered that the reality of life with an infant was even more complex than she anticipated. The unpredictability of the infant's schedule in conjunction with lack of help at home did not allow for planning of uninterrupted calls. The therapist noted: "It was a disaster. She was furious at me for not returning her calls on time." In retrospect, the therapist felt she had given in to the patient's demands because of her guilt at abandoning her. In addition, she noted that this particular patient, because of her relentless, abusive and rageful accusations, represented her own critical mother who had always accused her of being greedy and wanting things for herself. The thera-

pist was adamant about being a very different kind of mother. She, too, noted her "bending over backwards" and attempted to be as available as she could, at a time when this was unfeasible. In retrospect, she believed that this contact was not productive and did not prevent the patient's intense rage and narcissistic injury.

Gifts. Regarding the technical handling of gifts offered by patients prior to or after delivery, there was a consensus that if gifts were offered, they would be accepted. The rationale for this was that, not accepting the gifts felt rejecting and insulting to patients, particularly since they had witnessed the process for so many months. In addition, some therapists noted that for certain patients it was the first time that they were able to give something in a relationship. Therapists stated that they would evaluate the appropriateness of the gift and, in cases where the gift was grossly inappropriate or expensive, they would not accept it. However, this did not occur. All therapists noted the importance of exploring the meaning of the gift in the relationship. This could occur at the time the gift is offered or later in treatment.

Of all the therapists I interviewed, only two were offered gifts and accepted them. For one of these therapists, the gifts were left at the clinic, after she had delivered. In discussing the topic, many therapists felt a certain degree of conflict. One therapist who was not offered gifts was told by her patients that her "professional attitude"

led them to believe that gifts were inappropriate. The therapist recalled: "I didn't know if to be insulted or glad."

One therapist who received gifts following a premature delivery stated that she had some mixed feelings about directly accepting the gift. One patient discussed her wish to give her something prior to her leaving. The therapist felt that they were dealing with this as an idea. But she later found out that the patient had been secretly working on a handmade blanket that "was a real work of art, of handicraft. Her keeping it a secret only speaks to how special it was for her." The therapist noted that her conflict regarding gifts related to her guilt about leaving her patients. "I felt I was abandoning them and they were giving me a gift instead of getting angry at me. I was secretly, or not so secretly happy that they were doing this instead of getting angry. I needed to hear -- it's ok, you can leave me." All of the gifts this therapist received were from patients who were being transferred upon her leaving as they chose not to stay without treatment during her five month maternity leave.

Another therapist reported that while several patients spoke of their wish to give her a gift and even notified her of sending it, she never received it -- "There was some mixup with the address, and it came back." One female patient spoke of wanting to give the therapist infant clothing she had bought for a planned child, who was never conceived as a result of her husband's sudden death. In this case the therapist was relieved the wish had stayed in the verbal level.

Although the patient felt on one hand that maybe, through the therapist's giving birth she could change her life around and come through her loss, with hope for a future baby, she also did not want the therapist to have what she could not. Her choice of the gift reflected her strong ambivalence regarding the therapist's pregnancy.

Section III

When Things Go Wrong:

A Therapist's Miscarriage or Problematic Pregnancy

In the following chapter, I will present data from interviews with three therapists: two who experienced a miscarriage and one who encountered unexpected complications in an unplanned pregnancy. I will attempt to illuminate the internal experience of distress, loss and grief of these women, and its impact on their work including their relationships ("real" and transference) with their patients and colleagues. Special attention will be given to the objective difficulties as well as subjective conflicts aroused for the therapist under these unique circumstances, and to various choices of therapeutic handling of technical issues.

Miscarriage: The Case of D

D. is a 32 year old therapist who was in the midst of her psychiatric residency when she underwent a miscarriage in her sixth month of pregnancy. At the time she was working mostly with adults and adolescents in a hospital related outpatient clinic.

D. is married and the mother of one child. At the time of her pregnancy and miscarriage she was relatively inexperienced as a therapist and was in supervision. She is the eldest of three children with a brother 15 months her junior and a sister three years younger.

The Pregnancy (Themes and experiences prior to miscarriage). This pregnancy was not an unambivalent consciously planned one. While on the one hand both D. and her husband wanted another child, they were unclear as to when would be the "right" time and if they were ready. Financial concerns, and doubts about juggling both a residency and a pregnancy were causing ambivalence, but as soon as the pregnancy became a reality, it became the "right" time.

In describing the first 5 months of her pregnancy, D. reported no physical problems except the normal symptoms of fatigue and nausea in the first trimester. Yet emotionally, she experienced this time as very stressful, in relation to her work as well as her marriage. She felt like she was "barely keeping her head above water". Despite looking forward to another child, she also secretly thought that if she were not pregnant, her life would not be so crazy. D. was already feeling the baby's movements, at times even being distracted by them during sessions. Things were proceeding as planned, and D. was preparing for the arrival of the new baby.

The Experience of Miscarriage (Disruption and trauma). In December, when stress of residency demands peaked, D. became sick with a virus. It was in proximity to this illness that the fetus had died, without her knowledge. It took another three weeks before she would find out. In retrospect, D. remembered noticing a decrease in fetal movement, but was not particularly alarmed. Ironically, it was after the baby's death that she began feeling better physically. She went on with her life as usual.

Following a two week vacation during Christmas, in the course of a monthly checkup, the doctor failed to find the baby's heartbeat. The next day, a sonogram verified the baby had died: D.'s worst fears became a reality. There was not much time to adjust to the terrible news. D. was hospitalized the next morning, and as a result of the advanced stage of pregnancy, labor had to be induced, and she was to deliver her dead baby (a girl). D. chose not to see the deformed baby. She was mourning the loss of her child and the image of a healthy normal baby.

Loss and Grief. In reflecting on the process of grief over her loss D. reported the following: Despite the fact that there was a defined and specific developmental genetic problem with the baby (which was the probable cause for death), D. could not avoid thoughts regarding her own contribution to the miscarriage: What about the stress in her life had an effect? What about the stress in her marriage? If only the relationship with her husband was different . . . If only he'd been more helpful and supportive . . . If she had only taken better care of herself . . . If she were healthier and less stressed . . . D. was also faced with her ambivalent feelings regarding the pregnancy, wondering if her wishes, at times, not to be pregnant and so stressed may have had a fatal contribution . . . Old feelings of being punished for some unknown wrong were stirred up.

Regarding the lost baby, D. fantasized what it would have been like to have her, and would give her a name, then forget it and give her

another one. In reflecting on this she felt that it was her attempt to make the baby more real as she felt not completely entitled to grieve this loss. Other rituals in the hospital such as receiving the baby's footprint and nametag were helpful in this respect.

Working through the loss with other people was also difficult. D. described the time of recuperating at home as a time in which she withdrew from people, was extremely sad and "felt like a vegetable." Although her husband was there for her, he had recovered much faster, and she was left feeling alone with her grief, disbelief and anger. D. was not in therapy at the time and did not reach out to her therapist for help. Even her family, although they responded immediately in support -- coming and helping out with all the necessary arrangements, were not allowing mourning. Her mother responded to this loss through action (cleaning, cooking), and by denying the impact of the experience: "Don't worry dear, everything will be alright."

Another interesting component in this unacknowledged grief process was experienced in relation to her appearance, with family, friends and colleagues: "As soon as I didn't look pregnant anymore, nobody wanted to talk about it. People didn't treat me as if I'd just had this loss. I looked fine. I looked normal, so they just treated me like a normal person. But I was still very sad and mourning inside, and nobody asked about it, it just got lost. Some people sent me condolence cards, and people whom I barely knew, called to find out how I was doing. I didn't want this. I wanted the close people to lend an ear. I just wanted

permission, even after I came back, to still feel bad and talk about it. But nobody wanted to talk about it anymore."

The process of mourning continued long after D. resumed all her activities. D. noted a relapse of mourning around anniversary dates like her due date or the dates of the baby's death and of the miscarriage, the following year.

Particular difficulty was aroused by D's confronting and witnessing friends and family members (her brother and his wife) giving birth to normal, healthy babies. They had started the pregnancy together: They were having babies, she had lost hers. D. felt jealous and despite her being a mother, she felt she wanted a baby "very badly." These difficulties reactivated some dormant sibling rivalry issues which will be further discussed regarding their relevance to countertransference. For D., mourning went on, at times salient, at other times silent. It was only after she delivered a healthy baby the following year, that she was able to heal some of the wounds of this experience.

On Being a Pregnant Therapist -- Prior to Miscarriage. In this section I will describe some of the major difficulties aroused for D. by her pregnancy as they relate to her work. These experiences are not necessarily unique to miscarriage but will serve as background for understanding the complications introduced by such a disruption.

The most poignant experience D. described regarding the impact of her pregnancy on her work was her constant preoccupation with when and how to tell her patients of her pregnancy.

D. felt guilty for being pregnant and happy. She felt guilty about being a pregnant therapist. She was extremely anxious and self-conscious about her body and her appearance, concerned that she would not be able to look as "professional" as some of her "gorgeous female patients" who were very attuned to her presentation. She feared her patients' reactions upon recognition of the pregnancy, anticipating rage, disappointment in her, and feelings of abandonment. D. identified with these feelings. She felt she had it all, a husband, a child, a career while her patients were struggling with their pain. She could not be the "good mother" to them that she had hoped. She was pregnant, and therefore a "bad mother" to her patients.

In exploring her extreme preoccupation with her patients' noticing the pregnancy D. reflected on the conflicting wishes on the one hand to share her secret and on the other, to minimize, disguise and hide her pregnancy. In addition D. interpreted her supervisors' guidance to let patients acknowledge her pregnancy according to their unique patterns, at their own pace, as encouragement to let the pregnancy go unnoticed. She thus colluded with her patients in denial of the pregnancy and was not attuned to indications of their unconscious recognition appearing in the clinical material.

Thus despite changing her style of dress as of the second month of pregnancy and even after wearing maternity clothes, none of her patients (except the adolescent, who brought in pictures of babies) overtly asked or addressed her pregnancy. In particular, D. felt petrified regarding an anticipated rageful reaction from a female borderline patient about

D.'s age. This patient came to treatment after having gone through five elective abortions and much difficulty around pregnancy and sex. The patient's mother almost died in childbirth with her, and spent the rest of the patient's life reminding her of this. D. anticipated her pregnancy would evoke a stormy reaction for this particular patient. She felt unprepared to deal with the intense emotions and expected attack, as well as her own guilt for stimulating it.

Miscarriage (Conflicts and choices around technical handling).

Following a two week vacation during the Christmas break, D. resumed therapy for one session prior to the miscarriage.

The first problem aroused for her a day prior to hospitalization was: "What do I tell them? I haven't told them I'm pregnant, what do I tell them now?" D. felt she had been in some way deceitful and was angry at her supervisors, yet acknowledged she had chosen to go along with their advice. She was grieved, frightened, needy and self preoccupied and had no way of predicting what would follow or the rate of her recovery. Yet she needed to notify her patients of her upcoming absence. D. called her adult patients and told them she was sick and would not be in for the rest of the week. When the above mentioned borderline patient reacted in a rage, D. told her she was going into the hospital (but not the reason). There was no further discussion of this at this time, or later. D. felt too sad to directly confront her adolescent patient. She notified her mother, asking her to explain to her patient what had happened.

D. made an interesting observation relating to her setting an unrealistic, omnipotent return date, 4 days following the miscarriage. She did not consider the emotional turmoil following the miscarriage and assumed that if all went well physically, she would be able to return. As the scheduled date approached, D. realized she was still very sad, teary and "not ready to handle anybody else's problems." She needed to extend her leave at least two additional times. In reflecting on this process she stated: "I felt too guilty to either tell them the truth or just tell them I didn't know when I would be back."

Coming Back. In anticipating her return to work, D. was faced with additional dilemmas regarding the technical handling of the sudden and unexpected interruption in treatment, and the effect of her miscarriage on her patients.

In consulting with her supervisors (all highly regarded and experienced clinicians) D. received the following advice: She was told by a female analyst that if her patients hadn't noticed her pregnancy, they were not going to know or say anything, and she should not bring it up unless they do. Another supervisor gave D. permission to respond in any way that felt comfortable.

Upon returning to see her patients D. was asked by a gay patient about her illness. She told him the reason for her absence and he was shocked and denied acknowledging her pregnancy on any level. D. felt "like a fool" and decided not to bring it up with any of her other patients, unless they did. It was only a year later, when she was pregnant again, that she was able to explore these issues with her

patients. She then obtained striking validations of their unconscious and denied acknowledgement of her pregnancy and miscarriage. She could then acknowledge her own contribution in communicating to her patients: Do not notice, do not ask, it is unacceptable to talk about his in therapy. It was only after working through her personal motivations for denial, that D. was able to allow her patients to express the full gamut of their feelings including their jealousy and hostile and aggressive fantasies. Particularly poignant, were some of her patients' (including the above gay patient) unspoken fears that they in some magical way had caused this fatal outcome.

Other problematic issues emerging following a personal trauma such as a miscarriage relate to the therapist's feelings of extreme vulnerability and neediness. These may contribute to a possible "role reversal" with patients, or blocking any negative transference reactions.

D. reported that upon coming back she still felt very sad and in need of sympathy. "I wanted to be treated gently and couldn't stand the thought of anybody being upset with me." In retrospect, D. felt she fostered a basically positive transference, avoiding topics such as pregnancy, abortion, sex or babies, or anything that could evoke a negative reaction from her patients. On the other hand, D. felt much more attuned and empathic regarding her patient's experiences with death and loss.

In discussing her return to work after the miscarriage, D. noted an interesting phenomena: immediately after resuming work she took on a new patient. She recalled that in the early phase of pregnancy she had

taken on another patient, but soon after realized that she would not be able to "carry" that extra case load. The patient was transferred without being told of the pregnancy. After the miscarriage, D. reported feeling she had no right to continue without picking up a new patient, as she was no longer pregnant. One might wonder if D. was in some way filling the space created by both her lost child and her aborted patient, in her effort to restore a sense of competence and re-establish her self-esteem.

Countertransference Sources of Conflict. In exploring the possible sources of D.'s feelings about her pregnancy and her patients' anticipated reactions to it, several themes emerged.

D.'s intense guilt at being happy related to the role in her family of origin as the "victim," whose job is to keep everybody else happy through her misery. Being happy or successful was a threat to her parents, especially to her father who could easily get enraged and beat her up for wanting to play with friends. What would bring her joy, would cause others pain and distress. Thus, D. needed to hide and disguise her pregnancy to protect her patients from the pain and herself from their rage. The anticipated rage reaction reactivated the terror of feeling abused, rejected and bad she had experienced as a child. Her discomfort at facing her own childhood rage contributed to her colluding in denial. She subtly encouraged her patients to be as careful with her as she had been with her father, believing "he would not be able to handle it."

It was only through her own therapy following the miscarriage and working with her patients through another pregnancy, that she was able to let go of her need to protect both herself and her patients. She could now believe that she as well as her patients would endure the pain and rage and use it to enhance growth.

Another countertransference difficulty related to D.'s perception of her mother as "a person with no needs" who is totally devoted to her children. D. was operating under the assumption that "you do not show your vulnerabilities to your children." She carried this into her relationship with her patients to an extreme degree particularly regarding the miscarriage.

In addition, intense sibling rivalry issues were reactivated during D.'s pregnancy and miscarriage, without her full awareness. D. was 15 months when her brother, was born and received with great pride and joy. When he was approximately four years old he had some developmental difficulties and D. was overtly encouraged by her parents to "hold back" and underachieve so he could overcome his problems and succeed. Soon after D.'s miscarriage, her brother and his wife had a baby. D.'s early feelings of holding herself back to make way for her brother painfully resurfaced. Her own resentment and early feelings of abandonment and anger were reactivated. She was now "holding back" with her patients, and identifying with them. Considering the above dynamics, it is not surprising that after the miscarriage, she felt: "I could now be a good therapist to my patients."

Other sibling rivalry issues related to competition with a younger sister who D. perceived as prettier, always having it easy, and now very well off, able to spend much money on clothes. D.'s competitive feelings and jealousy entered the treatment via her overconcern with her professional appearance, particularly regarding two very attractive female patients about her age.

In retrospect, D. regretted not utilizing the experience of miscarriage as the powerful and meaningful stimulus it could be for enhancing patients' treatment as well as her own growth. D. felt that by not bringing it up everyone lost, particularly in being unable to explore the rich clinical material evoked regarding patients' unique history of losses and their real and transference relationship with her. It was only the following year while working through another pregnancy, that both D. and her patients had a second chance to work through the miscarriage and its effects. D. stated that it was very frightening, but also wonderful, as it intensified the treatment and enhanced it in many ways. For the borderline patient whose reactions and rage she dreaded this was particularly meaningful: it enabled her to see D. as a separate person, who underwent a crisis and is still struggling to overcome it. By acknowledging that D. was a person with pain, problems and even capable of making mistakes, the patient could let go of her perception of D. as the idealized omnipotent mother. Working through the impact of the miscarriage enabled both patient and therapist to give up the notion that pregnancy and childbirth necessarily meant death. D. had endured and survived, and so could the patient. She did not have to be des-

paired and feel shut out. She could grow as well. She could utilize D. in new ways as a role model. Both therapist and patient were now allowing this to happen.

Miscarriage: The Case of B.

I will now describe another therapist's experience of a miscarriage at an early stage of her pregnancy, and its impact on her life and her work. I will point out some common themes and differences in comparison with D.'s experience.

B. is a 41 year old clinical psychologist, married and working at a university counseling center as well as privately. She had been working as a therapist for many years and unlike D. was far more experienced when she became pregnant. B. is the second child of eight siblings, coming from a very child oriented family, where early on she assumed a maternal role with her younger siblings. B. went through two miscarriages in a span of a year, both at the same stage in pregnancy (approximately 10 weeks gestation). Both times the cause for the miscarriage remained unknown. (I will mostly address B.'s experiences in relation to her first and most traumatic miscarriage.)

The Pregnancy (Prior to the miscarriage). B.'s pregnancy was a planned and welcomed one. Both she and her husband were excited about becoming parents and felt ready. B. described the initial stage of pregnancy as mostly very energizing and exciting: "I felt very excited about being pregnant. It never occurred to me that I would have a miscarriage. My mother had eight children and there has been no history of

miscarriages in my family . . . I felt very in tune with myself and my body, very content and healthy. I was not pressured for time, and things were going just the way I wanted them to be. I was very excited about being pregnant on my 40th birthday. Despite some concerns about how this would change my lifestyle or impact my marriage, I expected to go through this like superwoman! I was not going to be one of those mopey people during pregnancy."

B. described the excitement evoked by her first sonogram. She reported having many positive fantasies and dreams all relating to a very easy and wonderful birthing experience. She felt all indications were that everything would be fine. She was optimistic and positive.

In addition, B. described the initial phases of pregnancy as a great time of approval by her mother and her entire family. For B.'s mother, who had always been a housewife and "all mother," professional achievements or a Ph.D. did not mean much. But having a BABY, that was something. "She was ecstatic! Everybody was celebrating." This time of pregnancy was also an evaluation time for B. of her own mothering experiences. While noting her mother was very nurturant and spontaneous with infants, she described her as "terrible" as the children grew up. At these later stages, her mother was impatient, unable to "sit down and talk," agoraphobic and needed to be taken care of. B. became the parental child, raising her younger siblings. She was now defining the kind of mother she wanted, or didn't want to be.

Miscarriage. In stark contrast to B.'s positive experience in the initial phase of pregnancy, she suddenly started bleeding at approximately ten weeks into the pregnancy. Although alarmed, she was still hopeful. But two days later she spontaneously miscarried in the middle of the night. She described this as an "awful traumatic experience" exacerbated by the hospital's refusal to treat her that night. She was sent home bleeding, cramping and in extreme pain, and there was nothing anyone could do. B. felt betrayed by her body, and thrown from omnipotence to complete powerlessness.

Not knowing the cause of her miscarriage, B. wondered about her own contribution in a very similar fashion to D. despite very different circumstances: "Maybe whatever was going on between my husband and I, wasn't working . . . maybe we didn't want the baby enough . . . Maybe I was stopping myself in some way." B. took a hard look at parts of herself that did not want the baby. There was no one to blame. There were no explanations. Just great sadness, disillusionment and a sense of total loss of control. Despite the early stage of pregnancy, B. felt the loss of a real person, a part of both her and her husband. He was also saddened and was very supportive, but had a different point of view: He perceived the pregnancy as something that didn't work, "a fluke," and for him the baby never materialized. They could try again.

Since B.'s miscarriages occurred both times prior to a planned vacation, she and her husband went away as planned. B. returned to her regular schedule within a week of her miscarriage. She reported that

except for some residual bleeding she felt well rested, recuperated and "not sick or debilitated" in any way.

Loss and Grief. Despite a quick physical recovery and resuming all her activities, B. very much like D., described a prolonged process of grief over her loss. She did not deal with her loss all at once. Initially, she let herself feel the pain and sadness. She cried and utilized the support of her husband, close friends and a women's group. She went back to therapy for one session, "to make sure that I was ok." B. needed help in accepting the reality of the miscarriage and dealing with her sense of helplessness and disappointment. It was no one's fault. While she noted that her family was very much there for her, she also described how hurt and saddened they were by the news, particularly the young children. When she became pregnant the following year, she did not share the news with her family. She was protecting them from the burden of her sadness, in case something went wrong; and it did. B. reported that after her first miscarriage she did not celebrate her 40th birthday: "There was nothing to celebrate": She was in mourning. It was only a year later that she could put some of her grief behind and celebrate her missed birthday. B.'s grief over her loss surfaced at different times and circumstances. Just like D. she acknowledged "anniversary effects" on her due date and at the time of her miscarriage, a year later. She fantasized about the child she could have had. Other difficult moments were in confronting friends who had given birth, or just noticing mothers and children in the street. Despite some jealousy, she was trying to

hold on to hope: If others were succeeding, maybe she could too. Nevertheless, when she became pregnant again, almost a year later, she was much more cautious and guarded. She would not easily believe the reality of the baby. She protected herself by "not making enough of a relationship with the fetus." B. was concerned about the sonogram. From a thrilling experience it became a devastating one. It was the sonogram that confirmed her worst fears, the second time as well: the fetus had dissolved. Angry and frustrated, B. had no explanations. She wondered if the sonogram was destroying the baby in some way. She needed to blame something!

On Being a Pregnant Therapist and Miscarrying. B. reported feeling very in tune with herself and her patients in the early phases of the pregnancy. She felt "if anything, being pregnant sharpened my ability to be more aware, listen to and be with my patients." B. speculated that had she started to feel fetal movements, she might have been more distracted, or self absorbed. She acknowledged not being fully available to her patients the day prior to her miscarriage, as she was bleeding during the session and was concerned.

Anticipating the change in her life, B. was planning ahead. The baby's arrival would technically impact her work first and foremost through the conversion of her office, at home, to a nursery. She planned to move her office to another location, outside her home. Thus, her patients would physically be replaced. While B. was concerned about some of her patients' reactions to her pregnancy, she reported "it never

came up in terms of their asking, because I never got to the point where I showed."

In retrospect, and in thinking about her patients reactions at the time of her miscarriages, B. made a few interesting observations: despite the fact that none of her patients overtly acknowledged or addressed her pregnancy or miscarriage, one female borderline patient, who came in as a rape victim, began threatening suicide, in proximity to both miscarriages. This was an atypical ideation for this patient, who became increasingly difficult by needing extensive attention and phone contact in between sessions. She fantasized that B. was going to leave her, and began working through her disillusionment with her own mother and family of origin. The patient was trying to make a lot of demands on B.'s personal life. As long as B. felt energized and things were fine, she responded to this patient by giving her some more time and extended contact. But after the miscarriage, B. felt frustrated and resentful at these relentless demands. She was angry at her patient for trying to "suck her in" at a time when her own issues came up and she herself was feeling drained. B. dealt with her dread of the patient's suicide threat in peer supervision and after her second miscarriage, she was more able to set clear limits with this patient. "There was a limit to how much I could give." This patient's acting out was never interpreted as related to her subliminal awareness of B.'s pregnancy, and miscarriage. It was only in retrospect that B. considered the possibility that by threatening suicide and increasing her acting out, the patient was making a desperate attempt to secure B.'s availability and

consistency as a therapist, at a time when she sensed B.'s heightened vulnerability and loss.

Another patient became pregnant and had an abortion around the time of B.'s miscarriage. In reflecting on the issue of abortion, B. noted the irony she felt in witnessing these events: "Those who want a child so much miscarry, and those who don't try and don't want to, get pregnant." B. stated that having gone through a miscarriage, she felt more capable of empathizing with patients who went through an abortion or were having difficulties in conceiving. She did not feel more distressed by discussing pregnancy or abortion with patients, even when she felt an identification with their experience. She observed that usually if she was upset or depressed prior to the session, working and being engaged with her patients helped her "snap out of it." She felt that despite the pain, these traumatic events in her life, made her richer as a therapist, increasing her knowledge, understanding and empathy, and therefore enhancing her ability to relate to her patients' difficulties.

B. commented on her continuous efforts at separating her own issues from those of her patients: "I take good care of myself personally, outside the treatment, so my issues do not interfere, and I can be there for my patients." Towards that end, B. utilizes the resources of peer supervision, a women's group, consultations with colleagues and friends and personal therapy.

Unlike D., who had no appropriate forum to work through her distress, B. had her own stage for expression of her needs, concerns and frustrations. This in addition to her being a more experienced thera-

pist than D. may have been a significant contributor to her sense that her personal crisis did not excessively intrude on her work. Obviously, other factors contributed as well, possibly relating to the early stage of pregnancy, B.'s past experience in her own treatment and her style of coping with personal distress.

Some Comments on Management of Technical Issues. Regarding notification of patients of an unexpected absence, B. was not confronted with the same difficulties as D. Both times she miscarried prior to a planned vacation. When she did need to cancel several patients' sessions, she told them she was sick.

Upon returning from her vacation and recuperating, there was no discussion of her pregnancy or miscarriage. B. believed that since she wasn't showing, there was no need to share this information with her patients unless they brought it up. She did not want to burden them with her sadness. One might wonder if in addition to considering patient's genuine needs B. was also partly motivated by the same factors that led her to protect her family members (particularly the children) from being hurt by her misfortune. Despite feeling "disappointed, let down and annoyed" after returning, she connected these feelings more to her personal life rather than to her professional life. She had not been out of work as a result of the miscarriage and was not debilitated or sick in any way. In discussing this we wondered together if maybe there was an element of her initial superwoman fantasy, in this omnipotent recovery.

In returning to work B. had to deal with confronting her office, the "nursery to be." She was relieved that she hadn't yet acted on her plans of change, and focused on the positive aspect of still enjoying the convenience of working at home. Resuming her role as a therapist definitely had some healing effects: She was needed and missed, and was now in a helping (rather than helpless) position, focusing on her patient's problems and concerns. She had returned to her normal routine, and life was going on.

Although B. did not make the following connection, one might wonder if her early experiences as a parental child to a very needy and vulnerable mother affected her work in some way. She wanted to be a very different mother to her future child, and maybe to her patients as well.

A Problematic Pregnancy: The Case of M.

I will now turn to describe a third therapist's experience of an unplanned pregnancy with unexpected complications which required hospitalization and additional interruptions in the course of therapy. I will address some of the specific conflicts aroused, and her choice of handling technical issues.

M. is a 38 year old clinical social worker, married and a mother of two. Prior to her first pregnancy, M. had been working full time at a hospital related outpatient clinic as well as privately. After giving birth, she resumed working privately (a caseload of 25 patients). M. is the second of three children, with an older brother (two years her senior), and a younger sister (five years her junior). She describes her upbringing as very strict, with a father "who had very little to

give" and a mother who was "extremely critical." M. was in intensive psychoanalytic treatment throughout both her pregnancies as a therapist. I will focus in this section on the second of these pregnancies.

Pregnancy. When M.'s son was eight months old, she suspected she might be pregnant. A test verified the unexpected news. M. reacted with shock and disbelief and was quite depressed for several weeks. Although she and her husband were planning another child, the timing was all wrong: It was too close to her son's birth, she was just beginning to feel she was "getting back into the swing of things" and had many concerns: "How was she ever going to manage with two kids, work and no sleep!" Other concerns were financial or related to lack of adequate space in their apartment to accommodate two children. M. worked through her ambivalence about this pregnancy with her husband and in her own therapy. Yet despite her choice to have the baby, she felt in some way that she had faltered and was not in full control.

Unexpected Complications. M's pregnancy proceeded with no problem until the 25th week. At that time M. had suddenly felt as if she pulled a muscle, and upon examination the first warning signals appeared: M. was completely effaced and was dilating. The implication was that there was a danger of a very premature delivery. The baby's chances to survive a delivery at that stage of pregnancy were less than 50%!

M. was given very strict instructions: She recalled: "I was not, under any circumstances to pick up my son (who was 14 months at the time). I was not to put him in the crib or take him out, put him in his

chair or bath, not ever" (until the pregnancy was over). M. was upset by this restriction, concerned about the impact it would have on her relationship with her son. She needed to re-arrange her whole life and schedule of activities around the house, at times just sitting with him on her lap until her husband came home. Nevertheless, despite her following the doctor's orders, "things went from bad to worse." At 27 weeks, she felt a leak of amniotic fluid, and was precipitously hospitalized, with no preparation whatsoever. M. felt guilty for "not having known" not to pick up her son so much in the initial stages. She felt maybe her age or having two pregnancies in a short span of time had caused the problem.

The above complications necessitated a two week interruption of her work with patients, the first of which was spent in the hospital, the second at home. Upon discharge from the hospital, M. was instructed to do absolutely nothing; she was to lie down at all times. Further evaluation, including consideration of her return to work was pending. Even if things stabilized enough so she could return to work, there were many physical stipulations mostly "staying off her feet."

In order to prevent an early and complicated delivery, M. had to follow all restrictions. There was a very real chance she could not return to work at all. M. felt very helpless and deprived. While she was mainly concerned with the impact on her son, she also felt guilty for being unavailable to her patients.

After two weeks, M.'s situation stabilized, and she was allowed to resume work under specified conditions. However, she was not "out of the woods" yet. She was constantly preoccupied with her physical state, monitoring any change very carefully. She debated if she should get up in between patients; she wondered if she and the baby were ever going to make it. At one time in particular (six weeks prior to her due date) she was distracted by contractions during a session, and believed she was going into labor. Uncertainty was the name of the game.

As time progressed, M. became more secure the baby would survive even if there was a premature delivery. She was relieved by the results of the amniocentesis and other tests revealing the baby was a girl who was developmentally fine. M. could now make more definite plans, look forward to the birth of her daughter and believe that both she and the baby would endure.

The pregnancy continued without additional chaos. Work was the only activity M. was allowed at this time. It provided an emotional as well as a financial relief. Working served as a distraction from her stressed and uncertain reality: She could resume her professional role and focus on her patients' concerns rather than on her own. This was the only place when she felt she could still function relatively normally; it was the only oasis left of her usual daily routine. M. noted: "Staying home, while being unable to do anything was a sure way of losing my mind." In addition to easing her guilt for the sudden disruption in her patients' treatment, working, and attending to their needs provided M. with an opportunity to secure some sense of competence and

self-esteem which were lost through her forced dysfunction and helplessness at home.

M. delivered a healthy daughter, with no complications, four and a half weeks prior to her due date. She worked until her delivery, took a six week maternity leave, and resumed her therapeutic work with her patients.

Conflicts Relating to Work, and Management of Technical Issues. The first issue arousing conflict for M. was the fact that her pregnancy was unplanned. She was dreading going through the process with her patients, some of whom had had intense rageful reactions during her previous pregnancy. Prior to the development of complications, she felt guilty for being the cause of yet another anticipated disruption in her patient's treatment.

One of M.'s female patients, a 40 year old single woman, unable to bear children, was the most distressed by M.'s previous pregnancy. Upon finding out about the current pregnancy she reacted in a "towering rage." She blamed M. for this "tremendous imposition" on her life, and felt misled and betrayed. She stated that M. had told her she would not get pregnant again (a fantasy) and assumed M. had "planned and plotted" this pregnancy. She needed to perceive M. as omnipotent and in full control. Upon contemplating the possibility that this was not the case, she became abusive and sarcastic. She stated that if M. had not planned this pregnancy, she had no respect for her whatsoever if she did not have an abortion.

This reaction was particularly difficult for M. as she partly identified with her patients feelings. The patient was berating her for getting pregnant in an unplanned way at the same time she was feeling she should have been in better control. M. utilized her own therapy, a colleague and her husband, who is a clinical psychologist to work through some of these feelings.

The next emotional and technical obstacle emerged upon M.'s precipitous hospitalization. Although as of the 25th week she was aware of the possibility of future complications, she felt disappointed and unprepared when suddenly faced with this reality. Thus there was insufficient preparation for her, none for her patients. M. needed to call her patients and notify them of her situation.

Despite many uncertainties M. was not conflicted regarding the content of this notification. She personally called all her patients and notified them she was in the hospital, and that while she was fine, a problem had developed with the pregnancy. M. told her patients she planned to return to work. However, she did not know exactly when. She therefore scheduled to contact them two weeks later.

An unusual situation emerged when M. was faced with the necessity to contact patients who had not yet overtly acknowledged her pregnancy. M. had begun to bring up the pregnancy (with patients who did not spontaneously address it), 3-4 weeks prior to her hospitalization. Two male patients were away for several weeks and she did not have a chance to discuss this with them. Yet, she needed to notify them of her upcoming absence. Because of the advanced stage of her pregnancy and of

her anticipating a further interruption she chose to tell them she was pregnant, that a problem had developed with the pregnancy and that she would not be in for at least two weeks. Both men were surprised and amazed at their self involvement, preventing them from noticing the pregnancy. They were not enraged and were genuinely sympathetic. At a later stage they could explore their motivations for denial.

In general, M. noted that patients' reactions to the news of her hospitalization were mixed and varied according to individual pathology. Approximately half of the patients were described by M. as "rather decent" and some were solicitous, concerned and caring. Others were "frigidly polite," but rageful underneath a controlled appropriate verbal response. A few patients (female) were absolutely enraged and even nasty. One female patient did not even want to talk to M. on the phone, and upon stating "This is great timing" hung up. Other patients blamed M. for planning and causing this course of events. There must have been something she could have done to prevent this. She must have wanted to damage her baby or cause her patients anguish. She should not have gotten pregnant in the first place!

M. was amazed at these patients' desperate attempts to preserve her omnipotence in the face of a dramatic reality pointing to the contrary. She was also aware of the extreme degree of anxiety and guilt those patients were feeling upon her hospitalization: Earlier in the pregnancy they had expressed their anger via direct hostile fantasies, wishing M. to have a miscarriage or an abortion. they now feared that they, in some magical way, had caused M.'s misfortune. They were concerned that

their angry outbursts had damaged the baby in some way, and were very frightened that some physical harm would come to M.

Luckily, M. did not share this magical thinking. Whatever her own feelings were about the complications in her pregnancy, she did not blame her patients. Nevertheless she felt that they needed to be reassured, since she could not predict the length of her absence. When asked, she gave them brief information regarding the nature of the complications, and felt they were somewhat relieved. This did not prevent additional angry responses upon her return, and after her delivery.

Upon resuming work M. was faced with yet another dilemma: Would she share with them the uncertainty of her future availability (for the remainder of the pregnancy)? M. decided it was necessary to prepare her patients for the unknown, and possibly complicated future. Her rationale was based on the high probability that further complications would prevent her from working altogether, and it would be unfair not to share this, since the patients would be directly affected. She therefore told them that while she was back, the problem had not been resolved, and that it was clear there would be an early delivery although she did not know how early.

Interestingly, M. reported that several patients were very hesitant in discussing any negative feelings they might have had during her absence. They feared it would be too stressful and something might happen to M. or the baby. Some of these patients waited until M.'s safe delivery and her return from maternity leave before they were able to

fully express the extent of their rage. This technical dilemma raises some interesting questions regarding the impact of disclosure of information or lack thereof under the unique circumstances of a sudden interruption in treatment.

The Therapist's Reactions: Conflicts and Countertransference.

While in most instances M. allowed her patients direct expression of their rage, she nevertheless had her own reactions to these onslaughts. Despite the fact that by this stage of the pregnancy she felt she had resolved her initial ambivalence about it, she identified with some of her patients' accusations regarding her possible contribution to the complications. Especially during her hospitalization, M. was vulnerable, frightened and uncertain of the future and of her baby's survival. Just like her patients, she was faced with her helplessness and total loss of control, despite her concerted efforts to maintain the stability of her pregnancy. She was angry as well, and resented those patients who were unable to transcend their narcissistic self-involvement and "put themselves in someone else's place for two seconds." On several occasions M. noted her temptation to "get rid" of a patient, particularly when confronted with intense and unrelenting hostile attacks. She described the sense of total powerlessness regarding the restrictions on her life. The only thing she could do was see her patients. At times, she wanted to reduce stress in any possible way: "It is a time when you're not feeling so great about yourself, and you can't do anything else. To sit there and hear from your patient that you're not doing anything right is very

difficult." M. acknowledged her awareness of a countertransference source of this difficulty. Several female patients who constantly berated her triggered her lifelong conflicts with her own mother whom she described as 'incredibly critical.' "I couldn't do anything right, whatever I did was not enough. I was being greedy: All I cared about was myself. Just like my mother, these patients were very good at making me feel very bad."

M. reported that utilizing her own analysis as well as consultations with colleagues enabled her to ventilate her frustrations and explore her negative feelings aroused by her patients reactions, including her countertransference difficulties. To a large extent this helped M. to be aware of her own responses and to guard against acting out of her countertransferential inclinations. But not always. There were several times she felt she mishandled her countertransference. One of these instances related to her failing to call a very disturbed female patient at a time she scheduled to do so during her maternity leave. She contacted the patient only upon her return to work, six weeks later. In reflecting on the course of events, M. noted her ambivalence regarding this treatment with a very angry and demanding patient who had been to numerous therapists but had been minimally helped. During this problematic pregnancy they had begun discussing termination and the patient's clinging as a resistance. Yet because of the reality of interruptions in the treatment in conjunction with M.'s guilt for being unavailable she failed to adequately pursue the issue. Following the birth of her daughter, after a stressful and rocky pregnancy, M.

felt vulnerable and overwhelmed. She felt she "needed a break" from this patient who did not contribute to her sense of competence, while exhibiting intense and unmanagable transference reactions. The difficulties inherent in this treatment were compounded by M.'s crisis as well as by her countertransference: She could not be the all available, tolerant therapist.

Some Concluding Remarks

The experiences of three therapists who encountered a sudden crisis during their pregnancy have been presented. For two of these therapists, the crisis ended in miscarriage, loss and grief. The third, was confronted with many moments of fear and uncertainty, prior to her early delivery of a healthy baby.

Despite the differences between these women in age, personality and level of professional experience, they all had to confront similar issues in dealing with the effects of a crisis in their personal life, and its impact on their therapeutic work. Each of these therapist had to confront her vulnerability, and sudden loss of control along with fantasized omnipotence. Each of them encountered pain, and sorrow and two of them also experienced guilt for enforced neglect of their patients. Each of these therapists needed to find a way to cope with her personal distress as well as with her patients' reactions to it. Unresolved conflicts of the past were reactivated during this traumatic period, and at times affected the therapist's judgment in handling technical issues. Each of these women, was confronted with the reality

and exposure of her human frailty, and its impact on her work. The above mentioned therapists found that they had the most difficulty with some of the more disturbed patients (defined as borderline) who exhibited intense, rageful and abusive reactions, alongside increasing demands on their personal life. These patients perceived the therapist's pregnancy and its consequent disruptions, as a narcissistic injury and had great difficulty in differentiating real from transference-determined aspects of the therapeutic relationship. These difficulties were compounded by the therapists' experience of their own increased vulnerability and neediness during this chaotic time. All therapists noted a need for their own forum of expression and emotional support. The accessibility of such an arena in the form of therapy, supervision or consultations with colleagues was perceived as invaluable: It enabled these therapists to express and be in touch with their own feelings and reactions to patients, thus minimizing their denial, avoidance or acting out.

In general, while acknowledging the numerous stresses aroused by their personal crisis, the therapists noted there was only a relatively small number of patients for whom the problematic pregnancy or miscarriage was completely intolerable and disorganizing. All three therapists noted that while this was an undesirable, stormy period in their lives and their work, dealing with it directly, by allowing patients to express the full gamut of their reactions, enabled them to utilize the trauma as an enriching and growth enhancing experience for themselves as well as their patients. (This was especially relevant for D. and M.,

less for B.) Some of the patients who had had the most difficulty and intense reactions at the time of crisis, seemed to benefit most. They had survived the disruption and could see that despite their worst fears the therapist returned alive, and treatment resumed in a consistent way. In the case of the miscarriages, the therapist had survived the trauma, and they could be reassured that they were not being held accountable for the loss of the fetus. They could turn to discover their own internal resources and offer genuine sympathy. The therapist had endured, maybe they could too.

Significant technical issues at a time of a personal life crisis emerged for all three therapists in varying degrees. These related to notification of patients upon the sudden interruption, the level of self disclosure and amount of information revealed during the crisis and upon returning to work. Decisions regarding when and how to return to work needed to be made, and questions arose regarding the therapist's initiative in exploring patient's fantasies and reactions. The choices of technical handling of the above issues were influenced by realistic considerations, theoretical assumptions and countertransferentially determined motivations. The implications of such decisions will be evaluated in the following discussion.

CHAPTER IV

DISCUSSION

In the following chapter, I will address some of the salient theoretical and technical issues which emerged from the clinical data regarding the therapists' experience of pregnancy and miscarriage and its impact on herself and her work.

Overview of the Results

All therapists interviewed described the period of pregnancy and early motherhood as one of intense fluctuation and change, with its inherent excitement, upheaval, regression, increased vulnerability and a significant disruption in their previously established identity and sense of self both as women and as therapists.

Alongside observations of patients' intensification of transference feelings (maternal transference in particular) as well as the nontransferential aspects of the therapeutic relationship, therapists noted a parallel and equally profound intensification of their own countertransference feelings as well as concerns regarding the realistic obstacles introduced into their work by this personal event in their life. These countertransference feelings impacted heavily on the therapists' ability to adequately handle patients' reactions to the pregnancy, and often had a crucial role regarding management of technical issues such as recogni-

tion of the pregnancy, setting a leave date, contact during leave or return to work. The actual interference of countertransference phenomena with therapeutic work depended on the degree of conflict aroused for each individual therapist, her awareness of those conflicts, the level of professional experience and in particular the availability of appropriate forums outside the treatment to air her own frustrations and concerns. Many therapists noted the crucial role of such forums (whether therapy, supervision or peer support) in meeting their own needs and alerting them to their countertransference. Where such opportunities were lacking, therapists often colluded more with patients' denial, fostered a positive transference, avoided full exploration of patients' feelings and at times utilized patients for their own needs (role reversal).

Although in varying degrees, all therapists commented on the ubiquitous experience of apprehending (even dreading) patients' acknowledgement of their pregnancy, particularly in its initial stages. In addition all therapists noted a unanimous relief once their "hidden agenda" was acknowledged and openly addressed. Common difficulties encountered by pregnant therapists in their work were reviewed. These included fear of patients' rage and aggression, guilt over their good fortune as stimulus for patients' pain and disruption of treatment, and conflicts around femininity and sexual exposure. Exploration revealed these difficulties were related to reactivation of the therapists' infantile conflicts and identification with patients around issues of abandonment, loss, sibling rivalry and oedipal competition. Thus, the

therapist, just like her patients, was mobilized to re-experience and re-evaluate her early object relations and identifications. In this parallel process, she often responded to patients as transference figures, representing her own mother, siblings, baby or projected aspects of herself.

Other sources of difficulties emanated from alterations in the therapeutic process introduced by the pregnancy and realistic limitations on the therapist's capacity for work. Major issues reviewed related to the violation of the therapist's relative anonymity and personal exposure, the realistic aspects of enforced neglect of patients through the anticipated interruption, and the therapist's adjustment to alterations in her sense of self as a professional facing major life changes. Conflict and discomfort were seen as related to loss of omnipotence and an idealized self image of the all available therapist-mother.

Most therapists noted an increase in patients' acting out behaviors during this period. These included missed sessions, pregnancies and abortions, increased demandingness, suicide attempts and flight from treatment. At least partially, these behaviors were viewed as related to the pregnancy and the interruption in treatment. They were most common among borderline and narcissistic patients who were the most reactive to the pregnancy. Beyond diagnostic category, therapists commented on their failure to set sufficient therapeutic limits or engage in vigorous interpretation as contributing to an increase in patients'

acting out. However, despite the turmoil and disruption, the above behaviors did not preclude significant therapeutic gains.

Overall, alongside reports of self absorption, neediness, and withdrawal from patients at various stages of pregnancy and early motherhood, many therapists noted an increase in acuity and empathic attunement to their patients' needs. During pregnancy in particular, therapists reported enhanced maternal and nurturant feelings towards their patients, at times needing to be curbed. The importance of the therapist as a role model for female patients was also noted. After delivery distinct changes in the quality of emotional investment and technique were noted. These pertained to closer adherence to limit setting, and an increase in confrontation and interpretation of transference. Other changes after delivery related to increase in sensitivity to developmental issues, enhanced tolerance of regressive states, greater flexibility in perspective and therapists' use of themselves. The above changes were related to alterations in the therapists' sense of self and redefinition of boundaries.

The therapists' struggle with the process of dual role integration was reviewed. Resuming therapeutic work, especially in the initial stages of maternal insecurity, was found to have a restoring, stabilizing and healing effect regarding competence and self esteem.

The effects of a sudden miscarriage or unexpected complications in a therapist's pregnancy were reviewed. While the reaction of each woman to such events is determined by the specific circumstances, stage in

pregnancy, her personality and style of coping with distress, some common themes were noted.

Regarding miscarriage, despite differences in the stage of pregnancy and whether therapists were parents or not, a process of mourning and grief over the loss was initiated, and continued long after the therapists resumed their professional activities. Despite the reality of their loss, therapists felt insufficient legitimacy to mourn. The role of denial of this physical reality by family, colleagues and supervisors as well as by the therapists themselves was illuminated regarding its impact on confronting patients. The therapists' difficulties in dealing effectively with the effects of miscarriage or a complicated pregnancy stemmed from countertransference sources as well as from reality obstacles introduced by the suddenness of disruption and enforced neglect of patients. Major issues emerging for the therapists at this time related to resisting giving up their omnipotent fantasies in the face of their narcissistic injury, loss of control, and regression. The therapists' increased vulnerability, guilt and countertransference played a crucial role in confronting patients' aggressive reactions and affected adequate handling of technical issues. These pertained to notification of disruption, level of self disclosure and information revealed at the time of crisis and upon recovery as well as decisions regarding when and how to return to work. A conflict between omnipotent recovery and regressive pulls in utilizing patients for gratification of narcissistic needs was noted. In this context, compensation for loss by adding patients was considered.

Finally, the need for therapists' own forum for healing and support was viewed as crucial in guarding against countertransference manifestations. Resuming work following the trauma of a miscarriage or complicated pregnancy, despite its inherent stress, was perceived by therapists as helping to restore self esteem, while relieving fears of loss of intactness and professional capacity.

The Issues

The results of this study confirm the general nature of pregnancy (particularly first time pregnancy) as a time of maturational crisis, regression and alteration in a woman's identity, sense of self and object relations (Deutsch, 1945; Bibring, 1959, 1961; Benedek, 1959, 1970). The pregnant therapist, as any other woman, is confronted with a myriad of intrapsychic as well as realistic dilemmas in her preparation for motherhood, and in response to the physical and emotional upheaval introduced by the pregnancy.

In addition, the clinical data presented is in accordance with reports addressing the profound emotional and physical impact which intercurrent life events and stresses have on therapists and their work (Aaron, 1974; Baum, 1974; Dewald, 1980; Abend, 1980; Lindner, 1983). These significant life events such as marriage, divorce, life threatening illness, physical injury, death or childbirth, intrude into the therapeutic setting as concrete and visual realities, often exposing highly personal aspects of the therapist's life. In addition they introduce objective obstacles such as physical limitations and interruption of therapeutic work. These are significantly compounded when the therapist

faces patients' intense transference reactions, often of a primitive nature, as well as the inevitable alterations in her professional self image and functioning.

When one considers the emotional pressures, regressive pulls and intense confrontation with one's human frailty in such events (including pregnancy and miscarriage), it is only logical to assume that the pregnant therapist's anxieties and conflicts will be triggered off or magnified within the therapeutic setting. Thus it is understandable how these circumstances may serve as fertile ground for intensification of countertransference, avoidance and denial (Lax, 1969; Dewald, 1980; Abend, 1980).

However, how these developments affect the therapists' attention, availability and therapeutic effectiveness, will depend on the manner in which they will be confronted and managed by each therapist in question. Thus the "countertransference storm" evoked during a therapist's pregnancy may lead to negative disruption of treatment or alternately to significant therapeutic gains.

Countertransference, Empathy and the "Real" Relationship

In order to assess the unique role of countertransference phenomena in this context it becomes necessary to explore the complex interrelationship between therapeutic empathy, countertransference and aspects of the "real" relationship between therapist and patient.

The important role of "empathy" in the therapeutic process, has been unequivocally acknowledged by most writers. There is relative

agreement among authors that therapists utilize their empathic and intuitive capacities in an attempt to understand the affective experience of another person in a meaningful way, or in other words, "step into their shoes" (Fleiss, 1942; Jaffe, 1974). For most of these writers, although not all, empathy or intuition are not synonymous with countertransference.

According to a majority of writers in this area, the therapist's empathic abilities depend on his/her capacity to tolerate a regression in which his/her unconscious primary processes are given full sway. If the therapist is to fully understand the patient's affective experiences and unconscious conflicts as they are manifested in the transference, he/she must be able to utilize the capacity for regression in the service of the ego, within the therapeutic alliance. This is done through a process of "trial identification" (Fleiss, 1942) in which the therapist temporarily identifies with the patient and his internalized objects. Usually this transient identification is broken off and the therapist separates from the patient and reflects from a distance, "bringing his cognitive abilities to bear on the emotional stirrings within him" (Beres & Arlow, 1974).

While there has been relative concensus regarding therapeutic empathy, there has been considerable difference of opinion and disagreement as to what constitutes countertransference, since Freud first introduced the concept in 1910. Various definitions evolved regarding its content, origins and theoretical and technical place in the therapeutic process. These ranged from viewing countertransference strictly as a noxious

development stemming from the therapist's unresolved infantile conflicts and always deleterious to treatment (Reich, 1951), to viewing it as a natural and even essential counterpart to the patient's transference, and a sensitive tool for understanding the patient and enhancing the therapeutic process (Heimann, 1950; Little, 1951; Searles, 1958, 1978; Racker, 1968).

It is beyond the scope of this presentation to discuss the various definitions in detail. For the purpose of this study countertransference was defined as the pregnant therapist's response to her patients and their transference stemming from her own unresolved childhood conflicts and personal history as well as her specific reactions to her patients and the analytic situation (Racker, 1968; Greenson, 1972).

Various writers have described countertransference as emerging in response to several processes in the therapeutic setting (Arlow, 1985). It may result from persistent identifications between therapist and patient, where the therapist shares the patient's unconscious conflicts and may consequently act them out, respond defensively through avoidance of related material ("blind spots") or condemn in the patient what is intolerable in oneself. Another source of difficulty may be created by the nature of the patients' material, which may evoke in the therapist fantasies or reactions not necessarily identical with that of the patient. At times material peripheral to the patient may have an evocative effect on the therapist. In other instances, the therapeutic situation as such evokes the therapist's conflicts as in the case of a

therapist's rescue fantasies which may be gratified in the therapeutic relationship.

Whatever the source of countertransference and the assessment of its possible value or danger, it is undeniable that countertransference is an inevitable and ubiquitous phenomenon in the therapeutic process. This stems from the fact that the analyst is no less human than the patient, that analysis and self analysis are interminable and that therapeutic work is replete with stresses, strains and deprivations. Patients will utilize their own empathic and intuitive skills to probe for the therapist's vulnerabilities and emotional conflicts, in order to exploit them for transference gratifications, rather than understand their origins. Even when one is not faced with the powerful implications of a personal life event such as pregnancy or miscarriage, there are constant pressures and pulls from patients as well as from one's own anxieties and tensions to slip from "analytic empathy" to countertransference acting out of the therapist's unconscious conflicts by using the patient as an object of gratification (Silverman, 1985; Arlow, 1985).

Taking the above dynamics into consideration it is relevant to explore how a therapist's pregnancy or miscarriage affect this delicate balance of forces and determine the therapist's contribution and therapeutic effectiveness.

The findings of this study confirm the assumption that when a therapist is more vulnerable (as during pregnancy and miscarriage), countertransference may interfere with her empathic ability.

Review of the clinical data suggests that the most common source of countertransference difficulties was related to therapists' persistent identification with their patients and their unconscious conflicts (Arrow, 1985). Such an identification was exemplified in the case of N. The therapist whose mother had committed suicide, identified with her patients' fears of abandonment and loss stimulated by the pregnancy. These in turn, triggered N.'s emotional trauma vis a vis the loss of her own mother and led to her fostering a positive transference. Patients were not allowed expression of their rage, a feeling N. unconsciously knew could be fatal. In addition, N.'s motivation to prove that she could be a different mother than her own affected technical handling of reality based obstacles. Similar countertransference difficulties were encountered by therapists who unconsciously identified with their patients' rage regarding sibling rivalry issues or in cases where the therapists' unacknowledged neediness clashed with patients' increase of demands and dependency. These difficulties invariably led to collusion in denial, avoidance of meaningful material which was threatening to the therapist, role reversal or utilizing patients to deny personal distress.

It appears from the above, that to the extent that therapists were unaware of their own conflicts and needs evoked by the pregnancy, or if they had no appropriate forum for their expression, they tended to be more threatened by patients' intense reactions and often experienced anxiety, anger depletion or excessive guilt. These interfered with the ability to be attuned to patients' needs and concerns as they manifested

themselves in the transference, and often resulted in breaks in empathy and difficulties in technical handling of practical issues.

It follows that this course of events would indicate that the trial identifications mentioned earlier as a prerequisite for therapeutic empathy did not occur, or broke down as the therapists' regression paralleled that of their patients, and prevented them from sustaining the fluidity of empathic identification and reflection inherent in productive therapeutic work. The decrease in therapeutic effectiveness may also be understood in terms of therapists' inability to clearly distinguish between what was emanating from their patients, from their own latent passions and fears evoked by the pregnancy (or miscarriage) as well as by their patients' reactions.

The interviews with pregnant therapists at various levels of training suggest that the issue at hand is not so much whether countertransference phenomena emerge or not during a significant life event such as pregnancy, but rather how they are confronted and handled. Given the ubiquitousness of these responses, the relative lack of attention, exploration and reports of therapists on their countertransference or counterreactions is puzzling. Such oversight may be attributed to therapists' rejecting their countertransference or defensively minimizing it, as it evokes in them feelings of shame, guilt or inadequacy and confronts them with their less than omnipotent functioning (Racker, 1968; Aaron, 1974; Silverman, 1985).

The data presented in this study clearly confirm the assumption that if pregnant therapists are aware of their own intrapsychic

issues and have their own forum for their expression and resolution, they will be able to sustain whatever feelings are stirred in them rather than act them out or discharge them. Thus, for example, particularly regarding therapists' experiences of miscarriage, abortions, death and loss, those therapists who confronted within themselves the feelings and pain engendered by such events, reported feeling enriched and being better able to empathize with patients when they were confronted with similar experiences. Thus, balancing their own needs and vulnerabilities vis a vis their patients, can enable pregnant therapists to harness their emotional experiences to further therapeutic understanding and growth for both their patients and themselves.

Thus the findings of this study lend support to views of countertransference which suggest that it need not necessarily be considered a "sin" (Gill, 1974) or just a pathological aberration connoting harmful effects. Many authors have suggested that despite countertransference phenomena being a source of serious obstacles, if detected and put at the service of the working alliance, they can contribute significantly to the therapeutic process and illuminate idiosyncratic dynamics of various patients (Racker, 1963; Greenson, 1974; Gill, 1974; Brenner, 1984).

It is important in this context to discuss two related issues that appear to be especially significant during a therapist's pregnancy or miscarriage, and are often interrelated with transference and countertransference manifestations. These issues pertain to aspects of the "real" therapeutic relationship and to the violation of the therapist's

so-called relative anonymity and neutrality, by the intrusion of the pregnancy into the therapeutic setting.

Several authors have commented on the value of the "real relationship" between therapist and patient as legitimate and essential for sustained collaborative work. It has been perceived as part of the "total human relationship" between therapist and patient (Stone, 1961), where both patient and therapist serve as reality objects for each other (in addition to their transference and countertransference roles). Although many a time, transference and countertransference are intertwined with aspects of the real relationship, it is important to distinguish between them. The real and nontransference aspects of the relationships are often considered as crucial in strengthening the therapeutic alliance and thus facilitating acceptance of transference interpretations, when those are made (Stone, 1961; Greenson & Wexler, 1969; Lax, 1969; Greenson, 1972).

The therapist's pregnancy intrudes into the therapeutic relationship as a concrete and physical reality, violating the therapist's so-called relative anonymity and neutrality. It will inevitably alter the course of treatment by realistically leading to an interruption. As patients witness the unfolding of physical and emotional changes in their therapist, they are provided with definite evidence of her existence as a real and separate person, a sexual woman intimately involved with others outside the consulting room. The fantasy of her exclusive relationship with her patients is shattered. This may contribute to disruption in the usually sheltering and consistent quality of

the therapeutic "holding environment" on which patients rely. Both patients and therapist are confronted with the need to adjust to a new image of the therapist, allowing for a less than idealized view of a changing, at times vulnerable human being (Nadelson, et al., 1974; Fenster, et al., 1986).

In this context the dynamics of "special events -- altering or intruding upon the basic analytic situation" (Weiss, 1975), are relevant. These events intensify transference and countertransference, and crystallize the intrapsychic clash between the therapist as a real person and as a transference figure. Unlike an isolated special event such as an illness or a chance meeting, the pregnancy is an ongoing process introducing a constant undercurrent into the treatment and altering the therapeutic setting on many levels. Often the therapist is tempted to collude with her patients in denying the growing presence of the baby in order to restore the stability of the therapeutic dyad. The shifts and disruption in the therapeutic environment necessitate appropriate modifications in technique. Interviews conducted with pregnant therapists make it clear that the therapist must recognize the significance of the pregnancy for the treatment and acknowledge that, in fact, something different has occurred. It appears from these findings that failure to recognize the realistic impact of a pregnancy or miscarriage may result in empathic failures on the therapist's part and may lead to acting out, collusion in denial or jeopardizing an entire treatment. This is particularly relevant for borderline and narcissistic patients for whom the disruption in the security of the setting and the visible

stability of the therapist may be catastrophic. This was repeatedly exemplified in therapists' reports of patients' suicidal threats and attempts, abortions, flight from treatment or loss of rich clinical material in the context of failure to address the pregnancy directly. Once therapists were willing to acknowledge their own realistic contribution, the way was paved for exploration of transference material. Thus the findings support the contention that therapists' genuine and realistic interactions with their patients will contribute to the latter's willingness to explore and accept interpretations of underlying transference and resistances. Thus, if the therapist adequately addresses both reality and transference, the therapeutic process may be preserved and even expanded (Lax, 1969; Berman, 1975; Fenster, et al., 1986).

Many authors have commented on the dangers of exclusive focus on either reality or transference aspects of the therapeutic relationship. Exclusive focus on transference interpretation disregards patients' adaptive, integrative and realistic perceptions, at a time when these are very prominent (Greenson & Wexler, 1969). On the other hand, there may be negative consequences of an exaggerated focus on the reality of the pregnancy to the detriment of therapeutic exploration.

The pregnant therapist presents her patients with a specific reality situation, rather than a "blank projective screen." While most writers agree that it is preferable that the therapist's private life does not impinge on the therapeutic process, one should acknowledge that patients invariably become aware of other life events in the therapist's life while in treatment (an illness, a marriage or a divorce). Although

pregnancy is definitely one of the more dramatic, prolonged and highly charged of these events, there are many instances in the most optimal of circumstances where the therapist cannot maintain constant anonymity and neutrality in her work. Several authors have raised the question as to whether the occurrence of a pregnancy or miscarriage in itself necessarily precludes productive work and the unfolding of patients' unique transference patterns? The answer is negative although this is not a simple task. The clinical data presented point to the fact that it is often difficult to sort out and differentiate between patients' transference dominated reactions, from those in which subtle and sensitive perceptions of reality play a central role. This is particularly compounded in the face of intensified countertransference and the therapist's increased vulnerability if she has not worked through her own reactions to the pregnancy. Her recognition that something realistic in her behavior or life situation has stimulated her patients' pain may cause her to experience intense guilt and overidentify with her patients by perceiving herself as the impinger of her personal issues and the abandoning figure. This was particularly poignant in the cases of D. and N. Therapists' overemphasis on the realistic aspects of the pregnancy's intrusion and the anticipated interruption at delivery, prevents adequate exploration of the transference. At the other end of the spectrum, the data indicate that therapists might be motivated (as are some of their patients) to avoid and deny the impact of the pregnancy and the growing child on themselves and on their work. They may not allow patients' genuine caring or concerned reactions to a clear event

in their life, and respond immediately with premature transferential interpretations. In this context it is relevant to mention therapists' ubiquitous experience of guilt and discomfort regarding the realistic implications of the anticipated interruption in treatment. These were compounded by countertransference and confirm Weddington and Cavenar's (1979) findings that an interruption or termination initiated by a therapist, stimulates a countertransference storm. Avoiding discussion of the pregnancy altogether is a denial of the patient's experience and perceptions. As Stone (1961) has suggested, to do so because of some notion of anonymity is to carry this concept to a pathological extreme. Along these lines, the pregnant therapist's silence in response to her patient's correct observations about her life situation may recreate a parent-child situation in which the bedroom "secrets" are not discussed. Patients may perceive this as a parental prohibition which will inevitably lead to intensification of the transference rather than to its resolution, and to significant loss of rich clinical material for therapeutic exploration. Thus it appears that the continuous assessment of both reality and nonreality aspects of the relationship is crucial if productive therapeutic work is to occur (Lax, 1969; Benedek, 1973; Weddington & Cavenar, 1979; Barbanel, 1980; Fenster, et al., 1986; Penn, 1987).

Parenting and Psychotherapy -- Some Parallel Processes

When one evaluates the complex experiences of pregnant therapists in their transition to motherhood and in the subsequent struggle of dual

role integration and a changing sense of self, an important issue emerges. This pertains to parallel processes operating in the context of the mother-child relationship as well as in the therapeutic setting.

Several authors have commented on the analogies between parenting and the psychotherapeutic process. Winnicott (1963) stated that in handling patients' dependency needs, and protecting a fragile ego from being overwhelmed "there is nothing we do that is unrelated to child or infant care" (pp. 251-252). Others have commented on aspects of the analytic situation which repeat the earliest characteristics of the mother-infant relationship as a "blackcloth for the more advanced conflicts and maturational processes" which will emerge (Greenacre, 1954; Chasseguet-Smirgel, 1984). Still others have elaborated on the parallels between the infant's environment after birth and the analytic setting or "womb" providing patients with the necessary conditions for transition from a pre-natal dimension to a post-natal one (Ferenzi, 1913). The therapeutic setting provides the patient with an environment repeating in many ways the mother-infant relationship in its most primitive and immediate aspects. The therapist's major function is to consistently listen and concern herself with the patient (without requiring a reciprocal concern) and to protect the dyadic contact from external interruptions or distractions (Rycroft, 1968). This environment, its ground rules and boundaries provides a sense of security and consistency which is often unconsciously equated with primitive aspects of the developing self, based on the early symbiosis between mother and child,

and has been referred to as a therapeutic "holding environment" in which the psychotherapeutic process may flourish (Winnicott, 1963).

In this context it is relevant to point to the origins of empathy in the mother-child interaction and to Freud's statements regarding "the relationship between one unconscious and the other" (Freud, 1913). Much of the communication in psychotherapy is carried through non-verbal channels, and thus the therapist's surrendering herself to her own unconscious in an "evenly suspended attention" is a prerequisite for meaningful and emotional understanding of the patient and his/her unconscious conflicts. The capacity for pre-verbal exchanges is often related to a "maternal attitude" parallel to that of a mother's ability to "know" her infant's needs. (This is not necessarily unique to female therapists.) This empathic communication has been described as non-directed, circular and reverberating (Spitz, 1965) and as occurring through a process of mutual attunement, requiring merging followed by differentiation (Brouggard, 1984) and involving a process of projective identification (Winnicott, 1963). The parallel in the therapeutic setting is in the form of the "trial identifications" described earlier as a prerequisite for psychotherapeutic empathy.

Thus it is not surprising that despite some reports of self absorption, neediness and withdrawal from patients, many therapists noted increase in acuity and empathic attunement to their patients needs, simultaneously with their turning to their own body and to the growing fetus within. The symbiotic union with the child accompanied by the therapist's experience of a peak emotional openness, may increase her

sensitivity to patients' symbiotic desires and to the primitive and irrational aspects in their material. As was apparent from the interview data reported, whether this capacity will be translated into greater empathic responsiveness or make the therapist more susceptible to countertransference and defensive distancing, will depend on her negotiation of the conflicts aroused for her.

At this point it is relevant to focus on therapists' reports of their increased maternal, at times overly nurturant and controlling feelings towards their patients during pregnancy, in contrast to the dramatic shift in the quality of their emotional investment in work and in definition of boundaries, after giving birth. These findings illuminate some of the parallel processes described (between parenting and therapy) as well as sources for gratification and countertransference in the therapeutic role.

Many therapists reflected on their frequent emotional overinvestment in their patients as "surrogate children" prior to the birth of their own child. Some felt reluctant to give up the exclusive symbiotic bond with patients, and encourage their growth and separation. Their need for their patients' dependence on their therapeutic "mothering" led to greater difficulties in setting sufficient limits or adequately interpreting transference. This resulted at times in confusion of boundaries, failures in empathy and patients' acting out of their conflicts.

These observations are in accordance with Chasseguet-Smirgel's (1984) comments regarding therapists' countertransference difficulties

in "loosening the intense symbiotic attachment" with their patients (p. 175), and thus unconsciously forbidding them to leave the analytic womb or invest in objects other than themselves. Winnicott (1960) described a similar difficulty in addressing the mother's need to remain merged with her infant and to delay her infant's separation from her "beyond the symbiotic stage of her motherliness." This interferes with the normal functioning of mothering. The difficulty in letting go may stem from the mother's own dependency needs and her enjoying nurturance and caring vicariously through her identification with her child (Ballou, 1978).

As indicated by therapists' reports, the birth of the therapist's "real" child modifies the therapist's need for creative expression and maternal nurturance via patients. As her priorities shift, the therapist gratifies her maternal needs and attains fulfillment through her absorption in her child. She has less of a need for merger, indulgence of her patients or utilizing them as a major anchor in her life. Consequently she can provide adequate limits, enhance her understanding of their needs and allow them to draw on their own resources for growth. The therapist's own process of redefinition of self, her gradual separation from her own mother and investment in her child, allows her to redefine her role and boundaries with her patients. In becoming a mother, she can move away from overinvestment in her therapy-children and enhance her effectiveness in promoting their individuation.

The process of dual role integration is unfortunately a gradual and complex one replete with stresses and conflicts which re-emerge in

varying degrees of intensity throughout different life stages. The therapist's successful adjustment to her simultaneous existence and functioning in both roles depends to a large extent on the manner in which she negotiates her changing self image and identifications, her feelings about her femininity and sexuality and issues of omnipotence vs. vulnerability, dependency and loss.

Femininity and Sexuality

Conflicts around the therapist's femininity and intrusion of her sexual functions into her work may lead to countertransferential difficulties. The pregnant therapist has often established a particular self image as a professional from which she derives a sense of competence, stability and self esteem. The obvious and blatant nature of the pregnancy and the anxiety introduced by the unfamiliar task of motherhood require a re-negotiation of her self image in all arenas. This often leads to the ubiquitous concern whether she will be able to combine the different aspects of her life and be all-available (or sufficiently available) to her child as well as her patients.

The direct intrusion of the pregnancy into the therapeutic spotlight confronts her directly with her feelings about being a woman and a therapist. It appears that if the pregnant therapist views the changes introduced by her pregnancy as a liability, she may tend to deny or minimize the impact of her pregnancy and will avoid explorations of subtle transference communications. She may also choose to interpret only those aspects of the transference relating to the impending break in treatment, a transference issue shared by all therapists, while

avoiding the more primitive transference material related to the pregnancy itself (Penn, 1987). Some therapists in this study denied the pregnancy's impact on themselves and took on too much responsibility in an attempt to prove their competency and involvement. On the other hand, other therapists reported excessive guilt for the impingement of their female functions, which led them to overemphasize the pregnancy's intrusion at the expense of exploring patients' reactions. In addition conflicts around sexual exposure or therapists' masculine identification in relation to their work, inhibited exploration and attunement to male patients' reactions and reflected the discomfort and fear of male (paternal) disapproval. It also prevented therapists from utilizing themselves and their feminine experience as a role model for female patients struggling to articulate a feminine ego ideal or differentiate themselves from a negative maternal introject.

Thus the findings of this study support the statement that to the extent that the therapist has not worked through her ambivalence and conflicts vis a vis her feminine identifications and self image, she will be unable to adequately facilitate her patients' mature growth in these areas.

The clinical interviews indicate that the therapist's feelings of legitimacy regarding combining motherhood with a professional career may also be profoundly affected by staff and supervisors' reactions to this event. Taking into consideration her heightened vulnerability, neediness and internal conflict, it is logical to assume that a negative reaction from supervisors may be potentially destructive for both her-

self and her work. If supervisors do not acknowledge the pregnancy as a powerful transference stimulus, and interpret her focus on it as an indication of narcissistic self involvement projected onto her patients, this may exacerbate the therapist's conflict and lead her to denial or mishandling of patients' communications. On the other hand a supportive supervisory context may provide legitimacy and enhance the therapist's ability for productive work at this time.

Omnipotence vs. Vulnerability

One of the central issues emerging from the clinical and theoretical data presented, relates to the therapist's struggle to reconcile her omnipotent fantasies with the reality of her human frailty, vulnerabilities, limitations and needs. This struggle is not unique to female therapists or pregnant ones, but is particularly intensified during stressful life events such as pregnancy, and even more at a time of miscarriage or life threatening illness.

In the regular course of uninterrupted therapeutic work, many therapists (if not all) harbor omnipotent fantasies, often sharing patients' transference expectations to be the idealized, all available indestructible therapist-"parent." Some therapists have also acknowledged rescue fantasies about their patients, in which they utilize their omnipotent capacities to save and heal their patients. These fantasies, often unconscious, take on a special meaning at a time of a therapist's pregnancy or miscarriage.

The pregnant therapist is going through an evaluative process in which she has to integrate her "maternal ego ideal" with the reality of her experience with her own mother. Many have noted the separation-individuation and the reconciliatory processes between the pregnant woman and her mother, as a pre-requisite for transition into competent motherhood. The pregnant therapist, as all women going through this developmental process, will need to work through her past ambivalences and resolve her own issues regarding dependency, loss and power.

In facing their physical and emotional vulnerabilities and the increasing anxiety regarding the limitations on their current and future all availability, therapists reported being confronted with the need to modify their wish to be the ever present idealized mother for both their patients and future children. Thus it follows that if the therapist is feeling disillusioned at her inability to maintain her omnipotence and is unable to deal with her anticipated losses (real and fantasized) resulting from her choice to be both a mother and a therapist, she may be more susceptible to countertransference difficulties. These are often aroused particularly by patients who need the idealized parent for sustaining their sense of self, and who respond to any deviation in the treatment with intense feelings of betrayal, rage and deprivation (usually borderline and narcissistic patients). The therapist's difficulties may be understood in Racker's terms of "complementary countertransference" (Racker, 1968), where the therapist's needs have caused her to identify with patients' idealized introject, and experience guilt and anger when she is unable to fulfill these idealized expectations

(Fenster, et al., 1986). Other expressions of the therapist's difficulty in facing her human limitations and giving up her fantasy of the omnipotent supertherapist (and woman), are exhibited in her taking on a heroic attitude and denying the impact of her pregnancy as well as her own needs.

Although clearly the pregnant therapist does not completely resolve her ambivalence and conflicts with her mother at the time of delivery, one might speculate about the effects of the reconciliation reported by many therapists, on themselves and on their therapeutic relationships. It appears from the clinical data that to the extent that the therapist is able to accept a less than idealized view of her own mother as well as herself as the new mother, she will be able to increase her empathy and effectiveness with her patients. She can help promote in them a more realistic and human perspective (vs. an idealized one) of their own mothers and herself. While accepting their dependency she can foster the development of a mature identity and enhance conflict resolution. When one considers the parallels between parenting and psychotherapy, and the impact of the reconciliatory process with the pregnant woman's mother on her ability to establish a sense of her child as a separate person (Ballou, 1978), one might wonder if there is a parallel implication for the therapeutic relationship.

It seems that the therapist who can become aware of and accept her own vulnerabilities and dependency needs can utilize her dual roles as mutually enriching. Thus, her experiences of motherhood can provide her

with an emotionally meaningful frame of reference for understanding her patients and the complexities inherent in a mother-child relationship.

Omnipotence, Trauma and Loss -- A Therapist's Miscarriage

The data presented in this study clearly illuminate the problems arising in the negotiation of the conflict between a therapist's omnipotent fantasies and human vulnerability in the event of a sudden miscarriage. In all cases, the therapist's experience of narcissistic injury, grief and loss accompanied by feelings of helplessness, loss of control, guilt, anger and personal isolation as well as the suddenness of the interruption and enforced neglect of patients, profoundly affected her functioning and her susceptibility to countertransference interference. The almost non-existent literature on a therapist's experience of miscarriage (or a complicated pregnancy), despite its high degree of incidence, is striking. Not even one article in the analytic literature has addressed the therapist's internal experience at such a time and its impact on her work, particularly regarding countertransference difficulties. How can this silence be explained? In attempting to answer this question it is relevant to refer to the literature dealing with transference and countertransference implications in the event of a therapist's serious or life threatening illness (Dewald, 1980; Abend, 1980; Lindner, 1984). These writers also comment on the relative paucity of literature regarding this topic and suggest that the anxiety and conflict such crises arouse is generally handled by avoidance and denial. The important role of denial warrants consideration both regarding the lack of exploration and reports of such life events, as well as the

potentially injurious effect on the therapeutic work itself at such a time.

The clinical data obtained from therapists who experienced a miscarriage or a complicated pregnancy, corroborate other writers' (Aaron, 1974; Dewald, 1980; Abend, 1980) observations regarding the factors determining therapists' avoidance of exploring and reporting of their experiences of trauma and crisis, and its consequent impact on their work. These writers have noted that even under normal circumstances there is often a reluctance to acknowledge or disclose to others experiences of irritation, frustration, personal gratification, vulnerability and threat evoked in the context of therapeutic work. Many therapists view these reactions as an indication that they have transgressed a therapeutic ideal, and therefore cannot function indefinitely as the all available, loving, benevolent and objective professional they wish to be. They apprehend exposure of aspects of their deep psychological makeup and fear censorship from colleagues.

In addition, many therapists harbor narcissistic and omnipotent fantasies that they are immune to life threatening debilitating illness or emotional crisis, and nurture the belief that they will be able to function effectively as therapists, indefinitely. The experience of a sudden and traumatic loss such as miscarriage or serious illness shatters this idealized perception in both the personal and professional arenas. It confronts them with their own human frailty and the consequent physical and emotional limitations on their capacity for work. The struggle to maintain the omnipotent image of the immune "superwoman" and

"supertherapist" by both patients and therapists in the face of dramatic evidence to the contrary, was exemplified in the cases of D., B. and M. These therapists' accounts of their experiences suggest that the therapist who has experienced a miscarriage or unexpected complications in her pregnancy is subject to similar emotional pressures and intrapsychic reactions described in the literature regarding life threatening illness.

She will need to confront her own reactions to her loss as well as patients' often intense responses to the sudden interruption in treatment and to the perceptible changes (often blatant if the pregnancy was advanced) in her physical appearance. Despite many common themes, the experience of miscarriage is also different from that of serious illness. A process that originated as a creative, life giving hopeful experience, is abruptly ended in narcissistic injury, loss and death. The dynamic characteristic of a loss initiates a prolonged process of mourning and grief which continues long after the therapist's physical recuperation and return to work. It is both a real loss of a person to whom an intense emotional attachment had begun forming, as well as destruction of part of the self and the accompanying fantasies regarding motherhood and productive capacities. Thus the experience of personal isolation, depression, and loss of self esteem is multidetermined. It is compounded by the frequent lack of adequate explanation of cause which exacerbates the woman's guilt feelings.

Another distinction between miscarriage and serious illness which emerged from the data relates to the frequent denial of this loss by family, colleagues and supervisors. The therapist who has experienced a

miscarriage is often not allowed the legitimacy of bereavement or the regressive pleasures and gratifications inherent in a dependent invalid status of illness. She is often encouraged to take on a heroic position in returning to work. This, combined with her own needs to re-establish her professional competence and self esteem, may make her more susceptible to role reversal and gratifying her needs via her patients, to the detriment of treatment. Her attempts at "omnipotent recovery" before she is psychologically ready may intensify the danger of prolonged and unresolved grief if she lacks her own forum for healing and support.

Therapists' reports on their experience of miscarriage point to significant dilemmas regarding handling of technical issues at a time of crisis, which arise for all therapists in various degrees.

The first issue relates to notification of patients of the sudden interruption. Conflicts regarding the nature of the message given, particularly if the therapist's pregnancy has not been acknowledged, are raised. The therapist's extreme distress in the acute phase of her trauma may increase her apprehension of patients' negative responses or may motivate her to seek their sympathy and not allow them expression of the full range of their feelings.

The question of how much factual information to provide patients at the time of crisis and upon resuming work is also a central one. It has also been discussed by several authors regarding an analyst's illness (Dewald, 1980; Abend, 1980). The basic theoretical assumption regarding self-disclosure, is that the more extensive the information given, the more it will interfere with the uncontaminated unfolding of patients'

unconscious feelings and reactions. On the other hand, to leave patients without factual information and without therapy to explore their fantasies, may overburden their adaptive capacities. Both providing or withholding information may be countertransferentially motivated: to avoid discussion where a therapist has clearly experienced a miscarriage, is to deny patients reality perceptions and may prevent them from exploring rich clinical material. It may lead in extreme cases to acting out of intense transference feelings that were not interpreted. These pertain particularly to intolerable guilt feelings regarding hostile fantasies in the face of the fetus' death.

The cases of B. and D. illuminate the effects of avoidance and denial of a therapists' pregnancy. B.'s observation of a borderline patient's sudden and atypical increase in demandingness and suicidal behavior during both instances of miscarriage may lead one to wonder whether despite the early stage of pregnancy, the patient was responding to the subtle unconscious recognition of the therapist's state, which was not interpreted.

In the case of D. who miscarried in her sixth month of pregnancy the probability of patients' "not noticing" was unlikely. Yet the therapist's countertransferentially determined fear of her patients' rage reactions contributed to her colluding in denial of this reality. In this case a unique opportunity was provided to validate patients experience at this time. Through exploration of an additional pregnancy a year later, it was found that rich clinical material had been lost regarding each patient's unique history of losses stimulated by the

miscarriage, and that patients continued to believe their hostile fantasies had in some magical way caused the fetus' death when the miscarriage was not discussed. This undoubtedly contributed to inhibition of patients' expression of the full gamut of their feelings in the transference, and thus prevented therapeutic gains.

A related and distressing finding pertains to supervisors' denial of the impact of a therapist's miscarriage on the therapeutic process. Supervisors, both male and female, regardless of their level of experience, had their own countertransference reactions. While it is understandable that one would want to encourage a distressed therapist to allow her patients their unique pattern of response, one should be alerted to the negative implications of denying the physical reality of an advanced pregnancy which has been aborted and witnessed by all. Future research should thoroughly explore supervisors' reactions and contributions stemming from their own countertransferential difficulties.

Several writers (Abend, 1980; Dewald, 1980) have stressed the possibility that providing factual information about one's illness may serve a countertransferential motivation, conveying covert messages to patients. This is particularly relevant to therapists' dealing with hostile and aggressive reactions. Thus, at a time of crisis and increased regression and vulnerability, it is more difficult to bear patients anger particularly if it evokes excessive guilt and pain in oneself. Therapists may subtly invite their patients caring and concern while deflecting their anger and rage. At times, they share their

patients concerns and anxieties that they are not fully recovered, that they have lost their professional capacities through their trauma and are consequently extremely fragile.

The return to work, following a miscarriage or other trauma, is determined by conflicting forces. Alongside the therapist's genuine concern for her patients are her needs to restore her self esteem, competence and intactness through gratifying work, and relieve her financial concerns. Some therapists respond to the regressive pulls of convalescence by reaction formation and nurturing the fantasy of an omnipotent recovery. In addition, one should be alerted to countertransference temptations to utilize patients to fulfill the sense of having been missed, and to require their appreciation for one's sacrificial return. Other temptations relate to utilization of patients for exhibitionistic or masochistic gratification.

It appears from the data reviewed that if the therapist who undergoes a miscarriage has her own forum for expression, healing, and support, she will be better able to guard against countertransference manifestation and utilize her experience of trauma and loss to enhance her empathic understanding of her patients' experiences.

A Few Recommendations Regarding Technical Handling of Practical Issues

The data obtained regarding countertransference and reality issues arising in the course of a therapist's pregnancy, suggest a number of areas of technical handling which require special attention. Careful consideration should be given to decisions about practical issues, and

the manner in which they are communicated. The prominent practical issues which emerged in this study relate to how and when to initially discuss the pregnancy, how to handle new referrals, the setting of a leave date and length of maternity leave, contact during leave, resumption of work and self disclosure.

Some general guidelines derived from the data will be briefly reviewed. There was complete agreement among all therapists as to the absolute necessity of open discussion and exploration of the pregnancy within the therapeutic context. While some therapists informed patients of their pregnancy before it was recognized, most analytically oriented therapists preferred waiting for some signal of the patient's awareness (subliminal or overt). This has been perceived as allowing patients their unique pattern of response at their own pace. In particular circumstances, taking into consideration the patients' level of pathology, personal history and the therapeutic setting, therapists felt some modifications might be appropriate. To the extent that the patient persists in not acknowledging the pregnancy on any level by the time it is visibly obvious or by the beginning of the third trimester, it becomes incumbent upon the therapist to broach the topic, in order to insure working through feelings about the pregnancy and the impending interruption prior to its actual occurrence. Failure to discuss the pregnancy and its implications may lead to extreme acting out and premature termination. The above findings support other writers' conclusions and recommendations (Balsam, 1975; Fenster et al., 1986; Penn, 1987).

Regarding the interruption, it has been found that setting a leave date (at times prior to due date) can relieve patients of the anxiety of uncertainty and provide all with a frame of reference in which to work through the issues regarding the separation. If the pregnant therapist is not planning to return to work, she should notify her patients as soon as she has decided, and arrange for alternative treatment.

Notification of birth is handled in various ways according to each therapist's degree of comfort in personal communication and self disclosure. It has been found by most therapists as significant in acknowledging patients' interests and concerns as well as reassuring them that both therapist and baby have survived and treatment will resume.

The length of maternity leave is a personal and individual decision and is often complicated by the fact that decisions need to be made early on in the pregnancy, when therapists cannot fully anticipate their feelings and needs after delivery. The length of leave, consideration of patients' capacity to withstand interruption, and availability of alternate therapists will determine decisions regarding intermediate coverage.

Decisions regarding contact during maternity leave need to be made. Therapists vary in their preferences, some have no contact, others have minimal contact pertaining to notification of birth and return date, while others are available on a crisis basis. Therapists need to have a clear procedure for handling requests of contact. Regarding gifts, all therapists reported that when these were offered, they were accepted.

This did not preclude specific exploration of meanings and underlying ambivalence.

Whatever decisions are made, therapists need to be vigilant to the emergence of countertransference difficulties which affect the choice of technical handling. If handled with foresight and awareness of both patients' and therapists' needs, these practical issues can be negotiated in a manner which preserves the integrity of the treatment.

Concluding Comments and Future Applications

A therapist's pregnancy and miscarriage are unique life events which have profound implications for both patients and therapists engaged in a therapeutic process. They are rare occasions when a personal and significant change in the therapist's life intrudes into the "analytic space" as a concrete and visual reality which cannot (and should not) be hidden or denied, and consequently alters many aspects of the therapeutic setting.

This clinical study has attempted to illuminate the internal experiences of a pregnant therapist at a time when she faces major life changes and alterations in her sense of self and identity as a woman as well as a professional. While the analytic literature has acknowledged the "transference storm" evoked in treatment by such life events, insufficient attention has been given to the parallel "countertransference storm" evoked in the therapist and to its impact on her work.

An attempt has been made to assess the unique role of countertransference phenomena as they relate to empathy and are intertwined with reality aspects of the therapeutic relationship. The significant role

of avoidance and denial in exploring and reporting on anxieties and conflicts which are intensified at a time of personal distress has been reviewed. The therapist's tendency to reject and deny her countertransference and reality based difficulties has been related to her struggle to maintain an omnipotent self image of the idealized, all available and immune therapist and mother, in the face of her human limitations and vulnerability. In addition, the frequent negative attitude to emergence of countertransference as signifying a pathological aberration, has contributed to therapists' experiences of shame, guilt and inadequacy when they are confronted with their "less than therapeutic" feelings towards their patients. It is of major importance to acknowledge that irrespective of the therapist's experience or length of personal analysis, countertransference phenomena are an ubiquitous and inevitable component of therapeutic work. While training can increase awareness and reduce countertransference acting out, it can not eliminate these difficulties. No therapist can maintain indefinite anonymity and neutrality or be impervious to the powerful external and intrapsychic pressures mobilized in the course of an effective emotional investment with one's patients. One should note that not all emotional reactions are countertransference and it is imperative to establish what are expectable and legitimate difficulties.

Thus the issue is not whether countertransference phenomena emerge in the course of one's work or are intensified at a time of personal crisis, but rather how they are managed and utilized.

Based on the findings presented in this study, it seems clear that it is not the actual occurrence of a pregnancy, miscarriage, or any other intercurrent life event in a therapist's life, and not the modification in technique consequently introduced by such an event that interfere with a coherent and meaningful therapeutic process. These findings lend considerable support to the views which suggest that it is the therapist's silence in the face of such life events which threatens the integrity of the therapeutic relationship.

If the therapist is unaware of her own internal processes, needs, and conflicts vis a vis her pregnancy, miscarriage, and femininity, she may be threatened by her patients' intense reactions and will be unable to be attuned to their concerns. Under these circumstances there is danger of collusion in denial or excessive emotional involvement, to the detriment of the therapeutic process. However, if she can utilize her feelings rather than fight them, she can become acutely aware of her own contribution and will be able to sustain an empathic and trusting engagement with her patients while focusing on their inner experiences and characteristic patterns of response. The availability of her own forum for expression and exploration of her concerns appears crucial at this time of upheaval, in helping her balance her needs vis a vis her patients.

An area of focus which has not been sufficiently explored and has direct implications for productive therapeutic work relates to the supervisory experience during a therapist's pregnancy or miscarriage. Supervisors will have their own myriad of conscious and unconscious

reactions to a therapist's pregnancy or miscarriage. Their own conflicts, values, and judgements regarding integrating motherhood and a professional career may profoundly impact both the supervisory and the therapeutic relationships with positive and negative ramifications.

The almost total neglect of the therapist's experience of miscarriage and of problematic pregnancy is striking and alarming. The impact of the collision between fantasy and reality requires further extensive exploration if one is to help therapists deal effectively with issues of narcissistic injury, grief, and loss. Differences in therapeutic and technical handling at various stages of the loss, and coping with hostile and aggressive reactions may be of special significance. This exploration may also prove invaluable in recognizing indications of therapists' unresolved grief reactions.

Other issues for future consideration relate to evaluation of femininity and masculinity in professional practice for both male and female therapists. In addition, observations of other significant life events and role integration may be useful in detecting parallel processes. Male therapist's experiences during their wife's pregnancies and the subsequent therapeutic implications of their transition to parenthood may offer interesting insights regarding parenthood and psychotherapy.

In sum, without neglecting consideration of the potential for turmoil and disturbance introduced by a therapist's pregnancy, it seems evident that this event can provide both patients and therapist a unique

opportunity for conflict resolution and growth. If handled in a sound and sensitive manner, it can accomodate the human dimension in the therapeutic relationship while facilitating a richness of experience and substantial therapeutic gains.

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