WHEN REAL MEETS PRETEND: AN EXPLORATION OF THE IMPACT OF THE THERAPIST'S PREGNANCY ON CHILD PSYCHOTHERAPY

By

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Chapter I

Introduction

A therapist's pregnancy has a powerful impact on the therapist, the patient, and the therapeutic relationship. It is an "intrusion" (Fenster, 1986) into the treatment space, created by the therapist that is physically obvious and irreversible. A number of articles have described the experience of pregnant therapists treating adults in dynamically oriented therapy (Lax, 1969; Etchegoyen, 1993; Bassen, 1988; Fuller, 1987; Imber, 1990). The range of issues discussed include the therapist's sense of preoccupation with her pregnancy and implications for her clinical work, common transference and countertransference themes to arise during pregnancy, patient reactions, and issues around disclosure. While their work is useful in offering some general understanding of the impact of pregnancy on the therapeutic process, it neglects to discuss the therapist's feelings about her body and its relation to clinical work. The meaning of the therapist's body and the way that pregnancy changes both the therapist's understanding of and feelings about her own body as well as the patient's relationship to her body have gone largely unexplored. This is particularly true in the area of child therapy, where one's physical body is so central to the capacity to play.

To date, there have been no systematic studies of pregnant therapists working with children. The work that has been done is largely retrospective and anecdotal in nature. The goal of the present study is to examine the experience of pregnant therapists working with children. Specifically, the study will explore the therapist's changing sense of her body and the ways that physical changes may impact her ability to engage in play. In other words, a therapist's expanding body often means that she

has difficulty sitting on the floor, picking up toys, playing catch or moving around the room with her usual speed. Just as any change in an adult therapist's way of communicating verbally, either in tone of voice or style may disrupt the patient, it is proposed that subtle changes in a therapist's capacity to play may affect child work.

The study was based on qualitative interviews with nine pregnant therapists, all of whom were working psychodynamically with at least two children. The women were interviewed both during their pregnancies and approximately six months after returning from their maternity leaves. The interviews are open-ended, structured by a series of orienting questions that focuses on the impact of pregnancy on the therapist's sense of self as a clinician and on her work with children.

In order to understand the particular importance of these issues to child therapy, it is necessary to review the work that has been done both on the experience of pregnancy in general and the experience of pregnant adult therapists in particular. Thus, the sections that follow will discuss both these areas, as well as the limited work that has been done on pregnancy specific to child therapy.

Chapter II

Literature Review

Pregnancy

The literature on women's emotional responses to pregnancy suggests that pregnancy is a process, and a woman's experience of her pregnancy changes over time. The aspects of the literature that are most relevant to the study at hand include women's experience of anxiety and preoccupation with their internal worlds.

First, anxiety is central to women's experience of pregnancy. Bibring (1959, 1961) describes pregnancy as a time of emotional upheaval and psychological crisis. Regarding her observations of women being treated in a prenatal clinic, Bibring (1961) writes that what often appears to be serious disturbance in pregnant women in fact does not represent underlying pathology but rather "something characteristic of pregnancy itself" (p.12). The crisis of pregnancy has been found to involve a loosening of defenses in the pregnant woman, a period of regression, and a shift in self and object representations (Diamond, 1992). A number of developmental theorists have proposed that the emotional turmoil of pregnancy may in fact be seen as a positive transition phase, leading ultimately to a new level of personality reorganization and integration (Benedek, 1970; Bibring, 1959; Caplan, 1961; Erikson, 1959). Such reorganization is often marked by profound anxiety. Pines (1972) writes that pregnancy, particularly a first pregnancy, may be seen as a point of crisis in the process of establishing an identity as a woman. "It is a point of no return...it implies the end of a woman as an independent single unit and the beginning of the unalterable and irrevocable mother-child relationship" (p.333).

Leifer's work (1980), consisting of in-depth interview with 19 pregnant women, supports the notion that pregnancy is a period of turbulence and stress for most women. Leifer argues that while some theorists have viewed anxiety during pregnancy as a pathological response suggesting a rejection of the pregnancy, the anxiety associated with pregnancy is in fact specific in content and shifts as the pregnancy progresses. Anxiety in the first trimester is linked to fears about miscarriage. In the second trimester, with the onset of quickening, anxiety is related to fears of deformity. Anxiety in the third trimester centers on the well-being and survival of the self and the fetus. As pregnancy progresses, women begin to see the external world as filled with potential threats. They become more cautious and fearful that they may be harmed or attacked.

Leifer (1980) found that throughout pregnancy, women experience an increase in self-preoccupation and a decrease in investment in the outside world, regardless of their profession. The process of declining investment in the external world begins in the first trimester and becomes more significant as pregnancy progresses. In the second trimester, with the onset of quickening, women "turn inward" (Bibring, 1961). During this period, a woman's psychological life becomes focused on pregnancy and impending motherhood, and psychological preparation for the baby becomes "intense and compelling," leading to decreased interest and involvement in other interests and activities (Leifer, 1980). Women tend to disengage psychologically from their jobs or academic life and to feel less interested and invested in their work.

Leifer (1980) argues that rather than representing a regressive phenomenon (Kestenberg, 1976), a woman's tendency to "turn inward" in fact reflects a heightened awareness of the self and the fetus and active preparation for the baby. Thus, increased

self-preoccupation during pregnancy may be seen as adaptive in that it allows for both the development of emotional bonds with the fetus and psychological preparation for parenthood.

Women's experience of their bodies also undergoes a profound shift during pregnancy. Leifer's study (1980) reveals that during the first trimester, women feel ambivalent about impending bodily changes. Commonly, there is a feeling of unreality about the pregnancy and a tendency for women to become more focused on their bodies to look for changes. The second trimester is a time of heightened positive feelings about pregnancy but mounting anxiety about bodily changes. These changes, particularly rapidly increasing body size, are experienced as somewhat ego-alien. The development of bodily changes such as stretch marks and veins is associated with feelings of damage to the body, worries about loss of sexual attractiveness, and anxiety about the degree of permanence of these changes. For many women, the significant growth and weight gain during the second and third trimesters represents a loss of control over their bodies.

While there is no reason to believe that a therapist's experience of her pregnancy is dramatically different from women working in other fields, there are a host of issues specific to therapeutic work that must be explored. First, a woman's heightened anxiety, vulnerability, and state of self-preoccupation may have a serious impact on her capacity to engage in affectively laden material with her patients. In particular, pregnancy may impact a therapist's capacity to work with countertransference themes. Second, pregnancy, by its very nature, acts as the introduction of powerful information about the therapist. This information, as well as the visible changes in the therapist's

body that are being witnessed by the patient in an ongoing way, may lead to a host of complicated feelings. Third, changes in a woman's physical being as well issues around disclosure suggest that pregnancy may affect therapeutic technique and the treatment in general. Fourth, changes in the therapist' body during the course of pregnancy may have particular meaning to both patient and therapist that may affect the treatment. These considerations were central in creating the foundation for the present study.

Pregnant Therapists

A universal finding in the literature on pregnant therapists is that they feel anxious and guilty about the possibility of becoming less responsive to their patients during pregnancy. In fact, pregnant therapists have been found to become increasingly self-absorbed and to withdraw from their patients (Balsam, 1974; Bassen, 1988; Fenster, 1986; Lax, 1969; Notman, 1974), so this concern is a realistic one.

Although the experience shifts over the course of pregnancy (Fenster, 1986; Fuller, 1987), therapists may begin to have difficulty attending to patients as early as the first trimester (Fenster, 1986; Paluszny & Poznanski, 1971). Therapists have been found to experience a state of self-absorption, an increasing sense of distance from the external world, and a sense of carrying a secret (Fenster, 1986). As is true of women in general in the first trimester, therapists tend to experience heightened fears and anxieties regarding the well being of the baby.

Although anxiety tends to diminish in the second trimester, physical and emotional vulnerabilities persist, and may even increase as the pregnancy becomes more visible (Fuller, 1988; Nadelson, 1974). Particularly with the onset of fetal movement, therapists tend to withdraw even further. "The kicking of the baby

constantly acted as a reminder, beckoning the therapist to retreat briefly into the small inner world" (Paluszny & Poznanski, 1971, p.274). This period, particularly the sixth month, marks the period when the majority of therapists confront patients' denial of the pregnancy (Browning, 1974; Lax, 1969). It is also a time where therapists may begin to experience a sense of external danger to the fetus and to engage in protective responses such as rubbing the belly and focusing on fetal movements during sessions with very angry patients (Fuller, 1988).

In the third trimester, therapists may experience an increase in self-absorption and concern with issues of life, death, separation, and attachment. A decrease in intellectual curiosity has also been noted (Fenster, 1986; Paluszny & Poznanski, 1971). With an increase in size, strength of fetal movements, and level of physical discomfort, therapists may feel even more vulnerable during this final phase of pregnancy (Fuller, 1988). As the baby becomes an imminent reality, the therapist experiences what Winnicott (1956) termed "primary maternal preoccupation."

Thus, a therapist's ability to stay attuned to her patients is likely to diminish as pregnancy progresses. Therapists become increasingly drawn into their own worlds and preoccupied with the life growing inside them. In addition, anxiety can be ever-present, as is a therapist's growing sense of her physical limitations and vulnerability. Not surprisingly, these changes have critical implications for a therapist's capacity to deal with countertransference themes.

Countertransference.

Common countertransference themes to emerge during pregnancy include helplessness, anxiety, guilt over leaving patients, fears and fantasies about harm to self

or baby during delivery, and withdrawal from work and patients (Ashway, 1984). Therapists also describe feelings of discomfort about excluding patients from more detailed knowledge of their pregnancies as well as difficulty dealing with particularly intrusive patients. In addition, pregnant therapists often wish to withdraw from threatening aspects of patients' material and to erect sharper boundaries between themselves and their patients (Bassen, 1988; Bienen, 1990).

Pregnant therapists have been found to be especially vulnerable in their capacity to attend to countertransference issues and tend to be more defended than usual in their awareness of countertransference reactions (Bassen, 1988; Bienen, 1990; Imber, 1990; Lax, 1969). In particular, negative countertransference responses are experienced as difficult and are more likely to be warded off during pregnancy. "The fantasies, wishes, conflicts, and anxieties which being pregnant arouses, both personally and professionally, may result in denial and avoidance of highly charged material with patients" (Imber, 1990, p.225). For pregnant therapists, intensely negative feelings such as hatred, envy, or destructive fantasies may be particularly hard to tolerate, both in the therapist and her patients (Bassen, 1988; Imber, 1990).

As one therapist writes,

> Preoccupation with the well being of myself and the baby, anxieties related to changing body boundaries, and heightened issues around control and achievement affected my willingness to actively explore transference material that was related to my pregnancy as well as to facilitate the expression of patients' aggressive or envious feelings towards me. In certain instances, these dynamics contributed to a tendency to distance myself from highly charged

affects in the treatment and to a collusion with patients' denial and avoidance (Bienen, 1990, p.611).

Uyehara et al. (1993) suggest that a therapist's physical vulnerability may further complicate her ability to deal with a patient's aggression. As she becomes more tired and uncomfortable and her body changes into a form that is more exposed, slowed, and less agile, she increasingly feels unprotected. Thus, patients' aggressive feelings may be experienced as quite toxic and dangerous. Imber (1990), offering another perspective, suggests that it is in fact the therapist's own hatred, more than the patients', that is so hard to tolerate. In order to be able to acknowledge powerful feelings of aggression in her patients, the therapist must be able to recognize them in herself. Strikingly, these feelings run counter to the task of becoming more maternal and nurturing in this phase. As the birth of her baby becomes imminent, a therapist may need to see herself as life-giving and nurturing rather than destructive and depriving (Uyehara, 1993). Thus, there is a danger that the therapist try to be an all-good mother-therapist and thus minimize both her own and her patient's ambivalence (Imber, 1990). This concern seems particularly relevant when considering the paucity of literature focusing on child therapy.

Diamond (1992) writes that the therapist's shifting sense of self-image in relation to the maternal object impacts the form and content of transference and countertransference material. Both the therapist's move towards maternal identification and her heightened sense of femininity have critical implications for both male and female patients. Diamond suggests that, "pregnancy causes a temporary disequilibrium in the balance of masculine and feminine aspects of the analytic situation" (p.330).

Rather than being able to move fluidly between maternal and paternal identifications, pregnant therapists may be in a temporary state where maternal identifications predominate. This imbalance may powerfully impact both the way she works and the way patients respond to her.

Imber (1990), in her discussion of countertransference during pregnancy, suggests a link between pregnancy and illness in that both are characterized by intense self-absorption. Winnicott (1956) described maternal preoccupation during pregnancy as a kind of normal "illness," highlighting the sense of self-absorption inherent in both events. Along these lines, Imber emphasizes that the heightened physical and emotional vulnerability characterizing pregnancy makes intense countertransference reactions difficult to acknowledge. Pregnancy, like a serious illness, represents a major disruption in the treatment that may cause unpredictable and powerful effects on both the patient and the therapist. Pregnancy, impending childbirth, and illness are understood as stressful life events where, in fantasy or reality, the very life of the therapist may be in question (Imber, 1990).

Dewald's (1982) writings on his experience with illness share certain parallels with the process of pregnancy, particularly with regard to countertransference (Imber, 1990). He writes,

> When something realistic in the analyst's behavior stimulates difficult or painful responses in the patient, countertransference reactions tend to be more intense and defensive; it becomes more difficult to sort out and differentiate the patient's transference-dominated perceptions and reactions from those in which sensitive and subtle reality perceptions play a significant role. The therapeutic

> problem lies in the need to adequately explore the full gamut of patient responses, affect, and associations to the illness, and to do this in the face of countertransference temptations either defensively to promote premature closure and evasion of more threatening affects and associations to the illness or to use the experience for exhibitionistic, masochistic, narcissistic, or other neurotic satisfactions (1982, p.361).

A critical difference between pregnancy and illness is that pregnancy is often a planned event, and one that is cause of tremendous happiness, anticipation, and narcissistic pleasure (Friedman, 1993; Marriotti, 1993). Despite this difference, however, the comparison between pregnancy and illness is worth noting when working with children, many of whom may be concerned about their therapist being sick, disappearing, and even dying.

Patients' reactions.

The impact of the therapist's pregnancy may range from minimal to major, from extremely productive to profoundly disruptive, often within the same therapeutic practice. Bassen (1988) notes that while some of the patients discussed in her study reacted by denying the pregnancy had any meaning to them, others responded with intense feelings of loss, dependency, rage, or acting out.

Given the fact that some therapists have been found to withdraw from their patients and to be somewhat less attuned to their experiences, it is not surprising that many patients react in a powerful way. As Paluszny & Poznanski, (1971) note, the therapist's withdrawal lends some degree of reality to patients' feelings of rejection and competition with the baby. Prominent themes that emerge in response to the therapist's

pregnancy include feelings of dependency, loss and abandonment, separation, competition, envy, feelings of exclusion and fears of displacement, feelings and fears about female sexuality, wishes and fears of pregnancy, conflicts about creativity, idealization and devaluation, anxiety and guilt about death wishes towards and destructive fantasies about the fetus and/or therapist, the idea of secrets being withheld, identity issues, and reparative concern. Themes of sibling rivalry and oedipal rivalry are also prevalent. (For a deeper discussion of these themes see Bassen, 1988; Fenster, 1986; Korol, 1995; Nadelson, 1974; Poluszky & Poznanski, 1971).

A number of factors have been found to mediate patients' reactions to their therapist's pregnancy. These include the patient's character structure (Hanett, 1949), gender (Diamond, 1992; Fenster, 1986; Nadelson, 1974; van Leeuwen, 1966), age (Browning, 1974), life circumstances (Browning, 1974; Leifer, 1980), the type of treatment (Lax, 1969; Rubin, 1980), birth order (Lax, 1969) and the stage of pregnancy (Fuller, 1988; Nadelson, 1974). Consistent with other literature and clinical observations, the patient's level of ego strength or diagnosis also has a significant impact on the way the patient responds to the pregnancy (Hannett, 1949; Fenster, 1986; Paluszny & Poznanski, 1971). For instance, borderline patients tend to become aware of pregnancy the earliest and are more likely to act out their conflicts (Fenster, 1986; Lax, 1969). Lax (1969) suggests that a patient's reaction tends to represent a reactivation of those elements of the infantile conflict which was most critical to the development of the patient's pathology.

Differences in terms of gender have also been cited. Women for the most part recognize the pregnancy before men and are more likely to undergo a "powerful

transference storm" (Lax, 1969). Female patients also tend to be more reactive, and common issues included identification, envy, and competition. Male patients tend to deny the pregnancy for a much longer period of time and to resort to more regressive defenses such as isolation (Fenster, 1986; Lax, 1969). Male pregnancy envy has also been cited (van Leeuwen, 1965). Diamond (1992) examines the variations in transference and countertransference themes she experienced with her male and female patients during pregnancy. In particular, she found critical differences in terms of male and female childbearing wishes and fantasies. She also found differences in the quality of aggressive fantasies towards the fetus. In her discussion of her own miscarriage during her second trimester, Gerson (1994) highlights gender specific reactions related to pregnancy loss. Findings of gender differences in the intensity of the transference, however, have not been universal (Uyehara et al, 1993).

There seems to be consensus in the literature that pregnancy introduces "a concrete, irreversible, and evocative impingement on the treatment setting and the therapeutic dyad" (Fenster, xii). It represents a shift in the holding environment, as the therapist is responsible for the introduction of such powerful stimuli into the treatment room. The supposed anonymity and neutrality of the therapist is disrupted (Lax, 1969). The pregnancy is a reality attesting to the therapist's existence as not only a real person, apart from the patient, but also a sexual person (Ashway, 1984; Fenster, 1986; Nadelson, 1974). The therapist's pregnancy offers proof of gender identity and the visible manifestation to the external world that she has had a sexual relationship (Pines, 1993). Patients often see therapists, like parents, as static; even patients who are in treatment over long periods of time do not perceive the therapist as changing in any

significant way. Pregnancy intrudes on this distortion and makes it virtually impossible for the patient to deny seeing her as a real person (Turkel, 1993).

Transference.

There seems to be agreement in the literature that a therapist's pregnancy intensifies the transference (Deben-Mager, 1993; Fenster, 1986). The most commonly noted transference themes to occur during the course of a therapist's pregnancy include sibling rivalry, envy, oedipal issues, fear of abandonment, identification, idealization and devaluation of the therapist, hostility and guilt feelings regarding destructive wishes towards the baby, and issues around female sexuality (Deben-Mager,1993; Fenster, 1986; Lax, 1969).

Typically, envy emerges in the patient's belief that the therapist has everything—a career, a man, and a baby—while the patient has nothing (Deben-Mager, 1993; Fenster, 1986). Sibling rivalry is often manifested in a patient's fear that the therapist will love the baby more. Fear of abandonment stems from the destruction of the patient's fantasy that the therapist exists only for him (Deben-Mager, 1993). Patients may even perceive the therapist's pregnancy as an act of infidelity or betrayal and become angry that they were not told soon enough (Uyehara et al, 1993).

Disclosure.

The issue of disclosure is an important one during the course of a therapist's pregnancy. Imber (1990), based on her own experience and discussions with colleagues, suggests that most therapists, at least on some level, wish to keep their pregnancies hidden from patients as long as possible. Lax (1969) in fact observed that it was common for pregnant therapists literally to begin to embroider large blankets or afghans

during sessions, thus disguising their changing bodies. She suggests that these therapists were in fact afraid of being "robbed."

The issue of when to tell patients about the pregnancy has received some attention in the adult literature. Uyehara et al (1993) suggest that a therapist's countertransference guilt, narcissistic preoccupation, heightened infantile conflicts, and strong patient reactions may in fact generate anxiety which becomes displaced onto various concerns about telling. "At times, the transference-countertransference paradigm of hostile patient and guilty analyst becomes transposed onto the issue of the timing of the analyst's disclosure of the pregnancy" (p.126). Wide variation has been found in terms of a therapist's approach to telling. While some analysts inform patients early, reasoning that their leaves must be addressed, others wait for patients to initiate the discussion (Bassen, 1988; Uyehara et al, 1993). However, since patients often give no indication that they are aware of the pregnancy, decisions about the telling are left to the therapist's discretion. Issues such as countertransference guilt as well as characteristics of the patient and treatment tend to shape a therapist's decision about telling (Uyehara, 1993). There seems to be some agreement that the therapist should reveal that she is pregnant by the beginning of the third trimester in order to allow enough time for processing the material before the therapist goes on leave (Fenster, 1986; Uyehara, 1993). It is also recommended that news of the pregnancy and details about the maternity leave should be given on separate occasions in order to accommodate the different meanings that patients may hold for the two events (Uyehara et al, 1993).

Acting out is also an issue in adult treatments with pregnant therapists. Premature termination is common (Fenster, 1986; Uyehara et al, 1993), and patients may even become pregnant themselves (Fenster, 1986; Uyehara, 1993). Patients often present with their own crisis, as if to suggest to the therapist how heartless and irresponsible she is for leaving them when they need so much from her (Imber, 1990). There is also some evidence that after feeling intensely involved with the process of pregnancy, patients experience a sense of loss when the baby is born. There is some indication that these feelings are akin to feelings of loss associated with the birth of a sibling (Fenster, 1986).

It is also quite common for patients to be able to process the issues stirred up by the therapist's pregnancies only after the therapist returns from maternity leave. Patients have been found to feel both freer and safer, particularly in their expressions of anger, competition with and jealousy of the baby, after they know that the therapist and baby are safe and they have not been abandoned. This was found to be particularly true among more disturbed patients, for whom the fear that their feelings and needs could destroy the analyst or force her to abandon them was quite profound (Bassen, 1988).

Child Treatment

The literature addressing pregnant therapists' experience of child work is sparse. Of the articles available, all are retrospective accounts of therapists' experience of pregnancy (Browning, 1974; Miller, 1992; Paluszny & Poznanski, 1971; Simonis-Gayed, 1994) or combine therapists' and their colleagues' retrospective accounts of pregnancy (Ashway,1984; Nadelson, 1974). The available literature focuses on the

reactions of both patient and therapist to the therapist's pregnancy as well as changes in the therapeutic relationship.

Children's reactions.

Children's knowledge of pregnancy has been found to emerge first in play (Browning, 1974; Ashway,1984). Children use play to express their curiosity, conflicts, fantasies and fears (Ashway, 1984), and it is a way for them to process and integrate a range of thoughts and feelings. A child's ability to use play to work through feelings of anger, jealousy, and fears of abandonment is especially critical during a therapist's pregnancy. Although several authors have addressed shifts in the content of play during pregnancy, there has been no discussion of changes in the quality of play that may occur over the course of pregnancy. In fact, children have been found to be highly attuned to a therapist's difficulty playing on the floor, picking up toys, and playing in a physical way (Simonis-Gayed and Levin, 1994). Thus, a further examination of the meaning of changes in a therapist's capacity to play is critical.

Once a therapist's pregnancy is acknowledged, children tend to react with denial, magical thinking, and fears of abandonment (Ashway, 1984). Common themes to emerge include themes of rejection, sibling rivalry, identification with the therapist and/or the therapist's baby, anger, and oedipal strivings (Ashway, 1984; Miller, 1992; Paluszny & Poznanski, 1971; Simonis-Gayed and Levin,1994). Heightened fears about being left, often compounded by anger and feelings of helplessness, may be marked by a period of regression (Browning, 1974).

Some children are quite perceptive about the therapist's pregnancy, commenting on it in a direct and open way (Ashway, 1984). For example, the following remarks were made by my own and a colleague's child patients during our pregnancies:

"I hate you...I think your baby is going to be deformed."

"OK, let's pretend you're pregnant and I'm the nurse and I'm going to help you get the baby out. Now pretend I'm a robber and I come and steal your baby and make it sick until it dies."

(therapist) "I want to tell you that I'm pregnant and I'm going to have a baby."

(six-year-old girl) "That's terrible...You'll love the baby most."

"I'm so mad I'm going to kick your eyes out one of these days. And I'm going to smush the baby and you won't be able to stop me."

"Oh My God, you're pregnant. Quick! You have to go to the hospital. You might die and go to heaven and then I wouldn't see you anymore."

" I was worried you might be offended when I killed the babies (by repeatedly running over baby doll figures with a train). Because you don't want me to do that to your baby."

Several authors note that their child patients asked them very direct and explicit questions about their pregnancy (Miller, 1992) and sexuality (Nadelson, 1974). Ashway (1984) describes feeling "on display" during her second and third trimesters and that she experienced both resentment and pleasure at the exposure of her personal and sexual life. Despite noting patient's curiosity and difficulties around issues of disclosure, therapists writing in this area offer few concrete recommendations in terms of what information is useful to children. Browning (1974) argues that children have a

significant emotional investment in the pregnancy and that disclosing information about the outcome is often appropriate. She also recommends that therapists treat each case individually in determining when to disclose the pregnancy.

There are several factors that shape children's responses to a therapist's pregnancy. First, a child's developmental stage impacts their ability to process information about pregnancy as well as maternity leave and reunion. Although this issue has not been addressed in detail, Miller (1992) discusses the fact that her latency-aged patient was unable to hold in mind the idea of the therapist's return, which left her unable to mediate her feelings of sadness, anger, and fears of abandonment. Miller notes that her child patients found that a six-week absence was "incomprehensible." In fact, children have been found to develop the concept of objective time between the ages of seven and nine years old (Marshall, 1990). Thus, for many children, the therapist's discussions about separation and promises that she will return may not be as meaningful or reassuring as the therapist hopes.

Another factor that impacts children's responses is the fact that issues such as separation, abandonment, oedipal strivings, and sibling rivalry may be very real, present-day experiences for them (Browning, 1974; Nadelson, 1974). In particular, the presence of a younger sibling has been found to be a significant factor in children's reactions to news of pregnancy, serving to intensify feelings of envy and competition. Ashway (1984) suggests that the immediate nature of such developmental events as the birth of a sibling or separation from a parent leads children to experience these issues with even greater intensity than adults.

The fact that children may respond to a therapist's pregnancy in physical ways has received little attention in the literature but is vital to understanding therapeutic interaction during pregnancy. While only one author refers to the possibility of child patients actually striking the therapist (Nadelson, 1974) others note the significant degree of anger in many children, as exemplified by one patient's play about making "baby soup" (Browning, 1974). Miller (1992) reports that she did not find any evidence of anger or aggression towards her or the baby. However, she did find that children throughout her caseload demonstrated an increased desire to touch her abdomen, a phenomenon that disappeared after she had the baby. She interprets this wish to touch her as a result of a loosening of boundaries and that her transformation into looking like a "mommy person" stimulated the children's intense desires for physical contact with their own mothers. She also raises the possibility that the touching may have been linked to the ongoing physical changes of pregnancy and children's own immediate experience with the physicality of gender differences. It is also possible that such touching may in fact mask a real desire to destroy the baby.

Although the issue of physical closeness and touch is addressed briefly by Miller (1992), there is no discussion of children who act out fantasies of wanting to be the therapist's baby that include being held, rocked, read to, and even nursed. In my own experience of treating a six-year-old girl, I often experienced such close physical contact and longing on the part of the patient to be my baby, and in fact to crawl inside me, as quite intrusive and difficult to manage. The meaning of changes in accessibility to the therapist's body during pregnancy has thus far been overlooked.

Countertransference.

Therapists working with children describe intense feelings of guilt, both for abandoning their patients and for becoming increasingly preoccupied with their own internal worlds (Ashway, 1984). Paluszny and Poznanski (1971) describe the unique situation of the pregnant therapist as, "existing in two worlds simultaneously" (p.274); the therapist and patient existed in one world while the therapist and the unborn baby inhabited the other. While therapists often experience a decreased emotional investment in their child patients, they may also feel more maternal and nurturing towards them (Ashway 1984). Nadelson (1974) points out that countertransference material may be particularly difficult with child patients because the therapist is struggling to integrate her own feelings of maternal identity. Thus, feeling that she is being a "bad mother" to her child patients may be quite stressful. In addition, a child therapist often plays the role of "protector" in the child's life. In such cases, the therapist's guilt over abandoning the child is especially pronounced (Simonis-Gayed & Levin, 1994). Wishes to be the protector or rescuer of a child may also lead to feelings of competition with the child's parents. During pregnancy, these feelings may become particularly heightened (Nadelson, 1974).

Parent work.

Parents may have quite powerful reactions to the therapist's pregnancy, and the way a therapist engages the parent during this time is critical for the child's treatment (Ashway, 1984). Despite this fact, not a single article addresses the nature of parent work during pregnancy. Parent work in general is often difficult for therapists, and pregnancy would seem to give rise to a host of complicated issues both for therapist and

parent. I found it to be the most challenging aspect of therapeutic work during my pregnancy. Navigating boundary issues and issues of disclosure was particularly difficult with the mothers of my child patients. While pregnancy offered an opportunity to connect around a shared experience, it also blurred a professional boundary that I struggled to maintain. For instance, one of the mothers I worked with wanted to talk to me at length about breast feeding. This continued after my daughter was born. I found it very difficult to both engage her in a way that I had previously been unable to and to set limits without causing her to feel rejected.

Changes in the capacity to play.

Although several of the authors above allude to the impact of the therapist's changing body on her capacity to play, none of them discuss this issue in any detail. In addition, the issues of physical closeness in child work and the resulting anxiety that may stem from real fears of bodily harm are largely ignored. The reality of treating two children during the course of my own first pregnancy highlighted the central nature of play and how physical changes during pregnancy may impact the process of playing together. In addition, the meaning of the therapist's body, to both patient and therapist and the way that this meaning may shift over the course of pregnancy has not been addressed.

Most of the discussion in the literature has focused on the therapist's internal experience of her body, i.e. a preoccupation with the fetus and guilt about psychological withdrawal. It does not address, however, the ways in which this competing inner world affects the therapist's actual stance in the room. Therapists may erect not only a psychological barrier between them and their patients but also a physical one. For

instance, as my pregnancy progressed, I became increasingly aware of the relationship of my physical body to the child in the room. I constantly repositioned myself physically so that my stomach would be safe from incoming toys, blocks, and even hugs. It should be noted that I was treating a six-year-old girl and a twelve-year-old boy, both of whom had very different styles in the room. The six-year-old often engaged in elaborate fantasy play with dolls and toys that required my physical closeness but not necessarily in an athletic way. In contrast, the twelve-year-old often played quite actively and at various points in treatment was extremely destructive. Both patients reacted quite powerfully to the decrease in my activity level and to the change in their access to my body.

There is a vast literature supporting the idea that play is the central medium of child therapy and that it is through play that the patient and therapist are able to create the transitional space necessary for therapeutic change to occur. What is largely missing from the literature is the meaning of the often intimate, physical nature of play and the way that the therapist's and patient's body coexist in the same shared space. A review of recent work on perspectives on the body in psychoanalysis (Aron, 1998) sheds some light on the powerful role of the body in treatment.

Klein (1975/1932) writes that play is the language of child psychoanalysis and that interpretation of play is what leads to therapeutic change. Klein writes, "Full analytic impact can only be obtained if we bring these play elements into their true relation with the child's sense of guilt by interpreting them down to the smallest detail" (p.8). She discusses the rapid effect of interpretation and the ways that interpretation leads children to become less inhibited in their play.

In contrast, Winnicott suggests that psychoanalysts have focused on the meaning of play's content and have neglected to look at the playing child or to understand playing as its own entity. Winnicott proposes that when play is spontaneous, it is therapeutic in its own right. Winnicott (1971) writes, "psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together" (p.38). The space of play exists somewhere between the internal and external world; it is a space between fantasy and reality or between the mother and her infant. Playing, writes Winnicott, involves the body, because of both the physical manipulation of objects and the fact that certain kinds of intense interest are linked to specific types of bodily excitement.

Slade (1994) echoes Winnicott's idea that in fact it is often the very process of playing rather than the therapist's interpretations of the play that is most therapeutic. While her discussion is primarily focused on younger or more disturbed children who have not yet developed the capacity for symbolization, she suggests that even older children often benefit from the act of playing itself. The very act of playing may allow children to consolidate ideas and feelings about inner conflicts whereas interpretation may intrude upon this process. As Slade writes, "simply playing," rather than trying to uncover the meaning of play, often facilitates movement in the treatment.

Looker (1998) also emphasizes the need of the therapist to immerse herself in play and suggests that it is the therapist's ability to be comfortable in her own body that in fact facilitates play. She writes, "there is an especially fluid, imagistic dialogue between psyche and soma in play...this fluidity makes reorganization, healing, and growth possible. During such moments, the analyst's verbal commentary can push the

patient back into a dissociative retreat from affect and bodily experience, and the mutative experience is minimized or aborted" (p.252).

Looker poignantly describes a three year treatment with a boy who urged her to "just play, just be." She writes that what he needed from sessions was "unselfconscious play" and the ability to just be in the company of the therapist. Verbal interventions were experienced as intrusions and in fact disrupted the connection the patient so eagerly sought. She describes her patient's desire to have her read to him and to sit very close together while they read, often with their hands touching. She writes about her struggle to hold onto the "simple embodied togetherness" in the face of threatened disconnection from her own and the patient's body. She acknowledges that she often had to fight the urge to talk, instead working "to get comfortable in my own body" (p.250).

Fonagy and Target (1998) take a more cognitive approach to the healing nature of play, suggesting that play functions as a transitional area for children to experiment with feelings and ideas. It is the therapist's "playful stance" that facilitates the child's ability to mentalize his experience. This ability to mentalize, or to think about one's own mental experience as well as others, in turn underlies his capacity for affect regulation, impulse control, self-monitoring, and self-agency. Through play, the child is able to find himself in the mind of the analyst as a thinking and feeling being. As Fonagy writes, "the internalization of the analyst's concern with mental states enhances the patient's capacity for similar concern towards his own experience" (p.109). Play is the medium through which the analyst may communicate her understanding of what the child is feeling and experiencing in order to strengthen the child's core sense of self.

The body.

Aron (1998), in his work on the meaning of the body in psychoanalysis, builds on the work of Fonagy and Target and Winnicott. He highlights Fonagy and Target's notion of the importance of allowing the patient to consider the child's mind, but he adds the need for the patient to attend to the analyst's body. He writes, "one of the ways in which patients routinely gain some understanding of the analyst's subjectivity is by attending to and noticing aspects of their analyst's body" (p.29). He discusses the impact of body and mind on each other and proposes that the analytic space is in fact a co-construction of the patient and therapist's mind-body.

Aron suggests that in fact the capacity to mentalize has intersubjective origins in the body. He cites work by Krystal (1988) arguing that affects are initially experienced as bodily sensations, and only gradually, through the ministrations of the caregiver, do these sensations evolve into subjective states that may be articulated with language. "Affects undergo developmental transformation as they become increasingly differentiated, articulated, and desomatisized....It is the caregiver's empathy and attuned responsiveness that fosters the development of bodily states becoming verbally articulated, leading to the experience of affects as mental and not only bodily phenomenon"(p.12).

Borrowing from Winnicott, Aron writes that the development of the self is created by the infant and mother together. Initially, infants do not experience a sense of boundedness; only gradually do they develop a sense of differentiation between self and other (p.20). It is through the caregiver's good enough handling of the infant's body that the infant is able to come into a bodily sense of personhood. "It is clear that in

infancy our bodily sensations are greatly affected by the qualities of 'holding' and 'handling' that we receive from caregivers, and so it is not much of an extension to suggest that our self is first and foremost a body-as-experienced-being-handled-and-held-by-other-self, in other words our self is an intersubjective body self"(p.xx). It is through such holding and handling of the child's body that the caregiver conveys her recognition that the child is a separate being.

Aron extends the notion of the "intersubjective body self" to the emergence of the self in psychoanalysis. He suggests that analysis is a process by which "patient and analyst mutually regulate each other's behaviors, enactments and states of consciousness such that each gets under the other's skin, each reaches into the other's guts, each is absorbed and breathed in by the other. For a while, patient and analyst share a jointly created skin-ego/breathing self" (p.26). He writes that for patients who have difficulty symbolizing, unformulated affective experience may only be processed vicariously, by communicating them to another person. Such a process of projective identification is one that allows for having "one's communication viscerally received, contained, lived through, symbolized, and given back in such a way that one knows the other has 'gotten it' from the inside out" (p.26). He notes that such a process of knowing the patient "from the inside out" has the effect of significant "wear and tear on his or her own body/psyche." He suggests that such unmetabolized affects are often communicated through nonverbal means that are felt by the analyst as changes in the environment, the body, or the "feel" of things. Thus, the analyst must be in constant awareness of her body and bodily sensations, becoming highly attuned to any changes.

Gunsberg and Tylim (1998) discuss the idea of psychoanalysis as a process leading to a patient's ownership of her own body and mind. They write that resistances in treatment are often linked to giving ownership of one's mind and body. They suggest that in this process the analyst must be willing to "own, reown, and at times surrender his or her own body and mind" (p.122). They describe clinical material of a woman who "wished to go beyond the bounds of the analyst's body and enter the analyst's womb" (p.131). When the analyst became pregnant, this patient felt she was in fact being pushed out of the analyst's body for the analyst to make room for her own babies. This led to aggressive fantasies towards the analyst for preventing her from staying inside the analyst's body. The authors write that the patient's desire "felt like a forcing, a pushing to enter the analyst's womb"(p.131) and suggests that "when a patient comes so close to the analyst's body with her own body, the analyst can feel temporarily invaded in a way that is different from invasion by the analysand's words. There is an intrusion in the analyst's own personal, private space" (p.131).

The authors conclude that patients who have difficulty owning their own minds and bodies are particularly attuned to changes in the analyst's body and affects. Such patients rely heavily on the immediacy of their sensory experiences in treatment and are likely to become "mind-body readers" of the analyst. While the authors argue for the necessity of promoting such freedom in the ownership of the analyst's and patient's mind-body, they suggest that such intimate involvement may be experienced by the analyst as a "bombardment" (p.134).

Burka (1996) writes of the analyst's body as an "analytic third" describing patients' use of her own overweight body in various ways as a creative medium for

transference. She describes the ways that her own feelings about her body shifts powerfully with different transference manifestations. "I too have very different experiences of my body at different times with different patients. I have noticed changes in my body image, sometimes dumpy and self-conscious, sometimes voluptuous and racy, sometimes motherly and nurturing, sometimes shriveled and empty" (p.263). She writes, "the shape of the therapist's body is the shape of the supporting object. Therefore, the therapist's body is both a concrete contour and the symbolic container of the holding and supporting environment" (p.259). She highlights the fact that by bringing her body into the interpretive discourse, she is allowing patients the freedom to wonder, consciously or unconsciously, what is in fact insider her body and to have the idea "that there's room in there" (p.263).

Burka builds on Andre Green's writing on the "analytic object" or the notion that an analytic object may be understood as the space between a patient and therapist; it is the world where the patient and the analyst meet. She suggests that, "the therapist's body belongs to both the therapist and the patient" (p.264). While the physical reality of the therapist may be understood and evaluated in its own right, what she terms the "psychical reality" of the therapist's body is meaningful only within the context of a particular patient-therapist dyad. It is this joint use of the therapist's body that contributes to a therapist's shifting sense of her body within different transference/countertransference relationships.

Burka points out the parallels that have often been noted between the mother/infant dyad and the psychotherapy relationship, in which "the therapist/mother creates a maternal environment for the patient/child, and the two partners interact in the

space between them." She suggests the possibility that another parallel exists involving the maternal/therapist's body. "That is, the therapist's body has great significance for the patient, and the therapist's actual and symbolic physicality plays a very important role in the patient's experience of aliveness and in the vitality of the therapy" (p.274).

Looker (1998) emphasizes the critical nature of the body in her work with two children. She discusses the "rift between psyche and soma" as originating in the child's relationship with the mother's body. She demonstrates the ways in which the mother's disconnection from her own body may lead to the dissociation of psyche and soma in her child. Looker writes that a child's discomfort in her body is rooted in her discomfort with her mother's body. "As an infant, the child needed her mother's body not only for soothing and containment but to poke and probe, to possess ruthlessly, to explore fearlessly. She now also needs her mother's body to be as resilient as a jungle gym. She needs an energetic body that can swoop her up, run after her, and release her when need be" (p.243). A child, according to Looker, needs to develop a sense of "personal dominion" by which he "projects himself intrusively into her mother's mind and body beyond body boundaries" (p.243). She sees psychoanalytic work as offering a bridge between the psyche and soma of the patient. In order to facilitate such reconnection, however, the analyst, "must keep her own body present in the treatment room" (p.238).

Looker conceptualizes the process of therapeutic healing as allowing the patient to have comfortable access to the therapist's body, both literally and in his mind. Describing a successful treatment with one boy she writes, "he could use intimacy with me or distance himself from me. He could think freely about my body, consciously and

unconsciously, with no harm done to either of us. Once he was able to take for granted access to my body on the level of his attachment needs, he was also free not to think about my body and to live on his own. His comfort with my body, and his own relation to it, kept our verbal work grounded and promoted integration of thought, feeling, and bodily experience" (p.254). Looker concludes that an essential component of treatment is "the awareness of what it actually feels like in the body for both analyst and patient" (p.256).

Thus, a strong argument may be made for the case that patients must be able to have access to and to make use of the therapist's body in the treatment process. As several of the authors point out, however, a therapist's giving over of her body for the sake of therapeutic healing may extract an exhausting price. She may feel intruded upon, invaded, bombarded, and taken over. She may be faced with patients who literally want to be inside her and must struggle to create the psychic room for the patient to in fact exist there. The central question addressed by this paper is the way that pregnancy affects this process. Does the fact that a pregnant women is often profoundly attuned to her body act to thwart or facilitate the use of her body in the therapeutic process? How is a therapist's capacity to give ownership of her body, albeit temporarily, to her patient affected when she is pregnant? Pregnancy is both a ripe and vulnerable time for therapists to consider their bodies in the treatment room. This issue seems particularly relevant in the case of child work because child therapists must make use of their bodies not only psychically but also in very real physical ways.

Chapter III

Method

Goals

The goal of the present study was to explore the impact of child therapists' pregnancies on their experience of themselves as clinicians and on their work with children. At the time of this study, the only papers on child therapy and pregnancy were retrospective in nature, based on the personal experiences of a therapist and/or the experiences of her colleagues. While this study is also experiential in nature, it is unique in capturing a therapist's experience of her pregnancy at two points in time: during her third trimester of pregnancy, when her body is at the peak of change, and after she has had her baby. Thus, she is able to reflect on her experience of her body in relation to therapeutic work as it is in the process of changing and again when she has had the opportunity to evaluate her experience as a whole.

Basis for the study.

The present study grew out of my own experience during pregnancy and the experiences of two pregnant colleagues. Originally, the idea emerged from a discussion with a pregnant colleague who was treating an extremely active and very troubled seven-year-old girl. Once the therapist disclosed her pregnancy, the patient repeatedly threw objects at her, despite the therapist's continued attempts to set limits. She also told the therapist that she hated her and thought the baby was going to be deformed. She expressed a strong wish to kill the baby and to take its place. Although her supervisor was supportive, none of the available literature helped to provide a framework with which to understand the impact of her pregnancy on the treatment.

Another colleague was completely blindsided by the father of a patient, who announced, in front of his daughter, that the therapist was pregnant. Since the therapist was only two months pregnant at the time, she had not yet revealed her pregnant status, nor had she made any plans to do so at that time. While she eventually felt able to manage the therapeutic issues that arose with the child, she found parent work during her pregnancy extremely complicated.

As discussed in the previous chapter, the adult literature on the impact of pregnancy on therapeutic work provides insight into salient issues that often arise during a therapist's pregnancy. Some of these include a therapist's increasing sense of preoccupation with her pregnancy and withdrawal from patients, changes in the nature of transference/countertransference, shifts in technique, a range of patient reactions, and a change in a therapist's sense of self as a professional. However, there are several critical areas inherent to child therapy that have not been addressed in the literature to date.

One of the most profound differences between adult and child work is that play is the primary treatment modality of child therapy. Although the quality of play and the degree of physical exertion during play clearly differ among both patients and therapists, play by its very nature involves being engaged with a patient on a physical level. Such engagement may involve vigorous movement, sitting in close proximity, or even direct bodily contact. A woman's sense of her body is heightened during pregnancy; this may stir up a host of feelings about being physically engaged with patients. Such feelings may translate into a subtle or even marked shift in a therapist's

behavior and her capacity to play. This in turn may have a significant impact on the therapeutic process.

Another critical issue in working with children when pregnant is how to manage anger and aggression directed both at the baby and the therapist. The adult literature describes the way that many therapists withdraw and become protective of their fetuses when patients express aggressive wishes or fantasies (Fuller, 1988). There is also evidence that some therapists have difficulty managing countertransference issues around anger and aggression (Imber, 1990; Uyehara, 1993). Unlike adult work, however, where issues of aggression are, for the most part, based in fantasy, children may express their anger in very real physical ways. A child may try to hit the therapist, throw balls or blocks at or near her, or act in a self-destructive way that calls for the therapist's intervention. Under normal circumstances, such behavior may necessitate increased limit setting and the reestablishment of boundaries but may not cause the therapist to feel in any way threatened by the patient. During pregnancy, however, such behavior may cause alarm on the part of both patient and therapist.

These issues became solidified for me during the course of my own pregnancy, when I was working with an eleven-year old boy and a six-year-old girl. It is hoped that a discussion of both these cases will provide some understanding of the types of issues that may arise in child treatment but have thus far been overlooked.

I had been working with the 11-year old and his family for approximately two years before I became pregnant. At times, he played in an extremely destructive way, throwing objects in the room, climbing on file cabinets, and trying to destroy toys. On several occasions, I had to physically restrain him in order to prevent him from running

away or hurting himself. While I never worried that he would intentionally hurt me, I was always aware of the possibility that he could lose control and harm me inadvertently. Physical play was extremely important to this patient, and I engaged in many games of football, basketball, baseball and soccer. While, for the most part, these games did not feel aggressive, they certainly demanded my full physical presence.

In the first two years of treatment, this patient was, for the most part, unable to verbalize his feelings and instead tended to act them out. He used his body to communicate his inner state, alternating between active physical play and more subdued, withdrawn play. Despite my desire to make verbal interpretations of his behavior, I found it much more useful to try to join him in play, which meant responding to him in very physical ways. In addition to playing sports, I spent much time sitting quietly on the floor with him while he was wrapped up in a mat, where he often retreated when he felt overwhelmed. Although challenging at times, it felt to me that the therapeutic work at this stage was about letting him know that I understood his experience and could tolerate being with him no matter how he was acting or feeling.

My feelings about working with this patient changed significantly at the point that I became pregnant. Despite the fact that I had never felt threatened, even when he was his most destructive, I suddenly felt very vulnerable. I became very aware of where my body was in the room in relation to him and often sat with my belly turned slightly away from him. While I still played sports very actively in the beginning, albeit with mixed feelings, I became less active as my pregnancy progressed. At one point, during my eighth month, we were playing catch with a football and, needless to say, I was not

very quick to retrieve the ball. He responded by saying, "boy you're lazy...you're so slow today!"

As my body changed physically, my stance in the room shifted, as did the way my patient responded to me. He became much more protective of me and aware of where my body was in the room. While he still threw things and lost control at times, he would strategically place me in a corner or simply throw things away from where I was. Occasionally as he was throwing a ball or tossing something in the room, he would watch me and ask whether he was making me nervous.

Looking back, I understand that while I had tried very hard to make my thoughts and feelings accessible to him, my pregnancy and the changes in my body somehow made me less available to him. One illustration of this is that for two years, we played with clay in almost every session. I provided blocks of clay, and he would give me sections of it to make soft for him. Once the pieces were soft enough, he would take them and sculpt them into very impressive objects. Unless I softened the clay for him, he would not use it. I understood this child's use of the clay as a type of transitional object (Winnicott, 1953). As Anna Freud (1965) writes, "the properties of the mother's and child's bodies are transformed to some soft substance...which serves as the infant's first play thing, the transitional object" (p.79). The act of softening clay and passing it to him was also a way we were able to repair ruptures in the treatment; it was our way reconnecting each week. When I became pregnant, he stopped playing with clay and did not touch it until I returned from my leave. Even then, we used the clay only a few times until the treatment ended two years later. It was as if by distancing myself from

him, he no longer had the kind of free access to me or my body that he did before I was pregnant.

My work with a 6-year-old girl was profoundly different, but just as powerful. I had been seeing her for a year before I became pregnant. Even before my pregnancy, this child had expressed a wish to be my baby and to have me take care of her in a very maternal way. She often wanted to sit on my lap to read stories, to play with my hair, or to have me pretend to feed her. While managing her desire to be close to me physically always felt complicated, it became very difficult for me and for her when I became pregnant.

Before my pregnancy, I felt confused about how to manage her desire for physical contact. I wanted to establish some boundaries, but worried that setting limits on physical closeness would make her feel rejected. Her access to my body, in terms of being able to sit on my lap or hug me was important to her, and she was very attuned to any physical changes in me from week to week such as a haircut or even clothes. She actually started to play symbolically about my pregnancy before I knew I was pregnant.

When I confirmed my pregnancy she said, "that's terrible! You'll love the baby most." Each week she would note my changing body, touch my belly and hug me with great force, asking if she had "smushed" the baby. In session, she wanted to be close to me almost all the time. When she sat on my lap as I read to her she would often readjust herself to sit closer to me, as if she were trying to crawl up inside me. She actually expressed a wish to be in my belly and to kick the other baby out. At one point, she put her head on my chest as if she were trying to nurse. She also told me that she knew the baby was a girl (which in fact it was) and asked me to name it after her.

When I became pregnant, our play, as well as my feelings about being in the room with her, shifted in a very powerful way. I found many of the sessions with this child extremely difficult to tolerate and experienced tremendous guilt about the depth of her needs, which I could not fulfill, and about my desire to push her away. I felt intruded upon in a very physical way and experienced the consistent desire to create firmer boundaries between us. Knowing the great degree to which her parents were emotionally absent made matters even more complex.

The idea of separation during my maternity leave was intolerable for her, and she told me that she was afraid I was going to die. Perhaps just as painful for her was the notion that I would forget her once I had a baby of my own. Despite my reassurances and promise to send her cards letting her know I was thinking of her, she was not convinced I would return. She also had so much difficulty holding me in her head from week to week before the pregnancy that for her, there really was a danger that I would die, or at least disappear.

Although my parent work was affected in both cases, it was especially profound in my work with the six-year-old. For the first year of treatment, I had a difficult time engaging her parents in the treatment. When I became pregnant, the mother suddenly began to return my calls and to be willing to meet with me. In these conversations and meeting she reminisced about her own pregnancies and asked me detailed questions about my changing body. Once I returned from my leave, she asked questions about whether I was breast-feeding, how managed to pump at work, and which pediatrician I had selected. I felt very torn in these conversations because while her questions felt intrusive and often inappropriate, she was reaching out to me for the first time. I

struggled with how to use motherhood as a way to engage her, and hopefully to help my patient, but also to maintain professional boundaries without making her feel rebuffed.

Pregnancy as a process is framed in much of the adult literature as a time of potential crisis. While there has been discussion of pregnancy as a complicated time that may lead to both positive and negative outcomes for treatment (Fenster, 1986; Turkel, 1993; Friedman, 1993), many authors have argued that if therapists are sensitive and able to manage complex issues in the transference and countertransference, pregnancy ultimately may have a facilitative impact on treatment. An exception to this finding is in the case of seriously disturbed patients (Bridges and Smith, 1988). Pregnancy has been described as intensifying the therapeutic bond (Stockman & Green-Emrich, 1994), facilitating the transference (Fenster, 1986; Stockman & Green-Emrich; 1994; Bassen, 1988), a productive period in the treatment (McGarty, 1988), a rich opportunity for emotional growth of both patient and therapist (Fuller, 1988; Etchegoyen, 1993), enhancing the overall treatment process (Korol, 1995) and the basis for empathy, repair, and psychological growth (Rosenthal, 1990).

In the case of the six-year-old girl, the idea that I had a baby in my life meant that she could not have me in the way she wanted me. In retrospect, my guilt over not being able to provide her with enough of myself to make her feel secure made it difficult to deal with the intrusion of my pregnancy. It may be argued that this knowledge in itself was therapeutic, but it was experienced by both of us as an intrusion into the work rather than an idea that could have emerged and been dealt with organically. She needed the fantasy that I was hers alone, and in my own mind I was not able to tolerate that fantasy. When I returned, she never stopped being anxious that

I would leave, emotionally or physically, to be with my "real" daughter. Once again, my own feelings about her need to be so close to me prevented us from fully exploring the meaning of my absence to her.

Many of the issues that surfaced during my own pregnancy also emerged in discussions with two subjects interviewed for the pilot study.

Pilot Study

A pilot study, conducted with two therapists in training, also helped to define some of the salient issues that a pregnant therapist may find working with children. Each subject was interviewed once for approximately one and a half hours. It should be noted that neither of the subjects would have been eligible as participants in the actual study. First, both subjects were in their second trimester of pregnancy. In addition, the second pilot subject was pregnant for the second time and treating only one child patient. Due to the difficulty in finding eligible participants, subjects who met all the necessary criteria were not included in the pilot.

The subjects were asked in an open-ended way to describe the impact of their pregnancies on both their experience of themselves as clinicians and on their work with two children. The interviewer did ask both subjects the same series of orienting questions (discussed below), although the order of the questions differed according to the material introduced by the therapist. Many of the probes were included in the subjects' narratives without prompting from the interviewer.

Pilot interviews.

A prominent theme to emerge during the first pilot interview was anxiety about patients' aggression and concerns about how to manage patients' destructive thoughts

and feelings. The therapist described her heightened sense of vulnerability and wariness about physical contact with her child patients. Once she learned of her pregnancy, she set firm limits on all forms of sports activities in the room. She said that she was not sure of the impact that this has had on the treatment but acknowledged that both her patients had become more subdued and ended up playing in less active ways. She suggested that her patients were responding to an unconscious communication of her needs and were thus feeling that they should play a caretaking role.

The subject discussed the difficulty of both fearing aggressive outbursts and being concerned that by setting limits she was stifling important clinical material. She had a sense that she was "supposed" to deal with her patients' aggressive fantasies even though she was wary about approaching the topic. This ambivalence is one that I experienced as well. Commenting on both the patient's and analyst's desire to protect the dyad and to pretend the baby-to-be is not in the room, Fenster (1986) writes,

> The pregnant analyst must actively pursue-through interpretation and questions-the significance and meaning of the pregnancy and the breach in the setting for the patient. These interpretations should allude to the feelings of disruption, betrayal, shock, and anxiety that often stem from the change in the therapist. Even if these feelings are not overtly stated or visible, they are assuredly there (p.51).

The notion that the patient must at some level be experiencing powerful feelings that have not yet been communicated may put significant pressure on both the therapist and the patient.

The first pilot subject also had an intense reaction to the "negative environment" that she feared she was allowing in the therapy room. Her patient's banging and loud singing were profoundly disturbing to her. She began to worry that being in such an environment would have a detrimental effect on her baby's development. She felt trapped in the therapy room and worried that even if her baby were in danger, she could not leave. While she recognized that these feelings were based in fantasy, she felt that they certainly affected her feeling towards her patients and possibly her behavior in the room.

The second subject did not experience the same sense of vulnerability because the type of play she and her patient engaged in was much more subdued. They tended to play board games or to play with dolls and toys in a contained way. The patient was also wary about trusting the therapist and kept herself at a physical as well as emotional distance. The therapist acknowledged that that fact that she was pregnant when she began treatment may have determined the type of play that the patient felt was acceptable as well as complicated the child's worries that the therapist, like her biological mother, could disappear at any time. The therapist also had a bad knee injury which prevented her from being able to play in a very physical way even when she was not pregnant.

The idea of rescue fantasies and the way these fantasies change during pregnancy was an important part of both subjects' experience. The first therapist discussed intense feelings before she became pregnant of wanting to take one of her child patients home and to be his mother. Once she became pregnant, however, these feelings dissipated. She was very aware of the shift in her maternal feelings towards her

patient and attributed this shift to a change in the way she defined her roles as a therapist and a mother. This topic will be addressed in more detail below.

While this therapist discussed changes in her own fantasies about her patient, she also noted changes in her patient's fantasies and his or her role in the pregnancy and/or life of the baby. She cited her child patient's belief that he was going to be an uncle to her baby and to help to raise it. Her other child patient worried that she would spontaneously "cough up" the baby or sneeze it out or have it in some other way during a session.

The second subject also discussed her rescue fantasies and how pregnancy actually intensified them. She said not only did she feel that she wanted to take her own patient home, but also that she wanted to be "mother to the world." Only when she returned to work after her first pregnancy did these feelings diminish.

Both pilot subjects described the way that pregnancy had helped them to define the boundary between being a therapist and being a mother. For the first subject, the change happened immediately upon learning of her pregnancy. She became very aware of the limits of her role as a therapist and felt more firmly grounded in her own life. The second pilot subject experienced a blurring of boundaries with her first pregnancy, which slowly evolved into a clearer definition of roles. She discussed the way that becoming pregnant made her feel very maternal toward her patient and actually fed her desire to take her patient home with her. Only when her daughter was born did she begin to recognize the limits of her role as a therapist and the desire to reserve her mothering for her own child.

The fear of abandoning or disappointing a child was also a prominent theme that emerged from both pilot interviews. There seems to be something specific to child work which stirs up powerful feelings of guilt. In particular, subjects expressed strong feelings about the pregnancy dispelling a child's fantasy that she could in fact be his mother. Related to this was the feeling that the therapist was replacing the patient with her own child.

Both subjects experienced complications in their parent work, although the second pilot subject struggled more with issues involving the sibling of her child patient. The first subject informed the mother of her child patient about her pregnancy before the patient, and the mother subsequently told the child before the therapist had a chance. The subject felt both betrayed and angry at the mother and also caught off guard when her patient confronted her. She came to understand the mother's need to tell was a way of asserting in a powerful way that she, not the therapist, was in fact the child's mother.

While the patient of the second subject had not yet acknowledged the therapist's pregnancy when the interview was conducted, the patient's sister, who was also treated in the clinic, had told the patient that her therapist was pregnant. The patient continued to deny the possibility, and the therapist had not yet addressed her pregnancy directly. The sister also told the father, who pulled the child out of one of her twice-a-week sessions.

Since the subjects were still pregnant were they were interviewed, the question of whether pregnancy ultimately had a facilitative impact on their treatments could not be addressed. However, both therapists described feeling challenged by trying to take

on the roles of both mother and therapist. The first subject acknowledged that she felt disconnected from her patients and felt less available in the room. She worried that her sense of physical vulnerability was being communicated to her patients in subtle ways and making their play more inhibited. She also said she thought about them less outside the room and felt guilty that she sensed herself pulling away from them.

The second subject, who already had one child, spoke about her continued ambivalence about working and expressed some resentment about the emotional drain of being a child therapist. While she remained committed to being a therapist and to working with the child she was seeing at the time of the study, she described returning to work after her least pregnancy as a "blow." She said that when she returned, she had the feeling that she needed to fix her child patient in an efficient way, so that she would be making the most use of time away from her daughter. She has had time to work through this issue and is now able to let the child take the lead again, but she acknowledged that her feelings may have put pressure on her patient in a way that is still being felt in the treatment.

Pregnancy Interview

The literature on pregnancy and child therapy is remarkably sparse. To date, every article that has been written is retrospective in nature and based solely on the experience of the author and/or her colleagues. Since the aim of this study was to explore largely uncharted territory, it was designed so as to gather as much information as possible about the details of both a therapist's experience of herself and her clinical work. Thus, it was determined that an open-ended format, structured by a series of orienting questions (Mahler, Pine and Bergman, 1975) would be most effective. Since

there is very little known about the areas that were explored, the study is hypothesis-generating in nature.

Pine (1975), in describing his and his colleagues' approach to studying separation-individuation, eloquently discusses the value of an open-ended clinical approach to research that involves an "active" process of data collection and formulation. He writes,

> We did not develop a method and 'find' results through it. Rather, we had inklings, or sometimes moderately strong convictions, or sometimes internally contradictory uncertainties about a particular phenomenon...These were then built into modes of organizing, of pulling together, of looking at, relevant segments of the data that could then be used to expand, confirm, clarify, or alter our initial conceptions (p.247).

In terms of related research in the field, Fenster's (1983) longitudinal study of twenty two pregnant therapists most closely approximates this one in design. Fenster administered two seminstructured interviews, once during the third trimester of the therapist's pregnancy and again within six and a half months of the therapist returning to work. Her combination of open-ended dialogue and structured questions was fruitful in gathering information on the therapist's relationships with patients and supervisors, her changing sense of self, and practical considerations during pregnancy. Her work, however, focused on the treatment of adults, with one chapter on working with adolescents.

This study is similar to Fenster's in that it was conducted from the point of view of the therapist, but it focused on issues that are unique to child work. In addition,

rather than a semi-structured format, the discussion was open-ended, guided by a series of orienting questions. Pine (1975) describes orienting questions as "intermediary formulations en route to subsequent clarification" (p.247). In this study, the orienting questions were rooted in the adult literature, my own experience during pregnancy, and the experiences of pregnant colleagues and pilot subjects. Throughout the interview, therapists were asked for specific clinical examples. The following issues were addressed in the initial interview:

Telling.

How and when did you disclose your pregnancy to your child patients? If the patient "knew" before you disclosed, how did the patient communicate this knowledge? How did the patient respond to the information? How did you feel both before and after disclosing your pregnancy?

The process by which a therapist reveals her pregnancy to a child may be a complicated one. First, there may be other family members such as parents or siblings who become aware of the pregnancy before the patient does. Second, depending on their developmental level, children have varying capacities to understand what a pregnancy will mean in terms of changes in the therapist and the idea of a maternity leave. For children who have not yet developed a sense of object constancy, this may become especially complicated. Thus, therapists were asked to describe in detail the way their patients learned of their pregnancies, why they told the patient when they did, and how they felt about the process of telling.

Sense of self.

Have you experienced any changes in the way you feel about yourself as a therapist? Has pregnancy affected the way you understand the definitions of your roles as a therapist and a mother?

The issue of role definition and changes in the ways that therapists understand the role of therapist and mother once they become pregnant has emerged as a significant one. Therapists may establish a sharper boundary between the role of a mother and that of a child therapist when they are pregnant. They may feel less maternal towards their child patients once they are aware of having a baby of their own. It is possible that the way a therapist manages any changes in the sense of herself as a clinician and comes to understand the limits of her abilities as a therapist and/ or a mother could impact treatment in an important way.

Fantasies.

How did you anticipate your child patients would react to your pregnancy and how did these expectations mesh with reality? Did you ever have rescue fantasies about your child patients and did these fantasies change at all once you became pregnant? Did your child patients express any fantasies about your pregnancy or about the baby?

An area that has not been addressed in the literature is a therapist's fantasies about her patients as they are related to her pregnancy. Subjects were asked two probes about their fantasies about their patients. First, they were asked how they imagined their child patients would react to their pregnancy and how the reality of their reactions meshed with these expectations. Based on my own experience and information gathered in the pilot, therapists may expect their patients to respond with overt anger

and find it more difficult when in reality patients respond in a positive way. A therapist may feel that she is "supposed" to uncover a child's true anger at her and in the process may overlook a range of other complicated feelings that leak out over the course of pregnancy.

The second probe involved the way pregnancy potentially affects rescue fantasies. Child therapists often have fantasies about saving or protecting their child patients, and pregnancy may complicate these feelings. As indicated by the pilot interviews, rescue fantasies may become more or less intense during a pregnancy and may change again once the baby is born. The therapist was also asked about her ideas of patients' fantasies regarding her pregnancy.

Play.

What was the quality of your play before you became pregnant? Did the physical nature of play change at all once you became pregnant? How did you feel as a play partner both before and after you became pregnant? How have your patients responded to any changes in your capacity to play? Has the content of the play changed at all over the course of pregnancy?

Therapists often become less mobile and more protective of their bodies during pregnancy. A central question of this study was how these changes impact the capacity to play. Based on my own experience, pilot interviews, and the experience of pregnant colleagues, therapists engage in less vigorous play when they are pregnant and may be more prone to set limits on the type of play that is acceptable. Therapists were asked to discuss the nature of their play with two children and ways in which the quality of play

may have shifted over the course of the pregnancy. They were also asked to describe the ways in which their patients responded to any change in their activity level.

Therapists were asked directly about their feelings about their body *while they were playing* and whether being pregnant has impacted the way they feel a play partner. Follow-up questions in this area included feelings about physical proximity and body contact both before and during pregnancy.

There is evidence from the literature on pregnant therapists working with adults that as pregnancy progresses, different bodily preoccupations become salient. In the first trimester, therapists are often fatigued and/or nauseated, which may distract them from clinical work. In the second trimester, therapists often become aware of the fetus' movements and begin to feel more protective of their bodies. In the third trimester, therapists are increasingly aware of their expanding size and of the impending birth of the baby. The therapist was asked how bodily changes and preoccupations at different stages may have affected her physical stance in the room.

Anxiety/aggression.

Have your patients responded to your pregnancy with any feelings of anger or aggression? Have you experienced any anxiety in the room with your child patients? How do you understand this anxiety and how have you managed it?

There is evidence in the adult literature that pregnant therapists experience anxiety and even respond in physically protective ways when patients express destructive fantasies about the therapist and/or her baby. Such anxiety around issues of aggression in some cases has been found to interfere with a therapist's ability to acknowledge and process transference and countertransference material.

In child psychotherapy, anxiety about a patient's aggression may have very different meaning because it may involve real physical acts, such as throwing objects in the room. Children may have difficulty putting their aggressive fantasies into words so they may be more likely to act them out.

While there certainly may be instances in adult work of a patient physically threatening a pregnant therapist, the threat from a child patient's incoming blocks, forceful hugs, or kicked balls may be more common.

My own experience, as well as information gathered in the pilot study, suggests that the potential for a child to physically harm the fetus is a very real fear on the part of some child therapists. While it is expected that therapists manage this fear in a variety of ways, the impact on the clinical process may be significant. Therapists may send subtle clues about their vulnerability through changes in bodily posture and a general slowdown in their response to physical play. They may also set firm limits around physical activity that alters the quality of play in the room. The therapist's worries about being injured may lead to changes in her feelings about being with a child patient which make it difficult to be fully present in the room.

Guilt.

Have you experienced any feelings of guilt in terms of the impact of your pregnancy on your child work?

In the adult literature, many therapists have been found to become increasingly self-absorbed as their pregnancies progress (Fenster, 1986; Paluszny & Poznanski, 1971) and to experience a significant amount of guilt about their withdrawal from patients (Balsam, 1974; Bassen, 1988; Fenster, 1986). The nature of this guilt,

however, seems to differ somewhat for therapists working with children. Personal experience as well as information gathered in the pilot interviews suggests that there is something qualitatively different about the guilt involved with treating a child while pregnant.

Parent work.

How did your patients' parents learn about your pregnancy and how did they respond? Have any issues around your pregnancy emerged in your parent work and how have you managed them? Have there been issues with any other family members involving your pregnancy?

None of the articles on pregnancy and child therapy have addressed work with parents or other family members. For some therapists, however, parent work may be one of the most powerful aspects of treatment during this time. Based on the reports of several colleagues, in addition to the pilot subjects, it seemed clear parents may notice and remark on the therapist's pregnancy in front of their child, before the therapist has revealed her pregnant status. They may also use the therapist's pregnancy as a way to remind their child that the therapist is not in fact the child's mother since she will have a real baby of her own.

My own experience also suggests that pregnancy may raise a host of boundary issues with parents, especially mothers. Issues of childcare, breast feeding, and birth suddenly become common ground, and mothers may want to share information or advice with the therapist. While offering an opportunity to build a better therapeutic relationship, navigating boundary issues with parents may prove particularly complex for some therapists.

Follow-up Interview (six months post-delivery)

The second interview was designed to allow the therapist to consider retrospectively the ways that her pregnancy and the birth of her baby affected child treatment. This interview took into consideration the initial interview with each of the subjects and was tailored accordingly. Although the focus of the second interview varied by subject, the following general issues were addressed with each of them:

Returning.

Therapists were asked to describe their feelings about returning to work, leaving their babies, and re-engaging with patients. They were also asked specifically to describe reunions with the particular patients that they had spoken about in the initial interview. An effort was made to understand how their responses and those of their patients may have been different from what they had anticipated.

This section of the follow-up interview was designed to address the process of re-engagement in clinical work. Therapists who did not return to clinical work or who terminated with the patients described in the initial interview were asked in great detail about how the process unfolded and about the feelings that drove their decisions.

The baby.

The second interview also focused on ways in which having a real baby may affect the therapist's feelings about herself as a therapist and about her patients. The therapist was asked in detail about the ways she was or was not thinking about her baby before, during and after sessions and how thinking about her own baby may affect the clinical process. The therapist was also asked to think about and describe the shift from being pregnant to being a mother in terms of feeling present in the room.

Fantasies.

Another aim of this interview was to examine any changes in the nature of the therapist's thinking about her patients since the birth of the baby. Did having an actual baby feed any rescue fantasies she may have held or help to dispel them?

Dual roles.

This interview also sought to elicit the therapist's experience of managing the dual roles of mother and child therapist. Did having an actual baby help her to more clearly define her sense of self as a clinician? Did she feel as available as a therapist or was she being pulled by the demands of motherhood in a way that may be intruding on the treatment? In general, how well did she feel she was able to integrate these roles?

Play.

The way that the play may have shifted since the therapist's return was also addressed. Was the pregnancy still reverberating in the therapeutic process? How did the playspace feel now that the therapist had retuned to the floor?

Parent work.

The therapist was also asked about the ways that parent work may have changed upon her return. Did she find herself more or less empathic with the parents of her child patients? How did she manage boundary issues and how much information did she disclose about her baby?

Recommendations.

Therapists were asked whether they would have done anything differently now that they were looking back on the pregnancy process. They were also asked to give

specific recommendations to other pregnant child therapists in order to help them navigate this complicated process.

Facilitative?

At the end of each follow-up interview, therapists were asked to discuss to what extent they felt that their pregnancies may have had a facilitative or negative impact on the therapeutic process. Once again, therapists were asked to give specific clinical examples in their responses.

Subjects

The sample was composed of nine psychodynamically-oriented therapists, including five licensed psychologists, two clinical psychology graduate students, and two clinical social workers, one of whom was in analytic training. The all met the following criteria: 1) they were carrying their first pregnancies to term; 2) they were working in a psychodynamically-oriented manner; 3) they were currently seeing at least two child patients; 4) they all planned to resume work after their babies were born; 6) they were married or in a relationship with a male partner; and 7) they were living and working in New York City.

The therapists were recruited through psychology graduate programs, post-doctoral training institutes, referrals through colleagues and supervisors, and posted notices in doctor's offices. Although they did not need to consider themselves primarily child therapists, all subjects needed to be seeing at least two children. Child patients were defined as those between the ages of four and twelve. In terms of demographic information, eight of the therapists were Caucasian and one was African-American. Their ages ranged from twenty-eight to forty-two.

The therapists were interviewed on two occasions, once during the third trimester of their pregnancies and a second time within the first six months after giving birth. Therapists were interviewed in their homes or offices.

It should be noted that the study was not designed to elicit an objective account of pregnancy. Rather, findings were based on the subjective perceptions of the therapists. Session notes were not examined directly, nor were any patients interviewed. Thus, the discussion will focus solely on the therapist's perception of her own and her patients' experiences.

As the research is based solely on self-report, several pitfalls should be noted. Therapists may have tailored their responses to what they perceived as being socially desirable, particularly when asked about sensitive topics such as countertransference. In addition, it may have been difficult for the therapists to talk about negative effects of pregnancy on their work. In order to address the possibility that therapists may have been tempted to gloss over any negative effects of her pregnancy on her work, a preamble was read to each subject before the beginning of the interview. The preamble read as follows:

> I would like to speak with you about the impact of your pregnancy on your experience of yourself as a clinician and on your work with two child patients. I am especially interested in the way that changes in your body may have affected your capacity to play and your feelings about being physically engaged with your patients.
>
> I personally had the experience during pregnancy of working with an 11-year-old boy who played in a very destructive way before I became pregnant and with

> a 7-year old girl who needed very close physical contact much of the time. For both these children, the changes in both my physical stance in the room and their access to my body had a powerful impact on the treatment. I'm wondering about the experience you are having as a pregnant child therapist.

In addition to the preamble, which was intended to open up the possibility of negative effects on the treatment, subjects in this study were presented the following question at the end of the interview:

> While the child literature has not addressed this issue, in the adult literature, therapists often frame their experiences about the impact of pregnancy on their clinical work in a positive light. They tend to say that their pregnancies, although disruptive, ultimately have had a facilitative impact on the treatment. What are your thoughts about that idea?

The combination of the preamble and specific question at the end of the interview were meant to allow for an open discussion of both the positive and negative aspects of introducing pregnancy into child work.

Procedure

Each of the subjects were contacted by phone and told about the study in greater detail. After the therapist expressed interest in participating, the appropriateness of her participation was assessed. The therapist was informed that each interview would take approximately one and a half hours. Each therapist's informed consent was taken at the initial interview.

Before the first interview, the therapist was read a preamble to orient her to the nature of the study. Subjects were interviewed twice, once during the third trimesters of

their pregnancies and again within six months of delivery. Both interviews were tape recorded, with the therapist's permission.

In the first interview, the therapist was asked briefly about her pregnancy and whether or not she has experienced any complications. This information was an attempt to understand the nature of a therapist's feelings of vulnerability. She was then asked to describe the impact of her pregnancy on her sense of herself as a clinician and on her work with two children. The interview was structured by the series of orienting questions described above.

In the second interview, the therapist was asked to reflect on her feelings and experiences as described in the initial interview. She was also asked about ways in which having her own child may have contributed to any changes in her feelings about herself as a therapist, her child patients, and/or the treatment process. She was asked about the reunion and how her patients responded to her return. She was asked whether she felt her pregnancy ultimately had a facilitative impact on the treatment. Finally, she was asked whether she would have handled any aspect of the treatment differently now that she has had some time to reflect on the process.

As described by Fenster (1983), the material to emerge during the first interview may in fact have alerted the therapist to issues surrounding her pregnancy that she was not aware of before the interview. Such awareness may have changed the way she otherwise would have handled the pregnancy with her patient.

Data Analysis

Audiotapes were transcribed verbatim. They were then read and re-read on two levels. First, the interview was examined on an individual level. All salient themes to

emerge were recorded, as was a general summary of the therapist's experience. Second, each interview was read in light of other therapists' experiences. In terms of understanding the interplay between the individual and shared experience, Pine (1975) writes, "the clinical researcher...develops an internalized set of standards against which he can measure the responses of any particular individual. He develops a conception of the range and varieties, sometimes with developmental sequences or the conditions for certain individual idiosyncratic responses, in the realm of the particular phenomenon" (p.250). It was expected that certain patterns would emerge around the series of orienting questions posed by the interviewer. The discussion of the data focuses on these patterns and the themes that emerge as most salient to this pool of subjects.

The issues that are highlighted and discussed in greatest detail are those most critical to child work. For instance, subjects' discussion of feeling preoccupied by nausea during the first trimester may be noted, but the emphasis in the focuses on the way this preoccupation affected their clinical work. The discussion focuses on the way a therapist's experience of her pregnancy may have affected her sense of self and her work with children rather than on her experience of her pregnancy in general. Similarly, the discussion is not focused on the changes a therapist notices in her body but rather her feelings about her body and the way these feelings may have affected her work.

Chapter IV

Results

The results of this study suggest that a therapist's pregnancy is definitely an intrusion into the treatment space. This intrusion, however, takes on a very particular meaning in child work. The therapist's pregnancy directly impacts the nature and meaning of the therapist and patient playing together. Since playing involves the therapist's body in such an immediate way, changes in the therapist's body have a significant impact on the treatment process, although not quite in the way that I had imagined.

The therapist's pregnancy does affect a child's access to her physical body, but in ways that are much more complex than had been anticipated. Physical changes in the therapist's body set a process in motion which not only fundamentally changes the way the therapist plays physically, but also the way she is able to stay emotionally present in the play. The transformation of the playspace, which is profound in many of the cases described, may start in the therapist's actual body, but takes hold of the therapist's mind and the space in between.

As the therapist moves away from the child physically during pregnancy, creating real distance between herself and the patient, she often moves away emotionally. This process of pulling away from the child and the profound guilt that ensues, leads to changes in the patient's access to not only the therapist's body, but also her mind. This process is evident from the therapist's initial thoughts about telling, to the way the play shifts, to the therapist's fantasies about the patient and her own sense of herself as a mother and therapist.

The experiences of the therapists interviewed, as well as the patients they described, fell along a spectrum. Some therapists were able to integrate their pregnancies into their clinical work more easily than others. Some of the patients described had little trouble managing changes to the therapeutic process while others became quite disorganized. Ultimately, it was the way the therapist was able to manage her own feelings about being pregnant and the way she navigated this process with her patients rather than the pregnancy itself that had the most significant impact on the course of treatment.

Telling

The issue of how and when to tell child patients about their pregnancies was a complicated one for the therapists interviewed. With the exception of two very experienced child therapists who had decided to disclose their pregnancies early, all other subjects described feeling unprepared for how to manage the issue of disclosure. In fact, with certain patients, some therapists chose not to tell at all.

Therapists expressed a belief that in general, they were supposed to wait until the patient introduced material that was directly related to the pregnancy. At this point, they would decide the best way to navigate the issue of telling. There was an expectation that children would notice their changing bodies and that this new information would emerge slowly within the context of play.

There were two distinct issues that affected the way a therapist disclosed her pregnancy. The first was whether the therapist thought the child knew, at least on some level, about the pregnancy. The other issue was whether the therapist thought the

patient was "ready" to know and whether she in fact was "ready" to tell. The second issue proved to be much more complicated than the first.

The idea of "knowing" was complicated by the fact that often themes to emerge in the play were not directly pregnancy-related or children made vague statements that they might later retract. As one therapist described in terms of her nine-year old female patient, "we walked down the hallway one day and she said are you pregnant and then she said oh no no no, it's just bad posture. So they kept giving me these little things then taking them back....then another one said oh, did you know your blood is purple?" In both these cases, the therapist decided not to confirm her pregnancy because she wasn't sure whether the child was really ready to know.

Even in cases where children did notice the pregnancy directly, therapists were often caught off guard. For instance, one therapist said that her patient asked her in her first trimester whether she was pregnant, and she reluctantly admitted that she was. The therapist reported, "she was jumping up and down saying I knew it I knew it, you are going to have my sister. You are my mommy and you are going to have my sister." In this case, the therapist had not told people in her personal life that she was pregnant, and she was overwhelmed both by her own feeling of being unprepared, and the intensity of her patient's response.

Once the therapist did tell the patient, she struggled with how to navigate the shift in boundaries that accompanied having her body change in a very public way. Therapists were ambivalent about how much information to provide during their pregnancies and how much to tell patients once their babies were born. In some cases, there was an awareness of wanting to tell too much; the therapist really wanted to just

sit down like a "regular" adult and talk about how she was feeling. As one therapist said, "it arouses non-therapist part of you-just want to talk about the baby and the experience and "you want someone to acknowledge that it's hard for you."

Other therapists described a sense of uneasiness with telling too much but struggled not to seem withholding. One poignant example came up with a therapist whose adolescent patient asked to see a picture of her sonogram. The therapist said, "I thought it was too personal a thing to share but then I started thinking that for them their lives are basically so miserable that the idea of seeing a baby in the womb—the idea is probably a very warm and safe one—they just don't have much like that they can identify with...but it crosses a boundary that is very personal."

Parent Work

This issue of how to navigate boundaries was especially complicated in parent work. Working with parents in general presents as one of the more challenging aspects of child work, and this proved particularly so during a therapist's pregnancy. Therapists found some parents to be "intrusive" and even to "out" the therapist in front of the child with statements such as "look at that belly, you're pregnant aren't you!?"

Especially with therapists still in training, working with parents can feel somewhat vague and undefined. Parents are not the identified patient but parent work demands that the therapist maintain her clinical role. Less experienced therapists expressed a great deal of confusion about how to manage the role of working with parents and how to navigate work with parents who understood a therapist's pregnancy as an invitation to cross boundaries. Parents, primarily mothers and grandmothers, often commented directly about a therapist's body, and therapists struggled with how to

address this issue analytically. One therapist said, "I walked (my patient) to the elevator and her aunt said, 'stand up, you don't look pregnant, let me see your belly' and touched it...so there is a boundary crossing but I didn't know how else to manage it"

It became clear over the course of the interviews that therapists' difficulty around issues of disclosure and navigating personal boundaries was intimately linked to their feelings of guilt from the inevitable distance that emerged between them and their patients over the course of pregnancy.

Moving Away

The body.

A unique aspect of child work is the constant renegotiation of physical distance between the patient and therapist that occurs within the context of play. Through mediums such as board games, basketball, clay, and drawing, different children pull for different degrees of actual physical closeness. Pregnancy alters this process in two fundamental ways. First, there is a feeling of needing to protect the body (baby) which commonly leads to some toning down of physical play and an increase in limit setting the part of the therapist. Second, changes in the therapist's body necessitate that she move away from the floor to a couch or chair. By doing so, the therapist fundamentally alters the character of the play space.

I had expected that a significant portion of the interview would be spent discussing ways in which physical changes in the therapist's body affected both the quality and content of play. Given the literature on pregnant adult therapists, which discusses therapists' difficulty managing aggressive material, I had thought that child therapists would be hyperattuned to the possibility of becoming physically injured by

their patients, particularly the more aggressive ones. In fact, while there was some awareness of needing to physically protect their babies from physical harm, which often led to limits on active play and objects being thrown in the room, therapists reported very little concern about being physically hurt. A child patient's destructive wishes or even aggressive play was not a cause of significant anxiety among the women interviewed. Therapists did describe some sense of dread working with very aggressive patients, but it was more about the prospect of having to bend down to pick up all the toys after an active session than about the possibility of physical injury. Therapists experienced children's more aggressive fantasies of wanting to "get rid of" their babies, by replacing them, magically having them disappear, or kicking them out of the womb, as manageable. In fact, a child's aggressive feelings proved much easier to manage and interpret than intense feelings of neediness and loss. As one therapist said, "I think there was a wish for anger on some level because it would have alleviated the feelings of guilt which were much harder to process and deal with."

However, therapists did describe a different kind threat to their babies and bodies in that they felt intruded upon or even "contaminated" by certain clinical material. As one therapist said, "I feel really protective of the baby. It's about the energy (the patient) brings into the space...I didn't used to feel that it could filter through my body in the same way and affect something that's so innocent and so vulnerable." Another therapist talked about a nine-year-old boy who said he was going to eat her baby. "I feel like he wants to get inside me and have control and he doesn't like another baby being inside me." Several therapists expressed concern about being depleted and needing to save their internal resources for their baby.

Therapists also expressed anxiety about treating patients who were sick or came into session with rashes or other visible physical ailments. They described a particular sensitivity to being coughed and sneezed on and bristled at the insensitivity of parents bringing children with fevers to session. Although not related to illness, one therapist described a feeling of intense anxiety when her child patient locked them in a small therapy room. The idea of being in forced close physical proximity with a child, either sick or well, without the possibility of being able to leave induced varying levels of anxiety in the therapists.

Another way that therapists described feeling emotionally intruded upon was the heightened worry about having a baby with special needs. It was as if the possibility of having a damaged baby was magnified in the therapist's mind because it seemed that every child around her was psychologically and/or neurologically impaired.

The floor.

The most powerful material to emerge regarding the impact of the therapist's changing body involved meaning of her move from the floor to a chair and the symbolic transformation of the playspace. To varying degrees, the women interviewed described their move away from the floor as a betrayal of the child and a rupture in the treatment. Therapists expressed a great deal of guilt about putting their own needs before their patients, taking away from the child's experience, and interfering with the child's sense that the therapist is an available and attuned play partner. As one therapist said, "there is something about the feeling that you cannot enter the play from above." Therapists experienced the real physical move away from the child as creating almost an

unbridgeable distance and felt extraordinary guilt about how they imagined the meaning of the move in the child's mind.

Moving away from the floor represented a loss of "magical space" and engendered a feeling that the therapist was becoming like any other adult in the child's life, or more specifically like all the other adults who had somehow failed, misunderstood, or disappointed the child. One therapist said, "I feel like I can't give them more than the other grown ups, I feel like I'm just another grown-up. I felt like before they could really get me in and engage me in the play and now I'm just like everybody else...there is literally this physical separation where I'm no longer down on the floor with you and you're down there and I'm this grown-up and I'm sitting up here."

On a personal note, as I write this section of the paper at eight months pregnant with my third child, I am thinking about the fact that I am still playing on the floor with the two child patients I am currently treating. This is true despite the fact that I almost fainted in a recent session because I could barely breathe. I am struck by the fact that a move away from the floor is somehow admitting to the patient that I am no longer the same play partner. (In a way it feels similar to the way I want my daughters to feel--that I am exactly the same mommy as I was before -- that I can run around and pick them up and carry them and hold them on my lap.) By telling my patient that I can no longer play on the floor next to him I am admitting that the baby is infringing on our space and disrupting the nature of our play, and that despite the patient's most profound wishes (which he clearly stated) I cannot make the baby go away. Moving away from the floor solidifies the idea that there is another living being in the room and that, for the

patient, I imagine he feels there may not be enough room for all three of us. In addition, not only is the baby crowding us, but also I am responding to the physical needs of my body (the baby) rather than staying with the needs of my patient. If my patient is competing with the baby, my move to the chair suggests that he is losing.

Fortunately, I am in supervision with a tremendously skilled supervisor who suggested that I move to the table and say something like "Let's draw at the table because I'm not so comfortable on the floor anymore and I don't want to be so far away from you. Let's keep working next to each other like we usually do." Thus, I am shifting the burden to me and also acknowledging the distance without making the patient feeling pushed away. Without good supervision, however, my own guilt would have blinded me to the possibility that acknowledging that my patient and I have separate needs was not necessarily bad for the treatment.

Another dimension of the move away from the floor, which worked to compound the therapist's guilt, was that for some therapists it offered protection from a child's intense feelings of neediness. This was particularly true among therapists treating severely traumatized children. Moving off the floor was a way to ward off a child's profoundly disturbing feelings of abandonment and loss.

The mind.

In the adult literature, there is a significant amount of discussion about the therapist's "turning inward" to focus on the baby and pulling away from patients to attend to her inner world. Rather than a process of "turning inward," whereby the therapist becomes distracted by the baby and moves away emotionally as a result, child therapists described a process by which they felt themselves moving away from their

patients emotionally because they were less able to tolerate the depth of their patients' needs.

The intense emotional neediness of some child patients seemed to heighten the therapist's awareness of the disparity between what she imagined giving to her baby and the reality of what she could give to her patients. One therapist said, "sometimes I almost feel angry at the kid for needing so much from me...one little girl, she's not so demanding in terms of the physical play, but she's emotionally very needy. And I almost feel resentful because I can't give her everything she needs so I feel bad about myself and upset over the situation." Another therapist echoed this statement when she said, "when I'm with him it feels so awful because it feels like there is so much stuff that I'm not giving him...not just in session but on the outside"

Fantasies.

One manifestation of the therapist's wish to create distance from the intense needs of certain child patients was the shift in the quality of her fantasies about them. Not only did the representation of the child and their relationship change, but also the therapist's representation of herself in the child's mind shifted.

Pregnancy, and the idea of impending motherhood, shattered the fantasy that the therapist could be the patient's mother. In some cases, particularly with children who had been abused or abandoned, this fantasy was central to the work, and the dispelling of this fantasy was the source of great pain for the therapeutic dyad.

> I feel sorry that (our relationship) can't ...turn into what it is she wants it to turn into—that she wants me to be her mommy and to have me take her home and be part of my family. So it makes me feel guilty and sorry for her and badly that

> I'm going to leave and these fantasies she's having—the reality will be gone. And it's harder now to explore those fantasies—it used to be easier let them fantasize about whether or not I had kids and what I might be like as a mother, and I had more space for that. But now I feel more protective of myself and my family and my environment and I can't tolerate that as well.

Many of the therapists interviewed said that within the boundaries of the therapeutic space, they tried to fill the child with a strong sense of being loved and cared for in a maternal way. As one therapist said, "I think in some way being a therapist, I often take a maternal role toward the children...but on some level I also know that I'm about to have my own child. It's almost like I'm playing mommy, and now I'm going to be a real mommy....I feel less that she's my child. I used to have this feeling that she's mine. And I don't have that anymore... It has started to impact me that really I am not these kids' mother...Before my fantasy of being her mother was much more central for me whereas now the boundaries are much more clearly defined."

Therapists who had imagined themselves as the "good mother" started to come to terms with the fact that in reality, they could not and did not want to serve this role. One therapist said, "before I acted in a certain way that was very maternal and in some way I think I had a fantasy of being that other parent - the good parent, the parent they could come to...I think in some way my fantasy world is just shifting"

Therapists described a process of de-cathecting from their child patients and replacing them in fantasy with their own babies. The quality of their descriptions were quite concrete; therapists experienced a process of direct substitution in their hearts and minds that was both irreversible and the cause of extreme guilt. As one therapist

remarked, " I realize I'm going to have someone who's more special to me than you...and even though this boy needs someone to care for him so desperately I am walking away to go care for someone else."

In the literature on adult work, there is some discussion of patients' fears of abandonment but nothing approaching the magnitude of that experienced by child therapists. With adults, a patient may have a fantasy of being the therapist's child or certainly to be taken care of by the therapist in that way, but with some children and child therapists the fantasy is quite active, real, and mutual. Child therapists felt that they were actively doing something terrible to the child by leaving them. Rather than the abandonment being in fantasy, as described in the adult literature, child therapists believed that they were abandoning the child in a very real and immediate way.

This dynamic is also related to the therapist's rescue fantasies, which shifted dramatically both during pregnancy and after therapists gave birth. As one therapist stated, "I used to allow it in my fantasy that I could be the parent or the savior of these kids and now it's very clearly my work and it ends." The majority of child therapists had rescue fantasies with at least one of their child patients, and in all cases, the fantasy was transformed over the course of the pregnancy.

The primary mediating factor in these fantasies was the nature of the child's background. The most powerful rescue fantasies were held by those therapists who worked with children in foster care, with homeless children, or with children who had experienced severe trauma and loss. Not surprisingly, these therapists experienced the most intense guilt and had the greatest difficulty managing their countertransference.

In these cases, concerning the most damaged and fragile children, dispelling the fantasy of being the child's mother and coming to terms with the fact that they could not and did not want to rescue them was experienced as crushing for the therapeutic dyad. In several cases, the degree of guilt on the part of the therapist was too much to bear.

> The guilt is so much stronger. I think before I could have fantasies about taking them home, I could give them so much more than the average therapist would, and I could have this fantasy about what I was doing for them and how committed I was to them and I could always stay with them...now the idea of my space and my home and my family, that's not available by fantasy anymore and I think that's part of the guilt. That I don't even want that for them anymore—that's their life.
>
> I've had the strongest fantasy about the 12-year-old who came to see me following the death of his mother. He's been really alone in the world. He's in kinship foster care.... But with him I've had the strongest sense of 'how can I do this to him?'

Therapists working with this population described a fear that they were setting up their patients for yet another traumatic loss. There was a sense that they were walking away from the most damaged children and dealing them a terrible blow because, "these kids have nobody else." It was as if the entire therapeutic arrangement was a set-up for the child; they had worked to make a connection--sometimes the child's only meaningful connection—and now they were destroying it. As one therapist said, "I have this feeling that I'm abandoning this child to a world where nobody cares about him."

Three therapists who had worked in the past with foster care children but were now in private practice commented that they would have felt much guiltier had they still been working in their old jobs. Somehow knowing that children were living in at least moderately stable homes made a significant impact on the way they framed the child's loss.

Therapists working with the neediest children also described a sense of feeling increasingly ineffectual; they felt that particularly compared to what they could offer their own baby, the impact they were making on the patient's life was negligible.

Working with this population also just highlights the differences between me and them...that I am so privileged and I have these things and they don't. It reminds me of my last session with this girl. She was talking about the World Trade Center, which she hadn't done in a long time... I had been thinking that I wanted to give her something and I asked her if she had a journal and she said she had one but how there are mice and rats in her apartment and one of them ate a hole in her backpack so the journal fell out and she lost it. She just found mouse droppings in the bag. And she was telling me without affect—the way I'm telling you. And basically she was saying you are leaving me to go be with your baby and this is my life.

Once they recognized how powerful their maternal love is for their own children and how much less of themselves they were able to give to their child patients, therapists began to have doubts about their own efficacy as clinicians. As one of them said, "the whole meaning for me became too upsetting, too hopeless...like I could never make any real difference...Everything felt beyond me. I just couldn't take home what

they had. I just couldn't do anything about it. There was too much guilt. Even now the guilt has stayed with me."

There seemed to be a process at work whereby the therapist had difficulty reflecting upon the child's experience because the meaning of the material became too close and the therapist's understanding of it too concrete. The relationship lost its "as if" quality.

> I have all these thoughts about her baby and it's growing and being born the same time as my baby and my baby got me and her baby got her and there's such a world between us...these are equally innocent beings being brought into the world and they're going to have such vastly different life experiences. Why did this baby get her and I'm so angry at her. I think that would have prevented me from treating her. I'm just so furious.

Therapists' feelings about children's vulnerability and innocence began to feel much more personal. They imagined the possibility of their own babies being born into equally dreadful circumstances and being unable to protect them.

> something has shifted since I became pregnant...I have a different sensibility about these kids...there just so vulnerable...and I'm sure this has to do with my baby and she's going to be this vulnerable being coming into the world and so I have a different sensibility about kids...like here's this kid who came into the world totally vulnerable and open just like my baby and they got dealt this really shitty life...it's something about what happened to their innocence ....like look what happened to these little kids and they bring it into the room and I can't protect them and I can't do anything about what has happened to them.

Therapists reported feeling helpless in the sense that they could not protect their child patients the way they imagined protecting their own babies. As a result, some began to doubt their own competence and the value of their clinical work. Often, the therapists who struggled so profoundly with managing their emotional responses to their child patients during pregnancy had an easier time working with adults. They also reported significantly fewer premature terminations on the part of their adult patients.

Bick (1961) suggests that in general, the "counter-transference stress" is more profound in work with children than with adults. She attributes this to the specific way that child work "strains" the mind of the analyst, both in terms of the content of the child's material and its mode of expression. She writes,

The intensity of the child's dependence, of his positive and negative transference, the primitive nature of his fantasies, tend to arouse the analyst's own unconscious anxieties. The violent and concrete projections of the child into the analyst may be difficult to contain. Also the child's suffering tends to evoke the analyst's parental feelings, which have to be controlled so that the proper analytic role can be maintained. All these problems tend to obscure the analyst's understanding and to increase in turn his anxiety and guilt about his work (p.171).

Bick (1961) emphasizes how difficult it is for therapists to allow the child to experience pain and to refrain from intervening in a "non-analytic" way. She writes, "The strain in bearing the child's suffering is greater than with adults, not only because of the child's weaker ego, but because of his appeal to one's parental feelings" (p.174).

This idea of the child's "appeal to one's parental feelings" is an important one, especially in the ways it may be heightened during pregnancy.

In many cases, the therapist was not able to manage these feelings alone in a way that allowed her to stay in her clinical role. Without good supervision, which I found to be rare, this dynamic interfered significantly in the work and often led to premature terminations. In the most extreme instances, the therapist's guilt made it difficult for her to reflect on the child's experience because imagining the child's mind was simply too painful. The therapist became preoccupied with what she was "doing" to the child and lost the capacity to be with the child. Rather than thinking or saying 'its hard to imagine that maybe I won't love you the same way as I love my baby,' therapists seem to feel 'I know I will not love you the way I love my baby and I need to spare you that feeling at all costs.' In other words, when guilt blocked the therapist from reflecting on the child's mind, she risked creating an enactment of the very situation she dreaded most. Either the child left prematurely or the therapist was emotionally unable to return to her work.

Supervision

The issues described thus far clearly highlight the critical need for good supervision of pregnant child therapists, particularly those treating children most in need. The countertransference in these cases is often too powerful for the therapist to manage alone, and therapists end up enacting exactly what they had sought to avoid. Interestingly, the topic of supervision was not one that I addressed directly in the initial interview. Rather, the therapists experience in supervision tended to emerge from the "anything else" question that I asked at the end of the interview. In the majority of

cases, therapists reported that they had not had adequate supervision, and this shortcoming adversely affected their work. Unfortunately, the quality of supervision described by these nine women was, for the most part, poor or nonexistent. Only five of the nine women were being supervised at the time of their pregnancies and only two of these women described their supervision as being helpful. Even in these cases, however, the therapists had more than one supervisor and these supervisors gave them contradictory messages and clinical advice.

Even extraordinarily experienced, well-regarded supervisors, who were very helpful managing other kinds of difficult cases, were not very useful in the work of pregnant therapists. The women in the study reported feeling as if their supervisors often had their own personal issues which intruded on the supervision. With few exceptions, therapists reported ignoring their own "gut" feelings about how to deal with issues such as disclosure and deferring to supervisors whom they felt ultimately gave them inappropriate clinical advice. Once again, this seems to demonstrate that the issue of pregnancy has not been explored adequately in the literature. Even the most well regarded supervisors, who were well versed clinically and theoretically did not have the knowledge to help therapists navigate this particular issue.

One area where supervision seemed particularly misguided was around the issue of disclosure. Even when supervised, therapists often disclosed her pregnancy very late (seven months or later) or not at all. In some cases, this was tied to the therapist's guilt about leaving, and in some cases it resulted from the advice of supervisors who discouraged therapists from telling. "My supervisor just kept telling me wait until she brings it up with you directly. But the thing was that this child was very invested in

keeping the outside world out of the room, and I was pregnant---I was bringing this other child into the room and I did not deal with it effectively."

In almost every case when a therapist did not disclose her pregnancy before the third trimester, patients left treatment prematurely. As one therapist said, "I think she actually knew and I should have told her earlier and I think a part of why she left was that there was this other person in the room and I did not address it properly. I was just feeling so guilty about being pregnant, as far as my patients go." Another one noted, "I think the little girl could not sustain it any longer with me being pregnant. It was too hard for her to keep coming. And I think if I had dealt with it earlier by talking about my pregnancy she would have been able to deal with it too." Another therapist (pregnant with twins) described feeling so guilty that she chose not to disclose her pregnancy at all. Rather than being able to focus on the clinical process, she described being aware of trying to hide her pregnancy from the child so he wouldn't feel bad. She said, "this is a kid who needed a lot of contact. So I felt like I wanted to get close to him but I didn't want him to see what was happening to me."

In perhaps the most striking example, a therapist described working with a family when both she and her co-therapist were pregnant. In this case, the supervisor discouraged them from bringing up the pregnancy in any way so the issue was never addressed. Even when one of the children displayed quite seductive behavior and repeatedly touched the therapist's (changing) body, the topic was never broached. She said, "the physicality in the room changed tremendously...but we never had a chance to explore it with the family...we just did not deal with it....because we did not deal with the pregnancy the case ended...we were both dealing with our own guilt over

being pregnant and...we just kept thinking this must be freaking this family out sitting in the room with us, and no one saying anything about it....the supervisor had no advice except don't talk about it, don't talk about it, don't talk about it. Wait for it, wait wait wait. And that was a mistake."

Outcome

While some treatments were able to weather the pregnancy and maternity leave, a significant number of child patients terminated prematurely. There were two types of premature terminations among the therapists interviewed. The first category included children who left treatment before the therapist had her baby or children who had planned to return but did not. The second category included the therapists who had planned to return to their child patients but for various reasons did not.

Perhaps the most disturbing finding in this study was that patients most likely to terminate prematurely were those who had been most severely traumatized as infants. The treatments of children in foster care or those living in extreme poverty and chaos were least likely to survive the therapist's pregnancy.

The issue of disclosure was especially problematic in these dyads because the therapist was overwhelmed by guilt. In several cases, the therapist did not disclose her pregnancy at all, fearing that the pain of knowing the therapist would be leaving would be too much for the child to bear. As one therapist, who did not disclose her pregnancy at all to a child who terminated prematurely, "I guess that's why I didn't tell her. Because she is so sad and she's been abandoned. So losing me is like a death—a catastrophic loss."

Even in the narrative construction of the interviews, the sense of guilt was palpable, and therapists showed notable lapses in remembering the most difficult material. In several cases, therapists "forgot" about certain patients until the end of the interview, at which point they described the most difficult separations or premature terminations.

> I wish I had had better prepared clients for termination...but I just couldn't, I guess ...because of my guilt. I can't stand to think...I hate even talking about it because I still have so much guilt because I feel so horrible for them. One teenage girl I saw for a long time was abandoned as an infant. She so obviously had intense abandonment issues and I felt I couldn't do that to her...so I ended up doing just that. I guess I was in such denial that I too would leave her that I just couldn't bring myself to do it.

> I was seeing this one 9-year-old girl and she didn't notice the pregnancy and finally I realized since we only had a few weeks left I needed to tell her. But it's just heart-breaking because the girl's mother died when she was 6 months old...from AIDS or substance abuse I think...and she lives in this really chaotic house with her grandmother and I just felt terrible telling her because I felt like I was betraying her. So I waited and she just moved away emotionally and we didn't talk about the pregnancy. And she was really sad... I finally told her, but only because I didn't want her to hear it from the other kids in the school. I thought it would be worse... I just didn't want to impose it on her.

> I also just thought of—I can't believe I forgot to mention him—I was seeing a nine-year-old boy for the past three years. And I was working very closely with his foster mother. And neither of them noticed I was pregnant...I think it was protective—she just did not want to know about it and neither did he. And I didn't tell them. I think he just had so many issues with his own mother and for me to be leaving was too much. The idea that not only would I be leaving but I was choosing my own baby over him would not be worth the pain. And I didn't think we had enough time to work it out in a way that would be useful. I did not want him to know because I thought it would hurt him. So I wore big clothing. But this is a vigilant kid who would notice this kind of thing so I thought if I could keep it a secret it would be better. That's my guilt.

The other category of premature terminations was on the part of therapists who had planned to return but did not. Of the sample of nine women, four did not return to seeing child patients. In one case, the therapist was in her early forties and had not expected to have children. She became pregnant accidentally and was thrilled about the prospect of motherhood. She described feeling that perhaps her work with children acted to fill a void in her life that she was now able to fill. She said, "I feel like maybe there was something unconscious at work where I didn't want to see these very troubled, very little kids...maybe some of my work with kids was because I didn't think I would have my own ...and now maybe I don't have to do that because I have my own kid." This therapist, who had significantly more clinical experience than the others, was able to manage the termination process with her child patients but acknowledged that she had probably ended treatment earlier than she otherwise would have.

The other three therapists who did not return to seeing patients had all been working with children in foster care or children who had been severely traumatized in their early lives. All three, in similar ways, described feeling too emotionally overwhelmed by the prospect of returning to such emotionally draining work with children who were so damaged by their own biological parents.

> I had one patient who was 15 and she was the same number of months pregnant as I was and she was taken away from her mother when she was one and a half and it's been really hard for her to know that I'm pregnant. She wants to know if I'm going to take good care of my baby...and I terminated with her. I don't think I could have tolerated it.

Two of the therapists left their clinical jobs abruptly, and one of the therapists terminated prematurely with her three child patients. All three returned to work after having their babies but only in a research, testing, or administrative capacity. None spoke about a wish to return to clinical work with children.

Even at the follow-up interview, six months after having their babies, these therapists expressed a great deal of ambivalence both about the way they had managed the termination process and the guilt that had led them to cut themselves off from the emotional worlds of their patients. All wondered whether they had made mistakes in letting their child patients become "too attached" to them and at the same time lamented their inability to give their patients what they "truly" needed.

It was clear that pregnancy changed therapists' ability to work with this population of children. It was as if having their own baby confirmed that they could not and did not want to be mothers to their patients. Giving any less of themselves to these

children felt intolerable, so they had turned away completely, unable to manage the depth of the child's pain and feelings of rejection. As one therapist noted, "I never thought I would prioritize my daughter over all these needy children. I imagined my daughter would be so privileged in terms of what I could give her that of course I would want to go back. But I just couldn't. It was too painful to tolerate."

Notably, the idea of object loss is very difficult for pregnant women and new mothers to tolerate, even on an academic level. One experienced therapist who considered herself a specialist dealing with children dealing with illness and loss said she was evaluating whether she could continue with her academic and clinical work in these areas.

Renegotiation of Roles

Part of the need for some therapists to discontinue child work once they have a baby may be understood as an inability to renegotiate and integrate their dual roles as mother and child therapist. Every therapist interviewed described the way in which the boundary between being a mother and being a child therapist became solidified over the course of pregnancy.

The most common sentiment expressed was the feeling that while they may have had maternal feelings towards their child patients, being a mother is a completely different entity. As one therapist said, "I definitely feel warmth towards my patients, but I feel profoundly attached to my son in a way that I never could have imagined. I used to feel much more attached to the kids. I think I still do but there is more of a distance, there is one less layer of love than I feel towards (my son)...the way I feel

about my son is nowhere near the same. The downside is that I'm a little less intensely committed than I was." This notion of de-cathecting from patients was common.

There also seemed to be some "toning down of the relationship" which centered on the feeling that the therapist was less available than she had been before. There was less tolerance for lateness and missed sessions and less "mental space" for note taking or creative thinking about patients. Therapists admitted a shift in priorities in their willingness to cancel patients for a sick baby or to allow themselves to be late for a session if they needed to nurse. Therapists described a sense of having split attention, particularly during the first two months of returning to work and a feeling of being slightly less present. There was an expression of caring and in some cases love for their child patients, but a love that was different in character from what they felt towards their own children in that it did not run nearly as deep.

A critical factor that complicated the successful renegotiation of roles was whether the therapist was able to integrate the fantasy of herself as both the "good mother" to her own child and "bad mother" to her child patients. For children in more stable homes, knowing that the child was going home to other "good enough" parents alleviated a significant amount of the therapist's guilt. She was able to imagine that the child would be held in her absence. In contrast, therapists working with traumatized children not only gave up the notion of themselves as the "good mother" but also, in their very real sense of abandoning the child, they became identified with the "bad mother." This identification became intolerable as they imagined mothering their own babies. It may be possible to understand the therapist's choosing not to return to child work as a way to ward off this negative identification.

This process of role differentiation was also more difficult for therapists who were relatively inexperienced. For more seasoned therapists, although there was some ambivalence about leaving their babies, it was a relief to return to a world in which they felt competent and one in which they had their own identity. Less experienced therapists, in contrast, seemed to have a more difficult time returning, possibly because their role as a therapist had not yet been internalized. Thus, they felt overwhelmed not only as a new mother but also as a new therapist, and they felt insecure in both domains. As one therapist who was still in training said, "I don't even know what it feels like to be a therapist. I only know what it feels like to be a pregnant therapist."

Facilitative?

The issue of whether or not pregnancy has a facilitative impact on child work was not clear given the experience of the therapists interviewed. Generally, therapists felt that for some patients, particularly those in more stable homes, the pregnancy "upped the intensity level" and helped move the work forward. Some therapists described feeling that the setting of boundaries was useful, as was the child's dawning understanding that the therapist was not endlessly available to them. One therapist remarked, "I felt a little guilty (about toning down physical nature of play) but there was also something reparative about building the relationship and modulating our behavior so we could be together...being able to tolerate difficult feelings and also to imagine what the other person was feeling." In addition, there was a sense that in the long-term, becoming a parent would give the therapist a better perspective and allow greater empathy and flexibility in their work with parents.

The area most often cited as being facilitated by the therapist's pregnancy was parent work. Therapists found that although difficult, parent work was in general facilitated by the therapist's pregnancy. First, therapists universally described feeling more credible working with parents knowing that they would be parents as well. They described a certain relief about no longer being a "fraud" or a new sense of being "in the know" or "more normal" by having children. One therapist remarked, "I didn't feel like so much of an innocent...I also think it gave me more of a sense of weight, both for myself and in her eyes...I think in some ways it has defined me more as a person like her."

Therapists described feeling more identified with parents, often for the first time after many years of identifying primarily with the child. As one experienced therapist said, "I've spent a very long time being around children and identifying completely with the child...now I'm realizing I can identify with the needs and concerns of parents ...I feel like I already have more interest and empathy for parents and the struggles of parenting." Therapists spoke about a new understanding of the magnitude of parental responsibility and an appreciation for the efforts of even their most fragile or difficult parents.

One caveat to this finding, however was that, like many aspects of this study, therapists' experiences were defined by the patient population they were seeing. While there was a greater tolerance expressed for parents in general and a shift in identification to the parents, this was not the case for therapists working with families with histories of abuse or neglect. In these situations, there was a heightened rage felt towards the parents for failing to protect the child, betraying the child's innocence and

allowing the child to be damaged in such a profound way. In general, as the degree of trauma, neediness, and loss increased, the therapist experienced the pregnancy as more damaging to the treatment.

Therapists also experienced a sense of "split-attention" upon their initial return to work. They described feeling more emotionally distant from their patients and less available to make phone calls, take noted, and think about their patients. Once they had been back at work for about six months, however, they generally felt more engaged in their work and better connected to their patients. None of the therapists reported feeling as if their child patients had benefited from their pregnancies in the short-term, but they left open the possibility that the process would be facilitative over the course of time.

The results of the study seem to suggest that pregnancy itself is not what threatens or facilitates clinical work. Rather, the therapist's ability to manage her guilt and to maintain her ability to think about the child's mind is what profoundly impacts therapeutic outcome.

Chapter V

Discussion

As Bibring (1961), Winnicott (1956), and others suggest, profound changes occur in the bodies and minds of pregnant women that initiate a kind of altered state. Women become increasingly preoccupied with their internal worlds and may experience varying degrees of anxiety and emotional turmoil. Changes during pregnancy, in terms of the therapist's growing body and declining investment in the external world have been shown to affect the ability of therapists to be fully present with patients. The results of this study suggest that in many ways, pregnant child therapists face challenges that are unique to child work. In powerful ways, pregnancy may alter a child's access to the therapist's body and mind. Most critically, pregnancy has the potential to change the very nature and meaning of play.

The impact of pregnancy on play is multi-layered. First, the therapist's growing body is a concrete intrusion into the play space that may disrupt the balance between what is real and what is pretend. As such, it may impact the transitional nature of the play space. Second, as the therapist experiences changes in the way she thinks about a particular child in terms of rescue fantasies or maternal fantasies, she may become less emotionally present in the play. Third, as the therapist struggles to create a safe holding environment for her own baby, she may have difficulty taking in and metabolizing the overwhelming or traumatic emotional experiences of her patients in a way that would help to contain them. In the most extreme cases, the therapist may experience such an extraordinary amount of guilt about the shift in her physical and emotional availability

that she may have difficulty thinking about the child's experience. If thinking about the child's mind becomes too painful, her ability to reflect may be compromised.

The pregnant therapist's changing body introduces a powerful new reality into the treatment space. To varying degrees, this concrete intrusion shifts the balance between real and pretend, altering the nature and meaning of what it is to play together. At this point, it is useful to revisit psychoanalytic notions of what it means to play and the nature of this space between the internal world and external reality.

Real and Pretend

A number of psychoanalytic theorists have written about the meaning of play. In terms of play as mastery, Freud understood play as a child's need to gain a sense of mastery over painful or overpowering events and as a way to rework unpleasurable experience, "reversing his or her original role of frightened, passive victim into an active, masterful role" (Marans et al., 1991, p. 11). Similarly, Waelder (1932) wrote about play as serving a "psychic metabolic function" and providing a "means of breaking down and repeating overwhelming experiences until they are mastered and assimilated" (p.218).

Winnicott (1971) views play as a "basic form of living" and highlights the importance of play as a "thing in itself" (p. 40). Slade (1994) builds on this notion that play is meaningful as an act in itself. She points out that in general, therapists hold the assumption that play means something relatively concrete and that the therapist's job is to figure out or uncover this meaning. Therapists look to the content of play as a kind of map to the child's unconscious experience. Slade proposes that in fact some children may not have the developmental capacity to represent complex emotional events and

situations. Children may not be able to make meaning of their experiences in a way that can be symbolized.

Slade argues that play therapy is not about uncovering meaning but about making meaning. "It is by means of play that they are discovering what they feel and, what they know, and what they want. It is also by means of play and imagination that they begin to make sense of what others feel and believe. *By putting experiences and feelings into play rather than into words, the child is creating structure*" (p.91). Playing, with the possibility of creating a narrative, is in itself therapeutic. The critical role of the therapist is to be engaged in the play as a play partner. Slade writes that intrinsic to this process is the therapist being both in the play and out of the play; the therapist is not only playing, but also helping the child to elaborate and define the play narrative. As the play is transformed, meaning will emerge, but this will happen only if the therapist is fully present.

Fonagy et al. (2002) suggest that one of the ways a therapist can make meaning of a child's experience is by entering the child's world in a playful way. By doing so, the adult takes on an "as-if" attitude in a way that facilitates the development of a representation of the child's state of mind. It is in this way that the child is able to "*play with reality*" (p.267).

Winnicott (1971) located the play space as neither inside nor outside but rather in the "potential space between the baby and the mother" (p.41). He imagined play as a "bridge" between fantasy and reality that incorporates elements of both. Play allows children to suspend reality and to take an active role in the recreation of events with, "the confidence that however closely the action approximates real events or however

intense it becomes, the action of the characters in play is not and does not need to be 'real'" (Marans et al., 1991, p.19).

Winnicott (1971) writes that, "the precariousness of play belongs to the fact that it is always on the theoretical line between the subjective and that which is objectively perceived" (p.50). Building on this notion, Fonagy et al. (2002) suggest that in order to facilitate the development of a child's mind, the child must be able to have a safe imaginary space where the "pretend" world and "external reality" do not necessarily meet. In the mode of pretend, ideas are not threatening to the child because "they have lost their equivalence to what is real" (Fonagy et al., 2002, p. 279). Children feel safe playing and possibly thinking about their thoughts and feelings in the play precisely because they are able to keep external reality separate. The child must be able to control the degree to which "serious reality" is incorporated into the fantasy. However, if the play becomes too close to reality or the link too explicit, the play may become frightening.

Fonagy et al. (2002) provide two very useful clinical examples of the way that reality can disrupt play by coming too close to the world of pretend. In one instance, a father bought a Batman costume for his 3-year-old son. The costume was so realistic that the boy was frightened when he saw himself in the mirror, refused to wear it again, and went back to using his mother's skirt as a batman cloak (p.263). Fonagy also describes how overwhelming it was for a girl he was treating that he was both her analyst and someone who looked like a daddy. For this child, in certain moments, his looking and acting like the father was the reality. There was no "potential space" to

explore the meaning of the child's experience of the analyst as a father because he *became* the father in her mind (p.289).

In the case of pregnancy, the line between 'playing' and 'reality' may become blurry for *both* patient and therapist. The pregnancy may feel too real for both partners to play about. It is critical that the therapist is able to maintain the line between real and pretend *in her own mind* in order to make the space feel safe for the child. If the therapist is able to monitor her own feelings about her real pregnancy intruding on the world of pretend however, she can keep the "potential space" open for the reality to be "shared, played with and changed" (Fonagy et al., 2002, p.289).

Transitional Space

Pregnancy, as a concrete intrusion that alters the balance between what is pretend and what is real, or what is inner and what is outer, may alter the therapist's ability to play. As she struggles to maintain the "line" between inner and outer, she may become less present as a play partner. In this way, pregnancy may affect the transitional nature of the play space.

Winnicott (1951) writes, "there is...an intermediate area of experiencing, to which internal reality and external life both contribute. It is an area which is not challenged, because no claim is made on its behalf except that it shall exist as a resting place for the individual engaged in the perpetual human task of keeping inner and outer reality separate yet inter-related" (p.230). Fonagy and Target (1998) suggest that is within this transitional, as-if area, between fantasy and reality, that patients can "both own and disown their rejection feelings and experiences and test out the analyst's attunement, respect, and responsiveness to the vulnerable aspects of the self." The

transitional nature of the space allows for a safe context in which to "play with ideas and come to experience them as ideas" (p.107).

Rosegrant (2001), building on Winnicott's ideas, writes that "mutual play, which resolves the heightened power of the external and internal worlds in enhanced transitional experience, is only possible if the internal and external worlds are experienced as potentially more or less in balance" (p.22). One of the most powerful elements of the therapist's pregnancy is that it has the potential to wreak havoc on this balance between inner and outer. As Slade highlights, the task of the therapist is to be both in the play and out of the play at the same time. In the case of pregnancy, however, the therapist is in some sense already outside the play because she represents the reality that is being played about. For therapist and patient, the pregnancy is happening in the moment in the room. As a result, some children may perceive that there is less space for imagining and playing about it. The concreteness of the therapist's changing body may infringe on the child's pretend space, both physically and psychically. The safety of the transitional space is more vulnerable in this situation because both the real and pretend are active in the same moment.

Holding Environment

As the concrete intrusion of the therapist's body shifts the balance between real and pretend, the therapist faces the challenge of keeping a "potential space" open for the patient to play about his thoughts and feelings. At the same time, the therapist must struggle with the way that her "altered" state of mind may impact her capacity to hold the patient's experience.

Winnicott (1956) writes about the idea of "primary maternal preoccupation" as the state women enter at the end of their pregnancies and emerge from some weeks after the baby is born. He proposes that the mother is preoccupied with or "given over to" the care of her baby. In this stage, the state of the baby is one of "absolute dependence" on the mother. The mother in turn is able to identify with her baby as a part of herself in a way that also renders her dependent and vulnerable.

Winnicott (1960) suggests that the very physical holding of the baby in the womb sensitizes the woman to later, more subtle psychological changes. He argues that from the very beginning of the pregnancy process, the woman experiences a change in her orientation towards the world and begins to direct her attention inward, shifting some of her sense of self to her developing baby (p.53). In terms of child treatment, he suggests that, "the analyst who is meeting the needs of a patient who is reliving these very early stages in the transference undergoes similar changes in orientation; and the analyst, unlike the mother, needs to be aware of the sensitivity which develops in him or her in response to the patient's immaturity and dependence" (p.53).

The material that emerged from the interviews strongly suggests that most therapists, regardless of experience, have difficulty holding both the experience of pregnancy and the experience of certain child patients at the same time. This is particularly true in the moments when holding one is experienced as threatening to the other.

The ability to hold the internal experience of children, particularly the most vulnerable ones, calls on the therapist's capacity to metabolize overpowering or traumatic affects and to "re-present" it back to the child in a form that is more

manageable. When the therapist is pregnant, she may have trouble digesting these emotions if she experiences them as threatening to her baby. In these moments, she may feel overwhelmed or invaded because she is taking in affects that she experiences as toxic to her baby. Particularly when working with very traumatized children, some therapists may struggle with simultaneously trying to metabolize intolerable affects and to create an environment for her own baby that is free from impingements. Thus, out of her basic maternal need to create a safe and protective holding environment, she may struggle to hold the patient and baby's experience at the same time in *body and mind.*

The Therapist's Mind

Coates (1998) suggests that the therapist cannot facilitate a patient's capacity for reflective functioning by, "standing outside the patient's emotional world and observing and commenting on his or her mind" (p.127). Rather, "the therapist must get what the child feels. And this kind of 'getting' has to be immediate and direct. It must come about through a kind of affect contagion. It must accord with the real quality and intensity of the patient's affect. One might more accurately say that, rather than get the patient's feeling, what the therapist must do is let the patient's feeling *get* to him or her" (p.127). Coates cites Fonagy, who writes, "one must permit and even in some circumstances encourage the patient to colonize one's mind and then recover to be able to offer the patient a fresh perspective upon their own mental functioning"(p.127).

It is precisely this inability to tolerate her mind being "colonized" that may render it more difficult for the pregnant child therapist to think about the child's mind. If the therapist has trouble taking in what the child feels in this very immediate way, she

may not be able to reflect back to the child the experience that the child's feelings have both been understood and contained.

This idea may also help to explain why therapists are able to manage their experience more easily with less needy children. In light of Slade's writing, children who are cared for in a "good enough" way will likely be more organized, both in terms of their presentation and their play. The therapist may find it easier to stay attuned to the experience of a child who is more coherent and organized. Children who are living with chaotic inner lives, in contrast, may look more disorganized and present more diffuse material because their ability to symbolize or represent their internal world is compromised. If the quality of the material is primitive in nature, such as the child expressing a wish to eat the baby or invade the therapist's body, it may penetrate the therapist's experience in a different way. It seems to be with this kind of material that therapists feel more vulnerable and anxious.

Rather than being able to take in the patient's disorganized, overwhelming, and highly charged material, therapists may feel the need to pull away and try to "organize" the patient's experience in a way that feels more manageable *to her*. Therapists may be tempted to make "sense" where "nonsense" is (Slade, 1994) because the child's material may be experienced as too disorganizing to her. Even experienced therapists who can help to process a child's disorganized material in another domain may find it more difficult to tolerate when it comes to her own body and baby.

This idea was also evoked in the therapist's fantasy that the child patient was in competition with the baby for her love. In a very real way, the therapist experienced her growing attachment, need to protect, care for, and think about her own child as a direct

substitution for the feelings she had previously held for her child patients. In every case, the love for her own baby was much more powerful, and the therapist felt that she was rejecting and abandoning her patients. In many cases, the therapist described feeling profound guilt about this transformation.

It may be argued that these changes, both in the balance between real and pretend and the shift in the therapist's capacity to hold the patient's experience, have the potential to affect the way the therapist is able to think about her patients. Some therapists described a shift to a more concrete way of thinking. In the most extreme cases, when she felt that being fully present with a patient was threatening to her baby, the therapist had a way of mentally turning away from or blocking out the patient's experience. It was in this type of situation that the therapist risked enacting a real abandonment of the child by abandoning his mind.

Reflective functioning.

The changing nature of the therapist's fantasies and the guilt that accompanies these changes may, in some cases, impair her capacity for reflective functioning.

Fonagy and Target (1998) define mentalization or reflective functioning as, "the developmental acquisition that permits children to respond not only to another person's behavior but to the child's conception of others' attitudes, intentions, or plans. Mentalization enables children to "read" other people's mind. By attributing mental states to others, children make people's behavior meaningful and predictable"(p.92). They argue that a critical component of child work is to help facilitate a child's capacity to mentalize. This developmental accomplishment is fostered through the act of playing. "The capacity to take a playful stance may be a critical step in the

development of mentalization as it requires holding simultaneously in mind two realities: the pretend and the actual, in synchrony with a moment-by-moment reading of the other person's state of mind" (p. 108). Particularly for children whose experience in early childhood was not "good enough," play with the therapist allows the child to "find himself in the mind of the analyst as a thinking and feeling being" (p.109).

The inherent difficulty during pregnancy, however, is that some therapists may not want the child to find himself in her mind because in her mind the child has been replaced. Thus, in attempt to protect the child patient from what is in her mind, she may become more distant and less able to think about the child's experience. The therapist may in fact experience her own shifting feelings and fantasies about the child patient as "unthinkable thoughts" (Fonagy and Target, 1998). If she becomes inconsistent in her ability to reflect on the child's mind, there may be pockets of thoughts that are not metabolized. These thoughts may remain encapsulated unless the therapist has support in analyzing them. Such additional support, in both her own therapy and in supervision, may help the therapist remain "one step ahead" (Fonagy and Target, 1998) of the child's experience of his mental self, which is so critical to facilitate representational capacities.

This is particularly true among therapists who are working with patients who have been traumatized. This population presents the greatest challenge to pregnant therapists. There is evidence that trauma changes the capacity to think. In addition, during pregnancy and in the initial post-partum stage, women tend to become increasingly sensitized to violence and material about damaged, ill, traumatized, and unprotected children. In fact, one pregnant therapist who was taking a course on object

loss felt that she could not continue because, even on an academic level, the material felt too painful for her to bear. It may be that being so close to a child who has been traumatized is traumatizing to the therapist and may impair her ability to think and reflect in a way that her work demands. This is consistent with the finding that therapists treating children who had been traumatized were most likely to terminate prematurely.

Maternal fantasies/countertransference.

As discussed previously, therapists described very powerful maternal fantasies and rescue fantasies about certain child patients that diminished over the course of their pregnancies. The shift in these fantasies caused an extraordinary amount of guilt on the part of the therapist, and therapists experienced this shift as an abandonment of the child in a very real way.

As the therapist's fantasy of the child changed, she seemed to have difficulty separating what she was experiencing in her own mind from what she was imagining was in the child's mind. In certain cases, when thinking about a child's mind became too painful, her thoughts became concretized. She imagined what the shifts in her feelings and fantasies about the child were actually "doing" to the child; maternal fantasies became real motherhood and therefore real abandonment and real loss. In a sort of temporary or encapsulated regression, the line between thinking and acting became blurry, and the therapist's capacity to mentalize was compromised.

Ideally, as Betty Joseph (1998) writes, the therapist's state of mind is such that, "she is sufficiently free from anxiety and concern to be able to be aware of what is being stirred in herself and emerging from the child" (p.366). During pregnancy,

however, the mix of the therapist's own maternal and rescue fantasies and her countertransference reactions are extraordinarily complex and difficult to tease apart. Therapists interviewed for this study consistently described a phenomenon of feeling that is outside the realm of what is typically called countertransference. Rather than being triggered by the patient, the therapist's feelings seemed to reside or originate from deep within her and to become evoked by the pregnancy. She described certain patients not exactly as a patient and not exactly as her own child but as if the child patient could be her own child. The feelings about the child, and the guilt about abandoning the child, were real.

Technique

The significant changes that occur over the course of a therapist's pregnancy have serious implications for technique. It may be argued that the "rules" of psychoanalytic technique may in fact hinder the therapeutic process in the case of a therapist's pregnancy. Even the most experienced clinicians struggled with boundaries and limits during pregnancy. Not only did therapists' boundaries become looser, but also therapists believed that to have maintained the degree of boundaries that they had set in their previous work would have felt withholding and somewhat punitive.

In classical psychoanalytic technique, the analyst's task is to maintain a position of neutrality, "equidistant from the various components of the patient's conflicts" (Eagle and Wolitzky, 1992, p. 119). This idea is related to Freud's notion that the analysis be conducted in a state of abstinence, or the idea that the analyst should not deliberately provide the patient with any gratifications other than those intrinsic to the analytic process.

> A neutral analyst is one who listens with evenly hovering attention, recognizes and tries to control personal biases, applies the rule of abstinence with appropriate tact and dosage, is genuinely nonjudgmental, safeguards the 'working alliance' recognizes his or her stimulus value to the patient, and creates an atmosphere of safety for the patient (Eagle and Wolitzky, p.121)

Disclosure

The way that the therapist managed, or did not manage, the issue of disclosure was particularly complicated by this idea of not gratifying patients. Telling patients very directly that they were pregnant, before they believed that the patient "knew," made therapists feel as if they were giving away too much. The results of this study strongly indicate, however, that telling in a direct, concrete way relatively early in the pregnancy is critical to the therapeutic process.

Once a therapist became pregnant, she began to struggle with how and when to disclose the pregnancy to her patients. One of the most striking findings was that very few if any of the child patients described in the study brought up the pregnancy in a way that had been expected or predicted. It seems clear that child patients simply do not bring up pregnancy in the ways that therapists (or supervisors) imagine. Patients certainly demonstrated various ways of "knowing" about pregnancy, but this knowledge generally did not emerge in a coherent play narrative or in the child staring at a therapists belly and asking, "oh, are you having a baby?"

This issue is critical because it directly contradicts the seemingly universal notion that therapists are not "supposed" to disclose the pregnancy until the child "knows." This study suggests that a child may "know" on some level that therapist is

pregnant, but it is unlikely that the therapist will definitely be able to tell what kind of "knowing" it is. For instance, several months ago, when I was 20 weeks pregnant, I had a session with a child patient who demonstrated his "knowledge" of my pregnancy by playing in a very sexualized way and ultimately by grabbing his crotch repeatedly and peeing on the floor. Clearly he "knew," but it was not communicated in the way that I had imagined. Despite the fact that I had planned to disclose my pregnancy around this time anyway and that I was obviously thinking about this issue, his disorganization caught me totally off guard. It was an extraordinarily difficult moment because even when I knew that he knew, which somehow made it acceptable to talk about, I did not have the tools to make it any less overwhelming for either of us. In some sense, it was my reality that was disorganizing him and because I had no distance from it, in fact since it was literally right in front of both of us, I didn't know how to contain it.

Interestingly, the way my supervisor helped me to manage the situation was to alter the play space in yet another way. In the next session, when he became as disorganized as he had been in the session before, I suggested that we sit at the table together with our hands on the table and draw pictures. This child was able to reconstitute himself by drawing incredibly fragmented images of his body, which he described as "in pieces." It is possible that since I was not actually able to hold his experience (and he was very aware of my changing body and the impingement of my belly into our space), my only option was to use the space in the room to help contain him.

Even when a child's material is more organized and themes about babies, sibling rivalry, loss or rejection of a parent, and abandonment clearly emerge, it does not

necessarily reflect the reality of what a child knows. The therapist may never truly be sure about whether the content of play is in reference to her pregnancy. As Slade (1994) highlights, there is not necessarily a one to one correspondence or direct relationship between a child's inner world and what is represented in play. Thus, a therapist's focus on the content of play may be especially risky in this case because she is invested in finding clues that in fact may be misleading. In addition, when therapists are focused on trying to decipher the meaning of a child's play, they may become disconnected from the more meaningful and therapeutic act of playing.

Another difficulty with waiting to tell until a child "knows" is that pregnancy imposes a very real time constraint on managing disclosure. Slade points out that it is not uncommon for a clinician to spend a period of weeks or even months wondering about how to make sense of a child's fantasies or play. She suggests that by just going on playing, the meaning will eventually emerge. In the case of pregnancy, however, the therapist's time to make meaning is limited. Rather than being able to just play and let the meaning emerge, therapists tend to impose the meaning in attempt to resolve it before the break.

Some therapists in this study described feeling pressure to have "closure" by making books, taking pictures, and making sure not to leave any "loose ends" before their leave. In doing so, however, the therapist runs the risk of closing down the space that the patient needs to explore what the pregnancy means *to him*. The therapist must be able to tolerate the possibility that *she* will not experience a sense of "closure" before the break and that it may take many weeks or months after her return for the child to begin to integrate the experience of her becoming a "real" mother to someone else.

Another aspect of the therapist's ambivalence about telling may be her own fear that by stating the fact of her pregnancy with language she is making it real. In some way, the therapist may still be struggling with her own feelings that the pregnancy is a reality, and she may not be ready to share this reality with the patient, even when it is therapeutically indicated. This is particularly true in the first half of her pregnancy. She may also have anxieties about the way that making the pregnancy real with words may hurt the patient in a more direct way.

To remove this issue from pregnancy for a moment, it is useful to consider the way a therapist might manage the literal changing of spaces that occurs when she moves her office or therapy room. In this case, it is highly likely that the patient would be told directly, with enough warning time to process the meaning of the move. It is unlikely that the therapist would wait until her office had been emptied to see if the patient "knew" that she was moving. Since the therapist would have some awareness that she was the one imposing a real physical change on the patient and therapeutic space, it is likely that she would tell very directly about the impending change and then keep in mind the meaning over time. Pregnancy in fact has a much more powerful impact in terms of the way it changes the space, but somehow because the change is located within the therapist's body, it is a space that is not deemed safe or "neutral" to acknowledge and talk about.

The findings of this study strongly suggest that the issues of telling and knowing must be disengaged. It almost is not relevant whether and what the child "knows." Rather, the particular meaning of pregnancy to the child may only begin to emerge once he is told about the therapist's reality. It may in fact be the act of telling, or the

acknowledgement of the *reality that is already in the room* that redefines the line between what is real and what is pretend and therefore creates a different kind of safe space for the child and therapist to play. Once this line is clearly marked, the child knows the boundary of what is the external reality and has some control over playing with the idea of it.

Several therapists in fact did not disclose at all, and in every case the child or the therapist terminated prematurely. It may be hypothesized that in the act of not telling, a therapist effectively denies the child's sense of himself as a separate and thinking being. Not telling creates a frame of denial that may be particularly confusing and overwhelming to the child who does not yet have the capacity to represent his experience. The situation calls to mind the infant experiment in which the mother, rather than mirroring the child's emotional expressions, maintains a blank expression. This blankness, no matter what the baby does to elicit a response, is disorganizing to the baby and causes the infant to withdraw. Similarly, not acknowledging the reality of her own body and allowing the patient to make sense of the therapist's changing body over time may further confuse the line between what is real and what is imagined.

There is also an important distinction that must be pointed out between using language to tell and using language to make interpretations. The ideas discuss thus far suggest that while some language may in fact help redefine the boundary between inner and outer and make the child feel safer, other kinds of language, such as linking a child's play to his feelings, may be quite disorganizing. Interpretations may be experienced as impingements and cause the child to withdraw and become disorganized.

Slade (1994) discusses the role of interpretation in play and suggests that particularly for less mature children, language may heighten a child's sense of anxiety and lack of control. Speaking about a child's emotional states may make them "more real than they already are" (p.89). Slade writes that, "once their feelings have been put into words, these children have few means from protecting themselves from an onslaught of overwhelming and threatening thoughts." Rather than helping children metabolize their experience, the interpretation of powerful feelings, "brings those feelings to the surface in a way that is overwhelming, shameful, and humiliating" (p.90). The articulation of these feelings may in fact lead a child to become more disorganized.

The very act of interpreting brings the therapist outside the play. By using language to reflect on the meaning of a child's play, therapists also assume that the child has the developmental ability to reflect on his inner life (Slade, 1994). If a child does not have the capacity for this level of abstraction, then addressing the child's feelings may be quite disruptive both for the play and for the level of organization of the child. Referring to Winnicott's idea of the "false self" Slade suggests that premature interpretations may inhibit children from making meaning of what they feel because the therapist's use of language creates the experience of being impinged upon. In response, the child may react by withdrawing in attempt to protect himself. It is only when the therapist and child are able to step outside the play *together* that an interpretation may become meaningful rather than intrusive.

For instance, in the example of a patient reporting that the therapist's blood is purple, it was critical that the therapist stay in the play, perhaps by saying 'wow purple

blood...something must be going on in a body that has purple blood' rather than 'oh maybe you think my blood is purple because I'm pregnant.' Premature interpretations about the therapist's pregnancy may be especially dangerous to the process because the child's response may make the therapist experience even more guilt. For instance, if the therapist interprets a child's wish to be the therapist's baby, the child may become overwhelmed and disorganized. The therapist may then feel that it is her pregnancy that is disorganizing to the child rather than the *interpretation about the pregnancy* that may have been experienced as too much. Thus, it may not be the telling in itself that is so disruptive to a child but rather the way that the therapist tries to manage the child's feelings by interpreting rather than by playing.

A 6-year-old boy with whom I was working initiated a play narrative about two months after I had disclosed my pregnancy. This has continued over the course of the past few months. Together, we created a family of ducks of all different colors and sizes that we play about, break, put together, make disappear, and play peek-a boo with. If I had interpreted the ducks as his desire to make babies with me (which I believe is the case), I may have terrified him and profoundly disrupted his play. Instead, I continue to try to help him create a narrative that allows him (I hope) to make meaning of my pregnancy. The work is the play.

Chapter VI

Conclusion

Pregnancy is a time of significant emotional upheaval and presents a type of psychological "crisis" that has powerful implications for clinical work. It is a time that presents particular challenges for therapists who work with children. Pregnancy affects both the body and mind in profound ways. In child work, where play is the central modality of treatment, the concrete intrusion of the therapist's changing body is a reality that calls for a redefinition of the line between real and pretend in the play space.

In a number of ways, pregnancy affects a child's access to the therapist's mind and body. As her body changes, a therapist's may become particularly sensitized to both physical *and* emotional intrusions that feel threatening to the baby. Not only do women become more protective of their physical bodies, but also the holding environment that they are creating for their babies. Physical objects and emotional affects both may be experienced as potential intrusions that may need to be defended against.

As women negotiate what it means to be becoming a mother, they simultaneously struggle with what it means to feel maternal, in varying degrees, towards their child patients. As feelings and fantasies about their own babies and bodies change, so do their fantasies and feelings about certain patients.

The common experience of rescue fantasies and strong maternal feelings towards certain patients must be highlighted as an area that has been largely unexplored in child work. Whether it is the particular constitution of clinicians who work with children or a response to a certain kind of child work, many women have deep and

powerful feelings and fantasies about some patients. These feelings seem different in character from what has traditionally been described as countertransference.

The way that women in this study described their rescue fantasies, it was as if the topic were taboo. Each woman described feeling that she knew her thoughts were somewhat "irrational" and that in reality she wouldn't have "really" acted out her fantasies. Nonetheless, certain women spoke with intensity about having wanted to "save" or "take home" particular patients and even described elaborate plans they had imagined about adoption. As these feelings shifted over the course of pregnancy, the therapist experienced profound guilt about abandoning the patient both in her own mind and in the treatment space. The way that women spoke about these feelings suggests that they had not been spoken about before, at least in any "professional" setting. In general, these feelings were unanalyzed, even for women who were in supervision with highly qualified clinicians. The way that therapists manage their maternal feelings is a vital part of the process. What is clear is that unless these fantasies are recognized, understood, and managed within the context of the pregnancy, they may spin out of control.

The therapist's pregnancy thus raises a host of complicated issues for women as they negotiate shifting boundaries in the play space with children, with parents, and in their own minds. Often, they must hold what seem to be competing interests between their developing babies and the profound needs of certain patients. When the therapist becomes overwhelmed in certain moments by the depth of what she perceives a child needs from her, which feels in many ways the *same as what her baby needs from her*, she may have difficulty holding the patient's thoughts and feelings in mind. Somehow,

when she feels unable or unwilling to "mother" certain patients, for whom she has previously held powerful maternal fantasies, the therapist may be left feeling not only ineffectual as a clinician, but also that she has abandoned or even traumatized a child. This process has the potential to undermine her ability to be "preoccupied" with her own baby since she is simultaneously trying to integrate her new role as good mother with the sense that she has been a bad one. It may be that in an effort to ward off these negative identifications with the "bad mother" of a certain child patient, she ultimately is faced with the decision of whether she feels emotionally able to return to her work at all. For a significant number of women interviewed, the chasm between what they felt they could give their own babies and what they were able to provide for their child patients seemed too large to tolerate. Somehow, nothing short of mothering seemed like enough, so they chose not to return to clinical work with children.

The results of this study suggest that even the most seasoned therapists and supervisors are challenged by the particular issues that are stirred up by the interplay of the therapist's body and mind and the impact on the treatment space. The tools that come with good training and experience are often not enough to prepare many therapists for the emotional upheaval that ensued during the pregnancy process.

If women are given enough support during this enormously complicated process of physical and psychological change, however, there is the potential for pregnancy to be a ripe time in the course of treatment. Therapeutic dyads may grow and mature together if they are able to find a way of using the pregnancy as a *shared* experience that can be played about. It is a time when the patient may be called on to keep the therapist's needs and experience in mind in a different way that may even facilitate his

capacity to think and reflect on the feelings of another. Therapists may ultimately be able to define their roles in a more appropriate way, and patients may be able to take in the idea that therapists have limits.

However, if the therapist feels that she must "hide" her experience, by not disclosing her pregnancy or not allowing the child access to her mind and body because it feels too threatening, the child may not be able to find himself in the therapist's mind and therefore experience a different kind of abandonment. In the most extreme cases, the therapist's difficulty keeping the child in mind may lead to a concreteness of thinking. Rather than being able to process her own fantasy of abandoning her patient, she becomes the mother who is abandoning; the fantasy gets lost and becomes a concrete action of "doing" something to the child. If these issues are not attended to in a meaningful way, there is the possibility of premature termination on the part of the patient, the therapist, or both.

It is clear that both pregnancy and the issues surrounding the therapists' use of and feelings about her body in child work must be explored in greater depth. In addition, the range of maternal and rescue fantasies that are so common among women who treat children is an area that has been neglected thus far. The idea that child work is about the play and that playing is meaningful in itself suggests that the ways that therapists use their bodies together and separately during play has profound meaning. Child therapy as two people playing together is also two bodies and two minds playing together. Pregnancy is a time in which the dual nature of this experience is powerfully heightened.

Recommendations

The results of this study raise a host of issues that are critical both to pregnant therapists and to the clinicians who supervise them.

Telling.

It is vital that pregnant therapists inform their child patients of their pregnancy in a simple and direct manner some time in the beginning of their second trimester. It is my belief that children should be told as soon as the therapist feels comfortable with the viability of the pregnancy (after 12 weeks) and has her test results back (such as an amnio or cvs) if she has had genetic testing done. It is recommended that details about maternity leave be left for a separate session. Even if a therapist does not know whether or not she will return, it is crucial that a child be told relatively early that the therapist is pregnant.

Once the therapist informs the child, it is recommended that she inform the parents immediately. Even if the therapist does not have frequent contact with the parents, she should tell them by phone as soon as she tells the child. Once again, she may simply say that she will update the parent about the details of her leave once it gets closer.

Supervision.

This study suggests that even for experienced clinicians, good supervision is crucial during a therapist's pregnancy. In order for therapists to be well supervised, however, supervisors must make a concerted effort to become better informed about the impact of pregnancy on the treatment process. It is clear that even well trained and

experienced supervisors have their own personal issues with regard to pregnancy, and this may interfere with their ability to work with the material.

Institutional support.

Since many of the women who become pregnant for the first time are trainees, it is important that training institutions become sensitized to the host of issues that may arise for therapists during pregnancy. In addition to making sure the therapist is well supervised, institutional leaders should make sure to institute clinic policies regarding covering pregnant therapists in their absence and helping to manage the transfer of patients when the need arises. It is also my firm belief that when possible, pregnant therapists should not pick up new long-term child patients, particularly when there has been a history of trauma and loss in the child's life.

Maternity leave.

Once the therapist has determined the nature and length of her leave, she should inform the child and the child's parents in a simple and clear manner. It may be useful to use language such as "my *plan* is to return on this date..." and to emphasize that she will provide more details as time goes on. It is also recommended that the therapist make a calendar with the child to show how many weeks she will be away and to set a start date (even if it changes) to mark on the calendar.

In terms of informing patients when the baby is born, I believe that it is very important that children are told that the therapist had a baby and is doing fine. While therapists may decide with their supervisors what they are comfortable with, I would suggest that the therapist send a postcard saying something like, "I wanted to let you

know that I had the baby and we are both healthy. I look forward to seeing you in X weeks."

It is very tempting for new mothers, therapists included, to want to talk about and show pictures of their newborn babies. Based on my own experience and those of the women in this study, I would advise that information about the baby be kept to a minimum. As an example, before I had my first daughter, a six-year old girl whom I was treating said that she wanted me to bring the baby to see her and that she would want to know everything about the new baby. When I returned from my leave, I brought a picture to show her, assuming that she would ask about it right away. In fact, I carried the picture to session for many weeks and she never asked to see it. She truly had no interest in the picture or in hearing anything about this new baby whom she believed replaced her. Before my most recent maternity leave, I asked a seven-year old boy whether he wanted my letter to include information about whether I had a boy or a girl. He said, "no, I really don't want to know anything."

Therapists must navigate the degree to which they disclose information about their baby according to their own comfort level. However, it should be noted that pictures and names and details about the baby may in fact hamper the child's ability to fantasize about the baby -- or to not fantasize about the baby -- in a way that is useful to him. The child may be relieved to reclaim the space for the dyad and be invested in recreating the fantasy of being the only child in the therapist's mind.

Parents may also ask for details about the baby. The amount of information disclosed to a parent should be carefully considered by the therapist and addressed within the context of the therapist's particular relationship to the parent. As with the

child, information may carry tremendous meaning for the parent that may stir up feelings of competition and envy. Supervision may be particularly important in helping therapists renegotiate boundaries with parents.

Future Research

There are several areas to emerge from this work that call for future study. First, it is clear that many if not most child therapists have maternal fantasies about one or more of their child patients. Such fantasies may be true "rescue fantasies" of adopting a child or maternal feelings that may vary from subtle to quite powerful in certain moments. The experience of the women interviewed suggests that such feelings and fantasies are considered off limits, inappropriate, or unprofessional so they are not addressed or analyzed in any professional context. While such fantasies may feel manageable under most circumstances, pregnancy seems to heighten them in a way that they may no longer be contained. This study suggests that it may be this range of maternal fantasies towards child patients that has the potential to disrupt the therapist's capacity for reflective functioning.

Investigating the nature of and changes in the therapist's capacity to reflect on her own and the patient's experience during pregnancy is an important extension of this study. The results of this work suggest that as a woman begins to enter a state of "maternal preoccupation" and to create a holding environment for her own baby, she may have difficulty holding the experiences of her patients. There is evidence that for some women, their quality of thinking becomes more concrete and the therapeutic relationship loses its "as if" quality. This is especially true for therapists who work with patients with histories of trauma and loss. Given the significant number of women in

this study who terminated prematurely with patients and/or did not return to clinical work at all, this issue is an urgent one.

Appendix A

Initial Interview

Preamble (read to all subjects before beginning of interview)

I would like to speak with you about the impact of your pregnancy on your experience of yourself as a clinician and on your work with two child patients. I am especially interested in the way that changes in your body may have affected your capacity to play and your feelings about being physically engaged with your patients.

I personally had the experience during pregnancy of working with an 11-year-old boy who played in a very destructive way before I became pregnancy and with a 7-year-old girl who needed very close physical contact much of the time. For both these children, the changes in both my physical stance in the room and access to my body had a powerful impact on the treatment. I'm wondering about your experiences as a pregnant child therapist.

Background

1. Marital Status
2. Age
3. How may child patients are you currently treating? How many times per week do you see them?
4. Please describe your orientation

Pregnancy

1. Have you had any complications during your pregnancy thus far?

2. Please describe your experience of your pregnancy in general

Telling

1. How and when did your child patients learn about your pregnancy?
2. How did patients communicate this knowledge?
3. How did you feel before and after telling?
4. How did your patients respond?
5. Did your patients' responses mesh with your expectations?

Sense of Self

1. Have you experienced any changes in your sense of self as a therapist?
2. Have you found any changes in role definition
3. Have you found any shift in the way you disclose personal information to patients?

Fantasies

1. Have you ever had any fantasies (such as rescue fantasies) about any of your child patients?

   Please describe the nature of these fantasies

2. Have you noticed any changes in the nature of these fantasies over the course of your pregnancy?
3. Have any of your child patients expressed fantasies about the pregnancy, birth, or future role in the child's life?

Play

1. How would you describe your style of play before you were pregnant?
2. Has the nature of your play changed since becoming pregnant?

3. Has the content of the play changed over the course of pregnancy?
4. Do you feel any different as a play partner?
5. How has the child responded to any changes in the style or type of play?

Anxiety, Aggression

1. Have any patients responded to your pregnancy with feelings of anger or aggression?
2. Have you experienced any anxiety in the room with any of your patients?
3. How have you managed your anxiety?

Guilt

1. Have you ever experienced any feelings about your pregnancy or impending birth or your baby?

Please describe the nature of these feelings in detail

Do you feel that such feelings have impacted the treatment in any way?

Transference/Countertransference

1. Have there been any changes in transference themes?
2. Please describe any changes in the nature of your countertransference

Parent Work

1. How did parents learn of and respond to your pregnancy?
2. Have there been any other issues to arise in your parent work?

How have you managed them?

3. Have you had any other issues arise with other family members of siblings?

Other

1. Has there been anything thus far that has surprised you?
2. Is there anything else salient that we did not cover?

Follow-up Interview

1. How did you feel about returning to work?
2. What has your work been like since returning?
3. What was the reunion like with the patients you described in the initial interview?
4. Do you believe that the baby and your patients' knowledge of the baby have affected the treatment?
5. Has the baby changed your relationship with or feelings about your patients?
6. Have there been any surprises in terms of your return to clinical work such as feelings or material you did not expect?
7. How are you managing the dual roles of mother and therapist?
8. Has your conception of these dual roles changed at all with the birth of the baby?
9. Has motherhood affected your sense of self as a clinician and specifically as a child therapist?
10. Has the quality of the play changed at all since your return?
11. Has parent work been impacted by the baby's birth?
12. Looking back, how do you feel that your pregnancy and the birth of your baby affected the treatment?
13. Looking back, is there anything you would have done differently?
14. Is there anything specific you would recommend to other pregnant child therapists?

15. While the child literature has not addressed this issue directly, in the literature on pregnant adults therapists often frame their experiences about the impact of pregnancy on their clinical work in a positive light. They tend to say that their pregnancies, although disruptive, ultimately had a facilitative impact on the treatment. What are your thoughts about this idea?

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