

THE IMPACT OF PRIMARY MATERNAL PREOCCUPATION ON THERAPISTS'
ABILITY TO WORK WITH PATIENTS

by

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Abstract

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This research examined clinical phenomena occurring in the phase of treatment following a therapist's return from maternity leave, with focus on the impact of primary maternal preoccupation (PMP; Winnicott, 1956) on the therapist and her clinical work. PMP refers to a psychological state of a new mother, occurring in the final weeks of pregnancy and into the postpartum period, that allows the mother to sensitively adapt to the infant's physical and psychological needs. Participants were 20 women who had returned to clinical work within six months of giving birth. Instruments were a PMP Questionnaire devised by Moulton (1991) and a semi-structured interview designed specifically for this study. Quantitative results revealed scores that fell within an approximately normal distribution pattern. PMP Questionnaire descriptive data did not differ significantly from those in Moulton's study, supporting the validity of the questionnaire. A *k*-means cluster analysis revealed that there were two distinct groups, one with high PMP scores and the other with low scores. Qualitative results from the interview revealed distinct characteristics of each group, though there were also some similarities. For therapists in the high group, PMP had both a positive and negative influence on their clinical work (positive: increased sensitivity to patients, a sense of feeling more vulnerable and "real" with patients; negative: increased distractibility, memory loss, fluid boundaries, and difficulty dealing with low functioning patients). In the low group, therapists were able to compartmentalize thoughts of their babies and felt that balancing dual roles actually served to

sharpen their focus in their clinical work. On the other hand, these therapists expressed a sense of conflict between work and motherhood, appearing less flexible in their dual roles, and also had difficulty feeling vulnerable with patients, tending to constrict emotions. Overall, the results suggest that Winnicott's theory of PMP can be a valuable way of understanding a therapist's developmental movement, with the quality and quantity of PMP impacting transference and countertransference in the clinical setting. Limitations, clinical implications, and suggestions for future research are also presented.

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TABLE OF CONTENTS

| | |
|---|-------------|
| Chapter One: Introduction | 1-5 |
| Chapter Two: Literature Review | 6-55 |
| I. Background: Literature on Therapist Pregnancy | 7 |
| Early stages of therapist pregnancy | 8 |
| Middle stages of therapist pregnancy: Patient themes | 11 |
| Middle stages of therapist pregnancy: Therapist themes | 15 |
| Late stages of therapist pregnancy: The third trimester and primary maternal preoccupation | 18 |
| II. Primary Maternal Preoccupation: Theoretical Perspectives | 21 |
| Introduction: Winnicott's theory | 21 |
| Theoretical extensions: PMP and related concepts | 24 |
| <i>Holding</i> | 24 |
| <i>'Good-enough' mothering</i> | 25 |
| <i>Reverie</i> | 26 |
| <i>Adaptive regression in the service of the ego</i> | 28 |
| <i>Flight into sanity</i> | 32 |
| <i>Other factors related to PMP</i> | 34 |
| PMP and attachment | 35 |
| III. The Therapist's Transition to Motherhood | 37 |
| Psychological stressors and postpartum mood disorders | 38 |
| <i>Baby blues</i> | 40 |
| <i>Postpartum depression</i> | 41 |

| | |
|---|---------------|
| <i>Postpartum psychosis</i> | 43 |
| The mother-therapist postpartum: A review of the literature | 44 |
| <i>Balancing dual roles</i> | 45 |
| <i>Capacity for empathy</i> | 48 |
| <i>The therapist as a container</i> | 49 |
| <i>Guilt and anxiety</i> | 51 |
| <i>Patient reactions postpartum</i> | 52 |
| Summary and Statement of the Problem | 54 |
| The Present Study: Research Questions | 54 |
| Chapter Three: Methods | 56-64 |
| Instruments | 55 |
| PMP Questionnaire | 56 |
| Semi-structured interview | 57 |
| Participants | 59 |
| Procedure | 61 |
| Data Analysis Strategy | 62 |
| Chapter Four: Results | 65-103 |
| Part I Moulton's (1991) Findings | 65 |
| Participants and procedure | 65 |
| Reliability and validity of the PMP Questionnaire | 66 |
| PMP Questionnaire descriptive data | 66 |
| PMP Questionnaire correlational data | 66 |
| Part II The Present Study: Quantitative Results | 67 |

| | |
|---|----|
| PMP Questionnaire descriptive data | 67 |
| PMP Questionnaire correlational data | 73 |
| Comparison between Moulton's (1991) and present study PMP | 73 |
| Questionnaire results | |
| Cluster analysis | 75 |
| Part III The Present Study: Qualitative Results | 77 |
| Distractibility | 78 |
| <i>Pregnancy and maternity leave</i> | 78 |
| <i>Resumption of work</i> | 79 |
| <i>Ability to compartmentalize</i> | 80 |
| <i>Breastfeeding</i> | 81 |
| <i>Five highest-five lowest comparison: Distractibility</i> | 82 |
| Autonomous ego functioning | 82 |
| <i>Resumption of work</i> | 82 |
| <i>Five highest-five lowest comparison: AEF</i> | 84 |
| Boundaries | 85 |
| <i>Increased understanding of patients</i> | 87 |
| <i>Merging of boundaries</i> | 88 |
| <i>'Moving faster'</i> | 89 |
| <i>Clarification of roles</i> | 89 |
| <i>Identifying as an adult</i> | 90 |

| | |
|---|----------------|
| <i>Clinic vs. private practice</i> | 90 |
| <i>Five highest-five lowest comparison: Boundaries</i> | 91 |
| Affect | 92 |
| <i>Conflict</i> | 94 |
| <i>Depression</i> | 95 |
| <i>Five highest-five lowest comparison: Affect</i> | 97 |
| Self-esteem | 97 |
| <i>Maternal self-esteem</i> | 97 |
| <i>Professional ambition</i> | 98 |
| <i>Work as an oasis</i> | 99 |
| <i>Clinical confidence</i> | 100 |
| <i>Five highest-five lowest comparison: Self-esteem</i> | 100 |
| Additional findings | 101 |
| <i>Supervision</i> | 101 |
| <i>Experience of the interview</i> | 101 |
| Summary | 102 |
| Chapter Five: Discussion | 104-134 |
| Research Question 1 | 104 |
| Quantitative results | 104 |
| Qualitative results: Content vs. process | 106 |
| Research Question 2 | 109 |
| Flexibility and adaptation | 109 |
| Increased empathy and attunement | 109 |

| | |
|---|----------------|
| Heightened authenticity | 112 |
| Increased motivation | 113 |
| Benefits of maternity leave and return | 113 |
| Increased clinical confidence | 114 |
| Research Question 3 | 115 |
| Distraction and decreased tolerance | 115 |
| Disruptions in autonomous ego functioning | 117 |
| Role conflict and guilt | 117 |
| Constriction of emotion | 118 |
| Overidentification | 121 |
| Decreased professional ambition | 121 |
| Depression | 121 |
| Limitations and Suggestions for Future Research | 122 |
| Clinical Implications and Recommendations | 126 |
| Talking about the pregnancy | 126 |
| Managing lapses in AEF | 127 |
| Managing return-to-work conflict | 128 |
| Managing emergent emotional material | 128 |
| Dealing with difficult patients | 129 |
| The need for support | 131 |
| Conclusion | 133 |
| Appendix | 135-145 |
| References | 146-158 |

LIST OF TABLES

| | |
|---|----|
| Table 1. <i>Demographic Characteristics (N = 20)</i> | 60 |
| Table 2. <i>Descriptive Statistics for PMP Questionnaire (Moulton, 1991; N = 66)</i> | 67 |
| Table 3. <i>PMP Overall and Subscale Correlations (Moulton, 1991; N = 66)</i> | 67 |
| Table 4. <i>Descriptive Statistics for PMP Questionnaire (present study; N = 20)</i> | 72 |
| Table 5. <i>PMP Overall and Subscale Correlations (present study; N = 20)</i> | 73 |
| Table 6. <i>Comparison of Descriptive Data for PMP Questionnaire in Moulton's (1991) Study and the Present Study</i> | 74 |
| Table 7. <i>Comparison of PMP Overall and Subscale Correlations for Moulton (1991; N = 66) and the Present Study (N = 20)</i> | 75 |

LIST OF FIGURES

| | |
|---|----|
| <i>Figure 1.</i> PMP overall scores | 68 |
| <i>Figure 2.</i> PMP Distractibility subscale scores | 69 |
| <i>Figure 3.</i> PMP Boundaries subscale scores | 70 |
| <i>Figure 4.</i> PMP Affect subscale scores | 71 |
| <i>Figure 5.</i> PMP Autonomous Ego Functioning subscale scores | 72 |
| <i>Figure 6.</i> Mean-score profiles for high- and low-scoring clusters | 77 |

Chapter One: Introduction

For a mother, the time following the birth of a child is one of intense psychological upheaval as well as much interpersonal growth. She is not only preoccupied with her infant; she must also deal with her own identity, which has been transformed by this experience. Her intense preoccupation with the new infant and new motherhood may cause a heightened sensitivity toward and preoccupation with the infant. This preoccupation may manifest in her being distracted and forgetful to the demands of the outside world. For the mother who is also a therapist, such demands may come in the form of patients who are accustomed to her attention. Although the new mother-therapist may be eager to reconnect with her patients after returning from maternity leave, she may also feel anxious about separating from her infant. Indeed, during this time her feelings may fluctuate among anger, withdrawal, guilt and a sense of extreme fulfillment as she tries to consolidate these dual roles.

As a result of the actuality of the therapist's pregnancy, as well as the internal changes the therapist may experience, a myriad of potential transference and countertransference issues are introduced within the consulting room. Particularly when the therapist has had her baby and then returns to clinical work after a hiatus, many issues may emerge with her patients. The patient may express transference having to do with his or her own parents or caretakers, such as abandonment or envy, or reenact internal conflicts by expressing anger upon the therapist's return to work. At that juncture, the therapist needs to encourage her patients to explore their intense feelings about this shift. At the same time, the therapist must be aware of the changes she has undergone and how those changes impact her role of therapist-mother.

This study will address and investigate the clinical phenomena occurring in the phase of treatment after a therapist returns to work from maternity leave (the postpartum phase), with a

focus on the role of primary maternal preoccupation (PMP). Winnicott (1956) introduced the concept of PMP to describe a special psychological condition of the “ordinary devoted mother during the final weeks of pregnancy and postpartum phase.” PMP is the psychological state that enables a new mother to be optimally attuned to her infant. When a mother is immersed in PMP, she presents with an intense preoccupation with and attunement to her infant, as well as a conscious and unconscious identification with her baby. This facilitates her ability to sensitively adapt to the infant’s physical and psychological needs. While providing optimal nurturance for the infant, the mother becomes immersed in this task and will naturally be distracted from other aspects of her life. During PMP, women tend to experience some temporary cognitive lapses, becoming forgetful, emotionally labile, distracted, and sometimes find themselves losing their train of thought (Moulton, 1991). This study will examine PMP in the new mother-therapist and examine how it impacts the therapist’s clinical work.

This project developed out of my clinical work, particularly from my experiences with a patient (known here as A), whom I treated bi-weekly with psychodynamic psychotherapy for four years. I became pregnant during the third year of this clinical relationship, and during the final phase of my pregnancy I felt vulnerable, preoccupied, and protective of my unborn child. I also felt guilty about my need to interrupt the treatment to give birth. Although important transference issues emerged, such as sibling rivalry, jealousy, and maternal transference, I felt that it took A awhile to acknowledge my pregnancy and react to it. I made attempts to explore A’s feelings about my pregnancy, but she denied any negative impact of the pregnancy and instead acted overly caring toward me. On some level I believe I was contributing to her inability to consciously express her feelings about my pregnancy: perhaps I felt too vulnerable to pursue her feelings further, given my own feelings of anxiety, self-consciousness, and guilt, which may

have made it difficult for A to be angry with me. Many feelings regarding my pregnancy, leave, and return were not addressed by A until I returned from maternity leave.

Integrating my roles as a mother and a therapist was both complex and difficult. I experienced anxiety in reconciling my dual roles, and I struggled to be flexible in both arenas and to find the right balance. I could not find research in the literature to substantiate the magnitude of my conflicts and feelings after returning to work. Although I was looking forward to going back to clinical work, the thought of leaving my infant created many conflictual feelings. I often found myself in session fantasizing about my infant, and at times I was preoccupied and distracted. I sometimes daydreamed about my infant and felt detached from the clinical work. At times I was also forgetful of clinical material and felt less curious about A. At other times, I felt more acutely attuned, more aware of nonverbal communication, and more empathic toward A. I sensed that A was aware of the changes in my psychological state as a mother with a newborn infant and that she may have accurately perceived my postpartum de-cathexis during the first several months of my baby's life. For me, the baby was present in the room.

There was clearly a shift in the therapeutic relationship when I returned from maternity leave. In our first session after my return, A said that she "did well" throughout my maternity leave, had "fallen in love," and was discussing marriage and children with her new boyfriend. Although she reported that her symptoms had subsided and that she did not need to be in therapy anymore, she began acting out in regressive ways, almost as if to say, "I want to be your baby." She also seemed to be competing with the baby's importance in my life by becoming more needy. She began calling me frequently, and she reported dreams that I was hurting her, picking scabs off her body and making her bleed. It also seemed that A wanted desperately to identify

with me. When my infant was five months old, A announced that she was pregnant. Although she was planning to abort the pregnancy, she soon miscarried. Following the miscarriage, A resumed cutting herself (something she had not done for 10 years).

Although it was difficult for me, I explored with A the multiple meanings of our parallel pregnancies in the context of our therapeutic relationship. This deepened our relationship, and she began to rely on me more. She gained more trust and self-awareness. As we continued to work together in the months following my return, the therapeutic relationship deepened. A seemed to feel more secure in the belief that I would be available to her on a continuing basis. Instead of denying any feelings about my pregnancy and maternity leave, she finally told me that she cried when she heard my voice on her answering machine when I called to let her know that I gave birth. There was a new openness and understanding as she began speaking more freely about issues of abandonment and dependence.

The shifts I observed in A led me to wonder if other therapists had similar experiences with clients when the therapist was in the postpartum phase. This curiosity became the basis of my research and future study, leading me to address the following questions: what is it like for new mother-therapists to return to work? How does the psychological state of the new mother impact treatment? And how do patients experience this phenomenon? In this project, I will address these questions through a qualitative and quantitative study. Although the psychological experience of pregnancy, motherhood, and the mother-infant relationship has been well researched, Winnicott's theory of the psychological state of the new mother-therapist and its impact on clinical work has yet to be adequately studied. The present work thus represents an opportunity to address unanswered questions about the therapist's return from pregnancy and maternity leave, with particular focus on PMP. Through quantitative and qualitative methods, I

hope to identify the types of changes that occur when a new mother-therapist returns to work, as well as address how PMP manifests in a therapist and examine how it impacts the therapist's clinical work.

Chapter Two: Literature Review

A large body of literature exists on the psychological effects of pregnancy, the postpartum phase, and therapist pregnancy. However, relatively little is known about the effects of the postpartum phase on pregnant therapists (i.e., new mother-therapists returning to clinical work after giving birth), and still less research has focused on the effects of the postpartum phase on therapists, their patients, and clinical work in general. The present study asks the question: What happens clinically when a therapist returns from maternity leave? As this review of the literature will demonstrate, the phenomenon of “primary maternal preoccupation” (PMP; Winnicott, 1956) would appear to play a crucial role in determining the quality of both therapists’ and patients’ experience of the clinical work postpartum.

In his observations of pregnant and postpartum women, Winnicott (1956) developed the concept of PMP to describe a special psychological condition of a new mother, occurring in the final weeks of pregnancy and into the postpartum period, that is characterized by intense preoccupation and attunement with her infant, as well as a conscious and unconscious identification with her infant that allows the mother to sensitively adapt to the infant’s physical and psychological needs. This adaptation provides optimal nurturance for her infant, resulting in the mother’s distraction from other aspects of her life. Of particular relevance to the present study is Winnicott’s (1960) likening of the state of PMP to the optimal stance of a good therapist, who is able to provide the kind of attunement and attention to patients that a new mother can to her infant. The question thus arises: How does the PMP of new mother-therapist affect her ability to attune and attend to her patients? In order to explore this question, the following review will focus on theoretical and empirical work on therapist pregnancy, PMP, and the transition to

motherhood (of both mothers generally and therapist-mothers), with particular emphasis on the impact of each phase on therapists, patients, and the clinical process.

I. Background: Literature on Therapist Pregnancy

Therapist pregnancy and childbearing are phenomena that have been only recently brought to attention in the literature. Prior to the last decade, only a few authors (e.g., Hannet, 1949; Lax, 1969; Van Leeuwen, 1966) examined the effects of therapist pregnancy on the therapeutic relationship. Through the mid 1970s, the literature primarily consisted of case reports and clinical anecdotes. Various authors have explained why so few articles have been written on the subject. Benedek (1973) discusses how the taboo of sexuality can hinder and obscure more open exploration of the topic. Clarkson (1980) points out that psychoanalytic literature tends to emphasize the male lifecycle, resulting in lack of material about women. Due to the increase of female psychologists (and women in the workforce generally) over the last 30 years, it is not surprising that interest in the topic has deepened since then. With the rising number of women in the field—and thus, the rising number of therapists grappling with both professional roles and motherhood—pregnancy has become an important reality to be confronted.

Pregnancy is typically depicted in the literature as a time of emotional and psychological turmoil for the mother-to-be (Ballou, 1978). Women's psychological equilibrium is disturbed by pregnancy; as soon as a woman becomes aware that she is pregnant, she must begin to reorganize her sense of self and her relationship to others in order accommodate her baby's needs. Pregnancy requires a working through of one's sense of self while becoming an integral part of another and becoming aware of a new role without feeling a narcissistic loss or sense of panic. A pregnant woman is thus confronted with multiple issues, such as role integration, self-image, maternal identification, public exposure of sexuality, ambivalent feelings towards one's

own mother, loss of control due to the pregnancy, increased dependence on others, and apprehension about her ability as a mother (Balsam, 1974; Diamond, 1992; Fenster et al., 1986; Nadelson et al., 1974; Penn, 1986).

With respect to the treatment process, pregnancy is an event that has a considerable impact, as it complicates the role of a neutral, non-intrusive therapist, evokes a range of responses, and can be intimidating for both patient and therapist. Recognition, therapist self-awareness, and analytic understanding, however, can bring tremendous therapeutic gains, increasing the quality of the real and transference relationship and strengthening the therapeutic alliance. In the best of circumstances, the experience can become, as Fenster et al. (1986) observed, a foundation of therapeutic empathy, repair, and growth. In the following sections, I will outline each stage of the therapist's pregnancy, giving attention to both the therapist's and the patient's experience.

Early stages of therapist pregnancy. In light of the physical and psychological changes that happen in the pregnant woman, pregnancy often has a profound effect on the therapist engaged in psychotherapy. The pregnant therapist experiences many of the same intrapsychic, interpersonal, and physical changes that other pregnant women experience, but must additionally negotiate being both a 'real person' and an anonymous, neutral person in order to perform the therapeutic work. In a psychodynamically-oriented psychotherapy, pregnancy will expose many aspects of the therapist's personal life that the psychoanalytic therapeutic situation has been designed to minimize.

Indeed, Fenster et al. (1986) have suggested that the pregnancy is a "special event" in the therapist's life. A special event is "anything that alters or intrudes upon the basic analytic situation" (Weiss, 1975, p. 69), and thus includes therapist serious illness, lateness, and chance

meetings outside of therapy. In the case of therapist illness, a therapist's denial may represent guilt over having violated the analytic neutrality by being ill (Abend, 1982). This observation can be readily applied to therapist pregnancy as well, with denial contributing to an avoidance of the discussion of pregnancy. On the positive side, however, other authors have pointed out that special events can strengthen communication of the patient's unconscious fantasies and can serve to illuminate the therapist as both a transference figure and a 'real person' (e.g., Fenster et al., 1986; Weiss, 1975).

Several authors (e.g., Balsam, 1974; Benedek, 1973; Fenster et al., 1986) have examined the ways in which the different emotional challenges of each trimester apply specifically to the mother-to-be therapist. As these authors note, in the first three months of pregnancy, there is not much externally to perceive, yet internally there may be a host of feelings that affect the therapist's ability to listen to patients. Some authors (Fenster et al., 1986; Nadelson et al., 1974; Penn, 1986) have suggested that a therapist's increased focus on her body can contribute to a heightened sense of awareness, attunement, and sensitivity to patients. In other words, the therapist's connection to her own subjectivity may make her more available to the subjective material of her patients. On the other hand, due to conflicts that can arise for the therapist in connection with her pregnancy, she may avoid affectively charged material brought by patients, consciously or unconsciously protecting herself and her fetus from feelings of hatred and envy that may arise in the therapeutic relationship (Imber, 1990).

With respect to patients' experience, generally speaking, a therapist's pregnancy intrudes upon the therapeutic space and as such can powerfully evoke a variety of patient fantasies, affects, defenses, and behaviors. It can also increase and intensify the transference experience, allowing for a deeper analysis of the central conflicts of childhood. As the reality of the

therapist's pregnancy eventually takes 'center stage,' it increases awareness of the patient's feelings of competition, envy, devaluation, idealization, and anger, thereby advancing transference issues (Fenster et al., 1986). Despite observations of termination and other defenses related to therapist pregnancy, research shows that many patients benefit from the experience. For example, 95% of respondents in one study (Fenster, 1983) who remained in treatment indicated that the therapist's pregnancy enhanced the therapy, leading to discussion of new issues, such as patients' previous pregnancies or abortions, childhood material, and other suppressed material. For this reason, 88% of those therapists surveyed reported that their pregnancy greatly intensified the therapeutic process, and 74% reported that the pregnancy helped them to further work through material that had been previously presented. For those patients able to remain in treatment, the intensity seemed to provide a rich atmosphere for growth and change.

The way in which the patient first recognizes the pregnancy may provide valuable information about the unconscious emotions and conflicts aroused. Before the patient consciously recognizes the pregnancy, he or she may allude to it through dreams that include themes of loss, competition, and betrayal (Penn, 1986). Patients often fear that the therapist will either physically stop seeing them or will be emotionally unavailable. Some patients may even terminate therapy as a defense against abandonment. Other defenses, such as isolation and reaction formation, may appear in the form of a protective attitude and excessive concern and may mask the patient's hostility towards the therapist and her baby. On the other hand, some patients may not express their anger in order to avoid burdening the therapist, just as a child may not want to burden his or her less available pregnant mother with his or her own needs (Fenster et al., 1986).

It has been observed that themes that frequently emerge in therapy in response to a real event in the here-and-now are colored by individuals' psychic constellations and "unconsciously, dynamically determined" by the therapist (Nadelson, Notman, Arons, & Feldman, 1974). In the case of a pregnant therapist, the fundamental shift from a dyadic relationship between therapist and patient to a triadic relationship between therapist, patient, and baby can bring to consciousness a variety of oedipal and other issues, such as sibling rivalry, sexuality, envy and competition, maternal transference, separation and loss, fear of abandonment, and ambivalence about mother-child relationships (Nadelson et al., 1974; Lax, 1969). In a series of case histories, Paluzny and Poznanski (1971) also found that, although patients varied in their reactions to their pregnant therapists (some attempted to solve childhood conflicts by reliving them in relation to the therapist, some displayed defensive reactions in an effort to handle new material stimulated by the therapist's pregnancy, and some were able to integrate new material stimulated by the pregnancy into the therapy, thereby progressing in their treatment), common themes as those mentioned above could be identified. These themes often become prominent in the middle stages of the therapist's pregnancy, detailed in the following section.

Middle stages of therapist pregnancy: Patient themes. During this phase, the therapist begins to "show," evoking a variety of transference reactions from patients. Some patients may envy the therapist "having it all"—career, marriage, and now, a baby—and have jealous feelings that the therapist has a relationship with her husband and unborn child (Fenster, 1983). Some may respond with a caring attitude that may be genuine, while others may respond defensively; patients usually do not verbalize a wish to destroy the baby, but instead defend against these wishes in the form of idealization, concern, and reparation (Klein, 1957). The therapist's defense

against being the recipient of the patient's "poisonous wishes" can also be a contributing factor in the patient's failing to directly express envy.

Another crucial transference theme brought about by revelation of the therapist's pregnancy is the "intensification of the maternal transference" and its related fears of abandonment (Fenster, 1983; Hannet, 1949). Many patients re-experience the feeling of loss and abandonment from early childhood when their mother gave birth to a sibling; the therapist's pregnancy thus allows patients to look closely at the relationship with their parents at the pre-oedipal and oedipal level, allowing them to recognize the ways in which they feel that the therapist's baby is a competitor for their attention (Fenster, 1983; Underwood & Underwood, 1976). Feelings of loss and abandonment may stem from the actual disruption of therapy and the reminder, provided by the pregnancy, that the therapist is a separate person. Analysis of transference during this time may give patients with preoedipal concerns an opportunity to work through issues of differentiation and the resolution of narcissistic issues (Domash, 1984). Some patients may also deal with sibling rivalry through identification with the therapist (Nadelson et al., 1974), a strategy that may be masked by the patient's stating, "I want to have a child" when they really mean, "I want to *be* the child." Patients often use the defenses they used in childhood when a sibling was born with the pregnant therapist (Penn, 1986). Interestingly, Diamond (1992) points out that the pregnant therapist, who once may have been able to move fluidly between maternal and paternal identifications for her patients, during pregnancy may feel temporarily immobilized within a predominantly maternal transference role.

Themes and conflicts around sexuality often arise in the context of therapist pregnancy, since pregnancy brings forth the undeniable fact that the therapist is a separate, sexually-active being (Diamond, 1992; Penn, 1986). In order for the therapist to work through the intense

countertransferential feelings that come up in therapy, she herself must come to terms with feelings of vulnerability and exposure as a sexual person (Diamond, 1992; Nadelson et al., 1974). Paluzny and Poznanski (1971) write that patients handle the maternal implications of the pregnancy first and then deal with sexual issues, most of which are based on oedipal conflicts and wishes. Depending on the patient's psychic constellations, different issues can be expressed. For example, some patients may feel betrayed when the therapist becomes pregnant, evoking feelings about the patient's parents' sex life from which he or she was left out. For other patients, the conflicts arising may be ones related to sexual identity, competence, and competition; these patients may feel safer talking about sexual issues after disclosure, perceiving the therapist as "de-virginized" (Naperstack, 1976). Similarly, erotic elements of the transference may be increased in light of concrete evidence of the therapist's sexual life (Penn, 1986). As Diamond (1992) notes, the therapist's immersion in her own maternal identification during and after pregnancy may make her more available for maternal and erotic transferences from her patients, who may have previously been able to deny her femaleness due to the ambiguity of the therapeutic situation.

Lax (1969) describes patients' reactions to their therapists' pregnancies as consistent with their psychopathology, suggesting that the pregnancy of the therapist is a "highly-charged event" that is likely to evoke conflicts that are at the core of the patient's pathological development. Lax points out that because the therapist's pregnancy interferes with anonymity and neutrality, the therapist can no longer function as a "blank screen" for patients. Still, the pregnancy can provide a reality stimulus that enables the therapist to function as an "optimal projective screen" onto which the patients can project what is most significant for the development of that patient's dynamics. In other words, the unique way in which the patient recognizes the pregnancy and

subsequently approaches the issue may provide valuable information about the unconscious emotions and conflicts aroused.

In this vein, several authors have described the specific ways in which patient characteristics differentially affect transference reactions to pregnancy, such as age, sex, diagnostic category, and particular aspects of the patient's life history. Borderline patients, for example, usually notice the pregnancy earlier than other patients and are more attuned to subtle changes that may arouse feelings of abandonment (Penn, 1986), and they may also respond to any pregnancy-related change in the treatment session with feelings of deprivation and rage (Fenster, 1983). As Diamond (1992) points out, because of the transient, self-other confusion and instability of internalized object representations characteristic of many severely disturbed borderline patients, they are predisposed to scan their interpersonal environment in search of even the most subtle shifts in the therapist's appearance or behavior. This may explain why borderline patients often detect the therapist's pregnancy early on, in contrast with neurotic patients who, in the interest of maintaining stable object representations, may simply "screen out" such subtle hints (Diamond, 1992, p. 334) and track the therapist's pregnancy in a more 'real' way.

There may also be differences between male and female patients with respect to transference reactions brought about by the therapist's pregnancy. For Diamond (1992), the primary issues for female patients include envy of and identification with the therapist's maternal functions, as well as the revisitation of childbearing wishes and associated fantasies. However, a very different clinical portrait may emerge for male patients, particularly those in the severely disturbed, borderline spectrum. These patients' fantasies and associations to the therapist's pregnancy may take an aggressive turn, spurring envy and rage against an all-powerful, all-

engulfing mother. These patients' fantasies may also reflect regression to intense symbiotic desires and/or primitive identifications with the mother's procreative functions at the pregenital level. Thus, for more disturbed male patients, the therapist's pregnancy may spur not only feelings of deprivation and rage, but also more primitive material that must be worked through in the transference.

In light of such specific patient characteristics, histories, and levels of organization, therapist interventions around the pregnancy may need to be adjusted. During pregnancy, especially with patients in the borderline range, therapists may need to wait with genetic interpretations, set limits on acting out, and discuss the immediate and forthcoming changes in the relationship or else risk intensifying the patient's feelings of abandonment (Litowitz, 1987). Some patients ultimately cannot tolerate the pregnancy and have to terminate, citing the pregnancy as the cause explicitly or manifesting resistance to such feelings by stating that they would have terminated anyway or simply leaving with the reasons unclear (Lax, 1969). However, sometimes patient termination may be related to the therapist's own discomfort in talking about her pregnancy. It appears that the better able the therapist is able to confront the transference issues here discussed, the more likely it is that the patient will be able to benefit from the treatment.

Middle stages of therapist pregnancy: Therapist themes. In the second trimester, conflicts may come up for the therapist between wishing for a child and experiencing hostility toward the fetus for interfering with professional career goals (Fenster et al., 1986). Concurrent with a decreasing anxiety about the health of her baby, the pregnant therapist may begin to exhibit increased empathy towards patients, paralleling the shift from introversion to the reality of the pregnancy. Transference reactions directed at the therapist, such as those described above,

have the potential to stimulate the therapist's unconscious infantile conflicts and heighten countertransference reactions during the middle stages of pregnancy. The conflicts stirred up will be particular to each therapist, and the pregnant therapist's understanding of her countertransference is a crucial factor in maintaining successful work with patients (Lax, 1969).

Indeed, several authors note that the second trimester is a crucial time for dealing with transference-countertransference around the therapist's pregnancy. As noted, countertransference during the second trimester is usually marked by decreased anxiety, heightened empathy, awareness of patient's responses to pregnancy, and interest in understanding the patient's reactions towards the pregnancy; it allows for the pregnancy to evoke issues that are important to the therapeutic process (Balsam, 1974). However, as the pregnancy becomes more apparent, countertransference issues around the therapist's exposure of sexual activity may arise. As noted earlier, this exposure may elicit sexual themes in patients' material, necessitating that the therapist be comfortable enough with her own sexuality as manifested in her pregnancy to hear and respond to such material. The second trimester is also the period during which the therapist may begin to experience more intense angry and hostile projections from the patient, which may cause the therapist to withdraw out of fear of attack to the self and unborn child (Naperstack, 1976). Resentment of lack of control, personal exposure, and guilt especially may contribute to unproductive countertransference feelings. Ultimately, the therapist must be able to endure these feelings and, as Naperstack urges, listen to patient reactions.

In this vein, Racker (1968) has noted that every transference circumstance brings about a countertransference reaction that comes from the therapist's own psychic constellation. Similarly, when patients recognize the therapist's pregnancy, they react according to their own psychic constellation and early object relations. Thus, unique transference-countertransference

occurs in each therapeutic dyad. Just as patients will sometimes tend to be “blind and deaf” to the therapist’s pregnancy (Lax, 1969), pregnant therapists may also deny the effects of the pregnancy on the therapeutic situation. Lax suggests that therapists’ failure to hear the patient’s recognition of the pregnancy may reflect therapists’ fear of the patients’ anger and hostility. By taking this position, therapists are seen as “colluding” with their patients in denial of the pregnancy. This denial may represent the therapist’s effort to lessen the anxiety about the patient’s reactions and unknown consequences to the therapy (Fenster et al., 1986). When patients deny the therapist’s pregnancy, their denial may lead to a bind in which neither the patient nor the therapist can talk about it. In other words, the patient’s denial can lead the therapist to collude, creating a transference-countertransference bind that is difficult to resolve.

With respect to the question of disclosure, Fenster (1983) found that therapists disclosed more personal information during pregnancy than before they were pregnant, and that they saw themselves as more verbally active and interpretive of the transference around pregnancy. Therapists’ increased interpretations may be an attempt to compensate for their tendency to focus inward; consequently, pregnant therapists tended to perceive patients’ feelings of anger and abandonment as real rather than as transference (Fenster, 1983). In other words, therapists tended to accept too readily the guilt imposed on them by their patients. Fenster also emphasized the importance of discussing patient’s fantasies before revealing information. Otherwise, she submits, patients may use the information to continue to question the therapist about her personal life. Ultimately, the therapist must come to terms with physical and emotional vulnerabilities and their effect on the work; as Penn (1986) notes, the way in which material around the pregnancy is handled in the treatment will establish “whether the work is disrupted...or used as a positive opportunity for new integration” (p. 292).

In summary, various authors have discussed the importance of the pregnant therapist's awareness of her emotional state during her pregnancy, particularly during the middle phase when the pregnancy is most often revealed. These authors underscore the kinds of transference reactions directed toward the pregnant therapist that can stir up unconscious conflicts and increase the likelihood of countertransference reactions, the consideration of which is critical for the pregnant therapist's sustaining of successful work with patients. Indeed, it seems that the therapist must be aware from the beginning that her pregnancy—from gestation to the postpartum period—may affect many aspects of the treatment process. Ultimately, the degree to which the pregnant therapist is aware of her patients' transference and her own countertransference seems to be predictive of her success in using the pregnancy to positively affect the therapeutic relationship. Indeed, positive gains such as affect tolerance and increase in self observation can come out of a therapist's pregnancy. Forming a plan, too, can assist the pregnant therapist and her patients in handling transference-countertransference issues (Schwartz, 1975). Meanwhile, increased empathy and the opportunity to explore and work through early conflicts seem to be crucial for the treatment and therapeutic relationship (Fenster et al., 1986). When aware of negative effects, such as a decrease in the therapist's ability to hear anger or the therapist's fear of negative patient response, therapists can sometimes use these countertransference reactions to ultimately explore a patient's transference issues (Naperstack, 1976).

Late stages of therapist pregnancy: The third trimester and primary preoccupation.

The third trimester has been described as comprised of issues of therapist self-absorption, fears of death, and separation and attachment (Deutsch, 1945). Fears of damage to, or death of, the self or the baby, may arise (Fenster et al., 1986). At this time, the visibility of the pregnancy

intensifies the transference themes described above; more adamant discussions about a patient's own concerns are salient, and issues of termination, separation, envy, and anger towards the therapist about abandonment are also expressed in implicit and explicit ways (Balsam, 1974). The therapist typically has a dual role of facing these issues in her personal and professional life.

A major issue in the third trimester is separation, as the therapist inevitably will have to take a break from her regular working schedule. Pregnant therapists often demonstrate "nesting behavior," preparing not only for their child but also for their patients (providing temporary therapists, updating charts, etc.) in an effort to achieve closure before giving birth (Fenster et al., 1986). Several authors (e.g., Fenster, 1983; Balsam, 1975) have also pointed out that it is important for the therapist to understand her own feelings about leaving; patients who sense her ambivalence about leaving may exacerbate her guilt, as she becomes the abandoning figure. Fenster et al. (1986) point out that the ways in which separation is dealt with in the therapy will have an impact on the maintenance and continuation of the therapeutic gains, so whereas this period can create a countertransference acting out, it can also provide the prospect for mastery and growth for both patients and therapist.

Therapists may also struggle with a role reversal in this phase, whereby patients may communicate, either implicitly or explicitly, the desire to take care of the therapist (Schwartz, 1975). The therapist must come to terms with her own vulnerability, which stems not only from her need to protect the developing fetus but also from changes in her physical appearance that her patients may notice and comment upon. Such exposure may be uncomfortable for the therapist, who in her profession is accustomed to being the caregiver, the 'noticer,' not the one cared for or noticed. Indeed, the therapist may be unable to hear her patients' concerns for her well-being, not allowing them to fully express themselves by quickly reassuring them of her

well-being (Balsam, 1974). Interestingly, Barbanel (1980) notes that some therapists have more difficulty tolerating patients' "tender and protective feelings" than patients' feelings of hostility. It appears that whereas patients' hostility can force the therapist to withdraw, patients' concerns for her well being can evoke a therapist's conflict between intense longings for kindness and the desire to maintain professional integrity.

Winnicott (1956) has described the "primary maternal preoccupation" (PMP) that occurs in the weeks prior to and immediately following the birth of the child. Although PMP will be discussed in detail in the following section, it is here worth noting that during this period the therapist might feel vulnerable and fearful, and have concerns that she might not be able to be both a good-enough mother and good-enough therapist. The difficulty of integrating both roles is reflected in the therapist's need to be emotionally available to the patient and the child, something that does not always feel possible. As Tuber (2008) notes, "it is...difficult when you have young children of your own and you're trying to be a therapist at the same time, because now you are serving as a container in two realms, and that is quite difficult" (p. 169).

Winnicott has suggested that PMP starts in the beginning of the third trimester and continues into the first trimester of the baby's life. Fenster (1983) has also observed this phenomenon in therapists. How does a therapist's preoccupation with her baby affect her, her patients, and the clinical process? Does PMP prevent the therapist from being able to work effectively, or does it actually facilitate the process? Can a therapist be absorbed with her baby at the expense of her patients, or does that absorption help the work, creating deeper empathy and increased sensitivity? Is it overwhelming for the therapist to have both at once? Can a therapist experience PMP with her baby and not her patients, or vice versa? These are the questions the present study seeks to answer. In the following sections, I will examine the literature on PMP

more closely, giving attention to both its theoretical foundations and its impact on new mothers, in order to develop such questions further.

II. Primary Maternal Preoccupation: Theoretical Perspectives

Introduction: Winnicott's theory. After many years of practicing pediatrics and working with mothers and their infants, Donald Winnicott expanded his work and study to include psychoanalysis. One of the many theories he developed was that of the special psychological condition of the “ordinary devoted mother”—“primary maternal preoccupation”—which Winnicott (1956) observed to occur during the final weeks of pregnancy and first few weeks postpartum:

There is found to be an identification—conscious but also deeply unconscious—which the mother makes with her infant... some aspect of her personality takes over temporarily... which enables [her] to adapt delicately and sensitively to the infant's needs at the very beginning... The mother who develops this state... provides a setting for the infant's constitution to begin to make itself evident... for the developmental tendencies to start to unfold, and for the infant to experience spontaneous movement and become the owner of sensations that are appropriate to this early phase of life... [and furnish] the basis for healthy ego establishment. (pp. 300-303)

Primary maternal preoccupation (PMP) is a psychological state that permits the mother to create an environment that optimally meets the physical and psychological needs of her infant.

Winnicott (1958) refers to this part of the personality as the mother's more regressed infantile primitive state, postulating that this special state begins during the final trimester of the pregnancy and does not diminish until several weeks postpartum. Winnicott (1971) describes the

regression as “benign,” occurring in a playful way that serves the function of psychological growth and results in pleasure and intimacy in mothering.

Winnicott’s well-known assertion that “there is no such thing as a baby,” only a “nursing couple,” was meant to suggest that the inherited potential of an infant is something that cannot be realized except as linked to maternal care. The mother needs to “feel herself into her infant’s place” (1956, p. 304), to be identified with her infant on both an unconscious and conscious level so as to anticipate the needs of her infant and to keep up the infant’s “illusion of oneness” for a considerable period of time. In PMP, the mother is exquisitely attuned to her infant’s needs, experiencing them as indistinguishable from her own. During this process, the infant comes to experience a state of “subjective omnipotence”; through its merging with the mother, the infant feels all-powerful and that whatever is wished for will appear. If the infant is hungry and cries, and the mother responds, to the infant it is as if the desire for the breast made it appear—that the infant created the breast. This “moment of illusion” (Winnicott, 1945, p. 152) is the infant’s belief that the wish for an object amounted to the creation of that object.

For Winnicott, the mother’s ability to enter into a state of PMP is vital to the development of an infant’s authentic sense of self. This specific phase becomes the foundation for the organization of the infant’s range of adaptive capacities and self-experiences, which Winnicott referred to as the ego. In fact, Winnicott’s theory of PMP is notably ego-driven; the “interactive mutual unit” of the mother and baby provides the foundation for the development of the baby’s ego resources, allowing for a growing sense of “me” versus “not me” (Tuber, 2008, p. 36-37). In order for the mother to be able to provide all of this for her infant, she must experience a sense of overall contentment and well-being and a sense that the fetus or infant are in accordance—not in conflict—with her own needs.

As Winnicott described, PMP manifests in the mother as extreme distractibility, intense preoccupation with her infant, and a blurring of boundaries between mother and infant. Indeed, the sense of oneness the mother has with her baby has been described as a loss of boundaries within her object world (Benedek, 1970). New mothers describe this state as a withdrawal from their usual interests and a loss of a sense of time while engrossed with the infant (Bergman, 1985). There is a slow narrowing of the mother's interests, shifting from outward to inward: a state that "could be compared with a withdrawn state, or a dissociated state, or a fugue, or even with a disturbance at a deeper level such as a schizoid episode in which some aspect of the personality takes over temporarily" (Winnicott, 1958, p. 302). Winnicott even went so far as to describe PMP as an "assault" on a woman's personality, echoing a form of psychosis were she not a new mother. The totality of the mother's absorption in her infant may in fact look like regressed primitive behavior, as the mother wants to keep the baby close to her and feels empty when the baby is not in close proximity (Benedek, 1970). The need to keep the baby close may stem from a wish to undo the separation and sense of emptiness caused by childbirth; these feelings can be so intense that they have been termed "affect hunger" (Benedek, 1970) and are characterized by the mother's eagerness after nine months to "get at" her baby (Tuber, 2008).

Tuber (2008) describes how Winnicott's observation of "hypochondria" in new mothers is actually reflective of the oneness they feel with her babies. Since hypochondria is essentially an exquisitely sensitive interface between mind and body, and the mother's empathy for the baby's bodily movements and expressions provides the basis of attunement, it is in fact a necessary precondition for good-enough mothering: "indeed, in what [Winnicott] refers to as PMP, the mother begins child rearing with an investment/need to enmesh. In other words, the

mother can only know about her baby if she is empathizing with his body. This cannot help but make her critically attuned (sometimes overattuned) to her own body” (p. 54).

Theoretical extensions: PMP and related concepts. PMP, as Winnicott first envisioned it, has been described and reconceptualized in many different ways by theorists, with various terms considered synonymous with or closely related to PMP, including “holding,” “good-enough mothering,” “maternal reverie,” and “adaptive regression in the service of the ego.” In the following section I will review these terms and their relationship to PMP, as well as note several phenomena that may affect a new mother’s level of PMP.

Holding. PMP can also be described as a mother’s mental state of “psychic holding,” by which the infant is “held” in both the mother’s conscious and unconscious mind (Winnicott, 1960, 1967). Psychological holding is a state of being held metaphorically in the mother’s conscious and unconscious mind through maternal attunement, empathy, and reverie. Being held without physical and psychological impingement enables the infant to slowly feel truly alive. In this psychological state the preoccupied mother is exclusively involved with her infant, with all other interests falling away: she and the baby are one.

A vital aspect of holding is the mother’s spontaneous and reliable meeting of the infant’s physiological needs, which she intuitively understands through empathy for her infant (Bowlby, 1958). The infant’s needs go beyond simply satisfying physiological needs:

[Holding] protects from physiological insult. Takes account of the infant’s skin sensitivity—touch, temperature, auditory sensitivity, visual sensitivity, sensitivity to falling (action of gravity), and of the infant’s lack of knowledge of the existence of anything other than the self. It includes the whole routine of care throughout the day and night... also it follows the minute day-to-day changes belonging to the infant’s growth

and development, both physical and psychological... Holding includes especially the physical holding of the infant, which is a form of loving. It is perhaps the only way in which a mother can show the infant her love. (Winnicott, 1960, p. 49)

A secure holding environment is perhaps the most important part of an infant's earliest life; it is "the maternal care on which there exists absolute dependence in a psychological sense" (Winnicott, 1960, p. 48). In its absence, or its failure to be good-enough, the infant experiences anxiety akin to "falling forever" or of being "dropped," a sensation also described as a persecutory fear of impending death. Hence, for an infant, not being contained or held can be experienced as worse than death, and mothers who fail to "hold" their infant in the PMP phase are in fact inflicting an extraordinarily painful and torturous experience on the infant, who in turn experiences anxiety and intolerable anguish. In the holding environment, the mother, like the child, does not recognize the separateness of the other: "the interests of mother and child are identical, and it is the generally acknowledged measure of the goodness or badness of the mother how far she really feels this identity of interests" (Balint, 1949, p. 253). When, in this state of PMP, the mother "holds" her child, the mother identifies with what the child might be experiencing, feeling herself in the infant's place and able to meet the infant's bodily and ego needs.

'Good-enough' mothering. Winnicott is also known for his concept of the good-enough mother, for whom PMP is in fact quite natural. As he writes, "it seems to be usual that mothers who are not distorted by ill-health or by present-day environmental stress do tend on the whole to know accurately enough what their infants need, and further, they like to provide what is needed" (1960, p. 54). He expanded this definition by stating, "the good enough mother meets the omnipotence of the infant and to some extent makes sense of it. She does this repeatedly"

(1960, p. 145). Tuber (2008) elucidated this statement, pointing out that “what is essential in this quote is not only its establishment of infantile omnipotence as a necessary fact of early life but also its emphasis on the repetitive nature of parenting as the key process behind the infant’s capacity to become real” (pp. 11-12). In other words, the most basic element of good-enough mothering is the idea that the mother is fundamentally reliable, such that the infant can take the mother for granted in the service of “going on being” (1963, p. 183) and becoming a “self” (Winnicott, 1963, as cited in Tuber, 2008, p. 40). When the mother is reliably there, the infant can begin to become aware of the world and of him- or herself without fear of impingement or needing to react. The question arises: Can the patient whose therapist has just returned from maternity leave similarly take him or her for granted? Does the pregnant therapist’s leave represent a betrayal of the reliability on which her patients have come to count?

Reverie. Bion’s theory of the mother’s capacity for reverie as a containing function is parallel and complementary to Winnicott’s notion of PMP. In this view, the mother enters a psychological state of “reverie” in which she intuitively knows the infant’s psychological and physical needs (Bion, 1962). She is able to do this because she has regressed in an adaptive way to a more primitive mode of ego functioning. In this mode, she is able to empathically ‘know’ the newborn child, to receive and understand his or her primitive elements of thinking (“beta elements”). For example, when the infant feels wet or over-stimulated and projects these impressions onto the mother, the mother becomes a “container” or “mental digestive enzyme” (Gooch, 1993) for the infant’s experiences. Since in this phase the infant cannot fathom the meaning of the impression and only reacts to those experiences, the mother uses her “alpha function” (thinking capacity) to contain, digest and respond to the beta elements projected by her infant. In other words, reverie is the “capacity of the object [mother] to receive and respond

creatively to the baby's projected, concrete experiences of chaos and confusion" (Issacs-Elmhirst, 1981, p. 87). This process, whereby the infant projects its beta elements and the mother contains and responds to them, could be characterized as a special kind of communication. Grotstein (1993), citing Freud's observation that one person's unconscious may interact with another's without any conscious exchange, believes that what a mother communicates to her child's unconscious is essential to the psychological, interpersonal, and adaptational development of the infant and its future overall psychological functioning.

Reverie can serve as an "emotional compass" to orient a therapist to his or her own unconscious feelings about a patient (Ogden, 1997, p. 571). In this view, reveries are a joint creation of the patient and analyst, rather than a solitary creation of the analyst; moreover, the reveries experienced in the analyst can differ depending on the patient. Ogden provides an example of an analyst who may be in 'reverie' over the illness of his or her child throughout all patient sessions, but the quality of the reverie will vary from patient to patient. Since these reveries belong to a kind of intersubjective field created by the unique analyst and patient, the term "intersubjective analytic third" is used to describe this unconscious, intersubjective space that the analyst and patient share (Ogden, 1994).

Of great relevance to Winnicott's notion of PMP, the mother-infant dyad, and the present study, Ogden (1997) noted that "there is no such thing as an analysand apart from the analyst" (p. 569). This description clearly hearkens back to Winnicott's famous words, "there is no such thing as a baby [apart from the mother]," drawing attention to the close connection between a therapist's role with her patient and a mother's role with her infant. Winnicott himself noted the parallels between the good-enough analyst and the good-enough mother, neither of whom need be perfect, but both of whom hold the patient/baby in a way that instills a sense that the world is

a safe, predictable place (Tuber, 2008). So what happens when the therapist *is* a new mother? Is she able to maintain PMP and its attendant reverie with both her infant and her patients at the same time, or is PMP in relation to her infant an obstacle to be overcome with respect to providing that kind of attention to her patients? Such questions have not yet been adequately addressed by research, and are the focus of the present study.

Adaptive regression in the service of the ego. As is clear from the preceding discussion, PMP involves a kind of regression that can be seen as a developmental step in the new mother's life. Early psychoanalysts originally conceptualized regression as a dysfunctional, immature, psychological state; however, Ernst Kris and Heinz Hartmann were among those who broadened this idea of regression, pointing out that under certain conditions, regression can be adaptive.

Hartmann's formulations regarding the ego provide the foundation for understanding the origins of the concept of regression in the service of the ego. Unlike Freud, who did not believe the ego existed at the time of birth as differentiated from the id, Hartmann et al. (1946) argued for the existence of an early ego or ego potential existing from birth and possessing its own energy not derived from instinctual drives. According to Hartmann, from birth an infant encounters the world not only with drives, but also with "constitutional factors important in ego development," including developing tolerance for anxiety, intelligence, and ultimately, differentiation and integration. Arbitration between the instinctual drives and the outside world is suggested as only one of numerous functions implemented by the ego: "Mental development is not simply the outcome of the struggle with the instinctual drives, with love object, with the super-ego, and so on. For instance, we have reason to assume that this development is served by apparatuses which function from the beginning of life" (Hartmann, 1958, p. 15).

According to Hartmann, the inborn apparatuses of the ego comprise perception, thinking judgment, reality testing, language, recall phenomena, productivity, and motor development. Under normal developmental conditions, these apparatuses or process are a part of a conflict-free sphere of the ego, but become involved in the negation of conflict often by means of regression. Indeed, Hartmann postulated that adaptation takes place not only progressively but also regressively through detours into fantasy: the unconscious is necessary for the development of the infant, who depends on unconscious fantasy and maternal projection. Some degree of irrationality is assumed necessary: “the normal human being is free neither of problems nor conflicts.” In other words, conflicts are part of the human condition. In this way, “regression in the service of the ego,” formulated by fellow ego psychologist and collaborator Kris (1936) is necessary to achieve optimal adaptation to the environment: “more primitive functions may be needed to supplement the highly differentiated ones” (Hartmann, 1964, p. 60). In this context, regression is not pathological but an essential part of sustaining ego strength.

As Knafo (2002) notes, regression in the service of the ego assumed a pivotal position in Kris’s (1952) theory of creativity.

A special form of ego mastery should be mentioned...namely the ability of the ego to initiate regression of its own functions in furtherance of its interests. Such regression is called *regression in the service of the ego*... imply[ing] a flexibility on the part of the ego, an ability to employ at will more primitive modes of functioning. (Kris, 1936, p. 167)

Kris’s formulations dealt with shifts in psychic levels (primary-secondary process) and cathexes of ego functions (inspiration-elaboration). The ego suspends its control by a temporary withdrawal of cathexis, but simultaneously controls and regulates the regression that is taking

place. The control of ego functions, however, varies with regard to “the organizational functions of the ego, its capacity of self-regulation of regression and particularly to its capacity of control over the primary process” (Kris, 1952, p. 28). Kris’s inspirational phase involves a suspension of higher mental activities and receptivity to unconscious material, where regressive processes emerge to communicate with the ego and transition from an active to passive mode of ego functioning. The elaboration phase is characterized by the reinstatement of secondary function and active use of ego function, such as reality testing and the reintegration of repressed material into socially acceptable forms. According to Kris, the inspirational phase provides the content to an artwork, while the elaboration phase is largely responsible for the transformation of that content into communicable form.

Following her discussion of Kris’s theory, Knafo (2002) argues against the view of the precondition that only individuals with a strong ego can regress in the service of the ego. She elaborates on Kris’s concept by including developmental and object relational considerations, suggesting that “creative regression is facilitated by the artistic setting and relationship to one’s craft, just as therapeutic regressions facilitated by the analytic frame and transference relationship” (p.46). She suggests that the artist’s relationship to his or her art is a kind of object relationship, infused with reality and fantasy, like that of patient and analyst. Knafo also suggests that art has reparative potential for early object relations, as it provides a medium for playfulness with one’s reality and fantasy of one’s maternal figure.

Primary process is a mode of thinking typical in dreaming and early childhood, when the sense of time is missing and symbolic representation is important. Although Kris used this concept to describe the psychological functioning of creative people, this mode of thinking can be said to generally dominate a state of regression, of which PMP is one example. Schaefer

(1958), elaborating on Kris's formulation, stated that regression utilized in this way is an important adaptive function. He later introduced the acronym ARISE—adaptive regression in the service of the ego—to describe the regressive mental state in women during the final phase of pregnancy and several weeks postpartum. Schaefer postulated that the ego can regress in an adaptive way while at the same time maintaining higher ego functions (i.e., reality testing).

It would seem that the state of PMP would be unattainable without ARISE, since a new mother capable of regressing in this adaptive way is open to the experiences inherent in PMP. ARISE operates in higher states of organization, including organized speech, perception, and movement, and these relatively automatic functions can become “de-automatized,” broken down to the bare elements of sensory, verbal, and motor experience (Schaefer, 1958). Indeed, new mothers immersed in PMP describe times when they are not sure of where their body parts are in space, feelings of being overwhelmed with emotion at things that at other times would not bring forth even a second thought, and the confusing experience of not finding language as a reliable means of communication (Moulton, 1991). These new mothers report not being able to hold on to a train of thought when talking, feeling at a loss for words, or using a vocal pitch that is normally reserved for interacting with an infant. Of key importance to ARISE is the mother's flexibility to accept a state of regression, to cope with the many fluctuations in her functioning, and to use her experience in the service of connecting empathically with her infant. With a strong ARISE function, the mother need not defend against the experience of PMP.

The mother's ability to function on a “dual track” provides the basis of PMP, where the mother simultaneously maintains adequate ego functions while regressing in the service of the ego (Grotstein, 1993). Some of the mother's higher ego functions are suspended so as to partially allow for the more regressive primitive states to emerge in order to enrich the maternal functions.

As the mother enters a state of unconscious reverie (Bion, 1962), or PMP, her ego functions on a dual track: on the one hand she maintains higher ego function, and on the other she regresses adaptively. This dual track allows her to tend to her own and her infant's psychical and psychological reality needs.

It has been noted that the experience of PMP is a "regression in the service of the baby" (Bergman, 2000, p. xvii), meaning that a new mother must achieve a level of mentation similar to that of her baby. Furthermore, she must be flexible enough to fluctuate in and out of that state. This flexible vacillation between regression and ego control is a central feature of ARISE. As Winnicott describes it, the mother must have sufficient adaptive and integrative capacities to enter PMP, as well as to recover from it slowly as "the infant releases her" to tend back to her own interests (1956, p. 302). The question thus arises: how do new mother-therapists who are returning to clinical work manage the fluctuations in and out of regressive states necessary to attend to both their infants and their patients? Is the therapist who is in a regressed state in relation to her infant more productive as a therapist than one who is not able to adaptively regress? And how do patients experience this phenomenon?

Flight into sanity. Winnicott (1956) points out that some mothers are unable to achieve the "normal illness" of PMP and have a "flight to sanity" (p. 302) despite having adequate ego functions. Such mothers cannot tolerate the experience of merging with their infant, and although they are able to provide for the infant's needs, they function on only "one track" of ego functioning, without the experiences of ecstasy and reverie characteristic of PMP. Winnicott recognizes that a mother's inability to experience PMP does not mean she is not a good mother:

There are certainly many women who are good mothers in every other way and who are capable of a rich and fruitful life but who are not able to achieve this 'normal illness'

which enables them to adapt delicately and sensitively to the infant's needs at the very beginning; or they achieve it with one child but not with another...It may be supposed that there is a 'flight to sanity' in some of these people. (p. 302)

Interestingly, women with compulsive character structures have been found to be unable to enter into this regressive state during pregnancy and early motherhood (Bibring et al., 1961). Mothers who cannot achieve PMP may feel too threatened by the loss of self and become too defensive to permit the regressive shift to take place (Bergman, 1985). Similarly, a woman's fear of pregnancy or hostility toward the fetus, which may be connected to negative maternal identifications or self-representations, may not allow her to enter PMP; her self-esteem as a mother will be vulnerable to her own infantile experiences or to fear of merging under the influences of the regression in PMP (Benedek, 1959). Furthermore, Winnicott underscores that a mother who did not enter the PMP phase, even if she is "good enough," will be in a future situation where the child needs remedial nurturing. If the early infancy bonding experience is missed, mothers do have future opportunities to acquire a special understanding of their children (Chess & Thomas, 1982); nevertheless, there is much evidence that the quality of the mother-child contact in the postpartum phase is critical.

Winnicott (1956) describes another possible negative effect of a mother's inability to achieve PMP: the infant's development of a "false self," for whom "the feeling of real is absent" (p. 304). As Winnicott stated, "the baby quickly learns to make a forecast; just now it is safe to forget the mother's mood and to be spontaneous, but any minute the mother's face will become fixed or her mood will dominate and my own personal needs must then be withdrawn otherwise my central self will suffer insult" (1967, as cited in Tuber, 2008, p. 12). When the mother is not able to adequately attune, the baby must adapt to maintain a connection with the mother, thereby

developing an overly compliant, “false self”; by contrast, when the mother is able to master her own emotional fluctuations enough to remain focused on the baby, the baby can allow its “true self” to emerge (Tuber, 2008).

Other factors related to PMP. There are several other factors that may impact the extent to which a mother experiences PMP. For example, single mothers or mothers who have babies without a partner may experience increased or decreased PMP, depending on particular circumstances. PMP may also be affected by whether the pregnancy was planned or unplanned. Another relevant factor that may impact PMP is whether the mother had a complicated delivery and/or Cesarean section. In the immediate period of time following birth, a mother who has undergone a complicated delivery or C-section must cope with her own physical recovery, something that may contribute to increased exhaustion or take her attention away from her infant. Studies have in fact found that mothers who delivered by Cesarean were more fatigued (Garel et al., 1988) and demonstrated significantly less tactile stimulation, caretaking, and intimate play with their babies one to five months postpartum than did mothers who delivered vaginally (Green, Coupland, & Kitzinger, 1988). This latter effect was stronger for unplanned Cesareans. Mothers who delivered by Cesarean also evaluated their babies significantly less positively than did mothers who delivered vaginally, and these less positive feelings also existed six weeks after birth (Green et al., 1988).

Another factor that may impact (or be impacted by) PMP is mentalization. Mentalization was identified by attachment researchers Peter Fonagy, Miriam Steel, Howard Steele, and Mary Target as the ability to interpret others’ minds, which in turn fosters the ability to read and understand one’s own mental states (Jurist, personal communication). While mentalization relies upon cognition, its source is the attachment relationship: secure attachment facilitates the

capacity to regulate affects, as well as the growth of the self and the mind's self-understanding. Mentalization, in which the mother reflects upon her child as having a distinct self and mind, is therefore crucial to promoting security in her child.

Swain, Thomas, Leckman, and Mayes (2008) reviewed work on the relationship between mentalization and a mother's capacity to become preoccupied with her baby, concluding that because early intervention efforts were most effective with mothers who showed greater investment in their infant during the first few months of life, a shift in priorities or mental focus toward the infant seems crucial for the transition to parenthood. However, they raise the question of whether mentalization is a facilitator of preoccupation, or the reverse: whether preoccupation is a precursor to mentalization with respect specifically to the infant. If the latter is the case, they argue that the more intense the state of early preoccupation, the more reflective a parent may be regarding her infant's emotional states and needs. It is natural to assume that the two states of mind overlap: when a mother becomes thoroughly preoccupied with the subjectivity of the baby, she learns its language quickly and completely, to echo Winnicott's terminology. In this way, PMP can be understood as both facilitating and epitomizing mentalization. Increased PMP thus may be related to a greater capacity to mentalize, but as Swain et al. point out, further empirical investigation is needed to further understand this relationship.

PMP and attachment. How might the phenomenon of PMP influence perceptions of maternal attachment style, given its characteristic appearance of preoccupation with the infant? A study by Fonagy, Steele, and Steele (1991) investigated the relationship between 96 primiparous mothers' attachment style before giving birth and child attachment one year later. Maternal attachment style was assessed using the Adult Attachment Interview (AAI) in the third trimester, and child attachment was assessed using the Strange Situation one year later. The

results indicated that Preoccupied attachment classification in mothers was, of the multiple attachment categories, the least predictive of their one-year-old babies' attachment. In this study, mothers whose interviews were classified Preoccupied were seen as overwhelmed and confused by the topic of attachment, evidenced in the interview context by incoherent, unfocused narratives and preoccupying anger or passivity. According to the authors, preoccupied mothers' behavior toward their infants may be inconsistent, making it difficult for their infants to develop modes of strategy to engage the parent and giving rise to an anxiously resistant pattern where infants' attempts to deal with their attachment needs are easily frustrated. Preoccupied mothers do not attempt to comfort a distressed infant; rather they attempt to redirect the infant's attention. In addition, these mothers may unconsciously want to maintain a heightened emotionality in their children as a way of remaining attached.

The finding in this study that Preoccupied attachment classification in mothers was the least predictive (of the attachment categories) of their babies' attachment is interesting, given Winnicott's suggestion that PMP originates in the last trimester of pregnancy. It is possible that, because these mothers were in the PMP phase, their attachment styles were incorrectly designated as Preoccupied. In other words, they were not preoccupied 'by nature' but rather by timing, and it was for this reason that the Preoccupied designation did not hold significant predictive power. It is possible that in the first year of their children's lives, these mothers' more 'baseline' secure attachment styles became reactivated. If PMP can be mistaken for a Preoccupied attachment style, how might PMP affect a new mother who is also a therapist, for whom exploring attachment issues with her patients may be a critical aspect of her clinical work?

This section has outlined the phenomenon of PMP. Still to be addressed, however, is the question of what happens when the new mother-therapist who may or may not be experiencing

PMP returns to clinical work. Winnicott specified that PMP continues throughout the first trimester of the baby's life, into motherhood; he also drew the connection between new mothers and therapists. What happens when the new mother *is* a therapist? The following section will review the literature on this often neglected topic.

III. The Therapist's Transition to Motherhood

Pregnancy and early motherhood are times of enormous change in a woman's life. Especially with a first pregnancy, women face new and often stressful tasks of adjusting to significant emotional and physical changes, renegotiating roles within their families, social circles, and professional life, and responding to the varied and demanding needs of their infant (Benedek, 1959). The experience is marked by a variety of physical and emotional challenges, including hormonal changes, physical discomfort, and lack of sleep; furthermore, pregnancy and early motherhood can provide the basis for the potential repetition of past psychological difficulty, evoking memories of the mother's own upbringing (Benedek).

The early stages of motherhood are thus, for many, a time of significant upheaval. In taking on many complex tasks and filling new and demanding roles, women must modify their old, familiar way of life (Bacon, 1974) and tolerate major disruptions in their relationships and rituals. As Norbeck and Tilden (1983) state, "pregnancy is an event with demands, constraints, opportunities, and an uncertain outcome" (p. 33). The rigorous requirements of the mothering role and of nurturing a completely dependent infant severely tests a woman's emotional capacities and resources.

The early postpartum period can be a critical time in life when the new mother must evolve a new identity and the baby must be integrated into the family system. Motherhood is not simply a "crisis" that is resolved by a return to previous roles; rather, it is an event that marks a

complete change in lifestyle (Lopata, 1972; Rossi, 1968). Furthermore, the physical return to a non-pregnant state does not reflect a corresponding return to pre-pregnancy psychological functioning; the literature indicates that many women are not at pre-pregnancy levels of functioning even six months after giving birth (Tulman & Fawcett, 1988). Conflicts within the family can remain unresolved even eight months postpartum (Mercer & Ferketich, 1990). Literature on marital satisfaction also indicates that the transition to parenthood can be a stressful time for not only the new mother but for the marital couple or partnership (Cowan & Cowan, 1995; Doss et al., 2009).

Psychological stressors and postpartum mood disorders. As mentioned in the previous section, in the postpartum phase new mothers may display psychological symptoms that mimic more serious psychopathology. Research has shown that over the course of pregnancy (from the first trimester to the postpartum phase), there is an increase in prior signs of conflict, regressive attitudes, and behaviors related to early childhood among women without any significant psychiatric history (Bibring et al., 1959). Pathological anxiety and regressed fantasy were also found to accompany the postpartum period; however, these can coincide with positive responses related to meeting the needs of the newborn that are necessary for the development of mothering (Brazelton, 1973). Challenges such as sleep deprivation, a sense of being overwhelmed by responsibility, and no time to spend on themselves—most of which are the hardest during the first months of the baby's life (Mercer, 1985)—also impact the new mother's psychological state.

Indeed, for many, the postpartum period represents a time of greater emotional stress than the pregnancy itself. In a study by Leifer (1977), two-thirds of new mothers reported that negative moods they had experienced during pregnancy became more pervasive and intense in

the postpartum period, with the intensity ranging from moderate to extreme. Thus, despite a sense of relief, accomplishment, and euphoria after giving birth that many subjects reported, varying degrees of anxiety and depression set in. The women were anxious not only because they did not recognize the negativity as a familiar response, but because the mood did not fit in with the way they thought they were 'supposed' to feel as mothers. Despite the pervasive idea that a new mother is radiant and blissfully involved in caring for her baby, most women are not at all prepared for the extent to which their emotional lives are disrupted by motherhood.

As shown by endocrinological and psychophysiological studies of pregnancy, hormonal changes during pregnancy and postpartum can contribute significantly to emotional fluctuations (Turnbull et al., 1974). Winnicott (1960) himself pointed out that during the phase in which PMP develops, the mother physically experiences an increase in estrogen and decrease in progesterone, which can mimic a state characteristic of ego regression with less controlled emotionality (Benedek, 1950). Physical discomfort that arises during pregnancy, such as weight gain, swelling, fatigue, nausea, vomiting, shortness of breath, muscle cramps, backaches, and frequent urination, can also affect the mother-to-be's psychological state (Hotchner, 1984). Indeed, "physiological changes sensitize the woman to the more subtle psychological changes that follow" (Winnicott, 1960, p. 53).

Thus, much work has shown that there is a dramatic increase in psychiatric disturbance in new mothers, particularly within the first 90 days of giving birth; these postpartum mood disorders tend to be found across cultures and associated with a range of psychosocial, psychiatric, and biological factors such as marital problems, lack of social support, personality characteristics, family history of depression, and autoimmune thyroid disease (Harris, 2002). With the arrival of a new infant often come a variety of postpartum emotional difficulties; these

have tended to be grouped by researchers into the categories of the “baby blues,” postpartum depression, and postpartum psychosis. How might each of these affect the new mother-therapist and her clinical work?

Baby blues. The baby blues are characterized by relatively mild affective symptoms, such as irritability, depressed mood, and anxiety, and are experienced within the first week after delivery, usually peaking between four and six days postpartum (Grigoriadis & Romans, 2006; O’Hara 1987). O’Hara (1987) reports that 50% of new mothers will exhibit symptoms consistent with the “blues,” but that the symptoms are fleeting and will resolve within 10 days of giving birth. Women with especially difficult blues symptoms are more likely to experience postpartum depression at a later point (O’Hara; Paykel et al., 1980).

Fatigue and emotional lability are other symptoms of the baby blues that may run parallel to those listed above. After giving birth, many women experience lower energy levels than during pregnancy (Leifer, 1977). Because this immediate postpartum period is the time when the mothers are most needed to care for their infant and less able to tend to their own needs, mothers may experience greater stress, depression, and irritability, which in turn effect more fatigue and a flooding of emotion. Their discomfort from having recently given birth, as well as their need to tend to their infants at night, may also contribute to a disruption in sleep. Some researchers have suggested the creation of a distinct postpartum condition, “postnatal exhaustion,” to capture these symptoms (Williamson, 1993). Symptoms of this condition are extreme tiredness that may begin right after giving birth or that may develop slowly over the course of the post-birth period. Although this condition can predispose some women to developing postpartum depression, for others, the exhaustion may last up to nine months but disappears before the baby’s first birthday.

How do the baby blues and exhaustion affect new mother-therapists? How do their irritability, depression, and anxiety play out in the clinical situation? When they return from maternity leave, are they too fatigued to work? Do patients notice their physical fatigue?

Postpartum depression. Postpartum depression, a more severe and disabling form of depression following birth, is characterized by the symptoms of Major Depression, as described in the DSM-IV. To be diagnosed with postpartum depression, a woman must exhibit most of the following symptoms: dysphoric mood, signs of sleep and appetite disturbance, fatigue, difficulty concentrating, irritability, excessive guilt or anxiety about the welfare of her baby, and suicidal ideation (O'Hara, 1997), and these symptoms must be present for at least several months. It has been determined through meta-analyses of postpartum depression studies that approximately 12% to 15% of the general population experiences postpartum depression (Freeman et al., 2005; O'Hara & Swain, 1996; Rychnovsky & Beck, 2006). By the third month postpartum, most women are 'back to normal' emotionally and have a satisfactory view of themselves as mothers (Leifer, 1977). Women who experience postpartum depression also report decreased levels of preoccupation, which negatively impacts the building of their relationship with their infant (Leifer, 1977). So whereas difficult infant temperament can undermine the ability of new mothers to attune to their baby's needs, postpartum depression can further disrupt the attachment process.

Several risk factors have been identified for postpartum depression. A woman may be at risk when she attempts to live up to an ideal good mother/career woman but has no internalized role models upon which to draw (LoCicero, Weiss, & Issokson, 1997). A prior history of depression, a family history of psychological illness, depression during pregnancy, and disharmony/lack of support in the spousal or other important relationships have been found to be

strong predictors (Rosalind, Unterman, Posner, & Williams, 1990). In fact, emotional support may be a crucial factor influencing the degree to which new mothers experience difficulty; women who report significant support by a partner tend to experience less strain in adjusting to new motherhood (Leifer, 1977). Research also suggests that women who develop postpartum depression tend to hold more negative representations of their own mothers than those who do not (Bibring & Valenstein, 1961) and tend to doubt their ability to be good at mothering (Campbell et al., 1992). A final risk factor for depression is hormonal changes that occur during and after pregnancy, but it is considered unlikely to be a sole cause given that most women do not develop major depression after giving birth (Hayworth et al., 1980).

The issue of baby temperament can also contribute to postpartum depression, particularly in the case of a ‘mismatch’ between baby’s and mother’s temperaments. If a baby cries frequently, appears unable to be soothed, or is by temperament more or less active than his or her mother, a mother may feel that she is inadequate, contributing to depressive feelings of “what is wrong with us?” Recent research indeed confirms that there is a relationship between postpartum depression and infant temperament. Infants with difficult temperaments are fussier, cry more and have poor sleep; factors that intensify a mother’s depressive symptoms during postpartum (Swendsen & Mazure, 2000). Depressed mothers with difficult infants are also prone to negative interpretations of their infant’s behaviors, which can bring out a negative parenting style towards the infant and raise doubts in mothers’ minds about their competence (Swendsen & Mazure, 2000).

Postpartum depression can also significantly impact the nursing couple. Recalling Winnicott’s understanding of how a “false self” can develop in babies who are attempting to match their mother’s moods, it becomes clear that if the mother is severely depressed, the baby

will likely struggle that much harder to win her attention and attunement. On the other hand, if the mother is driven to deny experiences of sadness and loss, the baby must then strive to deny those experiences within him- or herself: “the baby is thus in a ‘lose-lose’ situation: should he persist in his true feeling, he remains subdued but loses mother; if he complies with mother’s need to remain subdued, he loses (buries?) that feeling but acquires a compliant False Self” (Tuber, 2008, p. 55).

How would postpartum depression play out in the clinical situation, if a new therapist/mother is afflicted? To what extent are therapists in the 12% to 15% of women who experience postpartum depression? How would a depressed therapist’s ability to attune to patients be impacted?

Postpartum psychosis. Postpartum psychosis is another affective disorder associated with childbirth. Although it is quite rare (1.1 to 4 out of 1000 births), women who experience postpartum psychosis require immediate hospitalization, as this is a serious illness with potentially devastating consequences. Women who kill their babies frequently suffer from this disorder. Also, women with this condition often seem confused and incompetent, having difficulty functioning due to hallucinations and delusions that often involve self-harm or harm to the infant (O’Hara, 1997). Winnicott (1971) described this type of pathology as possibly occurring when a woman enters the regressive state of PMP but does not have the ego strength to emerge.

Postpartum psychosis is, in a way, an extreme form of the ‘normal’ intense preoccupation with one’s infant that many mothers in PMP experience in the first three months postpartum. What happens when a therapist returns to work before that three months is over, in that heightened state of pathology? As this review has shown, much has been written about new

mothers in general, but relatively little has been written on the ways in which these aspects of new motherhood affect therapist/mothers and their patients upon their return to work.

The mother-therapist postpartum: A review of the literature. How do the phenomena of early motherhood reviewed herein affect the new mother-therapist and her patients? As noted earlier, the number of women therapists who combine motherhood and career has increased greatly over the past 30 years. It is therefore timely and appropriate to examine the effects of early motherhood on the therapist and her work, given the significant psychological changes that accompany this time in her life. As has been described throughout this review, the emotional changes engendered by pregnancy can extend into the postpartum phase (Winnicott, 1956; Bibring, 1961, Basescu, 1996; McGarty, 1988; Nadelson et al., 1974; Fenster, 1983; Fenster et al., 1986). When the therapist becomes a mother, both the patient and the therapist experience a profound change in the treatment situation.

With the exception of a few studies (e.g., Bassen, 1998; Fenster, 1983), most empirical research to date has focused primarily on the pregnant therapist, rather than on the new mother-therapist in a state of PMP, or in the postpartum phase generally. Most authors focus on the unconscious aspects of the pregnancy that may impact treatment, implying that the birth of the therapist's child signals the end of any alteration the pregnancy might bring to bear on the therapeutic relationship. Visibility of the therapist's pregnancy appears to be the primary consideration for research of any transference/countertransference issues among therapists who become new mothers. This 'out of sight, out of mind' attitude is limiting and does not adequately address the effects in the consulting room of emotional and psychological changes that come with early parenthood. The present study seeks to elucidate this period of time, when the therapist returns to work after giving birth. What follows is a review of the literature that does

exist, based on themes observed; with the exception of Fenster's (1983) seminal study, most of this material is driven by clinical observation.

Balancing dual roles. Initial responses of therapists to returning to work can include feelings of removal, distance, or detachment, and when closeness to patients returns, it tends to be with noticeably less over-involvement and enmeshment (Fenster, 1983; Korol, 1996). Therapists report often being able to be more confrontational and interpretive and to set more limits regarding time, fees, and phone calls during this time, drawing new boundaries to protect "family time" (Davis, 1984). Some research suggests that because therapists are in the midst of experiencing absorption and fulfillment from their newborn, the need for approval from the external world for achievements decreases (Fenster et al., 1986). For these therapists, conflict about putting off professional goals may be minimal, whereas others may feel "a sense of deprivation, resentment or depression about interrupting career priorities" (Fenster et al., pp. 122-123).

In this vein, many clinicians have written about their experience as new mothers in terms of the challenges of balancing dual roles. For example, Macnab (1995) describes the difficulties of finding the ideal balance between psychotherapy and motherhood, concluding that as both a mother and a therapist, her roles entail shame and guilt. She became more aware as time went on that she was probably not going to be a "better mother" than those described to her by her patients, and that it was hard for her to mourn the fantasy of being the perfect mother. Macnab refers to the impact of motherhood on her ability to attend to her patients, identifying the primary challenge as one of balance between her personal struggle with parenting and her patients' similar conflicts. Relatedly, Basescu (1996) has noted that the dual role of being a mother and a therapist "can become a useful stimulus in the clinical work for patient and therapist as a unique

set of life experiences [that] shed specific light on clinical issues and the clinical situation” (p. 104).

Although some women may look forward to leaving a chaotic, new-baby atmosphere and going back to an adult-focused work environment (Waldman, 2003; Fenster, 1983), others may find that the task of balancing personal and professional selves is an ongoing one (Korol, 1996). As Winnicott points out, so much of what therapists do is related to care of an infant: being receptive and attuned and containing patients’ dysphoria, aggression, and disorganization. Indeed, some therapists may feel overwhelmed by doing two similar ‘jobs’ (being a mother and a therapist). On the other hand, for some therapists, going back to work may be an organizing factor “during a time when her sense of self is shifting in all arenas” (Fenster et al., 1986, p. 118). That some new mother-therapists experience their return as overwhelming whereas others experience it as organizing is an interesting observation, one that will be a focus of the present study: what accounts for the difference in these two groups, and how do these two differing reactions impact clinical work?

In this interface between good mother and good therapist, expectations of good performance in both roles sets the stage for conflict between the two worlds (Fenster et al., 1986). Awareness of this dichotomy is seen as critical to its resolution. A new mother returning to practice may cease to play the role of mother as fully with her patients as she once may have. As the therapist builds up a continuing sense of her own capacity to shift roles successfully, the therapist-mother finds that she is comfortable bringing her increased emotional openness into the treatment process. She is better able to maintain an empathic stance and to tolerate chaos without feeling excessively frustrated.

Indeed, the dual roles of child-rearer and therapist can be assets for a woman when the elements of each become well integrated (Fenster et al., 1986). In being able to be emotionally flexible with both the demands of the baby and of patients, the therapist acquires an increased ability to shift between the dual roles and an enhanced sense of self. Furthermore, mothering provides the therapist/mother with an increased understanding of patients' expressions of their own childhood. As Winnicott (1963) noted, therapists can apply what they are learning as parents to their patients; just as listening and empathy are fundamental to clinical work, so are they crucial for mothering. Being so close to the experience with her own child, the therapist may be able to relate directly rather than recalling retrospectively her own childhood memory (Fenster, et al., 1986).

The challenge of being a good-enough mother and good-enough therapist may never be fully resolved: "the feeling of perpetual conflicts provides a backdrop for understanding the therapist mother" (Fenster et al., 1986, p. 116). For example, breastfeeding mothers, while enjoying the exclusive and fulfilling bond, become exhausted. This may limit nursing therapists' availability when patients' and the infant's needs are experienced as similar in nature. As Tuber (2008) noted, "the task of being a good-enough mother is emotionally exhausting, no matter how 'easy' a baby may be" (p. 82); add to this the task of being a good-enough therapist, and the challenge increases considerably. Furthermore, the idea of being continuously in demand may be at odds with some therapists' sense of self. Ultimately, it is only by accepting that there will always be ongoing conflict involving career and child-rearing that the therapist/mother can minimize the emotional strain of the dual role. In order to deal with the demands of combining a career and motherhood, it is essential to learn to how to navigate the unrelenting pull there will be in both directions.

Capacity for empathy. Another aspect of clinical work that may change upon return from maternity leave is capacity for, or quality of, empathy. Becoming a mother may deepen understanding of developmental phases and make a therapist more empathic towards her patients (Waldman, 2003). Although it may be difficult for the mother-therapist to connect with anyone other than her infant in the early postpartum days, she may ultimately be able to feel patients' pain in deeper ways, particularly that involving longing for maternal care that was missed.

Waldman (2003) refers to a case where she found herself gazing at a patient's face and suddenly thought of her baby. At that moment, she deeply understood, or in her words "contained," an awareness that the patient yearned for the positive mirroring he never received and that she felt with her own infant. Such moments of clarity were supported by her experience of motherhood; they helped her to be more compassionate and ultimately facilitated the exploration of her patients' difficulties and struggles.

Postpartum, the therapist's effort to intuit the infant's needs raises the level of empathy of which the mother-therapist is capable (Waldman, 2003). While this may be a desirable and useful outcome, a balance must be found. Over-reliance on preverbal communication—too much assumption of understanding what the patient is trying to say—may be experienced as an intrusion into the patient's boundaries. The challenge is to extend full emotional availability to distressed, adult patients whose response to such attention may not be as immediately gratifying as that of an infant.

There appear to be several positive effects of mothering on a therapist's ability to attend to her patients; for example, her own experience of navigating new motherhood within her family may be central in establishing a working alliance and empathic lens for her work (Macnab, 1995). A new mother-therapist's successful negotiation of fatigue and the intensity of

her wish to remain with her infant may also be crucial to the re-emerging of attentiveness and availability to patients (Fuller, 1987). As a result of mothering an infant, a therapist may feel better equipped to listen to the experiences of new mothers and to offer understanding and support to patients' experience of parenting. She may also feel an increased sensitivity to female patients who long for children of their own or have accepted childlessness. Fenster (1983) raises the interesting idea that the challenge of rearing an infant helps therapists diminish any superiority they may have felt about their patients, or their own parents. Therapists feel a heightened sensitivity to understanding patient's child-like needs, and become better able to accept their loving feelings as their level of empathy deepens. Therapists also become more flexible in adapting to patient's needs, and become less afraid of patients knowing things about them and their life.

The therapist as a container. A therapist is in a metaphorical sense a container for the emotional development of her patient, and containing another life in one's womb challenges the boundaries of the therapy, especially when the pregnancy is obvious to the patient (Waldman, 2003). The boundaries of these containers may become blurred in therapy, especially during the months when the pregnancy is visible in the consulting room. As a result, pregnancy challenges the self-conception of mother-therapist and requires reorganization of her concepts of attachment; the visceral experience of carrying a child restructures her concept of both physical and emotional boundaries.

In a personal account of her transition to motherhood, Marlin (1988) relates how her work deepened as a result of becoming a mother, citing Winnicott's (1975) discussion of the holding and containing function of the mother and his comparison of the mother and the analyst roles. In his paper on hate in the countertransference, he wrote:

An analyst has to display all the patience and tolerance and reliability of a mother devoted to her infant; has to recognize the patient's wishes as needs, has to put aside other interests in order to be available and to be punctual, and objective, and has to seem to want to give what is really only given because of the patient's needs. There may be a long initial period in which the analyst's point of view cannot be (even unconsciously) appreciated by the patient. (p. 74)

Marlin points out that for the therapist who becomes a mother, "this strain is doubled": "it is this continuous emotional strain of being available optimally, as well as containing and processing conscious and unconscious affects without acting them out toward our patients, that is so very draining" (p. 473). The therapist must, in effect, contain aggressive and sexual feelings of patients in a way that is much like parenting, and in the process prevent making projections upon the patients themselves. Like the good-enough mother, the therapist must hold patients throughout regression, keeping at bay strong or even hateful countertransference feelings (Tuber, 2008).

The notion of the therapist as a container may play a role in a case study presented by Ulman (2001), who describes how she was able to encourage the patient to discuss negative feelings toward her only in the postpartum phase, when she returned to work. Ulman says she felt "off balance" with the patient while she was pregnant, more vulnerable, and unable to pursue the patient's negative feelings until after the baby was born. She believes that unconscious fear of her patient's anger may have played a role in her collusion with the patient's denial throughout the pregnancy. However, when she returned in the postpartum phase she felt a "sense of equilibrium restored," and felt more open to the patient's expression of negative feeling. Here, it may be that the therapist felt better able to 'contain' the patient's anger after being 'emptied'

by giving birth. This idea, while compelling from a clinical standpoint, has yet to be tested empirically. The present study will attempt to uncover the mechanisms by which the therapist functions as a container, given the demand for her to also contain her new infant's projections.

Guilt and anxiety. Many therapists experience guilt feelings and anxiety upon return to work after having a child. This time has been characterized as a “crisis of parenting” in which therapists may experience intensified guilt, anxiety, and preoccupation with the dilemma of attending to the needs of both her child and her patients (Basescu, 1996, p. 101). Other writers have also observed this phenomenon (Marlin, 1988; Fenster, 1983), noting that many therapists in the postpartum phase were addressing not only their patients' transference concerns stemming from pregnancy and maternity leave, but also the their own sense of guilt over having abandoned their patients for their own needs. Basescu (1996) worried about shortchanging her patients and struggled with decisions about canceling sessions when her children were sick. Indeed, some patients did perceive her as dividing her attention and felt resentful, while others reacted with a range of feelings, from sympathy to guilt, or obliviousness. She describes her vulnerability at this period in her life as “double edged” for her patients and herself, simultaneously helpful and troublesome.

The post-pregnancy phase may be especially stressful for the mother-therapist, in part because of sadness and anxiety about giving up the intimacy with her infant for that of the consulting room (Korol, 1996, Fenster et al., 1986, McGarty, 1988). Being a part time mother might bring up fears of losing connection with the infant, as well as “fears [about] a loss of connection and effectiveness with her patients” (Fenster et al., 1986, p. 119) as a part time therapist. A mixture of anxiety, relief, excitement, dread, and anger may arise in response to this issue. However intense these feelings may be, actual return to work typically allows the clinician

to start the process of role integration, to separate from her infant and reconnect with patients as she remains flexible enough for connection or to function well in the multiple spheres. The question of how these intense feelings may play out in the clinical interaction will be a focus of the present study.

Patient reactions postpartum. For Van Neil (1993), “the most difficult and affect laden period relating to the pregnancy seemed to occur after the birth for most patients and emerged generally nine months following the start of parental leave” (p. 131). Many writers concur that the postpartum period was a difficult time for patients, with the therapist’s return seemingly spurring a variety of patient reactions and experiences, including heightened maternal transference, competitiveness with the therapist as a mother, and issues of rivalry with the therapist’s child (Fenster, 1983), and even rage and loss of control and termination (Turkel, 1993).

Some therapists report that their patients feel that the atmosphere and dynamics of therapy relationships change upon their return, having “some sense that things are not going to be the same again, that something was lost and could never be had again” (Fenster, 1983, p. 98). This feeling of irrevocable loss may be important to explore in terms of a transference revival of a sibling’s birth, partner’s absence, or any of a number of important conflicts (Fenster, 1983; Korol, 1996; McGarty, 1988). The sense of loss may also clearly reflect the ‘real’ relationship, as patients may sense changes in the therapist’s psychological state as a mother with a newborn infant and accurately perceived the postpartum ‘de-cathexis’ during the first several months of her baby’s life.

As noted, following the therapist’s return from maternity leave, the “pre-pregnancy harmony” may never be fully restored: while patients are by no means abandoned, their position

is realistically and qualitatively different; many patients sense this (especially borderlines) and react with anger (Fenster et al., 1986, p. 124). This reaction may manifest initially as feelings of displacement by the baby, wishes to replace the baby, or curiosity about the therapist as mother. It is common for patients to exhibit behavior at this time similar to that during the pregnancy, including lateness, missed sessions, premature termination, pregnancy, suicidal threats, and late payments. Hostile feeling may often be acted upon with premature termination of treatment. Fenster et al. (1986) conclude that the effect of a therapist's pregnancy and motherhood on the patient "probably continue as long as the patient remains in treatment" (p. 125).

Given the extent to which therapists still feel the presence of and effects of their pregnancy and parenthood in the therapy room after returning from leave, Fenster (1983) considers it notable that most patients often do not talk about the baby. They may ask about the baby's name and sex, and then drop the topic as quickly as possible. This may be an attempt to re-establish the dyadic relationship and banish the triadic relationship that existed during the pregnancy. Ostensibly ignoring the baby may also be a denial of the existence of the baby as a rival who was so vividly in the room, or as an entity that threatens the patient's feelings of being special. Although, as discussed earlier, the therapist may comply with the patient's avoidance and denial of the situation (and perhaps feel relieved in doing so), therapists' reactions may depend on the patient's level of organization. Therapists may feel more protective with more disturbed patients upon returning from maternity leave; at the same time, they may feel more 'wary' of them, more concerned about these patients' more primitive fantasies as they attempt to reconstruct the integrity of the treatment.

Summary and Statement of the Problem

In conclusion, little research has explored either the clinical phenomena occurring in the phase of treatment following a therapist's return from maternity leave (the postpartum phase of treatment) or the impact of PMP on clinical work with patients. The existing literature on these subjects is primarily comprised of clinical vignettes of analysts who wrote about their own experiences of the early postpartum phase of treatment. Literature written on related concepts can be applied to the therapist postpartum phase, including therapist pregnancy, PMP, and transition to motherhood, but it seems clear that the therapist's return to work after maternity is a significant, less well-understood phase that has the potential to either facilitate or obstruct the therapeutic process. The present study thus represents an opportunity to address unanswered questions about the therapist's return from maternity leave, with particular focus on PMP, through quantitative and qualitative methods.

The Present Study: Research Questions

This is a qualitative and quantitative research study of clinical phenomena occurring in the postpartum phase of treatment. The postpartum phase of treatment refers to a therapist's return to the world of clinical work from her maternity leave. The major focus of this study is the role of "primary maternal preoccupation" (PMP); I examine the impact of early motherhood on the therapist and the quality of her work given the significant psychological changes that accompany this time in her life. The focus of this investigation is to examine how PMP manifests in the new mother-therapist and how it impacts her clinical work. In order to address this issue, as will be described in detail in the following chapter, questionnaires and interviews were conducted with therapists who had given birth within the previous six months and had returned to work in their clinical professional roles. The research questions are as follows:

1. How does primary maternal preoccupation (PMP) manifest in the therapists in the present study?
2. What are the positive effects of PMP on the therapist in terms of her clinical work with patients?
 - a. How does PMP positively affect the therapist-mother's ability to attend to her patients?
3. What are the negative effects of PMP on the therapist in terms of her clinical work with patients?
 - a. How does PMP negatively affect the therapist-mother's ability to attend to her patients?

Because of the small sample size and the fact that the quantitative measure, the PMP Questionnaire, has only been used once before (Moulton, 1991), no specific hypotheses have been generated. Any hypothesis put forth would still be very tentative, as the present study is an exploratory one. Therefore, the aim is to allow the data to reveal themselves and to identify and describe emergent group differences. Nevertheless, the above represent the guiding questions that inspired the creation of this study. Following the presentation of the data in the Results chapter, in the Discussion chapter I will address the relationship of the data to the research questions.

Chapter Three: Method

Instruments

The data for this research include the PMP Questionnaire devised by Moulton (1991)—an instrument that measures the level and quality of primary maternal preoccupation—as well as transcripts of one-to-two-hour audio-taped interviews with 20 psychotherapists who had returned to clinical work within six months of giving birth. The PMP Questionnaire was administered prior to the semi-structured interview in order to ensure that the structured (questionnaire) data remained unaffected by emotional responses that might arise during the interview.

PMP Questionnaire (Moulton, 1991). The PMP Questionnaire provides an overall score (overall degree of PMP) and also taps into four aspects of PMP. These are: a) Boundaries, b) Distractibility, c) Affect, and d) Autonomous Ego Functioning. Questions assessing the area of boundaries intend to capture experiences of the therapist's immersion with her baby. It is meant to illustrate the point that a blurring of boundaries occurs between her experience of herself and her experience of her infant (Winnicott, 1956; Bibring et al., 1961; Bergman, 1985). Questions assessing the area of distractibility are intended to capture characteristic distraction from aspects of daily living occurring outside the mother's experience with her infant (Winnicott, 1956; Bergman, 1985). Questions assessing the area of affect are intended to capture the increase in emotional intensity and loss of emotional modulation (Benedek & Anthony, 1970; Bibring, 1961; Brazelton, 1979; Stern, 1985). Questions assessing the area of autonomous ego functioning are intended to capture intermittent lapses in ego functioning that were previously autonomous, such as memory, verbal fluency, and grace of movement. Thoughts that are ordinarily repressed, such as a mother's vivid non-verbal memories of early experiences with her own mother, are

included in this dimension of the scale (Benedek & Anthony, 1970; Bibring, et al., 1961; Brazelton, 1982).

Fifty-eight true-false questions address each of the four categories, with “true” answers later assigned a numerical value of one (1) and “false” answers assigned a numerical value of zero (0). An overall score and scores for each of the four categories were assigned for each respondent. This instrument by Moulton (1991) has been shown to have acceptable reliability (Kuder-Richardson reliability coefficient of $r(tt) = .89$) and construct validity in its significant relationships to a conceptually similar measure, Adaptive Regression in the Service of the Ego (ARISE; see Moulton, 1991).

Because Moulton (1991) did not report which items of the PMP Questionnaire were classified into each category (Boundaries, AEF, etc.), the investigator of this study and an advanced doctoral student in clinical psychology reviewed Moulton’s conceptual definitions of her categories and independently classified PMP Questionnaire items into the categories. Following independent classification, the raters compared category assignments, and inter-rater agreement was relatively high. Any discrepancies were discussed and consensus was reached. The investigator then coded the 20 PMP Questionnaires according to these assigned categories.

Semi-structured interview. In addition to the above measure, a semi-structured interview was designed specifically for this study to allow for a richer elaboration upon data yielded from the questionnaire. Such qualitative data may allow future researchers to refine quantitative PMP questionnaires like Moulton’s (1991). Including both a quantitative and qualitative measure in the present study also served to compensate for limitations inherent in both approaches.

The interview was comprised of open-ended questions that allowed the respondent to spontaneously elaborate on her experiences. Following the posing of a general question, the interviewer provided a series of prompts guided by participants' responses (see Appendix). This method allowed the participant to spontaneously share relevant information while exploring her experiences and expanding upon her views. The interview included three main groups of questions, each with specific subgroups addressing relevant themes and issues. The three areas were 1) background information (therapist's personal and work data), 2) therapist's experiences (pregnancy and maternity leave and resumption of work), and 3) patient experiences.

The researcher initially planned to place the data into three categories: themes related to pregnancy and maternity leave, themes related to therapists going back to work after giving birth, and themes related to patients' experiences of therapist pregnancy and birth. However, as the analysis transpired, the researcher was struck by the extent to which the themes overlapped and interconnected, so much so that at times such distinctions felt artificial, particularly that between patient experiences and therapist experiences. For example, each therapist reflected not only upon her own experience, but also upon how her experience affected her patients, in turn further affecting her own experience. Thus, although ostensibly portrayed by only one of the parties involved, experiences were often ones in which both people were participating at the same time. Where such simultaneity exists, it is impossible to fully understand the experience on the basis of a single perspective. For this reason, throughout the remainder of this dissertation the category "patient experiences" has not been separated into its own section, but rather incorporated into results and discussion of therapist experiences of their clinical work.

Participants

Participant demographic data are summarized in Table 1. All but one participant were breastfeeding. This was the first pregnancy to term for 15 of the therapists, and the second pregnancy to term for five of the therapists. All of the therapists resided and practiced within a 50-mile radius of New York City. In terms of level of training, of the 20 participants 14 were licensed psychologists (12 Ph.D., 2 Psy.D.), two were advanced doctoral students in internship training (clinical psychology Ph.D.), three were licensed social workers, and one had a dual degree as a licensed psychologist and licensed social worker. Thirteen of the 20 therapists were in supervision, either through psychoanalytic training institutes, their work, or privately. The remaining seven therapists were not in formal supervision but were receiving informal supervision from colleagues. Three of the seven therapists who were receiving informal supervision were also supervisors themselves. All therapists endorsed the use of more than one therapeutic orientation; 11 described themselves as utilizing integrative, cognitive, behavioral, and psychodynamic psychotherapy on a regular basis. Four therapists described themselves as Freudian, and three emphasized their reliance upon relational techniques.

Table 1

Demographic Characteristics (N = 20)

| | <i>N (%)</i> | <i>Mean (SD)</i> | <i>Min</i> | <i>Max</i> |
|--|--------------|------------------|------------|------------|
| Age | | 35.76 (4.84) | 27 | 46 |
| Weeks since giving birth | | 23.25 (5.50) | 11 | 32 |
| Years since awarded degree (n = 18) | | 5.15 (3.45) | 0 | 13 |
| Race/Ethnicity | | | | |
| Non-Hispanic White/Euro-American | 20 (100) | | | |
| Relationship Status | | | | |
| Living with partner but not married | 1 (5) | | | |
| Married | 19 (95) | | | |
| Yearly household earnings | | | | |
| Less than \$50,000 | 1 (5) | | | |
| Between \$50,000 and \$100,000 | 1 (5) | | | |
| Over \$100,000 | 18 (90) | | | |
| Current pregnancy status | | | | |
| First pregnancy | 15 (75) | | | |
| Second pregnancy | 5 (25) | | | |
| Level of Training | | | | |
| Licensed psychologist | 15 (75) | | | |
| Licensed social worker | 4 (20) | | | |
| Doctoral student (clinical psychology Ph.D.) | 2 (10) | | | |
| Clinical setting | | | | |
| Hospital/clinic and private practice | 5 (25) | | | |
| Hospital/clinic only | 7 (35) | | | |
| Private practice only | 8 (40) | | | |

Procedure

Data collection took place in four stages. In the recruitment phase, I recruited as many therapists as possible who were in either their second or third trimester of pregnancy. Participants were chosen during this earlier pre-birth phase to initiate contact during their pregnancies and make arrangements for interviews after they had given birth and returned to their clinical positions. Therapists who had given birth within the past six months and returned to work were also recruited. To maximize the sample size, participants were not limited to first-time mothers. Therapists were recruited through a combination of formal and informal professional networks, including post-doctoral training institutes, colleagues, and referrals from existing study participants. Flyers were sent to a number of training programs and analytic institutes that stated the nature of the study and asked for referrals of women who may be eligible to participate. The women were then screened by phone to determine their eligibility for the study.

In the pilot phase of the study, a semi-structured interview was administered to two participants. The interview was developed for the purpose of this study (see Appendix) and administered along with Moulton's (1991) PMP questionnaire. The goal of the Pilot Phase was to test the viability of the assessment instruments and to examine the participants' ability to use the questions to explore their own process of PMP and its effects on their clinical work. Following the pilot phase, the interview questions were re-examined and adapted and the following questions about therapists' supervision were added: a) "Did your pregnancy affect your supervision? If so, how? (prompts: *Was there conflict around the issue, or did you see eye-to-eye? What was your reaction to your supervision during pregnancy? On your return?*)" and b)

“Were there any changes in your relationship with your supervisor that may be a result of your pregnancy? How do you feel about the supervision you received?”

In the research phase, 18 additional therapists were interviewed who met criteria for the study, utilizing the PMP instrument along with the semi-structured interview.

In the follow-up phase, a brief follow-up phone call was conducted with each participant three weeks after her interview. Since the literature suggests that so much in the PMP phase is difficult to put into words (i.e., there is so much emphasis on non-verbal experiences of being with the new baby), this follow-up phone call was designed to give participants a chance to discuss whatever may have been difficult to initially articulate in the interview. Questions asked in the follow-up phone interview are listed in the Appendix.

Data Analysis Strategy

The PMP Questionnaire was analyzed by deriving an overall score for each participant, obtaining the median score, and creating a median split (grouping participants into “high PMP” and “low PMP” on the basis of this sample’s scores). In a more refined variation of this type of analysis, participants were also grouped into these same categories according to extreme differences (i.e., comparing the five highest-scoring participants with the five lowest-scoring participants). Using participant data to determine high and low cut-offs is considered superior to using pre-determined scores for such cut-offs, given the relative newness of the instrument. The four areas of the PMP Questionnaire (boundaries, distractibility, affect, and autonomous ego functioning) were similarly examined, with “high” and “low” groups generated within each category. Descriptive data (e.g., means, standard deviations, ranges, distributions) are reported for all scores. As the PMP Questionnaire has only been used once before, part of the aim of the

present exploratory study was to determine whether these four categories held up in a different sample and whether true differences in the subgroups exist based on distributions of scores.

The goal of the semi-structured interview analysis was to provide richer data on participants who scored differently on the PMP Questionnaire. It was used to elucidate, enrich, and expand upon differences between those scoring high and low on the questionnaire overall and in the various categories and so provides a more clinical description of PMP, participants' areas of strength, and participants' areas of vulnerability with respect to the intersection of different levels of PMP and clinical work. As will be seen in the following chapter, this type of qualitative analysis demonstrates whether themes that emerged in interviews with PMP-high-scoring participants differed from those that emerged in interviews with PMP-low-scoring participants. Themes for each group were further examined in the context of each of three primary interview sections (pregnancy and maternity leave, resumption of work, and patient experiences). In order to maintain the integrity of the data and prevent interviewer bias, it was not known how participants scored on the PMP Questionnaire prior to the interview. After participants signed informed consent, all interviews were tape-recorded and transcribed with personal identifying information removed. Two independent raters coded the data in terms of thematic issues. Inter-rater reliability was established by pairing the raters with two transcripts; once reliability was established they independently rated the interviews.

The data analysis was therefore both quantitative and qualitative. The first question asked was: to what extent do groups of participants differ on the PMP Questionnaire? If the questionnaire was shown to be valid—that is, to yield an appropriate range of scores—categories of participants (high and low-scoring, both overall and in the four categories) could be generated; this did in fact occur. Following this initial analysis, the interviews were examined to provide a

richer, more clinical description of these participants. Because the present study is an exploratory one, no specific hypotheses were generated; the aim was to allow the data to reveal themselves and to identify and describe emergent group differences.

Chapter Four: Results

This chapter is divided into three parts. In Part I, I present Moulton's (1991) descriptive data, reliability, and correlational results for the PMP Questionnaire. Since this instrument has only been used once before, part of the aim of the present exploratory study is to determine whether these four categories held up in a different sample and whether true differences in the subgroups exist based upon distributions of scores. In Part II, descriptive data will be reported for all PMP scores in the present study. In addition, the PMP Questionnaire will be further analyzed utilizing a *k*-means cluster analysis. Finally, Part III presents the results of the qualitative data analysis from the semi-structured interview.

Here I would like to remind the reader that this is an exploratory study based on three questions that were posed at the end of Chapter 2. These are research questions, rather than specific hypotheses to be proven or disproven. The qualitative results reported in Part III of the present chapter will therefore be presented in accordance with the organization of the PMP Questionnaire (i.e., the four categories: Boundaries, Distractibility, Affect, and AEF, followed by a new, emergent category, Self-Esteem). This approach allows for the most rigorous analysis of the content of the qualitative interviews, and furthermore provides continuity and enables comparison of the two times this measure was used (e.g., the present study and Moulton, 1991). In the Discussion chapter, the data will be tied back to the research questions.

Part I | Moulton's (1991) Findings

Participants and procedure. Moulton's (1991) sample consisted of 66 healthy, primiparous mothers of healthy infants aged four months or younger. Participants were in their mid-30's (range = 20 to 42 years), well educated (95% had a BA or higher degrees), and financially stable (mean income = \$75,800). Participants received a research packet by mail,

which included a demographic questionnaire and three instruments: PMP Questionnaire, Experience Inquiry (IE)/Adaptive Regression in the Service of the Ego (ARISE), and Maternal Self-Report Inventory (see Moulton, 1991, for psychometric properties of these additional instruments).

Reliability and validity of the PMP Questionnaire. In Moulton's (1991) study, the PMP Questionnaire was found to have acceptable reliability (Kuder-Richardson reliability coefficient of $r(tt) = .89$). Its reliability was reported to be further substantiated by its relatively normal pattern of distribution, as well as the high correlations found between subscale and overall scores (presented below). Construct validity was supported by the significant relationships found between PMP Questionnaire subscale scores and those of a conceptually significant measure, Adaptive Regression in the Service of the Ego (ARISE) (see Moulton, 1991, for a detailed account of the correlational patterns between PMP and ARISE subscale scores).

PMP Questionnaire descriptive data. Scores on Moulton's PMP Questionnaire were within an approximate normal distribution pattern. As shown in Table 2, the overall mean score was 31.54 ($SD = 6.39$, range = 15 to 44 out of a possible 58). Also presented are the descriptives for the four subscales (Boundaries, Distractibility, Affect, and Autonomous Ego Functioning [AEF]). The Boundaries and AEF subscale scores demonstrated an approximately normal distribution pattern, whereas the Distractibility and Affect subscale patterns were weighted toward higher scores, which Moulton attributed to the fact that these subscales have fewer items compared to the other scales and are therefore skewed in their distribution patterns.

PMP Questionnaire correlational data. Table 3 shows the correlations among overall PMP scores and subscale scores. The only significant relationship between two subscales was between Distractibility and AEF ($r = .57, p < .001$).

Table 2

Descriptive Statistics for PMP Questionnaire (Moulton, 1991; N = 66)

| | <i>M</i> | <i>SD</i> | Range |
|----------------------------|----------|-----------|---------|
| Overall PMP | 31.54 | 6.39 | 15 - 44 |
| Boundaries | 15.94 | 3.80 | 6 - 24 |
| Distractibility | 4.23 | 1.47 | 1 - 6 |
| Affect | 3.92 | 1.55 | 1 - 6 |
| Autonomous Ego Functioning | 7.74 | 3.24 | 1 - 16 |

Table 3

PMP Overall and Subscale Correlations (Moulton, 1991; N = 66)

| | Overall PMP | Boundaries | Distractibility | Affect | AEF |
|-----------------|-------------|------------|-----------------|--------|-----|
| Overall PMP | - | | | | |
| Boundaries | .72** | - | | | |
| Distractibility | .70** | .28 | - | | |
| Affect | .48** | .15 | .24 | - | |
| AEF | .69** | .26 | .57** | .24 | - |

* $p < .01$. ** $p < .001$. AEF = Autonomous Ego Functioning.

PART II | The Present Study: Quantitative Results

PMP Questionnaire descriptive data. Scores on the PMP Questionnaire approximated a normal distribution pattern (see Figure 1).

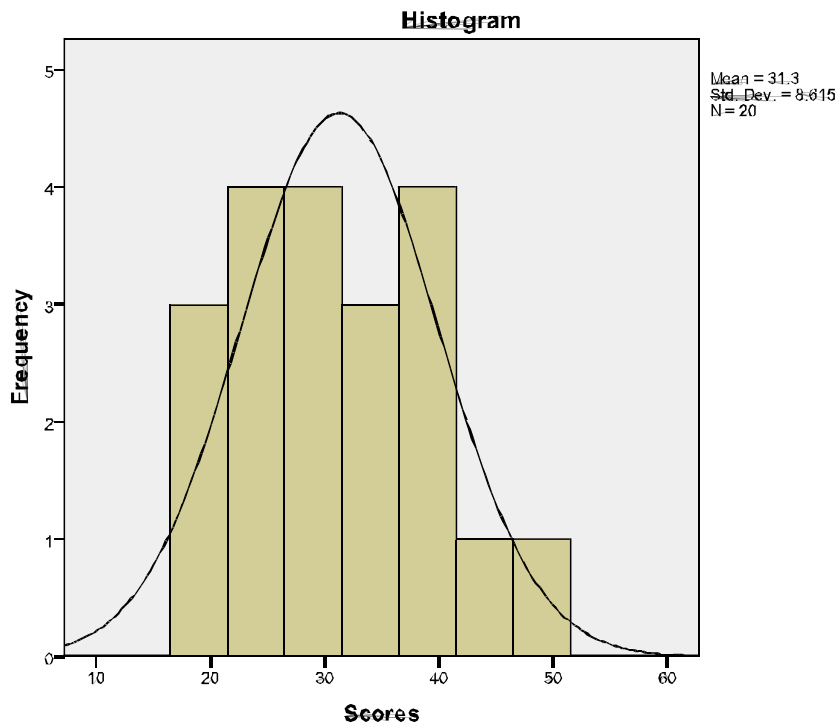


Figure 1. PMP overall scores.

Distribution patterns for subscale scores are shown in Figures 2 through 5. The Distractibility and Boundaries subscales show normal distributions. The Affect subscale is negatively skewed, and the AEF subscale is positively skewed. This pattern differs somewhat from that of Moulton (1991), who found that the Boundaries and AEF subscales had normal distributions, and that the Distractibility and Affect subscales were positively skewed.

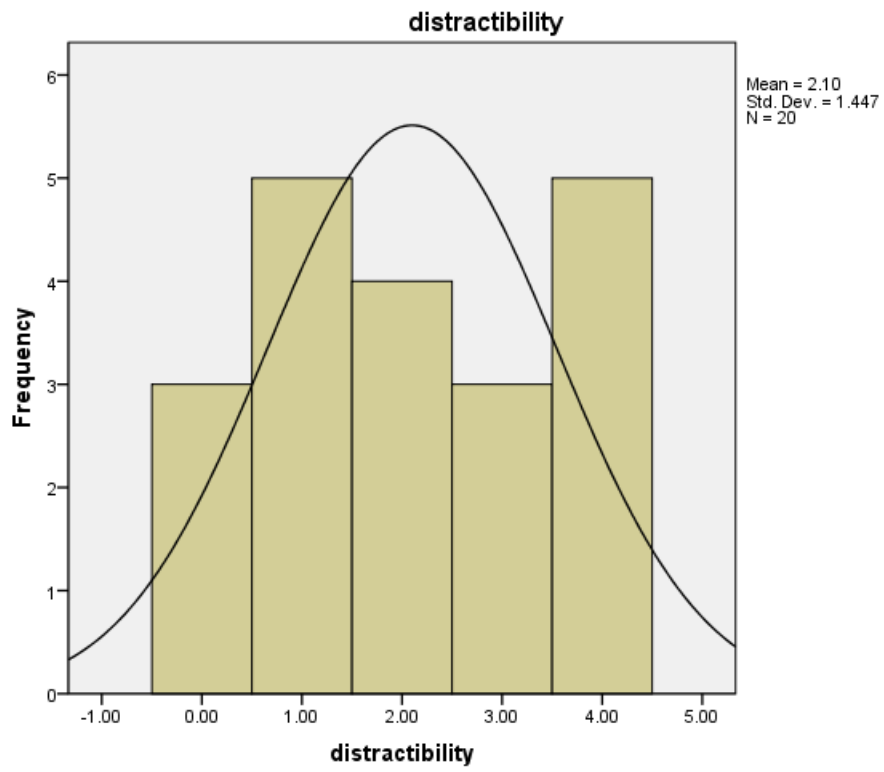


Figure 2. PMP Distractibility subscale scores.

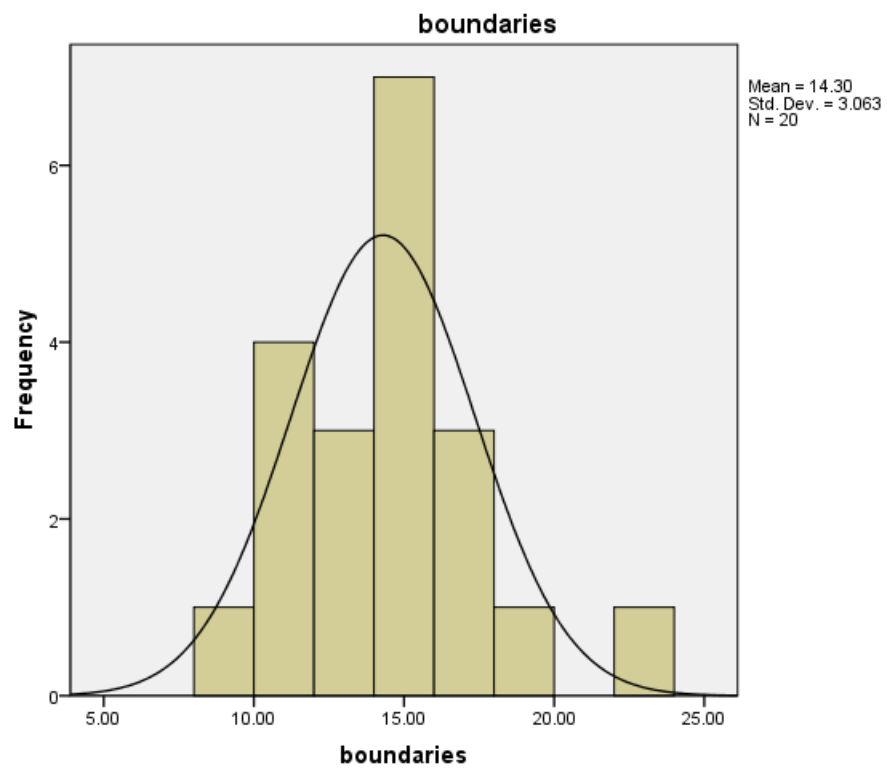


Figure 3. PMP Boundaries subscale scores.

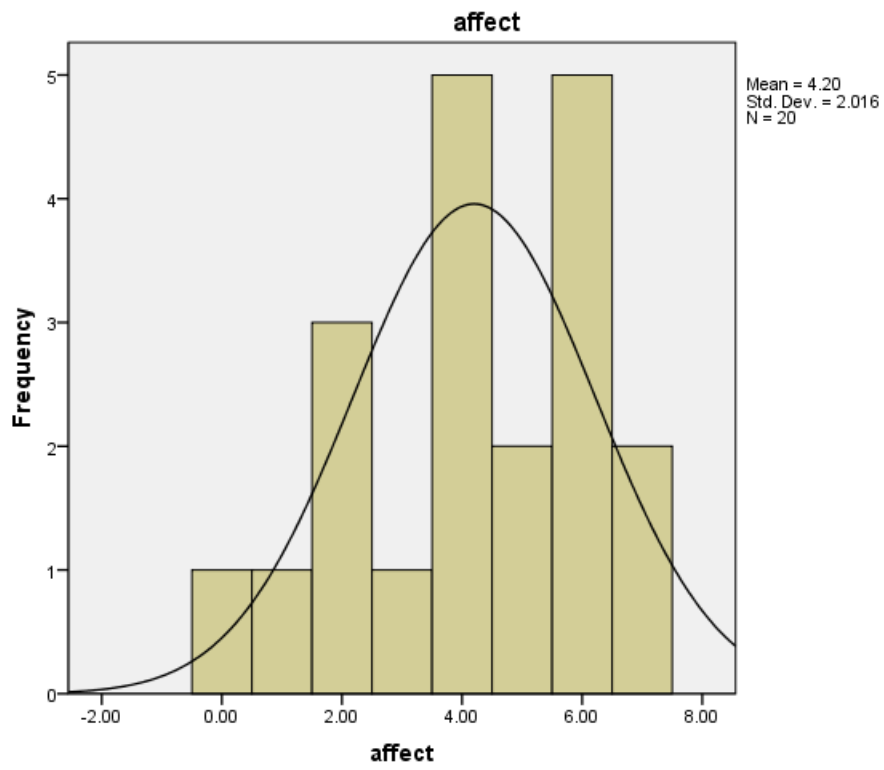


Figure 4. PMP Affect subscale scores.

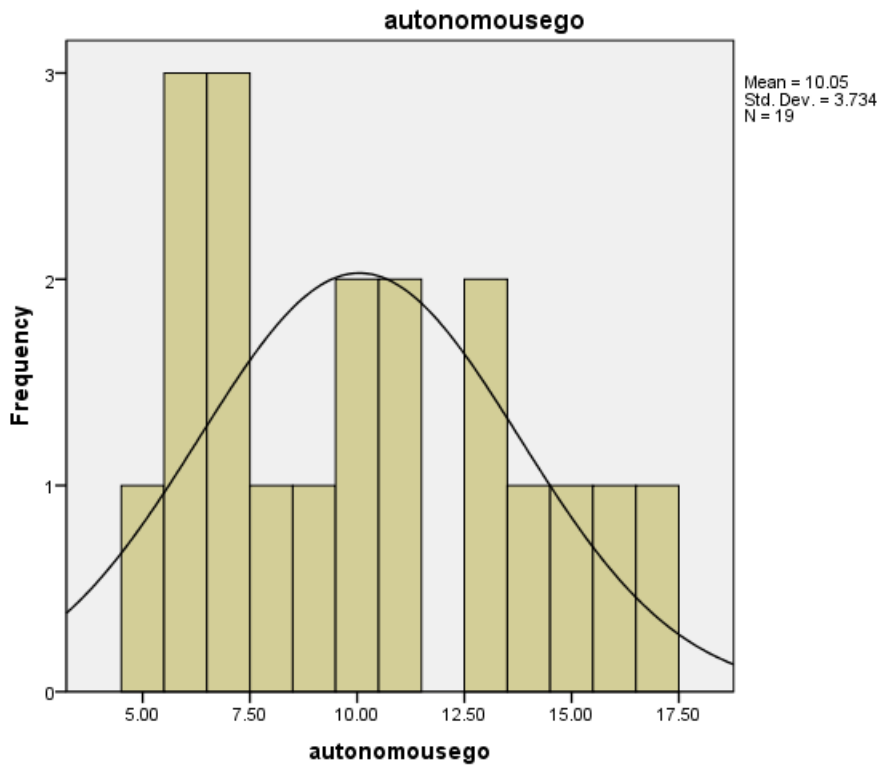


Figure 5. PMP Autonomous Ego Functioning subscale scores.

Table 4 summarizes the mean scores, standard deviations, and ranges for the PMP overall and four subscales.

Table 4

Descriptive Statistics for PMP Questionnaire (present study; N = 20)

| | <i>M</i> | <i>SD</i> | Range |
|-----------------|----------|-----------|---------|
| Overall PMP | 31.30 | 8.62 | 19 - 50 |
| Boundaries | 14.30 | 3.06 | 9 - 22 |
| Distractibility | 2.10 | 1.45 | 0 - 4 |

| | | | |
|----------------------------|-------|------|--------|
| Affect | 4.20 | 2.02 | 0 - 7 |
| Autonomous Ego Functioning | 10.15 | 3.66 | 5 - 17 |

PMP Questionnaire correlational data. As shown in Table 5, correlations were calculated between subscale scores and between overall and subscale scores. The strongest relationship between two subscales was that between the Distractibility and AEF subscales, $r = .70, p < .01$. The relationship between Boundaries and AEF was also significant, $r = .48, p < .05$.

Table 5

PMP Overall and Subscale Correlations (present study; N = 20)

| | Overall PMP | Boundaries | Distractibility | Affect | AEF |
|-----------------|-------------|------------|-----------------|--------|-----|
| Overall PMP | - | | | | |
| Boundaries | .71*** | - | | | |
| Distractibility | .73*** | .30 | - | | |
| Affect | .69** | .43 | .41 | - | |
| AEF | .87*** | .48* | .70** | .39 | - |

* $p < .05$. ** $p < .01$. *** $p < .001$. AEF = Autonomous Ego Functioning.

Comparison between Moulton's (1991) and present study PMP Questionnaire

results. A comparison of descriptive data for the PMP Questionnaire in Moulton's (1991; $N = 66$) study and the present study ($N = 20$) is presented in Table 6. The mean overall scores for both studies, $M = 31.54$ (Moulton), $M = 31.30$ (present study), did not differ significantly, $t(84) = 0.11, p = .91$, Cohen's $d = .03$, supporting the validity of the instrument. Also, the two samples

did not differ significantly on Boundaries: $M = 15.9$ (Moulton), $M = 14.3$ (present study), $t(84)=1.72, p = .09, d = .46$. Finally, the two samples did not differ significantly on Affect, $t(84) = 0.69, p = .49, d = .17$. However, significant differences did exist between two subscale mean scores. Moulton's sample had significantly higher mean Distractibility scores ($M = 4.2, SD = 1.50$) than did the present study sample ($M = 2.1, SD = 1.50$), $t(84) = 5.49, p = .001, d = 1.4$, as well as lower mean AEF scores ($M = 7.72, SD = 3.2$) than did the present sample ($M = 10.2, SD = 3.7$), $t(84) = 2.95, p < .01, d = .17$.

Table 6

Comparison of Descriptive Data for PMP Questionnaire in Moulton's (1991) Study and the Present Study

| | Moulton (1991; $N = 66$) | | Present study ($N = 20$) | | $t(84)$ | p | d |
|-----------------|---------------------------|------|----------------------------|------|---------|------|-----|
| | M | SD | M | SD | | | |
| Overall PMP | 31.54 | 6.39 | 31.30 | 8.62 | .011 | .91 | .03 |
| Boundaries | 15.94 | 3.80 | 14.30 | 3.06 | 1.72 | .09 | .46 |
| Distractibility | 4.23 | 1.47 | 2.10 | 1.45 | 5.49 | .001 | 1.4 |
| Affect | 3.92 | 1.55 | 4.20 | 2.02 | 0.69 | .49 | .17 |
| AEF | 7.74 | 3.24 | 10.15 | 3.66 | 2.95 | <.01 | .17 |

Note. Cohen's d statistic may be interpreted as follows: $d = .20$ ("small" effect size), $d = .50$ ("moderate" effect size) and $d = .80$ ("large" effect size). AEF = Autonomous Ego Functioning.

The comparison of PMP overall and subscale correlations for Moulton (1991; $N = 66$) and the present study ($N = 20$) is presented in Table 7. As noted earlier, each of Moulton's subscales correlated strongly with overall PMP (r values ranging from .48 to .72), as did each of

the subscales in the present study (r values ranging from .69 to .87). In both studies, Distractibility and AEF were also strongly correlated ($r = .57$ in Moulton; $r = .70$ in the present study). In the present study, a significant relationship was also found between AEF and Boundaries, $r = .48$, $p < .05$, whereas this relationship was not found in Moulton's study.

Table 7

Comparison of PMP Overall and Subscale Correlations for Moulton (1991; N = 66) and the Present Study (N = 20)

| | Overall PMP | | Boundaries | | Distractibility | | Affect | | AEF |
|-----------------|-------------|--------|------------|------|-----------------|-------|--------|------|-----|
| | Moult. | p.s. | Moult. | p.s. | Moult. | p.s. | Moult. | p.s. | |
| Overall PMP | - | - | | | | | | | |
| Boundaries | .72*** | .71*** | - | - | | | | | |
| Distractibility | .70*** | .73*** | .28 | .30 | - | - | | | |
| Affect | .48*** | .69*** | .15 | .43 | .24 | .41 | - | - | |
| AEF | .69*** | .87*** | .26 | .48* | .57*** | .70** | .24 | .39 | - |

* $p < .05$. ** $p < .01$. *** $p < .001$.

Note. Moult. = Moulton; p.s. = present study. Fisher's Z-tests comparing the two sets of correlations, all $p > .05$ (n.s.).

Cluster analysis. The PMP Questionnaire was further analyzed utilizing a k -means cluster analysis. Cluster analysis refers to an array of techniques for merging cases into groups. Classification is based on grouping objects into homogenous groups, such that cases within a cluster exhibit similar profiles, yet at the same time are as different as possible from cases in another cluster. In other words, cluster analysis seeks to identify a set of groups that both minimize within-group variation and maximize between-group variation, such that the

relationship between clusters is revealed. The advantage of this methodology is that groupings are not influenced by preconceived notions with regard to defining characteristics (Bonafina, Newcorn, McKay, Koda, & Halperin, 2000).

The cluster organization for this study was conducted using SPSS Quick Cluster, which utilizes a *k*-means clustering technique. *k*-means clustering is a method that utilizes divisive clustering, as opposed to conglomerative clustering. In *k*-means clusters, all participants start out as one cluster and then disaggregate, whereas in other clustering techniques, each participant starts out as his or her own cluster and then aggregates. Because data used in a cluster analysis are usually on the same standardized scale, the data in the present study were standardized into *z*-scores ($M = 0$, $SD = 1$).

With cluster analytic techniques, it is often difficult to ascertain the appropriate number of clusters to select; it is important that an emergent cluster display unique profiles that appear to be clinically relevant and also contain a sufficient number of participants so that validating analysis can be executed (Bonafina et al., 2000). In the present study, a 2-cluster solution was found to be of greatest clinical relevance and heuristic value. The 2-cluster solution generated two distinct groups, one with high scores and the other with low.

As shown in Figure 6, Cluster 1 contained nine participants who had relatively high scores on Distractibility ($M = 3.33$, $SD = 0.87$), Affect ($M = 5.00$, $SD = 1.66$), Boundaries ($M = 15.89$, $SD = 3.30$), and AEF ($M = 13.56$, $SD = 2.13$). Thus, the first cluster is comprised of those participants who scored high across all four subscales. Cluster 2 was the larger cluster, consisting of 11 participants who scored low on all scales: Distractibility ($M = 1.09$, $SD = 0.94$), Affect ($M = 3.55$, $SD = 2.11$), Boundaries ($M = 13.00$, $SD = 2.24$), and AEF ($M = 7.36$, $SD = 1.69$). The mean

overall PMP score for Cluster 1 was 39.00 ($SD = 6.16$), and the mean overall PMP score for Cluster 2 was 25.00 ($SD = 3.69$).

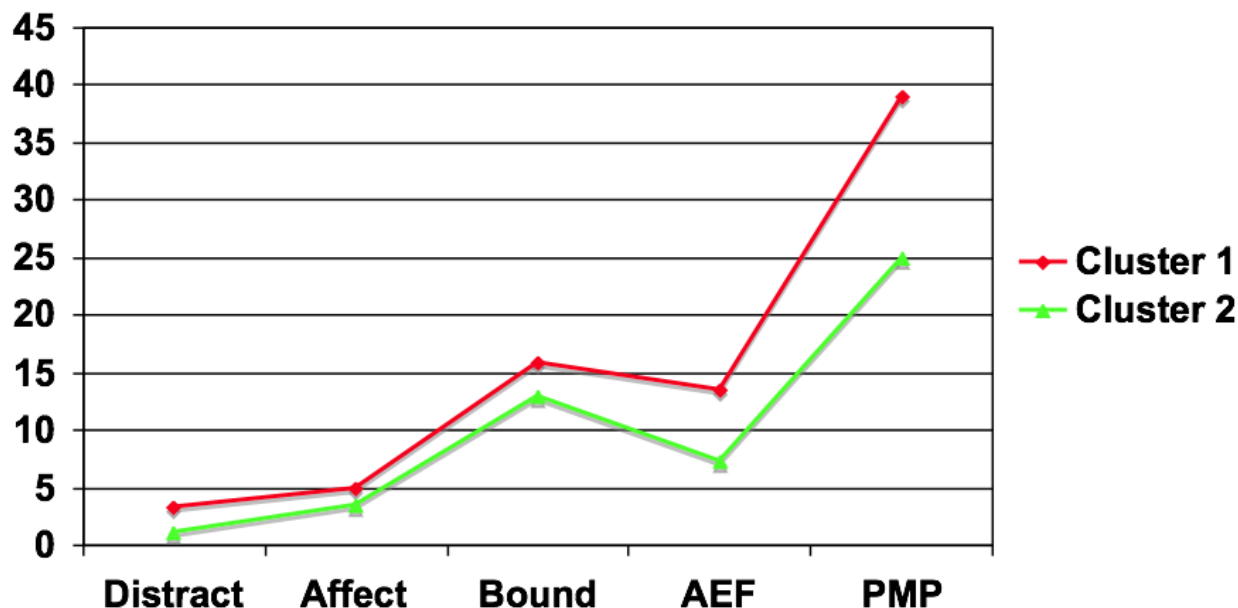


Figure 6. Mean-score profiles for high- and low-scoring clusters.

Part III | The Present Study: Qualitative Results

As noted earlier, this section will be organized according to the PMP Questionnaire categories (Boundaries, Distractibility, Affect, and AEF, followed by the new emergent category, Self-Esteem). The Discussion chapter will contain a complete analysis of the ways in which the data address the research questions.

The goal of the semi-structured interview analysis was to elucidate and expand upon differences between those scoring high and low on the PMP Questionnaire, both overall and in the various categories. Thus, this analysis will provide a more clinical description of PMP, subjects' areas of strength, and subjects' areas of vulnerability with respect to the intersection of

different levels of PMP and clinical work. This type of qualitative analysis will demonstrate whether themes that emerge in interviews with high-scoring PMP subjects differ from those that emerge in interviews with low-scoring PMP subjects. In order to further delineate the range and discrepancy of participants' experiences, subjects will also be grouped into categories according to extreme differences (i.e., comparing the five highest-scoring subjects with the five lowest-scoring subjects). The interviewer was guided by Moulton's categories a) Boundaries, b) Distractibility, c) Affect, and d) Autonomous Ego Functioning.

Once the review of the data indicated the categories, the transcripts were re-grouped both by categories and by participant. The interviewer made notes of impressions and interpretations and used them when writing the results. The interviewer also frequently returned to the transcripts to examine aspects of the data that reflected process, rather than content that had been previously codified. In other words, the following analysis took into consideration the weight and charge of what was presented by subjects, including divergent data and the relationships between one part of the data and another. Attention was thus paid not only to the content of an account, but also to how it was told.

Distractibility.

Pregnancy and maternity leave. When asked to describe their experiences working during the last trimester, all but one of the therapists in the high-PMP group reported feeling tired and distracted by the physical sensation of pregnancy, and having difficulty maintaining their focus. A striking difference emerged between the high and low groups. Although three therapists in the low PMP group reported similar responses to those in the high group (e.g., feeling preoccupied by the "baby kicking"), over half (six) of the therapists in the low group reported an increase in motivation with patients due to the impending maternity leave. For

instance, one therapist stated, “there was definitely a greater sense of motivation to get people to a certain point of stability, you know, even if not where they ultimately want to be but to reach homeostasis than there would have been otherwise.” Four therapists in the low group reported grappling with taking maternity leave because they felt as though they were “abandoning” their patients. Two therapists felt that work was a great distraction in a positive sense from their pregnancy, feeling that clinical work took their mind off the “anxiety” and “anticipation” of giving birth and thus were “glad to have something to do.” One therapist remarked, “I knew of people who had taken time off in their last trimester and I like, I honestly didn’t know what I would do with that.”

Resumption of work. A commonality between the high- and low-PMP groups was feeling distracted with patients after giving birth. However, there was again a notable difference between the two groups. In the high group, the majority (all but one subject) described an increased degree of distractibility and focused on how hard it was to not think of their babies during clinical work. In the low group, although a few therapists (three) reported distractibility with similar themes as the high group, the majority of therapists were able to compartmentalize thoughts of their babies.

In the high group, one woman described feeling like she “needed to crawl home.” Another moved her practice to her home after giving birth and talked about the distraction of hearing her baby cry during sessions. Still another described the physical sensations of breastfeeding as an added distraction and remarked, “I almost felt more focused on myself than on my patient.” Some therapists in the high group also felt guilty for feeling distracted from their patients: “I do feel distracted; I have to sit with this person and be with this person, this person deserves for me to be there with them.”

Notably, one therapist in the high group reported that she did not feel distracted. She attributed her ability to focus to her limited schedule, explaining, “I don’t feel as distracted as I thought I would with her, but it’s only one day. I can’t imagine what full-time will be like, which I’ll probably do in January, around there. I think that it will be very difficult. But so far, the one day’s great.”

Five therapists in the high group felt an increased degree of distractibility particularly with low functioning, dependent, and child patients. As a result, they would refer them out more readily. For instance, one therapist stated, “I’m more adamant [about] not taking patients that will overwhelm me. I was more permissive in the past. Now I think ‘I can’t handle you, you need more support.’ I refer more people out!” This therapist further explained her feelings about a patient she had been treating for five years who did not return after her maternity leave: “My patient that left, it registers, it’s emotional but I sort of can’t be bothered. I know that it must sound awful, this is a profession that I need to take seriously so these people should not be impacted that my head and heart is someplace else.” Indeed, the feeling of the “heart” being someplace else was a salient one in the high group, whereas in the low group the majority of therapists reported that their degree of distractibility was contingent upon on how engaging or related a patient was.

Ability to compartmentalize. The majority of therapists (nine) in the low group were able to compartmentalize thoughts of their baby, and work provided a kind of distraction-free “zone.” As one therapist remarked, “there wasn’t room to have sort of distracting thoughts about anything. I really had to be so active and work too hard with them.” These participants felt that once they were in the room, they could engage and be focused. Notably, one therapist in the low PMP group also described moments when she would think of her infant, then was able to “re-

focus” and be present with her patients: “There’s definitely moments when patients will bring things up or mention things that kind of remind me of her... Those moments are there, but I’m able to focus back to wherever they’re at... But I think when I’m in session I’m very much present.”

Furthermore, three therapists in the low group described feeling even more focused since giving birth. One reported a powerful experience she had during her first session back from maternity leave:

The first time was very hard but even the first day I found that when I was with the patient I had forgotten about the rest of my life. I forgot I had a child. I forgot I was married. I was just there thinking about what was going on and then in the middle of focusing on the patient I was “oh my god, I suddenly forgot. For the first time since she was born I forgot about her.” I forgot everything, which was really sort of wild; now that doesn’t happen most of the time.

Interestingly, one of the therapists in the low group reported that she did not feel distracted, but when asked if she had intrusive thoughts she related a powerful vignette: “I remember being struck by my thoughts. She was several weeks old when I had this thought that she was in a sling. I was crossing at a light. A truck was pulling up and did not stop. I remember having this thought of throwing myself in front of the truck to save her.” Thus, even though therapists in both groups were preoccupied with their infants, a significant difference for the majority of the therapists in the low group was that they were able to effectively compartmentalize thoughts of their infants.

Breastfeeding. Another interesting difference between the high and low groups was the issue of breastfeeding. Although 19 of the 20 therapists were breastfeeding, all women in the

high group (as compared to two therapists in the low group) talked about breastfeeding as a distracting variable in their clinical work. There was also a difference in how they processed the distraction. Therapists in the high group focused on the negative impact on their clinical work, on feeling preoccupied with bodily sensations, and on the restrictions on scheduling imposed by breastfeeding. In the low group, therapists felt that as a result of “juggling a lot” they became more ‘boundaried’ with logistical issues so that breastfeeding did not impact their clinical work.

Five highest-five lowest comparison: Distractibility. As seen in the overall findings, in the high group (here, the five highest-scoring participants on the PMP Questionnaire), all five reported increased distractibility and thoughts of their infants during work, whereas in the low group (likewise, the five lowest-scoring participants on the PMP Questionnaire), one therapist reported feeling “hyper-focused,” and four reported when they were with their patients they could compartmentalize thoughts about their infant. With respect to breastfeeding, although all but one of the therapists in the study were breastfeeding, all therapists in the extreme high subgroup talked about breastfeeding as a distracting variable in their clinical work, compared to one therapist in the extreme low subgroup. A final interesting finding in the five highest-five lowest comparison was the difference in logistical changes in terms of clinical hours upon returning to work. In the high group, one therapist had one patient, one therapist worked one day a week, and the other three worked two to three days a week. In the low group, four of the therapists had full-time jobs in hospitals or clinics.

Autonomous Ego Functioning.

Resumption of work. In the Autonomous Ego Functioning (AEF) category a powerful difference emerged between groups. All therapists in the high category reported a decrease in AEF and difficulty recalling clinical material after giving birth. Conversely, in the low group,

about half of the therapists (six) reported a decrease in AEF; however, most (four) of these therapists also reported feeling more efficient. A poignant illustration was provided by a therapist in the low group: “I think now I’m better at picking out the parts that I would want to be able to remember and I don’t need to hang onto the other pieces.”

In the high group, the majority of therapists found the postpartum period to be more of a challenge around issues pertaining to clinical work. Almost all felt that memory loss had been one of the most “challenging” issues to deal with. “I find myself merging stories of patients in my brain and coming close to screwing up and afraid of hurting them in session,” said one therapist. Said another, “I don’t remember to call back patients. I have to write down everything. I can’t remember what I deposited in my account.” A third reported, “I will think that something is important, but by the time I need to share an insight or reflection it is gone. It’s there one minute and gone the next.” As a result, these therapists felt worried about the negative impact a compromised memory may have on their patients.

Interestingly, one therapist reported that she was more efficient only with patients who evoked neediness like her infant, giving a powerful example:

I did an intake yesterday with a 16-year-old with panic, kid who smokes weed every day. I’m trying to remember why was it so easy to do that intake. I didn’t have to look at the form, but at the end of the session it was very easy for me to put it down on paper. Everything, I remembered everything, it was very organized in my head. I felt very attuned to the material he was bringing, because I think one of the things he said, ‘I want to talk to someone. But I don’t know if I’m making any sense.’ I don’t know if it was that, I don’t know if it was his neediness, it’s almost like my baby who needs me, you know, and expressing that made it much easier for me to be attuned to that. Rather than

you know when the adolescent is very closed off, you have no idea how to help him when they're oppositional, the ones, because they lie a lot, as you would imagine.

The majority of the therapists in the high group (six) but only two therapists in the low group felt as though they lost their clinical intuition. They felt their "cognition was slower," that they were "less sharp," and that they had "difficulty maintaining focus." A couple of therapists in the high group also reported difficulty with verbal fluency, describing their experience as having "baby brain." One therapist stated, "there are certain things I want to articulate, that I have difficulty talking and finding words." Furthermore, these therapists also felt less intellectually curious and were not reading scholarly material relevant to their clinical work. As a result, two therapists felt the "need to compensate." As one related,

This one intake I did and I had forgotten to read up on him before he came in. Typically, what you get from the referral, from the intake coordinator, is a very brief thing, and I thought I could fudge it... I didn't look myself, and then I went in to look and I couldn't find the email...and then the patient was like, so did you hear about my story? And I was like, no, I didn't, and I had to read the email there. And then this crazy personality disordered patient ended up writing to the director, 'My therapist had to read my information on the computer while I was sitting there, she wasn't prepared.' And at that point, like to compensate for that I ended up like speaking to him on the phone over the weekend; I was doing these things to compensate, where I might make myself more available maybe because I felt like I wasn't on top of things... I felt like I was busted, you got it. It was my first day back. I was not prepared, you know?

Five highest-five lowest comparison: AEF. In the extreme high subgroup, four therapists reported difficulty with memory, three reported feeling not as sharp, two reported difficulty with

verbal fluency, and one reported difficulty with grace of movement. Notably, three therapists lost their train of thought during the interview and asked the interviewer to repeat the questions a couple of times. In the low group, two therapists lost their train of thought during their interview, two reported difficulty with memory, and one reported difficulty with grace of movement.

Boundaries. The majority of therapists in both groups reported feeling conflicted around leaving their infants to return to work. For both groups, work became less narcissistically invested and secondary to being a mother. However, for the high group, their attitude toward work made a shift that corresponded to a decrease in number of patients, clinical hours, and less time spent thinking about their patients outside of session. For the low group, most of the therapists resumed full-time positions (or maintained the same number of hours as before), but also spent less time thinking about their patients outside of session. In other words, although both groups spent less time thinking about patients outside of session, each dealt with this shift in attitude in a different way (e.g., by adjusting or not adjusting their clinical hours).

Several more nuanced differences existed within this category. In the high group, therapists seemed to be more at peace with the aforementioned shift and reported less conflict. There was a sense of ease about their professional decisions in their narratives. One therapist stated how she felt about her decision to give up all but one patient: “I had no psychic space for anybody else but my baby, really for anyone else but my baby.” Another therapist described returning to work to a significantly reduced schedule, stating, “I go back one day so far, because I’m just not ready to go back. I have issues with it; I really don’t know how I am going to do it. I have less of a desire to help as I did before, because they have somebody to help them.” Another therapist remarked upon feeling content to be in her “own bubble.” Only one therapist in the high group ended up working full time and took on more responsibility than she had originally

planned. However, she still seemed to be at ease with her decisions. She felt an increased confidence to “walk away” if work interfered with her “role as a mother.” She summed up this issue, stating:

I think it’s still a process of accepting this job. It was really difficult for me. They were like, okay your old job doesn’t exist, but we want to promote you and make you Director. I have to say, I was the only one who wasn’t like, yeah! I was like, look, I’ll try it, and if I feel like it’s going to interfere, or it interferes with my role as a mother, or my family, then I have to resign. That was basically the conversation that I had. And I want to feel that at all times. I don’t want to feel obligated, because they gave me this position, they promoted me. I believe that the minute that it feels too much, that I’m not happy or not functioning as a good clinician, then I feel like I’ll be able to just leave the job. Now I have a child that I have to care for, I’m not just talking about financial things, I’m talking about emotionally being able to provide her with what she needs. It’s freeing, I have to say, and it freed me.

In the low group, a sense of conflict and guilt was palpable in their narratives. Therapists expressed feeling guilty and having difficulty tolerating the separation from their infants. One therapist stated, “I felt very possessive, my maternal instinct is so powerful. I cannot tolerate the idea of not being with her all the time. I always feel so guilty that I couldn’t tolerate being separate from her.” Another remarked, “I should be with her; I shouldn’t be away from her. I am her mother and she’s a little baby, I should be with her.” For a third therapist, her guilt over not being available to her infant was related to the fact that she had “set the bar very high” for herself in her professional life.

Increased understanding of patients. A theme that emerged for therapists in both groups was how having children prompted a more nuanced understanding of their patients. Therapists often described a newfound understanding and appreciation for their patients that were parents. These changes in attitudes were clearly tied to the experience of motherhood. One therapist stated, “I get it. I feel like any judgments that I ever had of parents I just don’t get those anymore because it’s hard, it is hard work being a parent.” Another therapist felt an “increased appreciation” for low functioning patients that are parents. She stated, “Some of my patients that just seem really low functioning and yet they raise pretty functioning children, like that’s impressive, and I don’t take that for granted anymore.”

However, there were differences between the high- and low-PMP groups. Therapists in the low group spoke with greater spontaneity and with more surprise at their increased sensitivity toward patients. The majority of therapists in the low group (eight) compared to only a couple of therapists in the high group expressed a greater degree of empathy, connectedness, respect towards parents, and tolerance for ambiguity. They felt that once they experienced the “powerful maternal bond,” they felt empathy rather than sympathy. One therapist remarked, “I was always an empathic, caring person but like there was such a depth to the relationship.” Another therapist in the low group felt a newfound appreciation for low functioning patients, as she found that they tended to address the transference explicitly: “I appreciated them more because then it’s just out there and you don’t have to be like looking for it implicitly.” Notably, one therapist in the high group also reported feeling increased understanding with psychotic patients. She gave a moving clinical example:

One of the patients was talking about how he still sees his mother, she’s been dead 32 years but he still sees her, and it’s just that understanding of, it’s definitely his most

important relationship, he can't let it go, you know, she wasn't good to him, but he still holds onto her. She is the only one he had. He put her down as his emergency contact even though she is not alive.

Merging of boundaries. Increased understanding among participants of the dynamic of parenting was balanced by the new potential for over-identifications and distortions. Therapists in both groups described having fantasies of their own infant during sessions that related to the content and dynamics of the session. For instance, one therapist in the high group described a scenario of a patient feeling terrorized as a result of her stalker being released from prison. The therapist felt overcome with fear and thought about her infant's safety. For another therapist in the high group who had a child after a long struggle with infertility issues, her increased difficulty treating patients led to her experiencing similar obstacles. Since becoming a mother the therapist felt as though she "was betraying them, leaving the club," and as a result was more tolerant of their "neurotic and obsessive thoughts."

Both groups had an increased tolerance for parents in general, but they also struggled with their patients whom they felt were abusive or neglectful parents. In these cases, there was increased rage towards these parents for not fulfilling their responsibilities. One therapist stated, "I get really angry, I want to smack their mothers that they were never there. That's something that I need to be aware of. I am thinking about my pregnant patient. I want to sometimes shoot the mother [laughs] when she refers to her daughter as a slut, it's like, god she is only four." Another therapist explained, "Certainly in terms of abusive parents, that is when I have to check myself when they are describing their abusive behavior towards their child. I have to separate that from wanting to protect my child and not wanting my children to ever be exposed to people

like that.” Notably, the majority of therapists in both groups who spoke to the issue of merging with their patients also referenced an “awareness” of these dynamics.

‘Moving faster’. Both groups felt that “time was of the essence.” Upon returning to work they became more active in session and increased interpretation. They also felt a newfound confidence as a result of their new status as mothers. One therapist responded with a description of working with depressed primary caregivers:

I’m much more motivated now to get going and make sure they’re moving out of that phase. Once, I recognize the effects on the children much more and two, because ultimately I end up seeing the kids at some point so I’d rather not get to the point where I have to see the kids. I think I’m much more now likely to send them for a psych pharm evaluation right away, where previous to that I’d say you know what you’re depressed and the primary caregiver let’s give it a little while and see how therapy’s working and because I know it could work but now I’m much more inclined to say once you get on meds we’ll get you stabilized because meds will work much faster than therapy will, then we’ll get you into therapy which will take a year, year and a half, two years. But in the meantime I’m much more protective of the children so they don’t continue to suffer the effects of the depression while we continue working. So I’m much more likely to recommend to the patient ‘have you considered medication?’

Clarification of roles. As mentioned earlier, therapists in both groups talked about their shift in priorities. They felt that becoming mothers created firmer boundaries and clarified their roles with their patients. However, in the low group the majority of therapists felt that their sense of limitation (balancing the demands of work and motherhood) also served to engender increased focus when they were at work. One therapist explained, “When I am at work, I am at work.

When I am home, I am home.” One therapist described a powerful experience her first day back to work: “The first time was very, very hard. But even the first day I found that when I was with the patient I had forgotten about the rest of my life. I forgot I had a child, I forgot I was married.”

Identifying as an adult. Another theme that emerged for therapists in both groups was one of feeling identified as an “adult.” However, this was more salient with therapists in the high group. They described identifying mostly with their child and adolescent patients prior to giving birth. As one therapist stated, “It’s a shift for me, I am not the adolescent anymore, I now identify with parents. In sessions, I feel when adolescents talk about stuff, I feel the shift. ‘I am not your generation,’ and for me it’s a real shift. Now I am considered the other side.”

Clinic vs. private practice. Another theme that differentiated the two groups was the issue of working in a private practice versus a hospital or clinic. Both groups felt that extended maternity leave and part-time work was very difficult to negotiate in hospital or clinic settings, but they dealt with this dilemma in different ways. For the high group, most therapists gave up their hospital positions if they felt that it interfered with their time with their infant. However, two therapists did continue working in that environment. One therapist only went back once a week and set clear boundaries with her employer, a situation that came at a cost. In one instance, a therapist felt that she had to keep her employer “in the dark” about length of maternity leave and felt guilty about her lack of straightforwardness with patients and supervisors. In the low group, by contrast, most therapists returned to work in hospitals and clinics despite struggling with the environment. They felt that motherhood was minimized and that employers expected them to be back to normal within six weeks after giving birth. Additionally, they also felt that logistical issues were difficult to negotiate between the administration and patients. This caused an increased amount of distress to these therapists. Finally, during the pregnancy, both groups

reported that with their clinic patients they felt more referral service as they were seeing patients a few times and referring them out due to their impending maternity leave whereas with private patients they felt more attached to their patients and work through important issues that emerged due to their pregnancy and maternity leave.

Five highest-five lowest comparison: Boundaries. Several interesting differences emerged between the two extreme subgroups with respect to the Boundaries category. In the high group, one therapist felt that her pregnancy created “space to work in a relational way,” whereas in the low group, therapists either felt they were disclosing too much or that they did not provide a space to process the pregnancy. In the postpartum phase, therapists in the high group seemed to struggle to maintain firm boundaries with patients, while therapists in the low group seemed to be able to maintain firm boundaries. A striking example emerged during the interview as a therapist in the high group explained her dilemma. She described a situation in which a long-term patient was asking to meet her infant. The therapist felt “too chicken” to negotiate this request with her patient. The therapist even asked the interviewer for clinical advice, stating, “What should I do? What would you do?”

Regarding resumption of work, another difference emerged between the two subgroups. In the high group, a few therapists noted increased flexibility with patients as a result of feeling guilty about being a “mother first and therapist second.” For instance, one therapist who moved her practice to her home after giving birth stated that she became “very flexible” with her schedule because she felt bad about all the changes and time off. On the other hand, the low-group therapists spoke about the importance of having very clear “boundaries” between “home and work” and around logistical issues as their schedules became more rigid. Two therapists remarked that their “commute” was advantageous, since it further delineated their home and

work lives. Thus, therapists in the high group seemed to make more changes due to giving birth, such as moving their practice, reducing their clinical hours, etc. As a result they became looser with boundaries. Therapists in the low groups made fewer changes to their clinical practice after giving birth and were firmer with their boundaries.

Affect. An overarching theme was the degree to which the therapists in both groups experienced a greater depth of understanding and an “ability to resonate” with their patients’ experiences. One therapist felt that these changes were tied to the experience of motherhood: “I am more aware of stuff. I feel after having a child I should go back to every patient I saw and tell them that I had no idea what you were talking about. I think it shifted my experience as a parent.” Two other women described similar experiences:

There are such maternal moments in therapy where I just like look at a child and I feel so connected to them and I think that’s only a way a mom can because you have that bond like I said before there is something so experiential you can’t do that... I didn’t know about before I had a baby. I’m so raw emotionally. I can’t help it my defenses are sort of down so I feel like the real human connection that takes part that can at times be threatening.

I’ve noticed unlike before I had the baby, I feel much more empathy when someone is talking about a child or talking about an issue with their own child and so that that’s a new experience for me. When I think about past experiences, people talking about their children in session, and maybe feeling it was more sympathy and now it’s more empathy, some kind of concern that I’m tearing up or because I’m thinking about my own child or and not that that’s necessarily a bad thing but it’s a shift.

Although both groups felt increased emotionality and sensitivity towards their patients, unlike the therapists in the high group, the majority of therapists in the low group went through great pains to constrict their emotions. For instance, one therapist stated, “I feel more but may not be as emotionally available.” Another therapist described her experience, saying “I really think about them [her patients] but I’m not sort of holding onto them emotionally in a certain way, I’m intellectually holding onto them and thinking about them but not like, not in my gut.” Another stated, “I am not as willing to engage with patients as fully.” The following statement particularly captures this constriction: “I’m very emotional, it’s that I don’t display emotion. I would very, very rarely cry. During my pregnancy I would cry at commercials. Everything made me cry. And after my pregnancy I sort of went back to a little bit harder again, I noticed that. So emotionally I got kind of reserved and tough and a bit of a hard ass.”

Another striking finding in the low group was that therapists had increased anger and hostility. They described feeling “possessive” and “enraged” when patients became “intrusive.” One therapist reflected, “I remember in supervision, I don’t remember why but I was like, ‘what the fuck is wrong with all of them? Leave me alone, leave my baby alone.’ I definitely had those moments where I couldn’t deal with it.” Notably, this therapist pointed out that she made the decision to return to therapy to process these feelings:

I also made the decision to go back to therapy before I started my work and supervision. I started to leave earlier because I just wanted to have an opportunity to process and contain some of my feelings. I think what happened in the beginning that it was definitely stressful, particularly the first few weeks. But then I actually found it became a nice escape because then I could feel like a person.

Another therapist talked about feeling disgusted by patients' intrusive comments. She recalled, "One scenario that stands out was a patient who asked if I was going to breastfeed. I said, 'what does that mean to you if I choose to breastfeed?' She just very crudely sort of grabbed her breast and shoved it up and said, 'oh!' I think it's just right out there. It was so crude and distasteful but she is also someone with no children and lost her baby."

Conflict. During their pregnancies, both groups reported increased sensitivity, vulnerability, and change in emotional responsiveness towards their patients. However, two therapists in the high group reported that their increased emotional vulnerability rose to the level of actual fear, describing it as a visceral sense of anxiety to the point where they did not want to work with certain patients. The following vignette describes a therapist's salient memory that highlights both the therapist's sense of responsibility and guilt towards a patient with whom the therapist found she was unable to work.

I guess at the time it was too much for me, and especially after my young patient threatened to kill my baby, and you know, our Director, the psychiatrist was like, "she would never do that," of course not, but that's not the issue here, all the things that she stirred up in me...I remember I had a big fight with my analyst, when my patient who threatened to kill my baby, I'm like, "oh how dare she, I did all these things for her." [Sighs] The patient's aggression wasn't handled well, it was partly my fault..., this poor woman in a way, if she was allowed by me and others to express [hate], the aggression wouldn't have become this destructive. So yeah, it was much easier for me to see it afterwards, but when my analyst suggested that... I got furious. I remember getting furious, and then I got furious at my supervisor, what the fuck?

In the postpartum phase, as noted earlier, not only did therapists in both groups experience heightened sensitivity, work also became secondary and less narcissistically invested. However, therapists in the high group felt conflicted and guilty for “abandoning” their patients, whereas therapists in the low group felt conflicted about leaving their infants to resume work with patients. Below are typical responses of therapists in the high and low group.

High group:

“I think I felt guilty that on some level I knew I wasn’t going to be able to keep this up, on some level I knew I was going to want to leave. And I had already felt so guilty about leaving my patients the first time.”

“I definitely, I get guilty, all of a sudden, and I make excuses and I fumble my response, and there’s a lot of guilt, cause I don’t want to come back. So there’s guilt... And terminating, that’s the saddest part about it because they are suffering from it.”

Low group:

“I did feel like a bad mother for taking off after 6 weeks... I had assumed it would be tough and get easier, it’s sort of been the opposite... I don’t know if it’s getting progressively harder but it’s harder now than it was before.”

“I am still ambivalent about being back at work but I think my ambivalence then was getting in the way somewhat of really connecting me as much as I can and as much as I have, I mean it feels complicated and unclear to me in some ways.”

“I didn’t even finish the first three months, it pained me so much, then I felt a tremendous sense of guilt. I didn’t want to leave.”

Depression. Although most therapists experienced a feeling of positive mood and sense of achievement, five women reported negative mood, including varying degrees of anxiety,

panic, and depression. In the high group, one therapist reported having postpartum depression, one reported postpartum panic, and one reported not feeling a connection with her infant for the first two months and her mother asking her repeatedly whether she was depressed. In the low group, one therapist reported having post-traumatic stress from the birthing process, and another felt increased sadness due to death of her grandmother coinciding with her daughter's birth. These therapists processed their negative affect in varying ways. In the high group, one therapist felt that her negative affect and emotional crisis were largely impacted by feeling torn between her infant and patient: "I was becoming more and more depressed, and I thought you know, 'what's going on?' And what was going on was that I hated working. And it was taking things out of me I didn't have to give. So that was terrible." As a result, this therapist gave up all patients except one. Another therapist in the high group reported returning to work only one day a week, stating, "this extended amount of time is good for me, because I actually enjoy it now, where the first two or three months I did not." Another described symptoms of postpartum panic and feeling "detached" from her body.

I had a huge hard time emotionally the first month after giving birth. So at eight weeks it felt like, 'I am still alive.' Now I am more like, maybe, sensitive to depression. I think I had postpartum panic as opposed to postpartum depression. I was very panicked!

Whereas eight weeks I felt 'I am barely making it, am I okay? Will I get through this day?' Now looking back, I am like that was really hard. I am out of it, that feeling is distant.

In the low group, therapists dealt with their feelings by constricting their emotions. The following quote captures how they processed their emotions: "I just had to move on, I can't

change it. It's a very kind of DBT way of thinking, of sort of radically accepting things in your life that you can't change and not continuing to suffer from it. So, that's how I cope with it."

Five highest-five lowest comparison: Affect. The comparison of the five highest- and five lowest-scoring participants on the PMP Questionnaire yielded essentially the same results as those described above. Both groups experienced conflict about leaving their infant to return to work; the high group focused more on feeling conflicted about abandoning their patients, whereas the low group focused on feeling guilty for being away from their infants. Emotional intensity and sensitivity was also more salient for the two extreme groups. Three therapists in the high category reported an increase in emotional intensity and sensitivity; two also reported emotional lability, and one reported difficulty modulating emotions. In the low group, one therapist reported emotional lability and another "feeling removed" from patients.

Self-Esteem.

Maternal self-esteem. In the high group, two therapists expressed increased self-esteem as a result of becoming a mother. One therapist described her experience with a sense of pride: "I was never around babies before and I think beforehand, 'will I be able to hold him? Will I know what to do in terms of holding?' It really surprised me how quickly I took to that, meaning I immediately knew how to hold him. It surprised me how fast I took to it." However, two therapists in the high group also expressed a low sense of maternal self-esteem. One described feeling "not up to snuff" with other mothers; the other felt "hyper-aware" and described her mothering experience as anxiety-provoking. Notably, both of these mothers also expressed significant changes in mood after giving birth. One reported suffering from postpartum depression and the other from postpartum panic. The highest-scoring PMP therapist expressed feeling insecure with her mothering abilities, describing how she felt good when her husband

pointed out that she was securely attached to her baby. Furthermore, at the end of the interview she stated, “it was very reassuring to read the true and false questions because clearly [tone changes] I am not alone in my inability to concentrate and remember what I am doing from moment-to-moment.”

In the low group, one therapist spoke about the enjoyment of spending quality time with her infant and difficulty returning to work. She explained, “this time, I felt like ‘oh I really don’t want to go back to work’ and again it’s not that I don’t want to be here when I am here but it’s that I didn’t want to leave and I felt like I was having really nice quality time with my whole family and I don’t know it was more difficult to leave.”

Professional ambition. Two therapists in the high group and one therapist in the low group spoke about their thwarted sense of professional ambition. These therapists felt that they had to come to terms with the fact that they weren’t going to attain their goals in a time-frame once planned out, despite their talents and ambitions. For example, one therapist in the low group compared herself to former colleagues who had published recently: “I was like, ‘if that guy wrote a book I could write a book.’ But also realizing that it is not what I am doing right now. It’s been helpful to talk with my friends and mom about that.” In the high group, one therapist spoke of the shift of her sense of self and her perpetual conflict between her professional and personal goals:

I want to publish my dissertation. I have this big fear, that my dissertation chair is going to contact me, because she did, and I told her I was pregnant, and I don’t have any time, and she’s like, “yeah take a month off, and then you know get back working on it.” I haven’t done shit! And it’s important to me, so I don’t want to just, like, trash it and not do it, so I don’t know, I have all these things.

Another therapist stated humorously, “I mean this is something I think about a lot in terms of my own goals, all those articles I’m going to write after I’m done having a baby [laughs].”

Work as an oasis. Over half of therapists in both groups (five out of nine in the high group, seven of eleven therapists in the low group) felt that their clinical work was an “oasis” from their infant. Several referred to work as a break from an “overwhelming” experience and enjoyed doing something different with their brains. This type of feeling was articulated by one therapist, who stated,

It’s so hard to feel like a person when you’re an early mom. You just feel like a huge boob and like I felt like getting dressed, I’m putting on clothing which is just a way of normalizing myself so that actually I think ended up working out really well fairly early. When I’m at work I think it’s really healthy for me and I can kind of be in the zone and it actually energizes me.

Another therapist remarked, “Work used to be work, and lack of work was ‘me time.’ But work has now become me time!” A few therapists spoke about the feeling of changing out of their sweats and getting dressed. One stated, “my professional self is a very important part of myself, and when I wasn’t working I was really feeling that.” A few therapists were surprised by their positive feelings once they returned to work. Another described her initial experience:

I thought I wanted to take more time off so I thought I would resent it actually. But it’s been like a good kind of way of getting back in touch with my professional side and integrating and providing some kind of identity. There are so many changes, like, we just moved, she was born, so many changes, and clinical work was the stable and familiar thing...I would definitely say, when they [therapists] are feeling conflicted about going back to work, I would recommend that they try it as it may be more rewarding.

As mentioned earlier, most of these women in the low group also expressed conflict between their professional and work lives. Although they felt their professional self was important, they also expressed the difficulty of being away from their infants. The high group women seemed more at ease with their professional decisions.

Clinical confidence. One therapist in the high group and three therapists in the low group felt increasingly confident in their clinical work. In the high group, a therapist described feeling “on top of my game,” but attributed her sense of confidence to her clinical experience rather than to motherhood. In the low group, one therapist felt she gained “credibility” as a result of becoming a mother. Another felt as though taking a hiatus for maternity leave and returning to clinical work gave her “fresh eyes” on old issues. She explained, “I felt like I was able to get in there with her [a patient] in a way that I hadn’t been with her.” One therapist expressed low maternal self-esteem but mastery in her clinical work: “I’m good at it because I did not have a lot of confidence on how to take care of my child, so at least when I come here I’m like ‘we’ll I’ve been here for a year and a half, I know the people here.’ I felt some mastery that I certainly did not feel at home.”

Two therapists in the high group and one therapist in the low group spoke about decreased confidence with their clinical work. For the therapists in the high group, one attributed these feelings to her self-concept, feeling “shakier,” and another to the lack of supervision. In the low group, the therapist felt that she did not do a “good enough” job to help her patients process her pregnancy and maternity leave.

Five highest-five lowest comparison: Self-esteem. No further findings.

Additional findings.

Supervision. As noted in the Methods chapter, 13 of the 20 therapists in this study were in supervision, either through psychoanalytic training institutes, their work, or privately. The remaining seven therapists were not in formal supervision but were receiving informal supervision from colleagues. Three of these seven therapists were also supervisors themselves. These therapists were asked to describe the impact of supervision during their pregnancy, maternity leave, and after giving birth, and whether pregnancy and childbirth impacted the supervisory process. Their descriptions of supervision relationships were analyzed to see whether there were differences between the high and low groups, but none were found. A salient theme that emerged in both groups was that female supervisors with children were the most helpful, whereas the majority of therapists felt that male supervisors were not as helpful as female supervisors and wished they knew more about the impact of pregnancy and childbirth on clinical work (e.g., they did not “understand” their experience). The majority of therapists participating in peer supervision felt that while it was supportive, it was not as helpful as they hoped it would be. Several therapists also felt that supervisors without children did not understand them. In addition, they felt underlying envy and jealousy in tandem with their pregnancy and therefore skirted the issue. Two therapists felt that their female therapist encouraged them to return to work earlier than they would have liked, which they later regretted doing.

Experience of the interview. As noted in the Methods chapter, in the follow-up phase, a brief phone call was conducted with each participant three weeks after her interview. Notably, the majority of therapists in both groups reported memory loss as a significant ongoing difficulty and significant issue. One therapist remarked in jest, “there should be a required memory test for therapists in the postpartum phase.” With respect to the experience of study participation, the

majority found the interview interesting and thought-provoking. They felt a sense of increased awareness, as it got them to “delve deeper” into their experiences, patients’ experiences, and the impact of PMP on the clinical milieu. They referred to the interview process as a “luxury” to be able to reflect amidst the “storm.” As one therapist stated, “it helped make meaning of the traumatic experience.”

On a related note, women in the high group were more likely than women in the low group to report feelings of “isolation” after giving birth. They talked about the difficulty confronting working with patients and being a new mother. In terms of study participation, they felt grateful to be able to process their thoughts and feelings concerning their choices and took comfort in the fact that this topic was given careful exploration. One woman got to the heart of the matter, saying:

I think there needs to be a forum for women in this position to share their thoughts and feelings. We spend so much time talking with our patients about their mothers, but somehow, when the therapist herself becomes a mother, this issue is seldom explored.

That's a gross oversight that needs to be corrected.

Summary

In order to examine how PMP manifests in the new-mother-therapists and what its effects are on their ability to attune to and attend to their patients, this study employed a mixed method examination. The data were examined quantitatively, using an instrument that measured the level and quality of PMP, and qualitatively by employing a semi-structured interview to allow for richer elaboration on the data yielded from the questionnaire. The results of the quantitative data revealed a range of scores that fall within an approximately normal distribution pattern.

Additionally, the average overall scores for the present study and Moulton’s study were similar,

supporting the validity of the PMP Questionnaire. The PMP Questionnaire was further analyzed utilizing a *k*-means cluster analysis that revealed that, on the whole, there seemed to be two distinct groups, one with high scores and the other with low scores. The examination of the semi-structured interview material yielded compelling examples of ways in which the high and low PMP groups differed. Themes that emerged in the interview with high-PMP-scoring participants differed from those that emerged in interviews with low-PMP-scoring participants, though there were some similarities between the groups. The results also showed that the quality and quantity of PMP impacts a therapist's clinical work both positively and negatively. The salient findings—both their relationship to the three research questions and their broader implications—will be discussed in the next chapter.

Chapter Five: Discussion

In this chapter, which is organized around the three research questions posed at the end of Chapter 2, I review the outcome of these investigations in a theoretical context, reflecting on their implications for clinical practice and the ways in which they might inform intervention. I also address the limitations of the study and suggest possible future avenues of exploration.

Before beginning this discussion, the general point must be made that when a therapist goes back to work with a very young baby she is essentially going into a place of great conflict. How can one be primarily preoccupied with a baby and patients at the same time? This is an incredibly intrinsically difficult task involving therapeutic imperatives that may be very much contraindicated with a mother's developmental task to be with her infant. Therefore it is important to note that no clinical judgment is implied in what follows; there are no heroes or villains. I believe this is useful stance to take when reading this chapter.

Research Question 1: How does PMP manifest in the therapists in the present study?

Quantitative results. Broadly speaking, the quantitative data revealed a range of scores that fell within an approximately normal distribution pattern. These findings comport with prior theoretical and empirical investigations pointing to the normative process of PMP occurring in new mothers (Bibring, 1961; Moulton, 1991; Winnicott, 1956).

The strongest correlation between the four category subscales was between the Distractibility and the AEF subscales, suggesting that new mothers who are temporarily distracted from daily responsibilities and focus solely on their infant have an increased likelihood of also experiencing frequent lapses in areas of ego functioning, such as memory, fluency of speech, or grace of movement (Moulton, 1991). In addition, the correlation between Boundaries and AEF was also significant. This suggests that when the centrality of the baby in a mother's

awareness is strong enough to affect the blurring of boundaries internally between the mother's mental representations of herself and of her infant, she may also experience intermittent lapses in the ego functions mentioned above.

One of the questions the investigator sought to answer was whether the basic findings of Moulton's (1991) study would be replicated. In fact, the average overall PMP scores of the present study ($M = 31.30$) and those of Moulton's study ($M = 31.54$) were similar and thus support the validity of the PMP Questionnaire. However, there was a significant difference in AEF scores, which merits some discussion.

Moulton's sample had significantly lower AEF scores than did the present sample. Moreover, Moulton viewed a high AEF score as a "weakness," whereas I argue that a high score may be viewed as a strength. The regressive content that the AEF questions 'pull' for, such as tolerance for logical inconsistencies, slips of the tongue, and repressed memories, may look worse in, and have different implications for, the general population versus mother-therapists. Specifically, having access to that kind of regressive content may be particularly helpful for a therapist. Heightened access to the unconscious may help a therapist with her intuition and enhance her alertness, making her more aware of the subtle changes in her patients. In turn, this may help the therapist become more empathic, or create a greater sensitivity towards her patients and their issues (Barbanel, 1980; Fenster et al., 1986; Nadelson et al., 1974; Naperstack, 1976; Penn 1986; Pielack, 1989; Rogers, 1994). On the other hand, this regression can feel threatening to a mother's defenses, as it may negatively impact her ability to care for her infant. Due to the small sample sizes in Moulton's and the current study, it is difficult to draw a definitive conclusion on this issue. It would be interesting in future studies, with therapist or non-therapist populations, to see whether these differences prove consistent.

The results of the cluster analysis generated two distinct groups of therapists. The first was labeled “high” due to their high scores on the PMP Questionnaire, while the second was labeled “low.” The first cluster contained nine participants who scored high across all four subscales. The second cluster was the larger cluster, consisting of 11 participants who scored low on all subscales. The significant difference in terms of PMP level represents a powerful finding, given that all participants shared many similarities, such as stable home life, stable partners, level of education, age, and socioeconomic status. To understand the meaning of this phenomenon, these findings will be examined in detail through the qualitative interviews. Part of the discussion will involve taking a closer look at the differences between the high- and low-scoring participants to elucidate the variation in PMP using this psychometric instrument. In other words, do therapists who scored differently within the categories describe differences in their clinical work?

Qualitative results: Content vs. process. With respect to Research Question 1, it is worth noting the ways in which the qualitative data illuminated differences between the high and low-PMP groups that the questionnaire could not capture. Specifically, the interview allowed for observations on the relationship between process and content. Indeed, the investigator noted that several subjects’ content and process were incongruent: material from the beginning of the interview stood in contrast to material from the end of the interview, affect was incongruent with content, and there was resistance to responding to questions posed by the interviewer. How can we understand these phenomena? The investigator assumes that subjects participated in this study at least in part because they were curious about the impact of the role of early motherhood on their clinical work. However, because these subjects were therapists talking to another therapist (the investigator), their wish to appear as good mothers and competent therapists

precluded more 'real' communication, and they instead gave 'appropriate responses' based on their theoretical knowledge. In other words, a social desirability bias may have been occurring.

In addition, it is noteworthy that on the whole, therapists in the high and low groups differed in the process of their narratives. Therapists' willingness in the high group to speak openly about their personal and professional struggles was striking. Their narratives were alive with adjectives and creativity as they described their experience—at times they became so immersed in what they were talking about that they appeared in a state of reverie, forgetting the questions posed by the interviewer. They were able to be authentic, open, and present, despite at times not fully comprehending their new experiences as a mother-therapist. Conversely, the majority of therapists in the low group were more boundaried, less emotional, and appeared uncomfortable discussing negative aspects of their personal and professional lives. For instance, one therapist in the low group who seemed to have difficulty being open called the interviewer after the interview, explaining that she was concerned that she came across in a "negative light." She then invited the interviewer to a lecture she was giving on this topic, "to get a feel of who she really is." Possibly, the majority of therapists in the high group felt that they did not have to be 'ideal' mothers or 'adequate' therapists and were therefore willing to be open about their struggles both personally and professionally, whereas therapists in the low group felt that they had to be 'ideal' and therefore had difficulty being open about their struggles.

This phenomenon of therapists providing different responses to the same questions posed in the beginning and end of the interviews relates to findings from work with the Adult Attachment Interview (AAI). Main (1995) has shown that people with insecure attachments show a tendency to provide incongruent or divergent responses from the beginning to the end of an interview. For example, insecurely attached people will often list positive adjectives to

describe their mothers, but when they are asked for memories to back up each of the adjectives, their memories seem to be negative, or exactly the opposite of what they described earlier in the interview. By contrast, a secure person will have adjectives that are in sync with what their descriptions were initially. This observation is considered a key component in determining attachment classification. In the present study, like the insecurely attached participants of Main, the majority of therapists in the low group provided divergent data between the beginning and end of the interviews. This raises a question for future study of whether PMP level correlates with attachment; that is, whether high-PMP individuals are more securely attached than those with low PMP.

At the same time, among the low-PMP group, some of the differing beginning-end responses suggested movement from a defensive position toward deeper understanding. For instance, for most of the interview one therapist insisted that her pregnancy and giving birth did not impact her or her patients, stating, “Your own stuff doesn’t come into therapy if you’re good at what you do.” However, toward the end of the interview she remarked, “I wish I would’ve opened up the door to talk about it a little more if they did have reactions.” In addition, she felt there was a lack of education and dearth of literature, and as a result she “felt lost and [like I was] experimenting on my own.” In these instances, the ability to move from rationalization to a deeper understanding of behavior suggested the therapist’s emotional accessibility when perhaps feeling less vulnerable. In addition, through the process of the interview they may have gained increased awareness of their experiences related to their pregnancy and early motherhood.

Research Question 2: What are the positive effects of primary maternal preoccupation on the therapist in terms of her clinical work with patients?

Flexibility and adaptation. Therapists in the high PMP group appeared able to relinquish control and accept the adaptation to motherhood. They were able to accommodate their new infant by re-adjusting and shifting previously-held professional and personal goals. They seemed more at ease with their professional decisions in their narratives. These findings are in line with Winnicott and Tuber, who identified the importance of a mother's "sense of overall contentment" and not experiencing conflict between her (in this case, work-related) needs and those of her infant (Tuber, 2008). Indeed, the majority of mothers in the high group appeared to have the emotional and cognitive flexibility to shift gears and maintain professional and personal equilibrium. They reported feeling fulfilled by the absorption with their infants and at ease with interrupting their career goals (Fenster et al., pp. 122-123). Despite the shift in priorities, these therapists felt devoted to their patients, using the therapeutic hour in the best way possible by prioritizing their time.

Increased empathy and attunement. A second salient finding regarding positive effects of PMP was that, for both the high and low groups, having a young infant prompted increased sensitivity and nuanced understanding of clinical issues. In the high group in particular, therapists felt their patients' pain in deeper ways and were able to be compassionate and to respond empathically to patients, which facilitated the clinical work. These findings concur with those of Waldman (2003), Macnab (1995), Basecus (1996), Fenster (1986), and Winnicott (1960), who note that the positive impact of mothering can provide an empathic lens on clinical issues. Enriched feelings of empathy may be associated with therapists' status as mothers because, just like the "good enough mother" intuitively understands the needs of her infant, so does the therapist

intuit the needs of the patient through listening and empathy, the fundamentals of the “good enough therapist” (Winnicott, 1960). Thus, the reciprocal influence that takes place between the mother and infant is crucial for both analyst and patient (Bassen, 1988; Fenster, 1986; Marlin, 1988; Saakvitne, 2000; Waldman, 2003). This also harkens back to Winnicott’s (1975) discussion of the holding and containing function of both, with the mother and analyst roles keeping at bay strong or even hateful countertransference feelings (Tuber, 2008). Indeed, as a group, therapists felt an increased awareness of their patients’ pain in the context of mothering an infant. However, therapists in each group dealt with their newfound sensitivity in varied ways. Whereas the high group was able to be vulnerable and affectively available, the low group tended to constrict their emotions. This will be expanded upon in the next section.

An interesting finding among the high group was that they were able to maintain PMP with both their infants and their patients at the same time. These mother-therapists are able to maintain a high level of ego functioning *and* adaptively regress so they can process primitive material and respond in an empathic and helpful way to those they take care of. How can we understand this finding? According to Winnicott (1956), if a woman is high in PMP, she would make, to paraphrase, a lousy therapist; if the patient can be considered somewhat analogous to the baby, then the baby is intrusive in the therapy, and mothers have a powerful conflict of interest. However, this study challenges Winnicott’s view that a devoted mother can only be preoccupied with her baby. In fact, the results show that PMP enhanced these mothers’ ability to do clinical work. One explanation may be that Winnicott’s theory of PMP was developed in an earlier period when very few mothers had careers. In our modern world women work more than they ever did before, balancing motherhood and professional lives. In addition, PMP as described by Winnicott and others (e.g., Bibring et al., 1961) may be different when a mother has other

preoccupation, such as work that provides self-esteem. Still another way to understand this finding is through the idea that love is generative: A mother can love her first-born so much that she cannot imagine loving another child. But then when her second child is born, she is able to love that child equally. She may love them differently and for different reasons at different times, but she still loves them both. Seen in this light, having a capacity for high PMP does not preclude devotion to patients.

Schaefer's (1958) notion of adaptive regression in the service of the ego (ARISE), as well as the earlier work of Hartmann (1946, 1958, 1964) and Kris (1936) on this subject, is relevant here as well. In describing the regressive mental state in women during the PMP phase, Schaefer postulated that the ego can regress in an adaptive way while higher ego functions are maintained at the same time. In line with this thinking, the way a mother is able to provide for her infant in PMP is that she has the ability to fluctuate in and out of regressive states and can therefore understand the primitive needs of her infant. Similarly, the therapist can utilize this back-and-forth to both attune to her patients' primitive material and respond appropriately, achieving "evenly suspended attention" (Freud, 1923).

One factor that may have allowed the high PMP therapists to feel less conflicted, more at ease, and more vulnerable and emotionally responsive to patients is their reduction of clinical hours, a characteristic of that group that notably distinguished them from the low group. As noted, these high PMP therapists appeared to be able to shift roles successfully, bringing their PMP and its attendant reverie into the therapeutic milieu. They did not appear to feel the need to defend against the experience of PMP; rather, they allowed themselves to become immersed in their PMP experiences without feeling threatened by the loss of their own identities. They were

able to significantly reduce clinic hours and remain emotionally available to patients without fearing the loss of themselves.

One might point out that not all mothers can afford to significantly reduce their clinical hours. However, as mentioned earlier, both high and low groups were relatively similar on demographic variables such as income, spousal support, age, and degree. Still, therapists in the low group made fewer changes to their clinical practice after giving birth, but at a cost. They reported feeling increased guilt towards their infants and described constricted emotions in clinical work, imposing firm boundaries to keep their work and home life separated as much as possible. Thus, one could conclude that decreased clinical hours can positively impact clinical work, as therapists feel content about their professional and personal decisions and can be emotionally available in both spheres. Conversely, maintaining full-time hours may have a negative impact.

One might think that women who had been therapists for a longer time would be more likely to decrease their clinical hours and take a longer maternity leave: that was not the case with this sample. Women in the high group were more likely than those in the low group to reduce their clinical hours, as they wanted to spend more time at home with their child and felt more secure with taking time off. Women in the low group felt insecure about reducing clinical hours and taking time off.

Heightened authenticity. Another meaningful positive finding was that, upon resumption of work, high-PMP therapists said they felt more real—more of a person rather than just a therapist—after having shared their critical “life event.” They identified feeling less afraid of patients knowing things about their lives and looked at this as enhancing the therapeutic alliance, taking the treatment to a deeper level. These findings suggest that when a therapist can

risk vulnerability and authenticity it can deepen and enhance the therapeutic relationship (Fenster, 1983; Miller, Jordan, Kaplan, et al., 1997). As Rogers (1961) notes, when a therapist can be authentic in a humane way, the effects on the therapist, patient, and clinical milieu are positive, and a foundation of therapeutic empathy, repair, and growth can be built (Fenster et al., 1986).

Increased motivation. Those therapists who scored low on PMP also described positive impact on their clinical work. Over half of the therapists in the low group reported an increase in motivation with patients due to the impending maternity leave. These findings are in line with prior studies showing that pregnant therapists not only prepare for the child but also for the patients in an effort to achieve closure before giving birth (Fenster et al., 1986), as well as Winnicott's notion that PMP starts in the third trimester and continues into the first trimester of the baby's life.

Benefits of maternity leave and return. As mentioned earlier, the majority of therapists in the low group returned to work full-time. Although these therapists seemed to feel conflicted around leaving their infants and constricted their emotions with patients, they also showed patients that they were "fundamentally reliable"; patients were able to take them for granted again in the service of "going on being" (Winnicott, 1963, p. 183). Therapists in this study reported that the 'betrayal' of the maternity leave was mended by their return to regular hours; things went 'back to normal,' and patients felt they could once again count on the therapist. In fact, several therapists reported that the leave and return positively impacted the therapeutic alliance. They could compartmentalize thoughts of their infants, reported having firm "boundaries" between home and work, and described how balancing dual roles actually served to engender increased focus in their clinical work. There were also some negative aspects of

therapists' full-time resumption of work, which will be discussed in the Research Question 3 section.

Increased clinical confidence. An unexpected finding in this study was the emergent theme of Self-Esteem. As a result of their "new status" as mothers, the therapists felt like "adults," "grown up," and "role models" with their patients. These positive effects varied with each therapist depending on her unique development and maturation at that time. The majority felt as though they had new authority, legitimacy, an evolving perspective, and shifting priorities. Both groups felt that as a result of having a young infant they had to use their time away from their infant productively in the clinical hour. As a result, they became more active, interpretive, and confrontational with patients. These findings are congruent with the work of several authors (Bassen, 1988; Davis, 1984; Fenster, 1983) whose subjects reported similar experiences. For both groups, maternal self-esteem and professional self-esteem were salient issues. Although there were few major differences, therapists in the high group did report high maternal self-esteem, whereas therapists in the low group reported increased confidence in their clinical work.

In addition, over half of the therapists in both groups felt that their clinical work provided structure and stability at a time when their sense of self was shifting in many ways. They felt that clinical work was a break from their unstructured overwhelming experience at home with their new infant. Several authors (Basescu, 1996; Fenster, 1983; Waldman, 2003) describe similar findings and sentiments. Still, other participants (specifically, the majority of therapists in the low group) experienced guilt and a perpetual need to balance their personal and professional selves (Korol 1996). These differences will be addressed in the following section.

Research Question 3: What are the negative effects of primary maternal preoccupation on the therapist in terms of her clinical work with patients?

Distraction and decreased tolerance. Both groups reported feeling distracted with patients after giving birth. However, in the high group, the majority described how hard it was not to think of their babies, whereas in the low group the majority of therapists focused on their ability to compartmentalize thoughts of their babies. Most therapists in the high group reported feeling preoccupied and tired by the physical experience of pregnancy during their ninth month. Similarly, in the postpartum phase therapists reported feeling distracted with thoughts of their infants during clinical work, especially when working with low functioning and dependent patients. They also described decreased tolerance with needy patients and, as a result, increasingly referred out patients that were difficult to handle. In line with the literature, these findings suggest that as a result of having a young infant, therapists may become increasingly sensitive to patients' symbiotic desires as their own personal issues around symbiosis emerge. They may also experience guilt and regret around not being with their babies and thus employ psychological tactics that allow them to create some distance between themselves and their patients (Paluszny & Poznanski, 1971; Penn 1986).

In the process of analyzing the data, the investigator found overlap between the Boundaries and Distractibility categories; items labeled as Distractibility could also fit under Boundaries. The experience of pregnancy and giving birth stirs up feelings of fluidity (e.g., boundary issues) as the mother begins to share her body with the unborn infant. These issues are heightened in the first months after the mother gives birth, when the notion of the infant being a part of the mother is set against the mother wanting to find respite from the baby at times. Given the ways in which 'boundaries' is an incredible salient theme around early infancy and early

motherhood as psychological and physical identities merge (Blos, 1980; Lester & Notman, 1986; Trad, 1991), it makes sense that distraction from aspects of daily life would co-occur. As Moulton (1991), who found similar overlap, noted, the blurring of boundaries in the internal object world of the mother is closely related to the distraction from aspects of daily life that do not immediately pertain to being with her baby.

Related to the topic of increased distraction is the finding of a negative impact of breastfeeding within the high group. As a result of breastfeeding, the majority of these therapists reported increased distractibility due specifically to being preoccupied with bodily sensations, and they imposed restrictions on their patients regarding scheduling. In many ways, this finding suggests the limit of nursing therapists' availability when patients' and the infant's needs are experienced as similar in nature. Furthermore, the idea of being continuously in demand may be at odds with some therapists' sense of self. However, this stands in contrast to other literature that suggests that a therapist's increased focus on her body can contribute to a heightened sense of awareness, attunement, and sensitivity to patients (Fenster et al., 1986; Penn, 1986; Nadelson et al., 1974). In other words, the therapist's connection to her own subjectivity may make her more available to the subjective material of her patients. How can we understand these divergent positions? It may be attributable to the differences between the high and low PMP group; therapists in the low group reported feeling similar to the latter findings (Fenster et al., 1986; Penn, 1986; Nadelson et al., 1974) that breastfeeding increased their focus. Therapists in the high group, on the other hand, could only focus on the disruption caused by breastfeeding. It may be that the high PMP group felt preoccupied with breastfeeding, while those in the low PMP group—because they were not as preoccupied with their infants—were able to maintain their focus on work.

Disruptions in autonomous ego functioning. Another salient finding was the link between high PMP and challenges around AEF, such as memory loss, difficulty finding words, feeling less inquisitive, logical inconsistencies, and slips of the tongues. The majority of the high PMP group felt that memory loss was the largest problematic issue and that their thought processes and therapeutic insight were slowed. Interestingly, they described having an increase in intuition, empathy, and responsiveness to patients, while simultaneously experiencing negative aspects of PMP such as distractibility, memory loss, and de-cathexis from the clinical work. As discussed earlier, disruptions to AEF can have both positive and negative implications. On one hand, heightened access to the unconscious may help a therapist with her intuition and enhance her alertness, making her more aware of the subtle changes in her patients. In turn, this may help her become more empathic or create a greater sensitivity towards her patients and their issues (Barbanel, 1980; Fenster et al., 1986; Nadelson et al., 1974; Naperstack, 1976; Penn 1986; Pielack, 1989; Rogers, 1994). At the same time, she may also struggle with memory loss and finding words.

Role conflict and guilt. A salient negative finding among the low group was a sense of conflict that was palpable in their narratives. Although many felt that work was an “oasis” from the chaotic environment of their home life, they also expressed guilt over leaving their infants and returning to work. These therapists appeared less flexible in transitioning back and forth between their roles as mother and therapist; as a result they felt the need to impose firm boundaries.

Common ways in which therapists in the low group managed their conflicts were denying physical and psychological vulnerability and experiencing anxiety and guilt about shortchanging significant others in both personal and professional realms. In addition, most women in the low

group expressed anger at those in the work environment who did not accommodate special requests related to their pregnancy and giving birth. Most therapists returned to work in hospitals and clinics despite struggling with these settings and made little or no changes to their schedules upon returning to work, in turn creating feelings of distress. It seems that the additional political stress at work from hospital and administrative staff caused some women to decrease their investment in their patients, while those who returned to a nurturing environment with increased emotional support from their employers had more positive feelings toward seeing patients. The majority of therapists in both groups reported feeling conflicted about leaving their infants to return to work. This finding is consistent with literature that discusses the dilemma therapists experience regarding their dual roles (Basescu, 1996, Marlin, 1988; Fenster, 1983 Korol, 1996, Fenster et al., 1986, McGarty, 1988). Upon taking a closer look at these results, however, the investigator found that therapists in the high group felt conflicted “abandoning” their patients and were at ease with their professional decisions to return to part-time work. This finding contrasts with the work of previous authors who describe that returning to work, even on a part-time basis, may bring up anxiety about therapists losing their connection with their babies (Fenster et al., 1986; Korol, 1996; McGarty, 1988). Conversely, therapists in the low group felt conflicted about leaving their infants, since the majority of them returned to their full-time positions. Differing clinical implications corresponded with the differing conflicted feelings in the high and low groups; therapists in the high group had difficulty maintaining firm boundaries and became very flexible around scheduling at a cost to their personal life, whereas therapists in the low group imposed firm boundaries and constricted their emotions.

Constriction of emotion. Unlike the high group, the majority of therapists in the low group went through great pains to constrict their emotions. These therapists felt as though they

were not holding onto patients “in their gut” or “emotionally,” but rather “intellectually,” and did not “engage” their patients fully. Indeed, most women in the low group were surprised by their increased sensitivity and empathy towards patients and felt uncomfortable with their new emotional PMP experience. Perhaps in an effort to deal with their increased sensitivity, they felt that constricting their emotions would provide them with self-control and protect them from the anxiety of the destabilizing effects of PMP, a notion consistent with prior research (Imber, 1990, Nadelson et al., 1974; Ulman, 2001). The literature also tells us that therapists may avoid affectively charged material to protect their unborn child and infant from the negative feelings that may arise in the therapeutic relationship (Fenster et al, 1986; Imber, 1990; Lax, 1969). The therapist’s need to constrict emotion and resist feeling vulnerable thus exists alongside her wish to nurture and protect her developing fetus/infant.

A related finding was that therapists in the low group reported less negative countertransference compared to therapists in the high group. Although it may seem that constricting or constraining one’s negative countertransference is a good thing, it may also be that the patients sensed their therapists’ emotional constriction and were unable to “use their therapist” in the service of working through important issues. Several therapists in this study in fact noted that while patients were resistant to discussing negative transference, they themselves were happy to oblige.

What do these findings regarding emotional constriction tell us about the quality of clinical work of the new mother-therapist? As a result of their constricted emotions, therapists in the low group tended not to process important material with patients relevant to their pregnancy and childbirth, which they later came to regret. As one therapist reported, “all went well,” and most patients reacted to her pregnancy with congratulatory feelings, but most did not return after

her maternity leave. Later on in the interview, the therapist reflected on her pregnancy and remarked, “I just never felt like I did a great job of really trying to encourage people to say what they were feeling.” In this context, results of the study suggest that the therapist’s inability to be emotionally responsive negatively impacted patients; therapists in the low group colluded with patients in the fantasy that everything was okay and tended to deal with patients on a superficial level.

This process can be likened to the ways in which a baby continually adjusts to the mother, according to Winnicott (1967): “The baby quickly learns to make a forecast; just now it is safe to forget the mother’s mood and to be spontaneous, but any minute the mother’s face will become fixed or her mood will dominate and my own personal needs must then be withdrawn otherwise my central self will suffer insult” (as cited in Tuber, 2008, p. 12). As Tuber (2008) notes, when the mother is not able to adequately attune, the baby must adapt to maintain a connection with the mother, thereby developing an overly compliant, “false self”; by contrast, when the mother is able to master her own emotional fluctuations enough to remain focused on the baby, the baby’s “true self” can emerge. Under circumstances in which the new mother-therapist is constricting negative emotions or countertransference, part of the reparative process can be to ‘find’ the patient by listening for derivatives that can be explored and worked through, so as not to run the risk of enabling the patient’s false self. Tuber (2011) described the process of mutual play in child therapy as involving, a) the need to be hidden, b) the more powerful need to be found, c) the aggressive need to penetrate and dominate, and d) the feelings of guilt and the need for reparation that follow this aggression. Being able to ‘find’ the patient and tolerate their aggression demonstrates that the acknowledgement of aggressive feelings is not toxic.

Furthermore, the more it can be communicated and the other person [therapist] can tolerate it, the less toxic the patient may feel inside about their own aggression.

Overidentification. Becoming mothers brought a newfound understanding of the dynamics of parenting to all participants in this study, regardless of group. This created a potential to over-identify with patients. All of the therapists talked about fantasies of their own infant that were related to the content and dynamics of the current session. They also had difficulty working with patients they thought to be abusive or neglectful parents. These results are consistent with the work of Waldman (2003), who compared the therapist to a “container” for the emotional development of her patient. She hypothesized that when a therapist is pregnant, especially during the time when her pregnancy is visible to her patients, the role of container can become less clearly defined. This is especially so, I would add, because the infant and the patient may pull for similar emotional needs. The potential for over-identification is so great because therapists have a potential to blur boundaries in the PMP phase.

Decreased professional ambition. A few therapists in both groups described decreased professional ambition—how work became secondary and less narcissistically invested in the postpartum phase. These therapists talked about accepting the fact that they were not going to achieve their goals in a satisfactory time frame, despite their talents.

Depression. Interestingly, despite a sense of relief, accomplishment, and euphoria after giving birth, five women (three from the high group and two from the low group) reported varying degrees of anxiety, panic, and depression. This finding was surprising, given that most of the mothers fell in the mid-range of the PMP scores, and merits some discussion. It is tempting to conclude that depressed mothers, by definition, will be so self-absorbed that they will have very low PMP. However, this study did not find that the mothers mentioning depression had the

lowest PMP; in fact, most of these women scored in the mid-range. Thus, these findings are somewhat inconsistent with previous work showing that a mother's postpartum depression was related to decreased levels of preoccupation with the infant (Leifer, 1977). It should be noted, however, that the present study did not attempt to formally diagnose depression in participants.

To study PMP is to attempt to capture a relatively transient phenomenon. PMP occurs within a relatively short amount of time: approximately the last trimester of the pregnancy and the first six months after giving birth. This is a very small window in a person's life, a small part of who they are. It is not surprising, then, to have depressed therapists who fall at various points on the spectrum of PMP. PMP has to do with a certain orientation a mother has towards her infant. It is a state of mind, yet does not capture the totality of one's mind and does not define one's personality. It also does not define a person's health or pathology before, during, or after pregnancy. Personality is a much larger umbrella concept, of which PMP is just one aspect. Thus, someone may be clinically depressed for reasons that are not necessarily related to PMP.

Notably, postpartum depression played out in varied ways between the two groups in the clinical situation. Depressed mothers in the high group reported that their heightened self-absorption and cathexis to their infant left them bereft of energy for their patients and, as a result, they extended maternity leave and significantly reduced their clinical hours. Therapists in the low group resumed their same workload, reporting that "work was back to normal" and had a positive view of their work. They reported that their depression did not impact their clinical work, consistent with past studies (Leifer, 1987).

Limitations and Suggestions for Future Research

While the current study expanded on our fairly limited base of knowledge about Winnicott's concept of PMP and its impact on clinical work, there were several important

limitations. The first is that we do not know whether the PMP scores calculated were determined by the mother's personality before they conceived or were situationally determined by having a baby. For example, to what extent would participants who scored high on AEF have had high AEF scores before they conceived? Was a high AEF score only the result of having a baby, or was it simply that they were more disorganized people? The same can be asked of issues pertaining to boundaries: because we do not have a measurement of therapist-mothers' boundaries before they were pregnant, we cannot say definitively that their preoccupation with boundaries was solely a function of their having a baby. Future longitudinal studies in this area could clarify the above questions by testing women twice, both before they conceived and after, in the PMP phase. Alternatively, the comparison could be between the PMP phase and later, when the child is a toddler.

Another limitation is that subjects were required to have infants up to six months old, and therefore there was variation among the women, with some having infants of two months and others with infants six months old. Several participants stated that the experiences tapped into by the PMP Questionnaire were most salient in the first few weeks after giving birth. Conducting the interview during the first month or two months postpartum, rather than within a six-month time frame, could have yielded more specific data. Alternatively, using a larger sample size and correlating the age of the infant with PMP scores would be helpful to clarify the timing PMP and its impact on clinical work.

Another issue that may have impacted the results is how the mother's perception of her infant's temperament might have affected her experience of PMP. Winnicott's (1956) assertion that "there is no such thing as a baby," only a "nursing couple" (p. 304), suggests that infant's inherited potential cannot be realized except as linked to maternal care. Thus, a mother's

perception of her infant—in addition to the “actual” temperament of the infant, the temperament of the mother, and the interaction of the mother’s and infant’s temperaments—may all be inexorably linked to PMP. Mothers of a difficult infant, who must confront an abundance of negative infant behavior on a daily basis, may become desensitized as a defensive response to the negative stimuli, which may diminish PMP. This could conceivably occur especially in the case of a ‘mismatch’ between baby’s and mother’s temperaments (e.g., the infant is more or less active than mother). If a baby cries frequently, appearing unable to be soothed, a mother may feel that she is inadequate, which may in turn impact her experience of PMP. While a few of the women in the depressed category in this study spoke about their perceptions of their infant’s temperament—specifically, difficulty soothing their baby—mothers were not specifically asked about their perceptions of their infants’ temperaments. Future studies could clarify this important question by adding infant behavior inventories and/or infant temperament items to a questionnaire for the mother to complete. These data could then be related to PMP scores, as well as other variables of interest (e.g., mother personality variables, demographic variables such as education level).

Another factor to consider with respect to mothers’ experiences of PMP is the quality of the marital relationship. Literature on marital satisfaction indicates that the transition to parenthood can be a stressful time for not only the new mother but the marital relationship or partnership as a whole (Belsky & Pensky, 1988, Cowan & Cowan, 1995; Doss et al., 2009). A question that arises is whether the mother’s PMP places further strain on the marital relationship, or lessens it. Conversely, if a marriage is strong, does that enable the mother to enter more readily into PMP, without the need to direct additional ‘psychic energy’ toward maintaining the marital relationship? Finally, how does a partner’s reaction to the mother-infant bond affect

PMP; for example, does he or she experience envy or competitive feelings around the mother's attunement to the infant?

The women in this study were not specifically asked about the quality of their marital relationships or partnerships, and most did not spontaneously discuss this topic in the interviews. A few women spoke about related issues (e.g., an increase in responsibility at home, husbands' views of their clinical work as secondary to being a mother, husbands not being fully supportive of their time away from their infants). However, not enough data were collected to draw definitive conclusions about the ways in which the mothers' marital relationships impacted their PMP. Future studies in this area could clarify this question by including a marital satisfaction questionnaire and comparing mothers low and high on marital satisfaction on the PMP variable. This line of inquiry would be particularly illuminating given the impact of having a baby on the marital relationship, regardless of PMP, as suggested by the above-cited literature.

Other factors that may have impacted the results include instrumentation, small sample size, and limited characteristics of the sample. As has been noted, the PMP Questionnaire was only used once before (Moulton, 1991). While the results of the questionnaire yielded similar means to the prior study, supporting its validity, it would be important to continue to utilize this instrument with larger sample sizes to further establish reliability and validity. In addition, participants were a fairly homogeneous group of 20 Caucasian, upper middle-class, well-educated mother-therapists from the New York area. For this reason, the study cannot be considered a representative sample of therapists of other ethnicities, geographical areas, income levels, and educational backgrounds. Thus, while the findings of this study may create a greater understanding of the phenomenon of PMP and its impact on clinical work, it is limited in its generalizability to other populations. However, the qualitative aspect of this study did allow for

the assemblage of rich data that provided a highly nuanced description of the complexities and degrees of PMP experienced by first-time mother-therapists who agreed to participate in the study. Thus, the project's objective—to increase understanding of this subjective experience and to measure its impact on clinical work—was achieved.

Finally, it is important to note that all measurements were self-reported. As mentioned previously, therapists may have been selective in their answers in an attempt to appear competent, possibly falling prey to social desirability bias.

Mention has already been made about some directions for future research, but a final important one is that, because no known previous work has involved interviewing patients directly about their experiences working with therapists in the PMP phase (and the present study's findings are based solely on therapists' perceptions of their patients' reactions), it would be valuable to tap into the patient's perspective. This information would represent a major contribution to understanding the impact of PMP on clinical work.

Clinical Implications and Recommendations

Talking about the pregnancy. In terms of clinical issues raised by the present study, that of processing the impact of the therapist's pregnancy and postpartum phase with patients is a crucial one. Therapists in the low group felt in retrospect that they did not encourage their patients to express feelings about their pregnancies and return to work. These therapists described how, due to their increased feelings of vulnerability, they colluded with patients' denial in an effort to avoid the intensification of feelings, and how in specific patients this caused regressions and early terminations. Therefore, it is suggested that therapists be cognizant of a patient's verbal and nonverbal reactions, and that they encourage patients to process their feelings. Although bringing personal issues into the consulting room is not the traditional

position, in this circumstance the pregnancy is already unavoidably brought into the room by the therapist. To ignore patient reactions to this intrusion is a kind of denial on the part of the therapist and may be harmful to the patient, spurring unproductive regression and intensifying feelings of abandonment. Conversely, a therapist's ability to be open enough to invite patients to process their feelings can provide an unusual opportunity for exploration that may not have come to the fore otherwise. It is important to be cognizant of derivatives the patient brings forth so that the meaning can be held, empathized with, explored, and processed as an essential part of the treatment in the PMP phase and beyond. In such a holding environment, patients may feel safe enough to accept the therapist's invitation to process their feelings. Addressing these issues can move the treatment forward and facilitate development and emotional growth for both the patient and therapist.

Managing lapses in AEF. The majority of therapists in the high group reported memory loss, difficulty finding words, slips of the tongue, and repressed memories of childhood emerging. Interestingly, therapists in this study found several of these regressive aspects to be a positive for clinical work. They felt increased intuition and newfound sensitivity to subtleties and nuances from patients. It appears that in this vulnerable and transitional phase in a therapist's life, the therapist appreciates these regressive aspects and acknowledges the richness they provide. On the other hand, the majority of therapists in both groups reported memory loss and were concerned about hurting their patients by forgetting important clinical material. Therefore it is also recommended that therapists try to compensate for their difficulty remembering clinical material from session to session by picking out the most relevant material, taking notes, recording sessions, etc. In general, attention should be paid to the positive and negative aspects of PMP: appreciating the newfound gains while taking care of weaknesses.

Managing return-to-work conflict. With respect to the conflict most therapists experienced in returning to work (in the high group, guilt over abandoning patients; in the low group, guilt over abandoning their infants), as well as to the different ways both groups handled this conflict (in the high group, reducing clinical hours; in the low group, returning to work full-time), the findings of this study suggest that a reduced schedule can ease the balancing act required to handle both familial obligations and return to clinical work. Fewer working hours may help a therapist ease into these dual roles—both of which are highly personal and involve a sense of obligation of human attachment—and enable the therapist to be optimally emotionally accessible to her patients.

Managing emergent emotional material. In the interviews, a few therapists in both groups mentioned feelings related to their relationships with their own mothers that emerged during the PMP phase and that may have impacted their understanding of their patients. Indeed, if new mother-therapists were raised by women who did not have full-time careers and were fully available to their children, the guilt these therapists experienced upon returning to work full-time may also relate to a more generalized guilt about being a professional working mother, so different than their own mothers. On the other hand, if the therapist's mother did work, the therapist's pregnancy may bring up her own resentment (conscious or unconscious) around her mother's lack of emotional or physical availability. As for the high group, anxiety about leaving their children may have been displaced onto their patients. Perhaps for therapists in the high group it was easier to feel guilty for abandoning their patients rather than abandoning their infants for their pursuit of their careers.

As is the case for the patient, for the therapist the themes aroused by pregnancy and new motherhood are personal ones that can often only be resolved by working through the

experience. In light of these concerns it is suggested that therapists enter their own treatment to deal with the upsurge of old emotions and intrapsychic conflict that can lead to reactions of anxiety and guilt and impact clinical work. The more aware the therapist is of her issues and difficulties, the less likely she will be to undertake major changes in her behavior and technique during this period. Treatment may facilitate understanding of this complex transitional phase in life, helping the therapist to work through her own potential issues of guilt around her professional decisions and her identity as a mother, and lessening the impact of the regressive aspects of PMP on clinical work.

Dealing with difficult patients. An important issue illuminated by this study was therapists' difficulty treating patients who were more seriously mentally ill, as they often reacted with increased intensity and sometimes psychotic transference. The majority of therapists in the high group experienced great difficulty treating low-functioning patients during the PMP phase due to this psychotic transference. In retrospect, therapists felt that instead of transferring these patients, they should have worked through the transference, made efforts to reduce their delusional thinking, and helped them maintain interpersonal relationships. They felt that colleagues and supervisors were too protective of their vulnerable state as a pregnant therapist. Retrospectively they felt that they should have tried to understand and connect with their patients and work through the important transference material.

However, interpretation of psychotic patients' transference is not always possible or advisable, as it can be met with resistance. Furthermore, the tendency to want to withdraw from difficult patients during this vulnerable period is understandable; a mother-therapist in the PMP phase not only has to tolerate the challenges of her newborn infant but also the those of the psychotic regressed patient who is akin to her newborn baby. Winnicott (1949) himself made this

comparison, noting that “in analysis of psychotics...even of a normal person, the analyst must find himself in a position comparable to that of a mother to her newborn baby. When deeply regressed, the patient cannot identify with the analyst or appreciate his point of view any more than the fetus or newly born infant can sympathize with the mother” (as cited in Tuber, 2008 p. 175). Regarding countertransference toward such patients, Winnicott also offered this thought: “A mother has to be able to tolerate hating her baby without doing anything about it. She cannot express it to him...the most remarkable thing about a mother is her ability to be hurt so much by her baby and to hate so much without paying the child out, and her ability to wait for rewards that may or may not come at a later day” (as cited in Tuber, 2008, p. 175). Tuber (2008) notes the ways in which this model is inherent in the capable mother, and one hopefully replicable by the capable therapist if she can hold the hate the way a mother can hold it from her baby.

Fully addressing the topic of treating patients with severe mental illness during the PMP phase is beyond the scope of this paper. However, based on this study, it is suggested that therapists try to understand the issues that can arise for psychotic patients and that can intensify transference and countertransference issues, as this understanding can guide decision-making in terms of handling these issues and working through fear. Working with patients during this time is not an easy feat, given the vulnerability of the therapist in the PMP phase. It may not be realistic to believe that this issue can be fully worked through with all severely mentally ill patients. However, understanding these dynamics is helpful to the treatment process, whether communicated directly or indirectly, as it lessens the likelihood of the therapist undermining the treatment by engaging in defensive countertransference enactments.

The majority of therapists in the high group reported feeling overwhelmed working with needy and angry patients, often referring them out with little hesitation. This reaction was most

common with patients who had traumatic histories of abandonment and who manifested intense reactions to the therapist's pregnancy. In retrospect, therapists felt that it would have been helpful to anticipate patients' feelings of anger and resentment for the perceived abandonment by the therapist. In such cases, clinical supervision could be especially helpful to understand the dynamics of patients with abandonment issues and to guide the therapist in making clinical decisions. Although not every therapist can do so, if the therapist can tolerate these patients' anger in the PMP phase, tremendous work can be done. According to Winnicott (1971), the patient needs to destroy the therapist with anger because of the perceived empathic failure; however, the patient's anger is seen as a developmental leap because he or she feels safe enough to work through these important feelings. Although a considerably difficult task for the already-vulnerable therapist, this process can represent a tremendous 'working through,' since a new response from the therapist can be a "corrective emotional experience" and foster the development of positive internalized objects.

The need for support. The majority of therapists in this study discussed their feelings of isolation and their difficulty finding professional women with whom they could identify as a therapist in the PMP phase. They felt as though they were in "foreign territory" and had difficulty handling treatment issues during this time. When asked if they had any suggestions for improvement, many voiced the need for support groups, forums, and continuing education programs. In addition, they felt that their training did not prepare them for the challenging reactions from patients to their pregnancy and childbirth. Therapists who had colleagues who experienced their own pregnancy found it enormously helpful to process these feelings with those colleagues. Therapists expressed that they were also positively impacted by sharing their personal experience with the interviewer; this was further demonstrated by the enthusiasm with

which the majority of therapists responded to the interviewer. It is recommended that training institutions, hospitals, and clinics implement educational programs and arrange for supervision during the PMP phase.

It is interesting to speculate on why, as reported in the Results chapter, women in the high group expressed feelings of isolation more than did those in the other group. By definition, it would appear that women in the high PMP group are more introspective and would withdraw from the outside world. Indeed, upon entering motherhood many subjects in the high PMP group reported withdrawing from people outside the realm of their infant. Turning inward towards their infant and away from others may create a sense of isolation and increased difficulty navigating their professional and personal worlds.

This study also found that supervision had an incredible impact and could be a great source of support to the therapist during this complex transitional time. Even experienced therapists need supervision with an empathic supervisor who is informed about the dynamics that may emerge for a therapist and patient in the PMP phase. As Fenster (1983) proposed, taking into consideration patient diagnosis, dynamics, defenses, and conflicts and early experiences is important. Therapists in this sample offered many examples of the responses of patients of all ages to conflict brought about by the pregnancy, including competition, hostility, and envy. Patients' biological age and current life situation can help the therapist forecast how they might react to the pregnancy. Importantly, as Fenster (1983) suggests, these issues should be explored in supervision prior to the disclosure of the pregnancy to the patient. Unfortunately, some therapists in this study felt that supervisors may have had personal issues that negatively impacted supervision at this sensitive time. It is suggested that these issues be voiced regularly within supervision. On the other hand, other therapists felt that in many instances the pregnancy

brought forth a “bonding experience” with their supervisors that ultimately fostered the therapeutic alliance between therapist and patient.

Conclusion

Winnicott’s construct of PMP is the theoretical underpinning of this study, in which this subjective state of the new mother was explored in 20 women in terms of its impact on their clinical work. It was found that women can be meaningfully classified into “high” or “low” PMP groups and that the quantity and quality of PMP affects the therapist, patient, and clinical milieu. Though the two groups were alike in some ways, therapists showed a greater similarity to the others in their group. Utilizing Winnicott’s theory of PMP can be a way of understanding a therapist’s developmental movement, as the quality and quantity of PMP can provide heightened understanding into the transference and countertransference in the clinical setting.

The major findings revealed distinct characteristics between the high and low groups as well as similarities between the two groups. For both the high- and low-PMP groups, PMP tended to enhance therapists’ abilities, facilitating attunement to and empathy toward patients, and drawing therapists’ attention to material of which they were previously unaware. Therapists dealt with their newfound PMP-related sensitivities in varied ways. For therapists in the high group, PMP had a positive and negative influence on their clinical work. In the positive realm, therapists were able to be devoted to both their infants and patients, and they were flexible and felt at ease with their professional decisions. Not only did PMP increase their sensitivity to patients, their sense of feeling more vulnerable and “real” with patients was seen as something that positively impacted the work. However, not all therapists in the high group were able to use their regression adaptively: they also reported increased distractibility, memory loss, fluid boundaries, and difficulty dealing with low functioning patients. In the low group, therapists

were able to compartmentalize thoughts of their babies, felt that balancing dual roles actually served to sharpen their focus in their clinical work, and described increased efficiency and clinical confidence. On the other hand, these therapists expressed a sense of conflict between work and motherhood, appearing less flexible in their dual roles. They felt the need to impose firm boundaries between home and work, had difficulty feeling vulnerable with patients, and tended to constrict their emotions.

Overall, the results suggest that not only does pregnancy and becoming a mother per se impact clinical work, but point out the powerful impact of the level and quality of PMP on clinical work.

Appendix

THE PMP QUESTIONNAIRE

This form contains 59 questions about your experiences as a new mother. Please read the questions and decide whether each question is true as pertains to your experience or false as pertains to your experience in the time since your baby was born.

Please circle "T" for those questions you wish to answer "true" and "F" for those questions you wish to answer "false". There are no right or wrong answers. Answer each question, sticking only to your own experience. If you are in doubt, pick the answer that is closest to your experience.

If you have comments, please use the back of the form to write them. Your impressions are appreciated. Thank you.

-
1. I seem to worry about things now that would have surprised me had I known before the baby's birth that they would be worrisome.
T F

 2. I'm just not interested these days in some things that were pretty important to me before I had the baby. **T F**

 3. Sometimes when I am holding my baby I find I can imagine being a baby in my own mother's arms. **T F**

4. Sometimes familiar sights look strange to me. **T F**

5. Sometimes I simply can't remember what I've just been doing.
T F

6. It's surprisingly hard for me to let someone else hold/care for my baby. **T F**

7. I seem to worry more now that I used to. **T F**

8. At times I may walk from one room to another and then have to stop and think to remember why I'm there. **T F**

9. When my baby nurses eagerly I can almost feel his/her delight.
T F

10. Sometimes I find I hardly recognize familiar places (an aisle at the grocery store, a particular block I often drive past...).
T F

11. I'm surprisingly possessive of the baby. **T F**

12. Sometimes even finding time to eat breakfast/ get dressed/ make the bed (or similar routine acts) is beyond me. **T F**

13. I'm much more emotional these days than I usually am. **T F**
14. I find it easy and satisfying to recognize myself in my baby.
T F
15. There are times in the day when I feel disoriented. **T F**
16. I feel as though I understand my mother better now. **T F**
17. Sometimes I find it difficult to pay *attention* to what people are saying to me. **T F**
18. I've been surprised at times to find sentimental tears in my eyes. **T F**
19. It bothers me to see certain characteristics of myself in my baby.
T F
20. I find I can spend much longer than it seems just watching my baby - he/she is so compelling. **T F**
21. Often when I go out without the baby I feel like I am missing a part of myself. **T F**
22. I no longer feel sure of my ability to gauge how much time it takes to do something. **T F**

23. My emotional reactions seem much stronger than they were before I had the baby. **T F**
24. Sometimes I feel a peaceful sense of oneness with my baby. **T F**
25. Sometimes it feels like I've just suddenly arrived some place when I've actually been there all along. **T F**
26. I feel empty when I'm not with my baby. **T F**
27. It seems like time passes differently with the baby around. **T F**
28. I react with strong feelings to situations I'm sure I would have been pretty indifferent to before I had the baby. **T F**
29. I feel like my baby recognized me as his/her mother right away.
T F
30. My body is hard to recognize as my own since the baby. **T F**
31. At times when the baby isn't with me I'm overcome by a longing to hold him/her. **T F**
32. It took a while for my baby to recognize me as his/her mother.
T F

33. I find myself very easily distracted. **T F**
34. It seems I've become less graceful in my movements since I had the baby. **T F**
35. I find it easy and satisfying to recognize parts of my husband in the baby. **T F**
36. At times I find I must stop in my tracks because I just can't remember what I was intending to do. **T F**
37. I feel less critical of my own mother now that I have a baby.
T F
38. I bump into things or trip over things surprisingly often recently. **T F**
39. My baby felt like mine right away. **T F**
40. It bothers me to see certain characteristics of my husband in the baby. **T F**
41. Sometimes when I'm having a *conversation* with another adult I forget what I was about to say. **T F**

42. I'm reluctant to take up my accustomed round of errands and activities. I'd rather stay home with my baby. Shopping, etc. seems less important to me now. **T F**
43. I pick my baby up sometimes even when he/she is content just to hold him/her. **T F**
44. I feel more critical of my mother now that I have a baby. **T F**
45. I've become very forgetful. **T F**
46. Sometimes I find myself swaying as if to lull my baby when the baby isn't even with me. **T F**
47. It took a little while for me to feel like the baby really was mine. **T F**
48. Sometimes I find I'm talking baby talk to myself. **T F**
49. I misplace things more than I used to. **T F**
50. The first hours after my baby's birth I was too excited to rest. **T F**
51. Often I say what I think my baby would be saying to someone if he/she could talk. **T F**

52. MY baby has ways of crying that let me know if he/she is hungry, tired or just wants to be with me. **T F**
53. I've been hesitant to take my baby out and about. I feel he/she should be protected from the "outside world" for a while.
T F
54. I've been surprised by how long it seems to taking to "return to normal." **T F**
55. I seem to know without consulting the clock when my baby is hungry even if we're apart. **T F**
56. The first hours after my baby's birth I was exhausted and just wanted to be left alone. **T F**
57. My baby often falls asleep nursing and I sometimes find myself dozing off or coming close to it then too. **T F**

Please feel free to use the back of the form for any questions or comments, but remember this form is coded to ensure anonymity so please don't include your name. Thank you.

SEMI-STRUCTURED INTERVIEW

Preamble

“My reason for conducting this study is both personal and professional. I have had three children and two of them are young children, so I have been thinking a lot about what this experience has been like, about the nature of my bond with my babies and the nature of my clinical work. This is what has prompted this dissertation, and I am very interested in your feelings about it.”

BACKGROUND INFORMATION

Therapist Personal Data

Age:

Marital Status:

Family annual income (under \$50,000, \$50,000-\$100,000, or over \$100,000)?

Number of children:

Number of weeks postpartum

How was the delivery? (Were there complications?)

Did you have help when your baby was born? If so, what kind (e.g., family, baby nurse)?

What was your physical experience/bodily experience of your pregnancy and post-pregnancy like (e.g., any complications?) (prompts: *Did you have a C-sections? Was your experience of your body different afterwards? Were you in pain?*)

Therapist Work Data

Please describe your area and level of training.

How many years post-PhD are you? (if still in training, what year?)

Please describe your primary therapeutic orientation (cognitive, behavioral, relational, Freudian, integrative).

Generally describe the type of patients you see (proportions of psychotic, borderline, neurotic character pathology; proportions of male and female).

Please describe the setting in which you provide treatment. If you are in private practice, where is your office (e.g., home, professional office rental)? How do you feel about this?

Do you breast-feed or bottle-feed? Have any issues related to feeding impacted your work with patients?

THERAPIST EXPERIENCES

Pregnancy and Maternity Leave

What was it like to be working during your last trimester?

Did your approach to patients change in any way? If yes, how so?

Did you notice any difference between male and female patients? Did you notice any difference in your higher functioning and more disturbed patients?

How long were you away from work before and after giving birth?

Looking back, do you feel you made the right decision about the timing of your maternity leave?

Resumption of Work

What was it like going back to work after giving birth?

(If participant does not mention the following, they will be prompted to discuss: *tiredness?*

distractibility? Change in thinking or cognition? losing a sense of time? preoccupied?

withdrawn? distanced? detached? possessive? intrusive thoughts? difference in emotional

responsiveness to patients? more or less tolerant? identification? nonverbal communication?

curiosity? memory of clinical material? dreams or fantasies?)

Did you have different responses to different patient groups (prompts: *age, gender, diagnostic category, whether patient is a parent*)? How has that impacted the treatment?

Did your approach change since giving birth (prompts: *boundaries, self revealing, verbal activity, interpretation*)?

Did you resume work at different times with different patients? What went into these decisions? (Resuming first with 'easy' patients, 'hard' patients, or patients with certain dynamics?)

Supervision

Did your pregnancy affect your supervision? If so, how? (prompts: *was there conflict around the issue, or did you see eye-to-eye? What was your reaction to your supervision during pregnancy? On your return?*)

Were there any changes in your relationship with your supervisor that may be a result of your pregnancy? How do you feel about the supervision you received?

PATIENT EXPERIENCES

What were your patients like when you returned to work? Were they any different? How were they different? (positive or negative) (prompts: *acting out [being late, missing sessions, late payments, suicidal threats, pregnancy, terminations], dreams and fantasies? boundary issues? Envy/jealousy? sibling rivalry? competition? personal growth?*)

Did this occur for some patients more than others? (prompts: *age, gender, diagnostic category*)?

Can you give an example?

Has there been a change in your ability to handle your countertransference since giving birth?

FINAL QUESTIONS

Is there anything you would do differently next time? What would you do the same?

Is there anything you would recommend to other new mother therapists?

Do you have any other concerns not brought up today that seem important?

How has your participation in this study been?

I am wondering if you would not mind if a few weeks later I can just check in with you for 10-15 minutes on the phone and see if you have follow-up thoughts about the things we discussed today?

FOLLOW-UP PHONE CALL QUESTIONS (Three weeks later)

What was it like to have this interview?

Was there anything about the interview that got you to think about things?

Now, a few weeks later, is there anything that you would like to add that you did not articulate in the interview?

References

- Abend, S. M. (1982). Serious illness in the analyst: Countertransference considerations. *Journal of American Psychoanalytic Association, 30*, 365-379.
- Bacon, L. (1974). Early motherhood, accelerated role transition, and social pathologies. *Social Forces, 54*(3), 333-341.
- Balint, A. (1949). Love for the mother and mother-love. *International Journal of psychoanalysis, 30*, 251-260
- Ballou, J. (1978). *The psychology of pregnancy*. Lexington, MA: Lexington Books.
- Balsam, R. (1974). The pregnant therapist. In R. Balsam & A. Balsam (Eds.), *Becoming a therapist* (265-288). Boston: Little Brown.
- Barbanel, L. (1980). The therapist's pregnancy. In B. L. Blum (Ed.), *Psychological aspects of pregnancy, birthing, and bonding* (232-246). New York: Human Sciences Press.
- Basescu, C. (1996). The ongoing mostly happy "crisis" of parenthood and its effect on the therapist's clinical work. In B. Gerson (Ed.), *The therapist as a person: Life crises, life choices, life experiences and their effects on treatment* (pp. 101-117). Hillsdale, NJ: The Analytic Press.
- Bassen, C. R. (1988). The impact of the analyst's pregnancy on the course of analysis. *Psychoanalytic Inquiry, 8*(2), 280-298.
- Bellack, L. & Goldsmith, L. A. (1980). *The broad scope of the ego function assessment*. New York: John Wiley & Sons.
- Belsky, J. (1986). Transition to parenthood. *Medical Aspect of Human Sexuality, 20*(9), 56-59.

- Belsky, J. & Pensky. (1988). Marital change across the transition to parenthood. *Marriage and Family Review*. 12, 133-156.
- Benedek, E. (1973). The fourth world of the pregnant therapist. *Journal of the American Medical Woman's Association*, 132, 419-422.
- Benedek T. (1959). Parenthood as a developmental phase. *American Psychoanalytic Association*, 78, 389-417.
- Benedek T. (1970a). The family as a psychological field. In Anthony, E.J. and Benedek, T. (Eds.) *Parenthood: Its psychology and psychopathology* (pp.109-136). Boston: Little Brown.
- Benedek, T. (1970b). Motherhood and nurturing. In Anthony, E. J. and Benedek, T. (Eds.), *Parenthood: Its psychology and psychopathology* (pp. 153-165). Boston: Little Brown.
- Bergman, A. (1985). The mother's experience during the earliest phases of infant development. In Anthony E.J. and Pollock, G.E. *Parental influence: In health and disease*. Boston: Little Brown.
- Bergman, A. (2000). Preface to the 2000 edition. In M. S. Mahler, F. Pine, and A. Bergman, *The Psychological Birth of the Human Infant* (pp. xv-xix). New York: Basic Books.
- Bibring, G. L. (1959). Some considerations of the psychological processes in pregnancy. *The psychoanalytic Study of the child*, 14, 113-121.

- Bibring, G., Dwyer, T, Huntington, D., & Valenstein A. (1961). A study of the psychological processes in pregnancy and of the earliest mother-child relationship. *Psychoanalytic Study of the child*, 16, 9-78.
- Bibring, G., Dwyer, T, Huntington, D., & Valenstein A. (1961). A study of the psychological processes in pregnancy and of the earliest mother-child relationship: Some propositions and comments. *Psychoanalytic Study of the Child*, 16, 9-78.
- Bion, W. R. (1962). Learning from experience. New York: Basic Books.
- Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psychoanalysis*, 39(5), 350-373.
- Brazelton, T. B. (1973). Effect of maternal expectations on early infant behavior. *Early Child Development and Care*, 2, 259-273.
- Brazelton, T. B. (1983). Why early intervention? In Call, J.D., Galenson, J.D., and Tyson, R.L. (Eds.) *Frontiers of Infant psychiatry II*. New York: Basic Books.
- Campbell, S. B., Cohn, J. F., Flanagan, C., Popper, S., & Myers, T. (1992). Course and correlates of postpartum depression during transition to parenthood. *Development and Psychopathology*, 4, 29-47.
- Chess S. & Thomas, A. (1982). Infant bonding: Mystique and reality. *American Journal of Orthopsychiatry*. 52(2), 213-222.
- Clarkson, S. (1980). Pregnancy as a transference stimulus. *British Journal of Medical Psychology*, 53, 313-317.
- Cowan, C.P., & Cowan, P.A. (1995). Interventions to ease the transition to parenthood: Why they are needed and what they can do. *Family Relations*. 44, 412-424.

- Davis, B. (1984). Wife, mother, therapist...Which comes first? *Psychotherapy in Private Practice*, 2(4), 17-24.
- Diamond, D. (1992). Gender-specific transference reactions of male and female patients to the therapist's pregnancy. *Psychoanalytic Psychology*, 9(3), 219-345.
- Deutsch, H. (1945). *The psychology of women, I & II*. New York: Grune & Stratton.
- Domash, L. (1984) The preoedipal patient and the pregnancy of the therapist. *Journal of Contemporary Psychotherapy*, 14, 109-119.
- Doss, B.D., Rhoades, G.K., Stanley, S.M., & Markman, H.J. (2009). The effect of the transition to parenthood on relationship quality: An 8-year prospective study. *Journal of Personality and Social Psychology*, 96, 106-119.
- Fenster, S. (1983). *Intrusion in the analytic space: The pregnancy of the psychoanalytic Therapist* (Doctoral dissertation, Adelphi University, 1983). Dissertation Abstracts International, 8317555.
- Fenster, S., Phillips, S., & Rapoport, E. (1986). *The therapist's pregnancy: Intrusion in the analytic space*. Hillsdale, NJ: The Analytic Press.
- Fonagy, P., Steele, M., Moran, G., Steele, H., & Higgitt, A. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, 12, 200-216.
- Freeman, M. P., Wright, R., Watchman, M., Wahl R. A., Sisk, D. J., Fraleigh, L., & Weibrecht, J. M. (2005). Postpartum depression assessments at well-baby visits: Screening feasibility, prevalence, and risk factors. *Journal of Women's Health*, 14, 929-935.
- Freud, S. (1915). The unconscious. In *Standard Edition*, 14. London: The Hogarth Press.

- Freud, S. (1923). Ego and id. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud*. 19. (1961). London: The Hogarth Press.
- Fuller, R. (1987). The impact of the therapist's pregnancy on the dynamic of the therapeutic process. Panel: The pregnancy of the therapist. *Journal of American Academy of Psychoanalysis*. 15, 9-28.
- Gerson, B. (1996). *The therapist as a person: Life crises, life choices, life experiences and their effects on treatment*. Hillsdale, NJ: The Analytic Press.
- Grigoriadis, S., & Romans, S. (2006). Postpartum psychiatric disorders: What do we know and where do we go? *Current Psychiatry Reviews*, 2, 151-158.
- Grotstein, J. S. (1981). Wilfred R. Bion: The man, the psychoanalyst, the mystic. A perspective on his life and work. In J.S. Grotstein (Ed.), *Do I dare disturb the universe?* (pp.357-416). London: Karnac.
- Grotstein J. S. (1981). Who is the dreamer who dreams the dream and who is the dreamer who understands it (revised). In J.S. Grotstein (Ed.), *Do I dare disturb the universe?* (pp.357-416). London: Karnac.
- Grotstein J. S. (1992-1993). Personal communication, Los Angeles, California.
- Hannet, F. (1949). Transference reactions to an event in the life of the analyst. *Psychoanalytic Review*, 36, 69-81.
- Harris, B., (2002). Postpartum depression. *Psychiatric Annals*, 32(7), 405-415.
- Hartman, H. (1958). Ego psychology and the problem of adaptation. New York, International Universities Press.
- Hartmann, H. (1964). *Essays on ego psychology*: New York: International Universities Press.

- Hartmann, H., Kris, E., & Loewenstein, R.M. (1946). Comments on the Formation of Psychic Structure. *Psychoanalytic study of the Child*, 2, 11-38.
- Hayworth, B.C. Little, S. Bonham Carter, P. Raptopoulos, Z.G. Priest and M. Sandler, (1980). A predictive study of postpartum depression: Some predisposing characteristics. *British Journal of Medical Psychology*, 53, 161–167.
- Hotchner T. (1984). *Pregnancy and childbirth: The complete guide for a new life*. New York: Avon Books.
- Imber, R. R. (1990). The avoidance of countertransference awareness in a pregnancy analyst. *Contemporary Psychoanalysis*, 26, 223-236.
- Issacs- Elmhirst, S. (1981). Bion and babies. In J .S. Grotstein (Ed.), *Do I dare disturb the universe?* (pp. 83-91). London: Karnac.
- Jurist, E. L. (2008). Minds and yours: New directions for mentalization theory. In E. L. Jurist, A. Slade, and S. Bergner (Eds.), *Mind to mind: Infant research, neuroscience, and psychoanalysis* (pp. 88-114). New York, NY: Other Press.
- Klein, M. (1957). *Envy and gratitude*. London: Tavistock Publications.
- Knafo, D. (2002). Revisiting Ernest Kris's Concept of Regression in the Service of the Ego in Art. *Psychoanalytic Psychology*, 19), 24-49.
- Kris, E. (1936/1952). *Psychoanalytic explorations in art*. New York: International Universities Press.
- Korol, R. (1996). Personal and professional aspects of being a pregnant therapist. *Women & Therapy*, 18(1), 99-108.

- Lax, R. (1969). Some considerations about transference and countertransference manifestations evoked by the analyst's pregnancy. *International Journal of Psycho-Analysis*, 50, 363-372.
- Leifer, M. (1977). Psychological changes accompanying pregnancy and motherhood. *Genetic Psychology Monographs*, 95, 55-96.
- Leifer, M. (1980). *Psychological effects of motherhood: A study of first pregnancy*. New York: Praeger.
- Litowitz, M.R. (1987). The pregnant therapist: Transference manifestations and management. Paper presented at the meeting of the American Psychological Association, New York.
- LoCicero, X., Weiss, X. & Issokson, X. (1997). Postpartum depression: Proposal for prevention through an integrated care and support network. *Applied and Preventive Psychology*, 6, 169-178.
- Lopata, J. (1972). *Occupation: Housewife*. New York: Oxford University Press.
- MacNab, S. & Scholfield, S. (1995). Listening to your patients, yelling at your kids: The interface between psychotherapy and motherhood. In M.B. Sussman (Ed.), *A perilous calling: The hazards of psychotherapy practice* (pp. 37-44). Chicago, IL: John Wiley & Sons.
- Main, M. (1995). Recent studies in attachment: Overview, with selected implications for clinical work. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental, and clinical perspectives* (pp. 407-474). Hillsdale, NJ: Analytic Press, Inc.

- Marlin, O. (1988). Parenthood in the life of the analyst. *Contemporary Psychoanalysis*, 24(3), 470-478.
- McGarty, M. (1988). The analyst's pregnancy. *Contemporary Psychoanalysis*, 24, 684-692.
- Mercer, R. (1985). The process of maternal role attainment over the first year. *Nursing Research*, 34(4), 198-204.
- Mercer, R., & Ferketich S. (1990). Predictors of family functioning eight months following birth. *Nursing Research*, 39(2), 76-82.
- Moulton, B.L. (1991). *The psychological birth of the mother: A study of primary maternal preoccupation*. (Doctoral dissertation, The Wright Institute, 1991).
Dissertation Abstracts International, 9116085.
- Miller, J., Jordan, J., Kaplan, A., Stevier, I., & Surrey, J. (1997). *Women's growth in diversity: More writings from the Stone Center*. New York: The Guilford Press.
- Nadelson, C., Notman, M., Arons, E., & Feldman, J. (1974). The pregnant therapist. *American Journal of Psychiatry*, 131, 1107-1111.
- Naperstack, B. (1976). Treatment guidelines for the pregnant therapist. *Psychiatric Opinion*, 13, 20-25.
- Norbeck, J. & Tilden V. (1983). Life stress, social support, and emotional disequilibrium in complications of pregnancy: A prospective. *Multivariate Journal of Health and Social Behavior*, 24(1), 30-46
- Ogden, T.H. (1994). The analytic third: Working with intersubjective clinical facts. *International Journal of Psychoanalysis*, 75, 3-19.

- Ogden, T.H. (1997). *Reverie and interpretation: Sensing something human*. Northvale, NJ: Jason Aronson, Inc.
- Ogden, T.H. (1997). Reverie and interpretation. *Psychoanalytic Quarterly*, 66(4) 567-595.
- Ohara, M.W. (1987). Post-partum 'blues', depression, and psychosis: A review. *Journal of Psychosomatic Obstetrics and Gynecology*, 7, 205-227.
- Ohara, M.W. (1997). The nature of postpartum depressive disorders. In P.J. Cooper & L. Murray (Eds.), *Postpartum depression and child development* (pp. 3-31). New York: Guilford Press.
- Ohara, M.W. & Swain, A.M. (1996). Rates and risk of postpartum depression: A meta-analysis. *International Review of Psychiatry*, 8(1), 37-54.
- Paluszny M., & Poznanski, E. (1971). Reactions of patients during the pregnancy of the psychotherapist. *Child Psychiatry and Human Development*, 1, 266-274.
- Paykel, E.S., Emms, E.M., Fletcher, J., Rassaby, E.S. (1980). Life events and social support in puerperal depression. *British Journal of Psychology*, 136, 339-346.
- Penn, L. S. (1986). The pregnant therapist: Transference and countertransference issues. In J. L. Alpert (Ed.), *Psychoanalysis and Women: Contemporary Reappraisals* (pp. 287-315). Hillsdale, NJ: The Analytic Press.
- Pielack, L. (1989). Transference, countertransference, and the mental health counselor's pregnancy. *Journal of Mental Health Counseling*, 11, 155-176.
- Racker, H. (1968). *Transference and countertransference*. New York: International Universities Press.
- Rogers, C. (1961). *On becoming a person*. Boston: Houghton.
- Rogers, C. (1994). The group and the group analyst's pregnancies. *Group Analysis*, 27, 51-61.

- Rossi, A. (1968). Transition to parenthood. *Journal of Marriage and the Family*, 30, 26-39.
- Rychnovsky, J., & Beck C.T. (2006). Screening for postpartum depression in military women with the postpartum depression screening scale. *Military Medicine*, 171, 1100-1104.
- Saakvitne, K.W. (2000, April). Your children are not your children: Therapist as adoptive and transferential mother. *Paper presented at the 20th Annual Meeting of the Division of Psychoanalysis*, American Psychological Association, San Francisco, CA.
- Schaefer, R. (1958). Regression in the service of the ego: The relevance of a psychoanalytic concept for personality assessment. In Lindzey, G. (Ed.), *Assessment of Human Motives*. New York: Holt, Reinehart and Winston.
- Schwartz, M. C. (1975). Casework implications of a work's pregnancy. *Social Casework*, 56, 30-34.
- Swendsen, J.D., & Mazure, C.M. (2000). Life Stress as a Risk Factor for Postpartum Depression: Current Research and Methodological Issues. *Clinical Psychology: Science and Practice*, 7 (1), 17-31.
- Swain, J. E., Thomas, P., Leckman, J. F., & Mayes, L. C. (2008). Parent-infant attachment systems: Neural circuits, genes, and early-life programming. In E. L. Jurist, A. Slade, and S. Bergner (Eds.), *Mind to mind: Infant research, neuroscience, and psychoanalysis* (pp. 264-303). New York, NY: Other Press.
- Tuber, S. (2008). *Attachment, play, and authenticity: A Winnicott Primer*. Jason Aronson, The Rowman & Littlefield Publishing Group, Inc., New York.

- Tuber, S., & Caflisch, J.M. (2011). *Starting Treatment With Children and Adolescents: A Process-Oriented Guide for Therapists*. Routledge Taylor and Francis Group.
- Tulman L., & Fawcett, J. (1988). Return of functional ability after childbirth. *Nursing Research, 37*, 77-81.
- Turkel, A.R. (1993). Clinical issues for pregnant psychoanalysts. *Journal of the American Academy of Psychoanalysis, 21*(1), 117-131.
- Turnbull, A.C., Patten, P.T., Flint, A.P.F., Keirse, M.J.N.C., Jeremy, J.Y., & Anderson, A. (1974). Significant fall in progesterone and rise in estradiol levels in human peripheral plasma before onset of labor. *Lancet, 1*, 101-103.
- Ulman, K.H. (2001). Unwitting exposure of the therapist: Transferential and countertransferential dilemmas. *Journal of Psychotherapy Practice & Research, 10*(1), 14-22.
- Underwood, M., & Underwood, E. (1976). Clinical observations of a pregnant therapist. *Social Work, 21*, 512-514.
- Unterman R., Posner N., Williams K. (1990). Postpartum depressive disorders: Changing trends. *Birth, 17*, 131-137
- Van Leeuwen, K. (1966). Pregnant envy in the male. *International Journal of Psychoanalysis, 47*, 319-324.
- Van Neil MS (1993). Pregnancy: The obvious and evocative real event in a therapist's life. In J.H. Gold and L.C. Nemiah (Eds.), *Beyond transference: When the therapist's real life intrudes* (pp. 125-140). Washington, DC: American Psychiatry Press.

- Waldman, J. (2003). New mother/old therapist: Transference and countertransference challenges in the return to work. *American Journal of Psychotherapy*, 57(19) 52-63.
- Weiss, S. (1975). The effects on the transference of 'special events' occurring during psychoanalysis. *International Journal of Psychoanalysis*, 56, 69-75.
- Williamson, L. (1993). Postpartum depression syndrome as a defense to criminal behavior. *Journal of Family Violence*, 8(20), 151-165.
- Winnicott, D. W. (1945). Primitive emotional development. In *Collected Papers: Through pediatrics to psycho-Analysis*. London: Tavistock Publications, 1958.
- Winnicott, D.W. (1947). Hate in the countertransference, In: *Through Pediatrics to Psycho-Analysis* (pp.194-203). New York. Basic Books.
- Winnicott, D.W. (1956). Primary Maternal Preoccupation. In Winnicott, D.W. *Through pediatrics to psychoanalysis*. New York: Basic Books. 1975.
- Winnicott, D.W. (1958). Primary Maternal Preoccupation. In *collected papers: Through pediatrics to psychoanalysis*. New York: Basic Books.
- Winnicott, D. W. (1958), *Collected Papers: Through Pediatrics to Psycho-analysis*, London: Tavistock.
- Winnicott, D. (1960). *Parent-Infant relationship in the maturational processes and the facilitating environment*. New York: International Universities Press.
- Winnicott, D.W. (1960). The theory of the parent-infant relationship. In Winnicott, D.W. *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. New York: International Universities Press. 1965.

- Winnicott, D.W. (1963). Communicating and not communicating leading to a study of certain Opposites. In D.W. Winnicott, *The maturational processes and the facilitating environment*. New York: International Universities Press.
- Winnicott, D.W. (1963). *Dependence in infant care, in child care, and in the psycho-Analytic International Journal Psycho-Analytic*, 44, 339-344.
- Winnicott D.W. (1967). Mirror-role of the mother and family in child development. In D.W. Winnicott, *The maturational processes and the facilitating environment*. New York: International Universities Press.
- Winnicott, D. W. (1969). The mother-infant experience of mutuality. *Psychoanalytic Explorations*. Cambridge, Mass. Harvard University Press.
- Winnicott, D.W. (1971). Playing: Creative activity and the search for the self. In *Playing and Reality*. London: Tavistock Publishers.
- Winnicott, D.W. (1970). The mother-infant experience of mutuality. In Anthony, E.J. and Benedek, T. (Eds.). *Parenthood: Its psychology and psychopathology*. Boston: Little Brown.
- Winnicott, D.W. (1975). *Through pediatrics to psycho-analysis*. London: The Hogarth Press and the Institute of Psycho-Analysis.