Facing the ‘baby bump’: how a psychotherapist’s pregnancy influences healing

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Abstract

Psychotherapists are not immune to major-life events impacting their work. The therapist’s pregnancy among such events has a deep impact on therapeutic alliance. The evident biological changes induce stressors that may hinder concentration and emotional involvement but a more crucial aspect of them is the dread of client’s reaction to it. In the commentary below, this issue has been explored from a psychoanalytic and an interpersonal perspective highlighting the magnitude of this conundrum from an ethical dimension.

Introduction

Psychotherapy is a complex change-oriented process which significantly relies on the relationship that cultivates between the therapist and the client, for positive outcomes (Ardito & Rabellino, 2011). It comprises of a series of interpersonal interactions that may easily invite influences from the therapist’s life, eventually having an impact on this alliance (Strong, 1968). One such event is the therapist’s pregnancy. While maternal mental health has been an issue psychotherapy had been increasingly sought for, what’s missing from franternitic thought is this paradoxical event, bringing in the therapist’s own pregnancy and its effect on her relationship with the client. The tables are turned. The obvious baby-bump in the room belongs to not the client but to the therapist. Would that alter the process, the journey, or much dreaded, the alliance? Or how would the client perceive it, itching the urge to ask many questions, including the one he/she has been asked a thousand times now, “how do YOU feel?”.

The idea of a psychotherapist’s (or any working professional) pregnancy may easily get entangled with prejudices against pregnant women, including instability in their mood or even decline of cognitions that make them “faulty decision-makers”. Most of these myths, charged with sexism, have repeatedly been debunked by research (Elliott, 2009). Pregnancy, nonetheless, is rightly linked with stress and anxiety governed by a spectrum of emotional and behavioural changes women experience as they proceed through the trimesters. Then how does one, with a

pregnant therapist, foresee a process of mental health treatment or healing that predominantly banks on significant confrontations with unacceptable feelings and conflicts?

To attend to such queries it is, first, crucial to acknowledge that pregnancy is as normal a part of the therapist's interpersonal life as it is, or would be, of the client. But this acknowledgement itself is charged with strong uncanny feelings bringing in new grounds of reality check for the client. For one, it impels them to pursue the idea that their all-neutral *tabula rasa* of a therapist is very much a sexual woman with a personal life experiencing pungent spirals of psychobiological manifestations (Etchegoyen, 1993; Cullen-Drill, 1994). The dyadic relatedness turns into a triadic form of interaction as a whole new person, much closer to the therapist, now sits between her and the client, both literally and figuratively.

In every scenario what remains constant is the notion that a psychotherapist's pregnancy is much more deterministic of their work than that of any other service providers'. Dyson & King (2008) have considered pregnancy to be one of the most influential life-events of the therapist that has an impact on therapeutic relationship. Similarly, literature on the issue posits that the therapist's pregnancy is a generator of a multidimensional outcomes. At one point, it can catalyze the relationship offering striking opportunities for emotional growth for both the therapist and the client but can also spawn negative feelings in the two resulting in a deteriorating progress of the same relationship (Fuller, 1987; Bassen, 1988; Fallon & Brabender, 2003; Hachem-Lynch, 2014). And it is for this very reason, pregnancy, in the context of psychotherapy, cannot be dealt only with maternity leaves. The therapist's metamorphosis initiates new meanings to the client and their expectations from therapy.

The psychoanalytic perspective

The therapist's pregnancy has been considerably discussed in the psychoanalytic literature (Fuller, 1987; Bassen, 1988; Etchegoyen, 1993; Cullen-Drill, 1994; Schmidt, Fiorini & Ramires, 2015) revolving largely around issues of transference and countertransference. Stockman & Green-Emirich (1994), although considering the therapist's pregnancy to be an opportunity for nurturance, warn of development of complex object relations directed by the emergence of issues with parenthood and sibling rivalry by making the therapist a visual stimulus on whom many emotions and feelings are projected (p. 4).

During pregnancy the maternal aspect of the analysis intensifies and hence the symbiotic relationship between the therapist/mother and the client/child is experienced with more vividness. This at times may either facilitate resolutions using the pregnancy as a representation of the client's own situation or induce separation anxiety and hostility towards the therapist.

Paluszny and Poznanski (1971) noted three kinds of outcomes of this interaction from the patient's perspective- a) the patients either relived the events with the therapist, resolving oedipal rivalries, b) expressed denial and other defensive reaction to the encounter or c) integrated the event and its implications within therapy to make progress (p. 267). On a similar note, the therapists found themselves splitting into two different kinds of maternal engrossments- one involving interaction between the therapist and the patient while the other between the mother and the unborn child. Not only this self-absorption declined the therapists' intensity of involvement into the former relationship, it also mirrored the same triadic relationship- the presence of the "third other"- in them (p. 274).

Such transference-loaded reactions prove integral to the alliance opening new avenues for therapeutic work to flourish. Most of the critical transitions in patients occur when the therapist enters her final trimester and finally takes a maternity leave (Chiaramonte, 1986). These changes idealise the therapist as the Winnicottian 'good mother' but are soon met with negative reactions towards the obvious 'new person'. In a paradoxical sense, the client's own oedipal war is reenacted where the unborn is perceived as a barrier between their desires to have the therapist all to themselves. The maternity leave serves as an intensifier of negative reactions since it shows the therapist/mother to make an autonomous choice of leaving the client/child.

Contradictory findings suggest positive changes not only in achieving milestones in therapy through transference but also assimilating the new identity of therapist's motherhood. Rosenthal (1990) considered the phase to be a modification of the therapist's own identity. This is consistent with Rubin's (1980) self-exploration asserting new grounds of empathy that a therapist builds by becoming a patient herself. Rubin (1980) also noted that taking advice from clients who have been mothers served as a medium of role-reversal that further initiated the patient's autonomy. Although, countertransference reactions may soon emerge.

Winnicott (1956) coined the phrase, 'primary maternal preoccupation' in mothers, usually occurring in the final trimester that makes them absorbed into accommodating the child's needs and demands in order to be the 'good mother'. Zackson (2012) in her work observed that the feeling of heightened sensitivity in this period towards the needs of the child made therapists more emotionally compliant towards the needs of the client (in Wolfe, 2013). As beneficial as this must have been, such times also reduce the therapist's capability to notice countertransference which may hinder their relationship (Cullen-drill, 2004).

Gender differences exist in client-reactions to pregnancy. Where most intense interactions surrounding the therapist's pregnancy take place with the female clients; men are more likely to deny the event and even distance themselves from the therapist (Chiaramonte, 1986; Cullen-drill, 2004; Benton, Swan & Whyte, 2010). Cultural influences may play a role

here. In several parts of the world, pregnancy is perceived as a period of isolation from the male gaze and men avoid direct interactions with women. Theorists link this isolation and discomfort with the unconscious envy towards women's ability to procreate, also referred to Karen Horney's concept of 'womb envy' (Brennan, Ayers, Ahmed and Marshall-Lucette, 2007). It is hence that in female clients, the event is considered more valid accelerator of new therapeutic work.

The interpersonal perspective

Besides the vastness of psychoanalytic thought, which is undeniable, the pregnant therapist and her relationship with the client must be viewed from an interpersonal lens. The intense journey to motherhood with its biopsychosocial perturbations is no different for the therapist. At the end of the day, their ambivalence, conflicts, desires and emotions compiling the "maturational crisis" is the most normal byproduct of this event (Fallen & Barbender, 2003, p. 92). And like any individual their potential to deal with the array of stressors depends on their coping styles and personality make-up. In the context of the therapist's pregnancy, therapists often find themselves stuck in the ethical dilemmas surrounding the extent of appropriateness in self-disclosure.

The degree of self-disclosure has existed on a continuum of comfort the therapist did or did not feel with the client's intrusion. While some hesitate in giving out too many details regarding the event, some saw it as a harbourer of new closeness between them and the clients (Wolfe, 2013). The acceptance of gifts which have earlier been perceived as an unconscious act of atonement against the guilt experienced by the therapist for bringing in the pregnancy (Fenster, Phillips & Rapoport, 2009) could also be interpreted as a disclosure of happiness and excitement as noted by Wolfe (2013).

What is crucial, however, is to scrutinize the perception of self-disclosure of therapist's personal life both to herself and the client. Humanistic proponents have encouraged such processes and saw value in them. Rogers (1961) regarded self-disclosure to be an important factor in establishing rapport with the client. However, pregnancy sets ground for more complex feelings to emerge than simply establishing a rapport. Existentialists argue for transition into motherhood to be a meaning-making process and must be interpreted more wholesomely than a reductionist biomedical point of view (Prinds, Hvidt, Mogensen & Buus, 2014). The same approach must be translated into the context of therapist's pregnancy.

Relational aspects are hence more inclusive of understanding the dynamics governed by events Yalom (2002) has proposed of viewing therapeutic relationship as a collaborative voyage carrying an equal weight of both the therapist's and the client's feelings about the process. His

term posing therapist-client as “fellow travellers” abolishes distinctions between “them” (the afflicted) and “us” (the healers) (p. 8) that represents the underlying theme of psychoanalytic discussions. This is not to say that interpersonal exploration of therapist’s pregnancy is more preferable than its psychoanalytic counterpart, but it highly depends upon the nature of the client, his/her issues and an optimal pace of disclosure that such explorations become possible and productive (Barbanel, 1980).

For example, in her personal experience, Somers (2006) noted how she, after being pregnant, gained more self awareness as a therapist in understanding how valuable therapeutic elements are to her client, which she had otherwise taken for granted. For Benjamin (2015) it was a liberating experience where she and her patient learned together about the importance of boundaries in interpersonal relationships through their own. For a therapist specializing in maternal mental health, Jessica Zuker’s pregnancy brought her lessons which proved beneficial both for her practice and her clients by discovering the diverse set of meanings it made to them. She advocated for a middle ground between the initial ‘blank-slate’ ideology and an overtly opened-up experience (Zucker, 2015). All these experiences, of course, are preceded with evident anxiety about the client’s reaction and dilemmas regarding intrusion of personal space.

Conclusion

Psychotherapists are not immune to major-life events impacting their work. The therapist’s pregnancy among such events has a deep impact on therapeutic alliance. The evident biological changes induce stressors that may hinder concentration and emotional involvement but a more crucial aspect of them is the dread of client’s reaction to it. Psychoanalytic literature offers a deeper look into the backstage of such encounters, involving affairs of transference and countertransference, while also providing insight into how pregnancy can both act as a facilitator or a breaker in progress depending upon an integration of interpretational skills and self-introspection.

Parellely, an interpersonal approach views the therapist and the client (and the pregnancy) co-existing, defying power relations and trying to explore how the event may deem beneficial to the two parties. Less research exists in the latter perspective, but collaborative guidelines exists for psychotherapists to cope with issues associated with pregnancy and work. These range from setting boundaries to taking time off work. Some even provide a step-by-step comprehensive approach to transition through the process while maintaining a check on its impact on work (Fallen & Barbender, 2003; Novotney, 2014).

The reason why most literature on the topic involves qualitative inquiries is the same reason behind the therapist's pregnancy being a complex event that cannot be explained in a single prospect. As sharply noted by Barbanel (1980), it is important to acknowledge that such a discussion only surrounds female psychotherapists as men do not have to experience this dilemma in practice. This advocates for accommodating a subjective experience of the therapist's pregnancy is consistent with the subjective experience of motherhood which is beyond biomedical understandings. What this contributes to therapy, as noted by many researchers, solely depends, not on its singular aspects, but a gestalt, inclusive of mothering and healing.

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