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Elizabeth Wolfe
The Therapist's Pregnancy and The
Client-Therapist Relationship: An
Exploratory Study

ABSTRACT

This empirical research study explored the impact of the therapist's pregnancy on the therapist-client relationship. Specifically, this study asked whether therapists and clients interact in less professional, more personal ways during the therapist's pregnancy, and how this is perceived by therapists to impact treatment. Relational psychodynamic theory was the theoretical underpinning of this study.

Thirteen psychotherapists were interviewed about their experiences of practicing therapy while pregnant. All participants were either currently or recently pregnant. Interview questions were developed by this researcher to elicit therapist experiences with clients who asked personal questions or offered baby gifts to the therapist, and how therapists felt about and responded to these behaviors. Interview questions also focused on how therapists perceived their pregnancy to impact the ways they conduct and understand therapy.

Findings were that most therapists had some clients offer gifts and ask personal questions during and following their pregnancy, along with a range of other boundary-crossing behaviors. Therapists responded to these behaviors along a continuum, depending on the degree to which they felt comfortable and whether they experienced client behaviors as appropriate, intrusive, or threatening. In some cases, therapists felt the need to reaffirm professional boundaries, while in other cases, therapists felt the pregnancy offered an opportunity to interact with clients in a more personal, less professional manner, which was perceived by some to positively impact treatment.

THE THERAPIST'S PREGNANCY AND THE CLIENT-THERAPIST

RELATIONSHIP: AN EXPLORATORY STUDY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2013

TABLE OF CONTENTS

CHAPTER I

Introduction

The therapist's pregnancy is a unique period in the course of psychotherapy. Unlike most other events in the life of a therapist, the highly visible nature of pregnancy means that clients will almost certainly be aware that the therapist is in the midst of a major life change.[1] Whereas a therapist can usually maintain some degree of personal privacy in her clinical work, the pregnant therapist's private life and personal decisions are asserted in the therapeutic dyad by the fact of her pregnancy. The present study explores, from the therapist's perspective, the ways the client-therapist relationship changes as a result of the therapist's pregnancy. More specifically, this study asks whether the therapist's pregnancy and the client's newfound awareness of the therapist's personal life outside therapy cause a period in treatment when clients and therapists interact in a less professional, more personal manner.

A number of previous studies on this topic suggest that the professional boundary between therapist and client seems to shift in this way during the therapist's pregnancy. For example, a number of studies found clients are more likely to ask personal questions of pregnant therapists, and therapists, in turn, tend to answer these questions honestly and directly (Fenster, 1983; Grossman, 1990; Byrnes, 2000; Zackson, 2012). Other studies have found that clients tend to offer gifts to the therapist during her pregnancy and therapists typically accept gifts (Fenster, 1983; Bashe, 1989; Fallon & Brabender, 2003). These findings suggest the therapist's

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[1] Throughout this thesis paper, the terms "client" and "patient" will be used interchangably.

pregnancy marks a departure from usual ways of relating. These behaviors, often considered outside the bounds of the professional relationship, are somehow more acceptable during the pregnancy. This study looks specifically at these behaviors to better understand how they are perceived and responded to by therapists.

As women are increasingly dominating the field of psychotherapy and mental health treatment, the therapist's pregnancy is likely a fairly common occurrence that deserves more attention. In 2006, 81% of all licensed social workers in the United States were women, and an even greater percentage of social workers under the age of 35 were women (Whitaker, Weismiller, & Clark, 2006). Like social workers, the vast majority of psychology students in the United States and Canada are female; in 2008-2009, 75% of students at the doctoral level and 77% at the master's level were women (Hart, Wicherski, & Kohout, 2010). These data suggest women are far outnumbering men in psychology and social work, the two disciplines that make up a majority of psychotherapists in the United States, and this trend is especially true for young people in the field. The therapist's pregnancy is therefore likely a quite common occurrence, but one that is relatively understudied. This study aims to build upon existing knowledge in order to further understand the complexities of this unique period during treatment.

CHAPTER II

Literature Review

Relational Theory

Relational theory forms the theoretical foundation of this project and informs my research question. Relational theory is an umbrella term that describes a number of theoretical models that have emerged within psychodynamic thought in the United States in the past four decades. Relational theorists are linked by their rejection of the Freudian, ego psychological theory of motivation which proposes that human behavior is motivated by internal biological drives, mainly for sex and aggression. By contrast, relational models emphasize the fundamental importance of relationships and propose that all behavior is motivated by the need to connect with others. As Aron (1996) has described, "relational theory is essentially a contemporary eclectic theory anchored in the idea that it is relationships (internal and external, real and imagined) that are central" (p. 18). Many have described this as a conceptual change from one-person psychology to two-person psychology, suggesting that human beings cannot develop or exist in isolation from one another, and that behavior is always inextricably linked to its relational context.

Relational theory represents a paradigm shift not only in the way human experience and mental illness are understood, but also in how to conceptualize and conduct psychotherapy. For Freud, psychoanalysis was essentially a one-person endeavor in which the analyst objectively observes the patient and offers interpretations. In his view, the analyst should be as neutral as

3

possible and countertransference responses were thought to impede treatment. As he famously stated with regard to self disclosure, "the doctor should be opaque to his patients, and like a mirror, should show them nothing but what is shown to him'' (Freud, 1912, p. 117).

Proponents of relational theory and two-person psychology challenge these conceptions and argue the central importance of the therapist-client relationship in psychotherapy. They emphasize that the therapist's subjectivity is unavoidably present and influences how the therapy unfolds. Some, particularly the intersubjectivists, have asserted that psychoanalysis is a process of co-construction in which therapist and client mutually influence each other (Stolorow & Atwood, 1997; Aron, 1991). As Aron (1991) has described, this understanding of psychotherapy "views the patient-analyst relationship as continually established and reestablished through ongoing mutual influence in which both patient and analyst systematically affect, and are affected by, each other" (para. 10). More recently, Ogden (2004) has described as critical to psychotherapy the "dialectical movement of individual subjectivity (of the analyst and analysand as separate individuals, each with his or her own unconscious life) and intersubjectivity (the jointly created unconscious life of the analytic pair)" (part 2, para. 20). In these ways, the analyst cannot be an outside, objective observer of the client, but instead is an active participant in the process of therapy.

Within these relational theories, a certain degree of intentional therapist self-disclosure is seen as important to effective therapy. As Aron (1991) articulates, clients intuitively and naturally "seek to connect to their analysts, to know them, to probe beneath their professional facade, and to reach their psychic centers much in the way that children seek to connect to and penetrate their parents' inner worlds" (Abstract, para. 2). The therapist, in turn, should be authentic and genuine, and judicious use of self-disclosure is encouraged. As Ogden (2004)

writes, "it is only through the recognition by an other who is recognized as a separate (and yet interdependent) person that one becomes increasingly (self-reflectively) human" (Part 2, para. 16). Recognition of the therapist as a separate, interdependent being can be facilitated through disclosure, by the therapist, of his or her thoughts, feelings, and reactions to clients, as well as some information about his or her personal life. Goldstein, Meihls, and Ringel (2009) have described the benefit of self-disclosure in plain language:

> When used in an attuned fashion, therapist self-disclosure can have many good outcomes. It can enable clients to feel that their needs are understood, to risk relating, to diminish their feelings of shame and aloneness, to explore their experiences, to feel validated in their very existence, and to explore the meaning of their patterns of relating (p. 120).

It is important to note that while most relational theorists espouse some use of self-disclosure, there does not appear to be a consensus in psychodynamic literature about how, exactly, it should be practiced. Many articles and books on the topic include lengthy case vignettes that demonstrate an intentional decision-making process, and more often than not, authors warn readers against the potential pitfalls of self-disclosure (e.g, Wachtel, 2008, 2011; Goldstein et al., 2009).

It is also important to note here that the most salient concept of relational theory – that relationships are fundamental, and that good psychotherapy must pay careful attention to the therapist-client relationship – receives some empirical support in recent "common factor" research, which has repeatedly found that across theoretical orientations, a strong therapeutic relationship is the most important factor that predicts positive mental health outcomes in clients (Norcross, 2002; Lambert, 2004; Wampold, 2001). The intense focus of relational theory on the

dynamics between therapist and client may engender the therapeutic alliance necessary for effective treatment.

I chose this particular theoretical foundation for my study because I see the therapist's pregnancy as a period when the subjectivity of the therapist is asserted in an undeniable, concrete way. A therapist who had previously maintained a fairly tight degree of personal boundaries with a client is revealed, by the fact of her pregnancy, to have a private life that must now be considered by the client. As described in further detail below, previous research has shown that pregnant therapists tend to be more self-disclosing with clients than they were prior to pregnancy. The central question of this study is how these changes impact the treatment relationship. Relational theory, with its focus on exploring the meaning of therapist-client dynamics, therefore seems particularly relevant in this context.

Research on Pregnancy in the Therapist

At least 76 articles and two books have been written about the therapist's pregnancy. A majority of articles written on this topic are personal accounts of psychotherapists who themselves became pregnant while practicing, and many of these are written from a psychodynamic perspective. There have been at least 13 attempts to empirically study the therapist's pregnancy, as shown in Table 1. All but one of these studies has been qualitative and exploratory in nature.

There are several limitations to the existing empirical research on this topic. First, much of the research was conducted over ten years ago. I have located only two studies conducted in the past ten years, and 9 of the 13 empirical studies I found were conducted between 1975 and 1994. Other limitations relate to study design. Because much of the research is qualitative and exploratory in design, sample sizes are small. Many of the studies collect retrospective data

through interviews with therapists who were previously pregnant, and this time lapse may lead to distortions in memory. Very little data have been collected directly from clients, and therefore much of the data about transference and client responses is conjecture by therapists. Additionally, there are no existing studies that specifically examine the perspectives of therapists of color, or therapists who identify as lesbian, bisexual, or queer, or any other historically marginalized population.

Table 1

Empirical Studies of the Therapist's Pregnancy

Author(s) and year of publication	Research Focus	Sample	Methodology
Berman (1975)	Patient acting out behavior during the therapist's pregnancy	9 psychiatrists	Checklists and unstructured interviews yielding retrospective data
Baum and Herring (1975)	Impact of resident pregnancy on resident, patients, colleagues, and on the supervisory relationship	Unspecified number of psychiatric residents	Interviews with former residents yielding retrospective data
Naparstek (1976)	Patient reactions to the therapist's pregnancy	32 therapists	Questionnaire yielding retrospective data
Fenster (1983)	Impact of therapist's pregnancy on all aspects of treatment	22 psychoanalytically oriented therapists	Longitudinal design including two interviews: one in final trimester and another 2-6 months postpartum. Retrospective and current data
Bassen (1988)	Impact of therapist's pregnancy on process of psychoanalysis	13 psychoanalysts	Semi-structured interviews yielding retrospective data

Table 1, cont.

Empirical Studies of the Therapist's Pregnancy

Author(s) and year of publication	Research Focus	Sample	Methodology
Bashe (1989)	Impact of therapist's pregnancy on all aspects of treatment	15 psychoanalytically oriented therapists	One interview conducted in last trimester of pregnancy yielding current data
Grossman (1990)	Therapists reactions to being pregnant while practicing psychotherapy	16 women psychotherapists, including 9 PhD psychologists and 6 MSW social workers, 14 of whom are psychodynamically-oriented	Individual and group interviews
Katzman (1993)	Impact of therapist's pregnancy on treatment of clients with bulimia	24 psychotherapy clients with bulimia	Behavioral checklists completed by therapist and secretary, process notes coded, 1-year follow up questionnaire completed by clients
Napoli (1999)	Missed appointments and late fee payments during the therapist's pregnancy	6 clients meeting with a single therapist before, during, and after her pregnancy	Analysis of fee payment and cancellations before, during, and after the therapist's pregnancy
Matozzo (2000)	Comparison of how pregnancy in the provider impacts the client-therapist relationship versus the patient-physician relationship	10 psychologists and 10 non-psychiatrist physicians	Semi-structured interview and questionnaire yielding retrospective data
Byrnes (2000)	Impact of therapist's pregnancy on treatment of children	24 therapists working from diverse theoretical frameworks with children	Longitudinal study, two structured interviews, one during third trimester, one within 2-7 months postpartum. Quantitative and qualitative data collected

Table 1, cont.

Empirical Studies of the Therapist's Pregnancy

Author(s) and year of publication	Research Focus	Sample	Methodology
Fallon and Brabender (2003)	Impact of therapist's pregnancy on group treatment	29 therapists who had experienced pregnancies while working as group therapists	Interviews and questionnaires yielding retrospective data
Zackson (2012)	The impact of primary maternal preoccupation on treatment following the therapist's return from maternity leave	20 therapists	Semi-structured interviews administered once during and once after pregnancy

For the purposes of this thesis, findings of the current empirical literature will be divided into four sub-categories: transference and client responses, countertransference and therapist responses, decisions related to self-disclosure and boundaries, and the overall impact of pregnancy on treatment.

Transference and Client Responses. There is general agreement in the literature that the therapist's pregnancy is a powerful stimulus for the client, although client responses vary widely. As described above, few empirical studies have gathered information directly from clients and most depend on therapist reports of client behavior and feelings. Katzman (1993) is a notable exception. Her study involved 24 of her own eating-disordered clients who remained in treatment during and after her pregnancy. Measurements included checklists completed by Katzman and her secretary after each session, which tracked punctuality, skipped sessions, and

9

changes in weight, dress, and appearance. She reviewed and coded process notes from each session for salient themes and compared results from before and after she disclosed her pregnancy. One year after she initially disclosed her pregnancy to clients, she sent multiple-choice questionnaires to all clients and received 16 responses.

Katzman's (1993) study shows that client responses can be complex and involve multiple, conflicting thoughts and feelings. This is even the case within her fairly homogenous subject pool, made up entirely of women diagnosed with bulimia. When clients were asked in the self-report questionnaire how they felt when the pregnancy was first discussed, 73% of clients selected "happy," as well as "jealous" (33%), "resentful" (13%), and "competitive" (13%). Just one client selected "indifferent" and none selected "fearful." For other clients, the experience brought about self-reflection about their own desire to have children. In response to an open-ended question on the self-report form, one client described her reaction as follows: "I was very happy for [the therapist.] I was also very jealous at first, and extremely angry, but in the long run the experience gave me the permission to say to myself, 'Yes, I want all these things out of life and it's okay to want them'" (Katzman, 1993, p. 27). While this study adds significantly to the literature by seeking responses directly from clients, there is also a considerable chance for response bias given that clients were likely influenced by knowledge that their therapist would see their responses.

In their review of the literature, Fallon and Brabender (2003) acknowledge complexity in client responses and identify common themes in the transference. First, they distinguish between responses that exist within the "real relationship" and those within the "transference relationship." They noted, for example, that many clients became anxious or frustrated while others expressed joy and offered congratulations upon finding out the therapist was pregnant.

They considered these responses natural, and distinguishable from more intense responses that distort reality and stimulate the client's internal conflicts. To illustrate this point, they describe a client who was struggling with fertility issues and became convinced the therapist got pregnant in order to make her jealous.

The authors then identified three main themes that often emerge, sometimes simultaneously, in the therapy: symbiosis and separation, envy and competition, and sexuality and jealousy. They describe that clients experience separation and loss during the therapist's pregnancy. The therapist is less available psychologically to the client, as she is focused internally and toward the baby. During maternity leave, the patient physically loses the therapist for a period of time, and some patients experience abandonment, anxiety, rage, and sadness around this separation. The authors also describe how some clients become envious of the therapist's baby, who receives more of the therapist's time, attention, and caring than the patient. Others become envious of the therapist herself, especially those clients who have fertility problems. The third theme, sexuality and jealousy, arises due to the unspoken communication, via the pregnancy, that the therapist has sex and relationships outside the therapy from which the client is excluded. Some clients feel jealous of the therapist's partner, which activates oedipal issues. They describe two reports that have shown some male patients experience an intensification of erotic transference during the therapist's pregnancy (Fenster, 1983; Pielack, 1989; as cited in Fallon & Brabender, 2003).

Fenster (1983) reported on client responses to the therapist's pregnancy in her study of 23 psychoanalytically oriented therapists. The study, limited to therapists who were first-time mothers, included interviews conducted once in the final trimester of pregnancy and again 2 to 6 months postpartum. Subjects noted that many clients responded with "pleasure" for the therapist

11

upon initially finding out about the pregnancy. Matozzo's (2000) study replicated this finding: 84% of the 20 physicians and therapists she interviewed reported that clients were happy or excited for them when they disclosed the pregnancy. Fenster (1983) additionally found that many patients were concerned about what pregnancy meant for their treatment. Many therapists noted that clients would become solicitous, tender, and helpful toward her – a role reversal where clients were care taking of the therapist. This sense of role reversal was also reported by Grossman (1990).

Almost all of the studies found increased levels of acting out behavior by clients during the therapist's pregnancy (Bassen, 1988; Berman, 1975; Fenster, 1983; Katzman, 1993; Napoli, 1999). In the first empirical study of pregnancy in the therapist, Berman (1975) found the most common form of acting out was early termination of therapy against the therapist's advice. Fenster's (1983) study showed that 77% of therapists reported at least one client who dropped out of therapy during or after the pregnancy, and a majority of therapists felt pregnancy played a role in the termination. She also noted other acting out behavior, including "missed sessions, cancelations… pregnancies, abortions and other crises" (p. 83). Napoli (1999) reviewed the cancellation rates of six of her clients during her pregnancy, and found a dramatic increase in cancellations: patients cancelled 0.7% of scheduled sessions before her pregnancy compared to 12% during her pregnancy. She also reviewed fee payment patterns before and after her pregnancy, but found no significant changes. Bassen (1988) interviewed 13 therapists, 11 of whom reported increases in missed sessions, tardiness, and late payments. Additionally, 4 of 13 therapists reported that at least one client became pregnant or impregnated someone during the pregnancy or maternity leave. Katzman (1993) found higher than usual rates of sexually promiscuous behavior during her pregnancy: "17% of the ongoing clients at least once reported

late or missed menstrual periods, three became 'accidentally' pregnant, two reported instances of 'forgetting' to use birth control, and one woman reported bingeing 'until her belly felt pregnant'" (p. 26).

Byrnes (2000) studied the impact of the therapist's pregnancy on the course of child psychotherapy. She found the most frequent reactions among children included "an increase in personal questions, excitement and interest in the pregnancy, congratulatory feelings for the therapist, fear of abandonment, and an increase in maternal themes" (p. 222). She noted that an increase in personal questions was the most universal client response, and that therapists tended to be honest and forthcoming in answering client questions.

Stockman's (1994) study of 60 undergraduate students suggested that the therapist perceived efficacy is impacted by the therapist's pregnancy. In the study, each participant had one 30-minute individual session with the therapist to discuss a personal or interpersonal problem they were currently having. One experimental group of students met with the therapist when she was 7-8 months pregnant, and another group met with the same therapist six months later when she was no longer pregnant. After each session, students completed several measures of perceived therapist efficacy. Results indicated that overall, subjects perceived the therapist to be more effective when she was not pregnant. The strongest finding was that subjects tended to find the therapist less "expert" while pregnant.

Countertransference and Therapist Responses. Fallon and Brabender (2003) describe the identity crisis that often faces the pregnant therapist, especially one who is having her first child. Women psychotherapists often become pregnant during the most intense career-building phases of their lives, which can bring about a personal-professional crisis. As they describe, "just as the therapist begins to solidify her professional identity, the inception of a pregnancy

challenges the primacy of her intense focus on professional goals, creating an emotional upheaval and state of flux for the therapist's role identification" (p. 49). Some therapists resolve this conflict by leaving the profession altogether and becoming full-time parents, while others learn to cope with their two sometimes conflicting roles.

Grossman (1990) conducted individual and group interviews of 16 pregnant therapists specifically designed to understand pregnant therapists' thoughts and feelings about the process. She found many therapists reported being less available to nurture clients than they had been prior to their pregnancy. They felt a greater need to limit clients' rage and were less able to be flexible with clients. They tended to see clients as more healthy and independent of them. Some felt vulnerable at having to disclose intimate parts of their lives (e.g., that they have sexual relationships with men), while others felt heightened anxiety about their physical vulnerability, particularly in settings where violence was more likely. Some therapists noted a role reversal within the therapeutic relationship, where clients were at times more nurturing and caretaking of the therapist than vice versa, and this caused discomfort for some therapists.

A common theme reported in much of the literature is feelings of guilt from the therapist. Grossman (1990) found therapists felt especially guilty when working with clients who "were not married and wanted to be, or were having infertility problems, or were having a threatening health problem, or had lost a loved one" (p. 70). Therapists also experienced guilt at having to abandon clients for their baby's needs, or abandon their baby because of client needs. Bassen (1988) noted that many therapists reported feeling discomfort or guilt when their pregnancy had not yet been disclosed to clients, as if they were harboring a secret. Fenster (1983) similarly found that feelings of guilt were noted by nearly all 22 therapists she interviewed. She found

that a majority of therapists reported feeling preoccupied with themselves and having less empathy for clients, as well as feeling more irritable and annoyed with patients than previously.

Byrnes (2000), in her study of child psychotherapists, found therapists' most common response was excitement and anticipation about the pregnancy. She noted that no previous study had found these positive emotions to be the salient response of the therapist. This change could be related to shifting societal expectations about women in work; it is possible that since Fenster (1983) and Grossman (1990) completed their studies, it became more socially acceptable for women to work during childbearing years, and therefore fewer negative emotions are reported. It is important to note that Byrnes additionally found that therapists also experienced "anxiety regarding self or baby, an increase in self-absorption, and physical or emotional vulnerability" during the pregnancy (p. 222).

Decisions Related to Self-Disclosure, Boundaries, and Maternity Leave. Through the course of pregnancy, the therapist is forced to make several important decisions related to self-disclosure and boundaries with clients. These include when to disclose the pregnancy, whether to wait for clients to initiate conversation about the pregnancy or to disclose the pregnancy unprompted, how to respond to personal questions from clients, and whether or not to accept gifts.

Fenster (1983) found the majority of therapists waited to disclose their pregnancy until patients directly asked or indirectly indicated recognition of the pregnancy. Katzman (1993) waited for clients to initiate conversation about her pregnancy. She found that some clients did not acknowledge the pregnancy at all, and these clients tended to leave treatment early and refused to participate in her study. She hypothesized that, for these clients, "terminating may serve as a means of asserting control over intense rage or impending loss" (p. 28). She described

wishing she had told clients earlier, which "would not only allow a greater opportunity for emotional exploration, it would also place the burden of exposing an obvious, but mutually unaddressed secret on the therapist" (p. 28).

Byrnes (2000) found that 72% of child psychotherapists disclosed their pregnancy to clients during the second trimester. Only 20% of therapists waited for clients to directly ask before they disclosed the pregnancy. While some therapists spontaneously disclosed their pregnancy to child clients, 64% of therapists reported that some clients directly asked, and 44% reported that some clients found out when their parents directly asked in front of the child. In addition, 8% reported that clients found out from other clients, and 12% reported clients found out from other staff. Therapists in the study on average estimated that one third of child clients found out about the pregnancy prior to the therapist disclosing the information.

In terms of maternity leave, Byrnes found that most therapists "began leaves on or before their due dates, set concrete end dates, and planned absences of twelve weeks or more" (p. 223). Average length of maternity leave varied from study to study, from 4 to 8 weeks (Fenster, 1983), to 8 weeks (Naparstek, 1976), 10 weeks (Bashe, 1989), and 11 weeks (Fallon & Brabender, 2003). During and after maternity leave, therapists must also decide whether to disclose information about the new baby. Matozzo (2000), in her study of 19 therapists and non-psychiatrist physicians, found that 89% of all subjects gave birth date, weight, and general status of the baby. Less than 10% gave specific details about the birthing or gave no information at all.

Fallon and Brabender (2003) describe how "pregnancy, more than any other event (e.g., Christmas) is likely to elicit a presentation of gifts to the therapist" (p. 122). Among the therapists interviewed in their study, almost all accepted gifts from clients when offered. The authors posit that therapists are more open to accepting gifts because "within our social world,

giving a baby gift is almost a required social behavior" (p. 124), which causes therapists to be uncomfortable rejecting gifts. Likewise, Bashe (1989) found that all 15 psychoanalytic therapists interviewed were willing to accept gifts from clients. She summarizes the rationale behind this decision described by her participants: "It is the therapist who brings the pregnancy into the room. Therefore, to reject the patients' responses to this intrusion by refusing to provide information or accept gifts would be an insensitive deprivation" (p. 82). Fenster (1983) similarly found that all 22 therapists in her study accepted gifts if they were offered. Some therapists reported they felt they owed it to clients to accept gifts. Reflecting on this finding in their 1986 book on the therapist's pregnancy, Fenster, Philips, and Rapoport (1986) write, "it was felt that the acceptance of such gifts was reparative in nature, especially because the patients have no choice but to become part of this process in the therapist's life" (p. 65). In this way, the authors suggest that therapists accept gifts out of guilty feelings and a desire to repair damage done to the relationship during pregnancy.

In a similar vein, several studies have shown that therapists are significantly more self-revealing with clients during pregnancy than usual, indicating a loosening of boundaries. Fenster (1983) asked therapists in their third trimester of pregnancy to rate the degree to which they self-disclose to clients during pregnancy versus non-pregnancy. She found that therapists viewed themselves as significantly more revealing during pregnancy. She described that many therapists felt "a new sense of flexibility vis-à-vis patients' knowledge of the therapist's humanity" (p. 100) and many found increased disclosure had a positive impact on patients. She relates the response of one participant, who explained, "I'm less afraid of patients knowing things about my life… I'm not so crazy and worried about preserving my privacy" (p. 100). Similarly, Byrnes (2000) found most therapists reported they were "direct and forthcoming" in response to personal

questions from child clients during pregnancy (p. 223). Grossman (1990) described a shift in the style and manner of many therapists she interviewed, generally toward more self-disclosure and being "more real" with clients.

Zackson (2012) described a similar tendency among the therapists she interviewed. She met with 20 therapists during the period following their return from maternity leave, and found that about half of her subjects had high levels of Primary Maternal Preoccupation (PMP) upon returning to work, based on a scale of PMP developed by Moulten (1991). She used Winnicott's (1956) idea of PMP, which she defined as "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" (p. iv). She found that therapist with higher levels of PMP described 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" (p. 112). She describes a general loosening of boundaries, which many therapists found enhanced the treatment. As she states, "the intrusion of the pregnancy also offers both therapist and patient an unusual, evocative, and reparative moment within the treatment, a chance to meet each other more simply and directly, a moment which holds out the possibility of mutual caring and concern" (Zackson, 2012, p. 123).

Overall impact of pregnancy on treatment. While there is consensus in the literature that pregnancy has a strong impact on the process of psychotherapy, there is not general agreement on whether this impact is positive or negative. Byrnes (2000) found that, in terms of overall impact of the pregnancy, therapists reported that some children benefitted while others were set back by the pregnancy. Overall, she found that "therapist pregnancy is equally positive and disruptive" (p. 190). Matozzo's (2000) comparative study found that pregnancy has a

greater impact on the therapist-client relationship than the physician-patient relationship, though did not specify whether this impact was positive or negative. Stockman and Green-Emrich (1994), in their review of the existing literature, found a trend toward intensification of the therapeutic bond during the therapist's pregnancy, including more intense transference and countertransference. They also found that many therapists report the general sensation of a "third person" in the room during therapy, which altered the therapeutic relationship (Balsam & Balsam, 1974; Bridges & Smith, 1988; Fenster et al. 1986; Goodwin, 1980, as cited in Stockman & Green-Emrich, 1994). Fenster (1983) found that all of the therapists she interviewed reported the pregnancy generally enhanced treatment, and that setbacks in treatment related to pregnancy "were generally viewed as providing the treatment with invaluable grist for the therapeutic mill" (p. 104).

In Zackson's (2000) study of primary maternal preoccupation, she found that high levels of PMP had both a positive and negative influence on the therapist's clinical work. Positive outcomes included "increased sensitivity to patients, a sense of feeling more vulnerable and 'real' with patients", while negative outcomes included "increased distractibility, memory loss, fluid boundaries, and difficulty dealing with low functioning patients" (p. iv). Katzman (1993) evaluated clients' overall responses and wrote, "many women expressed the value of their therapist's pregnancy in terms of identifying personal desires, gaining a new role model, and allowing themselves to address the often conflicting demands of professional and personal aspirations" (p. 28).

Research on Therapist Self-Disclosure

In recent decades, there has been an upsurge of interest in therapist self-disclosure (TSD) and a number of studies have been conducted. Much of this research acknowledges that TSD is

a difficult phenomenon to standardize for research. There are a multitude of different disclosures any individual therapist could make, ranging from their emotional reactions to clients to disclosures about their lives outside the therapy room. Further complicating efforts to define TSD is the fact that therapists may disclose verbally or nonverbally, through facial expressions and body language, and may not be aware when they are disclosing. As Basescu (1990) has further described, therapists "show themselves all the time in their dress, in their office surroundings, in their manner of speaking, in the way they establish time and money ground rules, and in the myriad ways of being that are publically observable" (p. 51). A precise definition of self-disclosure is outside the scope of this literature review.

In a recent article on self-disclosure, Gibson (2012) found the following definition to be common in much of the literature:

'TSD' is defined as intentional, verbal revelation of the therapist's life outside of work, therefore excluding the realm of ''professional'' disclosure such as professional training, theoretical orientation, professional experience with particular populations or issues, or office policies about availability or vacation times and the like. (p. 289)

While this type of self-disclosure of the therapist's "life outside of work" seems to be the most common type of self-disclosure in pregnant therapists, and thus a good definition for the purposes of this project, it curiously appears to leave out disclosures related to the therapist's emotional response to clients.

In their qualitative review of the literature on TSD, Henretty and Levitt (2010) found that over 90% of therapists self-disclose to clients at some point (Edwards & Murdock, 1994; Mathews, 1989; Pope, Tabachnick, & Keith-Spiegel, 1987, as cited in Henretty & Levitt, 2010). However, self-disclosure is an uncommon practice and only compromises an estimated average

of 3.5% of therapist interventions (Hill & Knox, 2002, as cited in Henretty & Levitt, 2010). The

same researchers found that therapists who self-disclose are perceived as warmer and are better

liked by clients, although they found no indication that TSD impacts client perceptions of

therapist trustworthiness, expertness, or empathy. They found that moderate TSD elicited

increased client self-disclosure, and that clients responded more positively to "self-involving"

therapist disclosures (of thoughts and feelings about the client) compared to "self-disclosing"

therapist disclosures (of experiences outside therapy). Finally, they found no indication that

there is a relationship between client ethnicity and TSD, or between client or therapist gender, or

gender pairings, and TSD. This research suggests TSD may have a positive impact on therapy

relationships.

Other Major Events in the Life of the Therapist

There are other major events in the life of a therapist that might impact treatment and the

therapeutic relationship in a similar way as the therapist's pregnancy. For example, a therapist's

acute, chronic, or terminal illness may necessitate self-disclosure to clients, a leave of absence

(similar to the maternity leave), or ultimately termination of therapy altogether. Other major life

events that could impact treatment include the death of a loved one, divorce, or marriage, among

others. These events would have a clear emotional impact on the therapist, but might not be as

physically obvious to clients in as pregnancy or physical illness would. At least one book

(Gerson, 1996) has been written on this topic, in addition to many personal accounts published

by therapists who have practiced during their own illness (Henry, 2009), while mourning death

of a spouse (Stolorow, 1999), or while mourning the death of a parent or taking care of acutely ill

children (Weingarten, 2010).

Counselman and Alonso (1993) describe some of the common dilemmas that face therapists who are ill, including whether or not to give information to clients about the illness, and the therapist's ethical responsibility to prepare clients for unanticipated absences or other ruptures in treatment. They also describe the countertransference responses that ill therapists often confront, including feelings of anxiety and vulnerability, as well as defensive responses like denial of mortality and fantasies of omnipotence. They argue that the therapist's illness could constitute a rupture in treatment unless countertransference responses are explored and managed by the therapist.

Goldstein (1997) argues that major events in the life of the therapist may intrude into therapy whether or not the therapist discloses information to clients. She describes how illness, divorce, re-marriage, death of a loved one, and other major events may limit the therapist's emotional availability to clients, disturb the therapist's mood and affect, or necessitate breaks in treatment. As she describes, decisions about whether and how to disclose major life events to clients, and how to make these disclosures therapeutic, should be based on the developmental issues of each client and the nature of the transference. While these two articles do not cover the therapist's pregnancy, which is distinct from illness and other events mainly because it is typically quite obvious exactly what is happening to the therapist, the recommendations are nonetheless potentially useful to pregnant clinicians.

Summary

This study aimed to build on previous literature about the therapist's pregnancy by intentionally focusing on self-disclosure and gift-acceptance, and by using theoretical concepts of relational theory to examine how the therapist's pregnancy impacts the therapist's view of the therapist-client relationship. The theoretical underpinning of this study marks a departure from

previous literature, as it does not appear that any studies have explicitly used relational theory in

this way. Relational theory has gained influence in the field of psychotherapy since many of the

studies on the pregnant therapist were conducted, and as a result, therapists today may be more

likely to reflect on the impact of their own subjectivity in the therapist-client relationship.

Therapist views about self-disclosure, spontaneity, and authenticity – concepts that are central to

the relational approach – may also have changed. In light of these changes, the present study

aimed to update knowledge in the field about how therapists understand the impact of their

pregnancy on treatment.

CHAPTER III

Methodology

The purpose of this study was to explore the impact of the therapist's pregnancy on the client-therapist relationship. More specifically, this study asked three main research questions: 1) Do pregnant therapists report increased self-disclosure and increased gift acceptance?, 2) How do therapists understand these changes, if they occur?, and 3) How does pregnancy impact therapist views about therapist self-disclosure and anonymity in general? This study sought to expand upon existing literature and is the first study of pregnancy in the therapist to sharply focus on therapist self-disclosure and accepting of gifts from client to therapist. This is also the first known study to intentionally locate this inquiry within a framework of relational theory. Given the large number of women in the field of psychotherapy, many of whom are of childbearing age, pregnancy in the therapist is likely a common occurrence, and one that deserves more empirical attention.

This study used a qualitative design for a number of reasons. First, as described in the above literature review, there have only been a handful of empirical studies of the therapist's pregnancy and almost no research in the past ten years. As such, there is not much existing data that could inform a specific hypothesis to test in a quantitative study. There also do not appear to be any validated measures to quantify phenomena related to the therapist's pregnancy. Using a more exploratory design, this study aimed to gain a preliminary understanding of how the therapist's pregnancy impacts treatment. Secondly, a qualitative study is better suited to capture

the complexity of the therapist's experience of being pregnant while practicing. Interpersonal relationships (the therapeutic relationship included) are complicated and nuanced, and qualitative research allows for more flexible, open-ended questioning to capture this richness of experience. Thirdly, the high level of specificity of the study population – women who have recently been pregnant while practicing psychotherapy – made recruitment efforts challenging. Because this study was conducted with limited time and resources, the extensive recruitment efforts needed to produce a large enough sample for a quantitative study were unfeasible. The smaller sample size required for qualitative research was more realistic for this particular project.

Sample

This study employed non-probability methods to recruit a sample of 13 participants. To be eligible to participate in this study, participants needed to be women psychotherapists who were currently or recently pregnant while practicing psychotherapy. Therapists could be licensed mental health providers of any discipline, including social workers, psychologists, psychiatrists, and licensed professional counselors. They needed to be currently pregnant in the second or third trimester, or have been pregnant within the past five years. Therapists who were in the first trimester of their pregnancy were excluded because they were likely not visibly pregnant and the issues this study aimed to explore would probably not have arisen. Therapists were not excluded from participating based on their practice setting, treatment modality, or the theoretical orientation that underpinned their work.

Recruitment. Prior to recruitment, approval for this study was obtained from the Smith College School for Social Work Human Subjects Review (HSR) Committee to ensure it met all ethical standards (Appendix A). The recruitment process consisted of distributing an email (Appendix B) to my personal and professional network, including friends, colleagues, Smith

MSW classmates, and Smith professors, and that of my research advisor. The recruitment email included information related to the research topic, inclusion criteria, and the nature of participation. The email asked those interested in participating to email or call me directly in order to confirm eligibility criteria were met. Recipients were also asked to forward the email to others who might be eligible.

I received 18 initial responses via email stating interest in participation, and I emailed each participant a screening questionnaire (Appendix C) to confirm eligibility, as well as a copy of the Informed Consent letter (Appendix D) and a preview of the interview questions (Appendix E). The Informed Consent letter detailed the nature of participation, risks and benefits of participating, and safeguards made to reasonably ensure participant confidentiality. I asked participants to complete the screening questionnaire and sign the Informed Consent letter, and scan and return both documents to me via email. Thirteen participants returned screening questionnaires and signed Informed Consent letters to me. I then emailed each participant to schedule a 45 to 60 minute phone interview.

The sample that resulted from this recruitment is representative of several disciplines within the mental health field, including social workers, psychologists, and psychiatrists at the masters and doctoral levels. Although eligibility criteria specified that women needed to have given birth in the past five years, nine of 13 participants were either pregnant at the time of the interview or gave birth in the past two years, which means they likely had clearer (though still retrospective) memories of their pregnancies to report. While this sample is strong in these areas, it is also important to note that I did not make any effort to independently verify eligibility criteria of the participants. Also, due to this study's small sample size, no specific recruitment techniques were used to achieve diversity in terms of sexual orientation and race/ethnicity, and

these characteristics were allowed to vary randomly. The resulting sample was mostly made up of participants who identified as white or Caucasian.

Data Collection

Participation in the study involved a 45 to 60 minute semi-structured interview with me conducted via Google Voice. Each interview was recorded on Google Voice and then transcribed in full into Microsoft Word. I personally transcribed eight interviews, and seven volunteer assistants transcribed the remaining five interviews. Each volunteer signed an HSR-approved confidentiality pledge. I reviewed each interview transcribed by an assistant to ensure accuracy.

During the first minutes of the interview, before turning on the recording, I gathered the following demographic data and recorded it in a separate Microsoft Word document: age, gender, sexual orientation, race/ethnicity, geographic location, highest degree obtained, and type of licensure. I also asked for the dates of their most recent pregnancy, how many children they have, whether they had any notable complications during their pregnancy, and whether their most recent pregnancy was the first time they practiced while pregnant. Finally, I asked each participant to describe their practice setting, theoretical orientation, and treatment modalities, as well as the demographics and typical presenting problems of clients on their caseloads. I then turned on the Google Voice recording and followed the pre-planned interview guide during each call.

The interview questions were developed to capture the ways therapists feel their pregnancy impacted the therapist-client relationship, paying particular attention to issues of therapist self-disclosure and therapist acceptance of gifts from clients. These questions also aimed to explore changes in therapist views during or after pregnancy about therapist self-

disclosure. I attempted to make the initial, scripted questions open-ended in nature, and then asked unscripted follow-up questions to participants about the specific experiences they described. Prior to conducting the interviews, I developed the script of questions over a period of weeks and refined them based on feedback from my research advisor and the Smith HSR Committee. I also piloted the full interview with a friend who helped me to further clarify the questions and ensure the interview would last no more than one hour. A full list of the interview questions is included in Appendix F.

Data Analysis

Transcribed interviews were imported into Dedoose, a computer-based program specifically designed for textual, qualitative data analysis. My research advisor and I independently reviewed and co-coded three interviews, then compared results and came up with a list of preliminary codes. We used open coding methods in this process (Padgett, 2008). I then used the preliminary code list we developed to code the remaining ten interviews myself. Through this process, the initial list of about 40 codes was trimmed down to 25 as codes were merged with each other or deleted because there was too little content to support them. I then conducted content analysis by reviewing all the coded excerpts to identify patterns and underlying themes in the content (Rubin & Babbie, 2013). The results of this analysis will be discussed in more detail in the following chapter. Efforts to increase rigor in the data analysis will be discussed in the next section on limitations.

Limitations

A sole researcher completed this study over the course of ten months for the purposes of a master's degree, and as such, it is limited in scale and scope. Some basic limitations include the fact that this study only looks at changes in the therapeutic relationship from the therapist's

perspective. Therapists were asked how they perceived clients to think, feel, and act in response to their pregnancy, but no actual clients were interviewed. Ten of 13 participants were not pregnant at the time of the interview and were therefore giving retrospective accounts of their experiences, which may not be the most accurate. Also, because participants were interviewed by phone, communication was limited to verbal means, and no non-verbal communication, such as hand gestures or facial expressions, could be observed.

There are also a number of threats to validity related to the sample of participants interviewed. The sample is small (n=13) and comprised entirely of married, heterosexual women. It is racially and geographically homogenous, with all but two participants self-identified as white or Caucasian, and all but three located in the Washington, DC region. Also, the sample is weighted toward therapists who work in women's mental health or with clients dealing with perinatal and postpartum issues, possibly because my research advisor circulated the recruitment email to her professional network of women in this field. These factors limit the degree to which this sample is representative of the population of pregnant psychotherapists at large.

Researcher bias and respondent bias may also limit the rigor and validity of this study. Interviews were not anonymous and respondents may have been affected by social desirability bias, reporting on and emphasizing what they thought I wanted to hear. I aimed to make interview questions as neutral as possible, and the questions were amended based on suggestions from my research advisor and the Human Subjects Review Committee at Smith College to make them more neutral. However, my unscripted follow-up questions were likely impacted by researcher bias. I personally value therapist authenticity and judicious use of self-disclosure in clinical interactions; relational theory guides my thinking and work with clients, which is partly

why I chose it as the theoretical underpinning of this project. It is therefore possible my unscripted follow-up comments and questions tended to draw out positive experiences participants had with self-disclosure.

A number of strategies were used to increase rigor of the study during the data analysis phase, including triangulation, negative case analysis, and the creation of an auditing trail (Padgett, 2008). As described above, my research advisor and I co-coded the initial three interviews, then compared our respective code lists, discussed the evidence for each code proposed, and finally agreed on a list of codes that I used to analyze the remaining interviews. By triangulating the perspectives of multiple observers of the same data set in this way, some degree of inter-subjective agreement was reached. Next, I used negative case analysis to intentionally search the data for evidence that disconfirmed the themes and codes I had identified. Negative case analysis helped manage research bias that included a propensity to seek out positive therapist experiences with self-disclosure and authenticity over other experiences. Several of these negative case analyses are described in the Findings chapter of this paper. Lastly, throughout the data analysis process I left an audit trail, including my original data set (recordings of interviews), the preliminary and subsequent list of codes, coded transcriptions, and memos. Another researcher could review this audit trail to replicate the study, understand my decision-making process in coding and analysis, or confirm that I used the above strategies for rigor.

CHAPTER IV

Findings

The purpose of this exploratory study was to better understand the ways the therapist's pregnancy impacts the client-therapist relationship, paying specific attention to the ways clients and therapists might interact on a less professional, more personal level during this period. This chapter first describes the sample for this study, and demographic information is presented in aggregate form to protect participant confidentiality. I then describe when and how therapists disclosed their pregnancy to clients, and review the responses from clients that therapists observed, including the propensity to ask questions, offer gifts, take care of the therapist, comment on the therapist's body, and touch the therapist. I then discuss how therapists perceived and responded to these potentially boundary-violating behaviors, and how client behavior and therapist responses were perceived to impact the therapeutic relationship. Finally, I have included a section on the overall impact of the therapist's pregnancy on treatment, from the therapist's perspective. I have woven negative case analysis into these findings to show where I found evidence to disconfirm trends in the data.

Demographics

The sample for this study consisted of thirteen women who were interviewed by phone between February 15th and April 10th, 2013. Interviews lasted between 35 and 65 minutes. At the time of the interview, the youngest participant was 29 years old and the oldest was 43. Mean and mode participant age were 35. All participants reported being married and identified as

"heterosexual" or "straight." Eleven participants identified as "white" or "Caucasian," one participant identified as "Indian-American", and one identified as "Hispanic." Nine participants lived in the Baltimore-Washington metropolitan area, with others from Sacramento, CA (n=1), Philadelphia, PA (n=1), and Boston, MA (n=2).

Three participants were in their third trimester of pregnancy at the time of the interview. The remaining participants gave birth within the past year (n=3), one to two years (n=4), and two to three years (n=3). Eleven of 13 participants reported no complications during pregnancy. Two participants had minor complications during their most recent pregnancy, but were able to continue to work throughout the pregnancy. For eight of 13 participants, their most recent pregnancy was the first time they had practiced psychotherapy while pregnant, and the remaining five participants had practiced during one previous pregnancy.

In terms of highest completed academic degree, participants had master's degrees (n=9) and doctoral degrees (n=4). Asked what type of licensure they hold, participants reported being licensed as independent clinical social workers (n=7), psychiatrists (n=2), professional counselors (n=2), and PhD-level clinical psychologists (n=2). Participants had an average of 7.8 years experience practicing psychotherapy. Four participants had been practicing for less than five years, six participants for six to ten years, and three participants for 11 years or more.

Participants practiced psychotherapy in a variety of treatment settings during their pregnancies, including private practice (n=5); community-based, non-profit settings (n=5); a maximum-security state forensic hospital (n=2); a college counseling center (n=1); an OB-GYN clinic (n=1); and an academic research setting. Two participants reported working in private practice in addition to other settings. All thirteen participants stated their main treatment modality is individual psychotherapy. In addition to individual work, participants stated they

also provide group therapy (n=3), family therapy (n=3), couples therapy (n=2), and "clinical case management" (n=1). Participants also worked with a wide variety of populations. Asked to describe their caseload, three participants stated all or some of their clients are women dealing with infertility, pregnancy loss, or perinatal or postpartum mood or anxiety disorders. Three participants worked mainly with young children and their parents, and another worked only with adolescents. Two participants worked with adults with major mental illnesses who have committed a felony.

When asked to describe their theoretical orientation, participants gave a wide range of responses and all but one gave two or more theories or orientations. Common responses included "psychodynamic" (n=6), "cognitive-behavioral" or "CBT" (n=6), "DBT" (n=2), "attachment theory" (n=2), and "relational" (n=2). Other responses included "systems theory," "social constructionism," "trauma-informed and client-centered," "solution-focused," "narrative," and "emotion-focused." Four participants stated their theoretical orientation is "eclectic" or "integrated."

When and How Therapists Disclosed

All participants reported they disclosed their pregnancy to clients. Eight participants told clients before clients asked them, while five participants waited for clients to notice and ask, at which point they confirmed they were pregnant. Two of three participants who worked with young children reported they disclosed to parents before disclosing to children, and then waited for children to notice and bring it up in therapy. Most participants waited until at least the end of the first trimester before disclosing. Among those who disclosed up front to clients, two participants chose to disclose before they were visibly showing, while most others waited to disclose until they were "visibly" pregnant or beginning to show. Participants tended to disclose

their pregnancy to clients and share their plans for maternity leave in the same conversation. Participants who waited for clients to notice the pregnancy reported that some clients did not bring up the issue until very late in the pregnancy, while others noticed earlier.

Most participants described an intentional, well thought-out plan about how to disclose to clients. A majority described telling clients in different ways depending on the client and the specific dynamics of the therapeutic relationship. At least six participants described it being important that clients hear directly from them, instead of "through the grapevine." Two participants described cases where clients found out from other sources; neither participant had planned for this to happen, and both described a somewhat negative impact on the therapeutic relationship in these cases as a result. One participant who worked with young children and parents discussed her strong desire to disclose to clients herself:

> It felt really important to me to meet with parents ahead of time privately and let them know that this was something that was happening for me, and to give them time and space to be able to process that a little bit before the kids knew. And also to make it clear to the parents that I wanted to be the one to tell the kids so they could find out in session with me as opposed to from their parents.

The same participant described later in the interview:

> You know with preschoolers they don't really notice if you look a little big around your mid-section or if you start to have a bump ... but parents definitely were gonna notice, and it felt really important to share the news with them before they had an opportunity to notice and then feel like I was deceiving them in some way. That was … my primary motivation for sharing, so I shared with parents around like 20-21 weeks, and then with kids within a few weeks after that.

Another participant described a similar sentiment related to her clients struggling with infertility:

> I had patients who were going through infertility where they are so sensitive to being
> around pregnant women that I did not want them finding out through one of the
> physicians who just said 'Did you just hear [therapist's name] is pregnant?' That would
> be devastating to them if I didn't disclose that to them myself.

At least two participants reported deciding to disclose earlier to clients who had histories of trauma and might feel abandoned by the therapist during maternity leave. One of these participants reported that, although she waited for most clients to ask her about the pregnancy, she offered up the information to one client who she was particularly worried about:

> I did decide with one client that I was going to tell her before she asked me. Due to some
> very serious past trauma regarding her own pregnancy… and sexual assault around
> pregnancy, I thought this might come up and she might have feelings about it, and I really
> don't want her to be worried about it. She's also someone that I feel may worry about
> being abandoned. Am I gonna quit? Am I gonna leave? … So I thought I'd better address
> this first … I don't want it to become a clinical issue that she's so worried about this.

The same participant used a different strategy in disclosing her pregnancy to the rest of her clients. She described the rationale behind her decision to wait until clients noticed the pregnancy and asked her:

> The same way I didn't come in and tell my clients I got engaged, and I got married, and
> I'm going on vacation, I don't tell my clients my exciting news… I really decided this is
> really personal, this is my life, and I wouldn't share other exciting news with my clients,
> and so I'm not going to share this news. But if they ask me, this is different than getting
> married because it's going to start showing and I'm not going to be able to deny it. It's

not going to stay private. So that's how I decided that I would wait for clients to ask me, but I'd be happy to reveal that information.

All three participants who worked with women on issues related to infertility and post-partum disorders reported these clients had a heightened sensitivity around their pregnancy. Two of the three reported that these clients would ask directly whether they were pregnant very early in their pregnancy. As one participant described:

> …There was [a set of clients] that was more sensitive, you know, probably my pregnant population or my population that wanted to get pregnant, or my population that had post-partum depression … they were more in tune, and so they would notice actually before I intended on telling anyone. Like, you know, week 10 or something. They'd start to … ask me, "Are you pregnant?"

Another participant reported a similar phenomenon:

> Because I do a lot of work with pregnancy and post-partum, some patients constantly would ask, which is a fascinating dynamic that plays out. They always want to know, like, "Are you pregnant? Do you want to have kids? Do you have kids?"

Personal Questions from Clients

All participants reported at least some clients asked personal questions either directly following disclosure or later during the course of the pregnancy. The most common question was about the sex of the baby; all 13 participants reported at least some clients asked about this. Ten of 13 participants reported that clients asked whether the therapist had chosen a name for the baby or what the name was. Seven of 13 participants reported clients asked how the therapist was feeling or how the pregnancy had been. Five participants reported questions about the therapist's birth plan, including where she would give birth, whether she was prepared for labor

pain, and whether she had a doula. Five participants reported clients asked how the baby was doing when the therapist returned from maternity leave. Less widely reported questions were about nursery décor (n=3), due date (n=2), and whether the therapist planned to breastfeed (n=2). Participants also reported questions about whether the therapist planned to have a baby shower (n=1), and how members of her family, including her parents, husband, and other children were responding to the pregnancy (n=2).

Some participants noticed a definite increase in personal questions from clients during their pregnancy. As one participant reported:

[Clients asked] interestingly personal questions that I think they would otherwise not normally ask you. "Oh, how are you feeling? Do you know what the sex of the baby is? How do you feel about the sex? Do you have names picked out? Did you decorate a nursery? What does the nursery look like?" I mean, questions after questions … fascinating stuff people would never ask you about in life in general, "Are you gonna breast feed?"

Another participant echoed this sentiment. When asked whether clients asked personal questions, she responded:

Oh my gosh, yes. I hope you have a long, long piece of paper that you can write my whole list on… it's amazing the way that women's pregnant bodies become all of a sudden public domain… everybody wants to know if I'm finding out if it's a girl or a boy, and when I say that I'm not finding out, then it's open for speculation. So then it's lots of like examining what my body shape looks like, and commenting on whether they think it's a boy or a girl based on the fact that, you know, the old wives tale that if you're

37

pointy and sticking out one way then it's a boy and if you're more splayed out then it's a girl.

Other participants reported clients did not ask many personal questions, or asked fewer personal questions than they expected (n=5). When asked whether clients asked personal questions, one participant responded, "Actually no, and… that was something I was surprised about because people do tend to ask sometimes." Another participant reported that, aside from asking about the sex of the baby, "[clients] actually didn't go into a lot of personal questions that I would have to think about disclosing a lot of personal information or not." Another participant, when I asked whether she noticed an increase in personal questions, responded:

> No, not really. Other than, "Do you think you'll find out if it's a boy or a girl?" "Congratulations. That's really happy. That's great news." And, "oh you'll have your hands full." But no.

One participant who worked with young people similarly reported not getting many questions. She offered the following hypothesis about the lack of personal questions from her client population in particular:

> I mean I generally feel like clients have been reluctant to ask [personal questions]…I kind of expected more questions than I'm getting… A lot of my clients are pretty young and don't feel very entitled to very much. I mean if you think about like an 18 year old developmentally and the power dynamic that may be at play in the therapy relationship. You know, some 18 year olds feel comfortable asking for things, asking questions that they're curious about, but many of them don't.

Another participant felt that her clients were not very interested in her life, and because they were in therapy to discuss their own issues, they did not ask many questions of her:

38

I mean most people who come to see me are pretty focused on themselves. And there's a sense of entitlement. You know, rightfully so because they're paying a lot of money to see me. But they don't really want to know that much about me, and they don't really ask that much about me… So in a large part my pregnancy was sort of ignored.

Of the participants who worked with children, reports varied. One participant described children asking many questions:

…Lots of kids asked if it's a boy or a girl. What will I name it? Where will he or she sleep? Do I have any other kids? Did I want this baby? That was a little telling, those types of questions. Many kids asked me that.

However, another participant reported getting few questions from children, but many questions from parents:

The kids didn't talk about it a whole lot. They more wanted to know, like, "How does it impact me?" You know like, "How is this going to change how therapy is?" The parents wanted to know all sorts of details about the gender and the names and the nursery and where I'm giving birth and like every detail.

Participants who worked mainly with female clients who were pregnant or facing problems related to infertility or post-partum mood disorders tended to report more specific, personal types of questions related to childbirth and breastfeeding. As one participant described:

So a lot of what came up were people's questions about birth plans and you know, was I going to use an epidural, and was I going to have a doula, and you know, what my plans were for the delivery. So that would come up a lot because that would be something we would discuss anyway with a pregnant patient, especially the anxious ones.

Another participant who worked with a female client had a similar experience:

I have one client that this was fairly personal but it was fine by me. She was a mom of

twins and I was her therapist during that whole transition for her, and she asked me about

breastfeeding when I was coming back, because I came back so quickly. So that was a

real personal question, but it was in context of our relationship it was fine, because we've

talked about that stuff plenty in her own therapy.

Gifts Offered by Clients

Eleven of 13 participants were offered at least one gift during pregnancy or following the

birth of their baby. Two participants reported no clients offered any gifts, though one of these

participants was still currently pregnant and responded "not yet." Seven of 11 participants who

were offered gifts reported that just one or two clients offered them, and it was not the norm for

most clients on their caseload. One of these participants reported that her therapy clients did not

offer any gifts, but some clients on the unit got together and made her an art project; another

reported no clients offered any gifts except one who invited her to the art supply store where she

worked to pick something out, though the therapist did not follow up on this offer. The most

commonly reported gifts were baby clothes (reported by four participants), baby blankets (three

participants), and cards or letters (three participants). Four participants reported that at least

some gifts were handmade, including hand-knit blankets and hats, pieces of art, and greeting

cards. Other participants reported receiving candles, picture frames, photographs, stuffed

animals, bath towels, CDs, and bags. Nine of 11 participants who were offered gifts reported

accepting all the gifts that were offered.

Many participants described that clients often put thought into gifts and gave items that

had special meaning to them. As one participant described:

One client… made me a card… it was around the holidays, but it was actually more of a 'congratulations on being pregnant' card. And she had made it herself, and it was a picture of two birds, two sort of robins in a nest that were sort of nuzzling together with a little egg in front of them… and she wrote me a note about how happy she was for me, and how she thinks I'll be a great mom, and I've taken good care of her, and that sort of thing.

Another participant described a similar experience receiving a card from a client:

I had one who had picked out two cards and one was like, the baby, and one was like, 'welcome back' or something… She had spent a lot of time like putting stickers on them and changing the message to make it more appropriate.

A third participant worked with a client who was severely mentally ill, and reported he offered her a photograph to hang in the baby's nursery that had a special meaning to him. As she described:

[The picture] was of the courtyard at another state hospital where he had spent a lot of time and developed a relationship with a stray cat… it was actually pretty profound that he was able to develop this caring relationship with this animal, because he had a history of abusing animals and even torturing animals. And so it was sort of a turning point for him… He had talked a lot about that in therapy, so for him it was very meaningful and he wanted me to have that.

One participant, who reported "a lot" of her clients brought baby gifts, received a special baby blanket from a client:

So one patient… who was asking me like, "Did you decorate the baby's room? What's the baby's name gonna be? What color is the baby's room gonna be?" I mean it was like

nonstop… And so she apparently wanted to know those questions because she was

having her mother knit my baby a blanket, and so she brought me a beautiful, hand-knit

baby blanket…

The same participant also received CDs from clients that they had made themselves, with music
that was personally meaningful to them:

One patient who actually made the CD herself, like put together a mix of songs she

played her children when they were little. Another patient who gave me a CD that her

brother wrote, who writes children's songs. And another patient who, I didn't know

before my pregnancy but apparently used to write children's songs and has published

them, and gave me one of the CDs that he published.

Six therapists described an awareness of the monetary value of gifts and felt gifts were

affordable for clients. One participant stated gifts were typically "very low cost items;" another

stated clients offered gifts "in the $20.00 range." One participant stated "[gifts] were small

things; no one tried to give me a, you know, $300 stroller or anything." As one participant

described:

It's never been a gift that's been of high monetary value. I feel like that would be

different. A lot of the families I work with are low-income and they might be little things

from the Dollar Store… or a re-gift, so it doesn't seem like there's any sort of financial

burden.

Just one participant reported being offered a gift she thought was too expensive, a set of baby

clothes from a high-end store, and she felt it was necessary to discuss with the client the

monetary value of the gift before accepting it.

Other Boundary Crossings

Participants reported a number of other boundary issues that came up during their pregnancy, apart from the tendency of clients to ask personal questions and offer gifts. These included clients showing concern or wanting to take care of the therapist during pregnancy, making comments about the therapist's body, and physically touching the therapist. Some but not all participants observed these phenomena, which are described below.

Clients taking care of the therapist. Seven participants reported that some clients seemed to nurture or take care of the therapist during pregnancy, which for many participants felt like a role reversal in the relationship. One participant described how some clients seemed to filter what they shared in therapy so as not to distress her. As she stated, it was as though "[clients] don't want to burden me with extra things that's going on for them in the moment." Other participants reported clients expressed concern about how the therapist was feeling, or offered the therapist advice on pregnancy or parenting. One participant who worked with children described how clients, particularly parents and caregivers, responded in this way:

> They're just like very curious like, am I in pain, am I uncomfortable, am I hot, am I cold, can I – I mean I had one school that I consult to, like people telling me, like not to, "don't stand in front of the copier" – like I mean, sort of like all the weird things that – I mean I can't. I need to leave the house.

Another participant who worked in private practice reported a similar trend:

> [Clients] give me advice on babies … not detailed advice … trite advice that sort of people just would say, but still… they hadn't given me advice before on something. "Oh, wear a coat, its cold outside." They hadn't said these sort of trite advices that people might offer, but somehow it seemed to come out more once I was pregnant.

43

Interestingly, the two participants who worked in the forensic hospital each had an older, female patient on their caseload that seemed to be more nurturing toward them during their pregnancies. As one participant described:

> [The patient] took on a maternal kind of role. She wanted to give me advice. She didn't have any children herself, although there - and we talked about this – there was a part of her that wished she could have had children. But she would tell me things that she read in magazines about different ideas for parties to disclose the sex of the baby. So she wanted to give me – she wanted to provide encouragement and nurturing back to me.

The other participant described working with a female patient in her sixties who had an adult son:

> I got the impression that my pregnancy -- I felt in some ways as though she was somewhat happy for me and excited for me. She would make some statements, kind of sporadically, I think that at one point she told me she thought I would be a good mother… Generally she had a somewhat of a flat affect and somewhat guarded. And sometimes it seemed like talking about my pregnancy -- like I remember one time when I was very pregnant, I was shifting in my chair and she would ask me how was I doing, and seemed to want to talk about my pregnancy. It seemed as if she wanted to ask me about… physically how was I doing. I don't know if I recognized it at the time, but I think she may have had some concern about me.

Commenting on the therapist's body. Four participants reported clients commented on or joked about their changing bodies during their pregnancy, though they did not typically observe this behavior from clients previous to their pregnancy. As one client described:

People feel more comfortable commenting on your body while you're pregnant. There's this permission people feel like they have. You know, like, "Oh, you look so cute pregnant," or "Oh, you're so small," or "Oh, you're only in the front," or – I mean all these like, things that it's okay to say.

Another participant who worked with children and parents described a similar experience:

Typically that happens in the waiting room for my individual clients. That's where the parents like, examine how my body is taking shape, and then speculate about whether it's a girl or a boy, and then the child pipes up also speculating and commenting.

Others observed similar comments about their body from clients, including one participant who reported "almost all" of her clients have remarked that she "looks good" for someone who is pregnant. Another participant described how some clients joked about her growing body when she needed to move to a more comfortable seat in the office.

Touching the therapist. Another three participants reported clients touching them during their pregnancy when they would not normally. As one participant described, "[I had] one parent in the waiting room pinch my side, my like, love handle, one day, and say that I was definitely having a girl." Two other participants reported clients touched their stomach. One participant who is currently pregnant and works with adult victims of human trafficking described it this way:

[Clients] all want to rub my stomach… and almost all just start rubbing, just come and start doing it. They ask [if I'm pregnant] and are touching my stomach. So they're really wanting to feel my stomach, wanting to know when I'm due, and telling me I look really good.

Another participant described how strangers in the hospital where she worked seemed to lose boundaries in the same ways her clients did:

> In the clinical setting I was at, in the hospital, people just lose boundaries. People touch your stomach, you know. Kids touch my stomach; that didn't bother me as much. Parents did not. But people walking around the hospital would say weird things like, "Looks like you're having twins. You must be due any day."

Therapists Responses

Depending on the client, the dynamics of the therapeutic relationship, and the type of boundary transgression, therapists tended to think, feel, and respond differently to the boundary violations described above. Therapist responses tended to fall somewhere on a continuum; on the one end, some therapists found boundary violations to be intrusive and felt vulnerable or uncomfortable, or felt as though the focus of treatment was shifting onto them instead of staying on clients and client issues. Toward the other end of the continuum, some participants found the boundary violations to be predictable and overall not to impact treatment very much. On the far end of the spectrum were those who found the loosening or shifting of boundaries to positively impact the therapy, as clients felt closer and more connected to therapists, which deepened the work. Again, therapist responses tended to vary depending on the type of transgression, the dynamics of the relationship, practice setting, and client factors like age, gender, diagnosis, and social history. Therapists tended to respond to clients according to how they felt and thought about the transgression.

Intense discomfort and concern for personal safety. At one end of the spectrum, three participants reported feeling physically vulnerable or unsafe with more severely mentally ill

clients, and in these situations they tended to have the strictest boundaries. Two of these participants stopped meeting with high-risk clients in person. As one participant described:

Particularly with the first baby, in the community psychiatry, I just felt more vulnerable. Especially when I was dealing with more violent or high-risk patients. I just felt more vulnerable to someone kind of getting agitated or being inappropriate or whatever. I just – from a physical standpoint I just felt more vulnerable. There were a couple of patients that like, after certain interactions where I felt like they were becoming sort of agitated, I just asked to not see them anymore while I was pregnant.

The two participants who worked in a forensic psychiatric hospital reported that as a matter of hospital policy, visibly pregnant therapists do not visit the maximum-security ward. Pregnant therapists meet with maximum-security clients elsewhere in the hospital. These participants tended to have more concerns about their physical safety, given the intensity of psychopathology in their clients. One participant described not wanting to give personal information in order to protect her safety. When asked to elaborate, she explained that she had concerns for her physical as well as psychological wellbeing:

I guess the most extreme concern with safety is physical assault… being assaulted where you or your baby is in danger. And that is the most extreme, but then I guess along the continuum is kind of just an instance where someone touches you or maybe wants to touch your stomach, or even just asking information about you or your child. I guess concerns that I've had have been along the lines of, "Is the person having too much information?" or you or your family being at risk by them trying to look for you, should they be discharged from the hospital… I have heard of an instance of where a staff member… had a child who died, and then patients making comments. Like this one

patient who is very sick and with a personality disorder making a statement like, "I'll kill your child," or "I'm glad your child is dead." So I mean, in terms of safety, it's not so much that you would be at physical risk, but more of an emotional or psychological risk. Disclosing things about your children and then it being used against you or used to harm your children in some way.

Another participant who worked in the same forensic hospital reported having a patient who actually made a threat toward her baby during her pregnancy. She felt especially threatened because this particular patient was hospitalized because he had murdered a young child. This led her to stop meeting with him in person and instead conduct therapy over the phone:

[The patient] started making statements to staff members on maximum security that he wished that my unborn child was dead… He started making very extreme, provocative statements… And at that point, when he started to make those statements and started to say he was suicidal… his treatment team decided that they didn't feel that it was safe for me to meet with him, given the fact that his crime was that he killed a child because he was jealous of the loving relationship, and he articulated to me that that was one of his main issues, that he would imagine what kind of relationship I would have with my child and that that made him angry because he didn't have that, and he wanted me to be the mother figure to him… At that point the treatment team wanted me to stop doing therapy with him until after my pregnancy. I didn't want to do that; I felt like it was important to maintain the connection with him, and so the compromise was that I would do the therapy by telephone. So we would have set times when I would call the phone on the ward from my office and we would talk on the phone.

In situations where therapists felt physically or emotionally threatened by clients, therapists tended to have the strictest boundaries or terminate the relationship altogether. The participant whose client threatened her baby described other situations with this particular client where he violated boundaries. At one point, the client offered her a gift, a photograph of a courtyard in a previous hospital where he had lived, and asked her to hang it in her home, in "little brother or little sister's room." In this situation, she reaffirmed the professional boundary in a clear, direct way, and did not accept the gift:

> Well when he [gave me the gift], he said something like, "Put it in little brother or sister's room." That kind of freaked me out… With him, I was much more clear and concrete with my boundaries... I pretty much just said, "No, I can't take that. I can't take gifts from anybody." I also focused on the fact that it was very meaningful for him and he needed to keep it because the meaning was his. He needed to keep that.

The same participant, later in the interview, described how her feelings about boundaries shifted due to her relationship with this particular patient. She has noticed that beyond keeping personal information guarded and private, she also now tends to be more clinical and detached with patients instead of using her authentic self:

> As I was reflecting about these questions, I think [pregnancy] did change the way that I approach individual therapy. I think that it came from that one patient, the experience I had with this one patient and how he unraveled with the pregnancy. I know that it was because of his history, but it made me definitely look at my boundaries more clearly. I've always been pretty careful about the information I disclose, but then I've also started to look more at how I connect and how I respond. How much do I encourage the patient? Almost the dynamic of the connection. I think I tend to now be less personable and more

clinical… I guess especially when working with someone like him who has no

boundaries, it was definitely a lesson for me in being more aware of my boundaries and

my relationship boundaries. Not information as much, but just more the dynamic of the

interaction. I think some of that has carried over into all of my interactions with patients

because it was very difficult for me. Like the times he would make threats towards my

baby, even after the baby was born and I came back from maternity leave. I had been

home taking care of this small little being and all of my time was devoted to caring for

this infant. Then to work with this patient who was making threats – it was hard for me. I

could deal with it clinically, but it definitely was challenging. I think that's made me

more reserved.

She goes on to describe:

… I think prior to [my experiences during pregnancy], I used myself in my clinical

interactions and I felt fine with that. When it hit something so personal, though, and

engendered such a strong reaction from somebody that is threatening in that way -- to

your child potentially -- to the point where the team thought I wasn't personally safe

meeting with him -- that's a very real threat to not only my own wellbeing, but my child's

wellbeing. And just the intensity of his reaction was such that -- like I said, there have

been patients who have stalked people -- and I can see him looking me up if he was ever

to leave the hospital. He has said to me, "I would never do that because I care too much

about you." Well even that is kind of scary!

Mild discomfort and feelings of intrusion. While the experiences described above are

on the extreme end of the spectrum reported by participants, others reported a more mild sense of

discomfort and vulnerability during pregnancy. Some participants reported feeling exposed

50

simply by being visibly pregnant. One participant wore loose-fitting clothing well into the second trimester of pregnancy, and stated, "pregnancy isn't something that I could hide, but if I could, then I would have." Another participant described feeling as though her pregnancy revealed her sexuality to clients in an uncomfortable way:

> I mean the one thing I did feel when I was pregnant, it was just really vulnerable and it made me feel so uncomfortable knowing that every single kid and parent that I came into contact with knew basically that I had had sex. Of course- that's how babies are made! But that piece of information felt so violating to me. Like every day I would walk into the hospital and think, "Oh my god, people know that." It's so uncomfortable! I just couldn't stomach it… I mean it's silly! I'm an adult. That's how babies are made. But it just felt like somehow I had let them into my room, where it's in a situation where someone is spying, like, "Oh, but I haven't cleaned my house," and like "Oh, no no, it's fine," and then they kind of like charge in and go into your room, and your room is disgusting and messy and you feel -- I felt that way.

Other participants reported feeling as though their privacy was being intruded upon because of certain questions, comments, or behaviors from clients that crossed boundaries. In these situations, participants tended not to discuss boundaries or explain to clients why their behavior, question, or comment was inappropriate. Some described removing themselves from the situation, answering questions with vague answers, skirting around or deflecting questions, or outright lying. For example, one participant reported that many clients touched her stomach, which typically did not bother her, but when a client touched her stomach for a long period of time she became uncomfortable. She did not discuss the issue with the client, but made an excuse to remove herself from the situation:

51

I did have another who came in who I hadn't seen in a long time. She's an old client and coming in for something else, and I saw her and she asked me [if I was pregnant] right away, and she kind of touched my stomach. But she kind of continued and I became uncomfortable. And I didn't really know what to do. I know it's my body and I know I can say, "No," of course. But she was so excited, I felt really conflicted of – Do I stop her from rubbing my stomach because I feel uncomfortable? Or do I let her do this because she's so excited about it? … I felt really conflicted and ultimately I kind of got up, saying, "Oh I have to grab something" to end it.

Another participant who worked with children reported an instance where she felt uncomfortable during a provocative play therapy session, but did not feel the need to discuss the violation with the client.

[One client's] play has been fascinating around my pregnancy… One day she brought out the play doctor kit and was like, she was the doctor and I was the patient … and then she brought out like, this little … play knife in the doctor kit, and she cut open my belly, basically gave me a C-section. And first explained that she was going to cut open my belly because the baby needed to come out. I was like 25 weeks at this point… I had to remind myself that she didn't know that I wasn't yet full term, she wasn't trying to put me into preterm labor, but in her mind it was actually that the baby was being delivered and this was her image of how the baby would be delivered. So in my mind it felt like, "Oh my god, she's cutting me open, and this is like really graphic, and not how the childbirth typically happens," but in her mind like, "OK, I'm the doctor, I'm gonna take the baby out."

Two participants reported that clients asked them during the first trimester whether they were pregnant. Both reported they lied and said they were not pregnant because they were uncomfortable sharing that information so early in the pregnancy. One of these participants stated that female clients who were pregnant or dealing with infertility tended to ask her very early:

> They'd start to be like, ask me, "Are you pregnant?" Which I thought was a little bit intrusive and I didn't really want to answer. 'Cause I had lost a couple of pregnancies and I didn't want to answer, necessarily. So I actually lied a couple of times, and then later on told the patients once I was in the second trimester, "I am pregnant, obviously, and I told you 'no' early on because it was too soon for me to say anything; I didn't feel comfortable." And they understood and it wasn't a big deal.

Another participant described a similar encounter with a client. She also lied and said she was not pregnant, but later felt some guilt and discomfort at having lied.

> I lied once. I felt really bad about that… I was really sick the first trimester, and I had cancelled with a client two weeks in a row, because I had the worst morning sickness and I just couldn't do it. And she asked if I was pregnant, and I was like 10 weeks or something, and I said no. And later when I told her… I was pregnant, she was like, "Oh, well I asked you if you were pregnant and you said no, you didn't know then, did you?" And I should have just said I didn't know, but I said, "No I knew, but I wasn't telling anyone yet." And that was weird. It was just so weird, I wish I hadn't even have gone there and I don't know why I did.

At least four participants reported feeling uncomfortable when clients asked whether they knew the sex of the baby or had decided on a name. In these situations, participants typically

deflected the question, answered vaguely with as little information as possible, or, like the

participants in the above examples, lied and said they did not know yet. As one participant

described, sharing her baby's name felt like more of a boundary violation than other questions:

> So the question about have I named the baby… I sort of didn't answer that question. I
>
> mean, I guess I answered the question, but I sort of didn't offer much information. That
>
> felt like, sort of like, too personal of a question in some ways. Or what the name was felt
>
> like too personal of a question. So I would sort of be a little bit more I think guarded in
>
> my response to that. Maybe not like purposefully, but it just feels like a more invasive
>
> question in some ways. So I imagine that was experienced in some way. That I was a
>
> little bit more guarded, or sort of less open to dialoguing about that.

When asked to describe how she would typically respond when a client asked whether she had

named the baby, she stated:

> I imagine myself saying something like, "Nope. Not yet." Or something that didn't feel
>
> like it invited much conversation. It was probably not my finest clinical moment [laughs],
>
> but if I'm being honest I think that's probably how it sounded.

Another participant felt uncomfortable when a client asked about the sex and name of the baby.

This participant worked in the forensic hospital, and the client she was working with had

murdered her partner and their adopted child. She reported that when the client asked about the

name, she lied and said they had not yet chosen one yet:

> Well, I know that she asked at one time about the sex of the baby. And I remember
>
> feeling ambivalent about disclosing what the sex was and I'm trying to recall if I did
>
> disclose or if I didn't disclose. I can't really remember if I did tell her or not. During
>
> another time she asked about a name, if we had chosen a name for the baby. Come to

think of it, I think I did disclose to her that it was a boy, that I knew it was a boy. My

husband and I had chosen a name for the baby, but that I think I did not disclose, and I

remember telling her that we were calling the baby "Peanut." And that was kind of my

way of handling it… I felt that I didn't want to disclose the name that we were choosing.

Another participant who worked in the forensic hospital stated she felt more comfortable

disclosing information about the baby after her maternity leave, once she knew her child was

healthy and safe. During her pregnancy she did not disclose the sex or the name to clients. As

she describes:

When I came back from maternity leave, I did share the sex of the baby… But [during the

pregnancy], I was feeling more protective of my pregnancy and I wasn't sure -- and in

that setting, too, it's a maximum-security prison, I tend to not want to share a lot of

personal information. There have been experiences where patients I've known have

stalked social workers and things like that, so I tend to be pretty closed and not share

personal information… I didn't feel like it was really appropriate to have a big

confrontation or anything like that about overstepping boundaries. At that point, I was

just avoiding the issue… I guess I still had concerns about wanting to make sure the

pregnancy was healthy and came to term and all that kind of stuff. I just wasn't

comfortable sharing things like that prior to my maternity leave. Afterwards, when I

came back, I did disclose just the sex and the name.

Another participant felt comfortable sharing the sex of the baby, but decided to share the name

only with some clients and not others:

The name I was unsure about, when it came to that, I didn't initiate it, but if people asked,

which not that many people did after they asked me at the end when I came back if he

was healthy or whatever and I'd say yes. But a couple people asked the name and I told

them, and I think I felt comfortable with those individuals to say that.

Several participants stated they were generally more careful in answering personal questions

when they came from clients who had more intense psychopathology, interpersonal issues, or

"bad boundaries." One participant summed up this feeling and said that when asked personal

questions by these clients, she tended to reaffirm the boundary:

I do have some patients in my practice who are, so to speak, sicker, and more concrete.

And I would try to appreciate their concern, answer them a bit more concretely, but also

do a little bit of education about boundaries, that this is about their treatment, and I know

they're curious about me, and I'm happy to tell them a little bit, but I wanna make sure

the focus is on them and our work with them. And that sort of thing. Just in a very

concrete, reset the boundaries for the treatment.

Striking a balance. Several participants, in describing their rationale for giving vague or

dishonest answers or reflecting personal questions back to the client, described wanting to strike

a balance in the relationship. They wanted to disclose some information without sharing

anything too private, and wanted to set the professional boundary without shaming clients for

asking questions, or seeming overly withholding. As one participant described:

My style is to be honest but vague and reflect back, so not to give a lot of detail, but not

to dodge it either. It just needs to be a balance. If you don't answer enough times then it

seems weird that you're not answering, you know?

Another participant described a similar desire to maintain privacy and boundaries without

causing damage to the treatment relationship by "shutting down" clients:

56

I generally give the least information possible without being rude. It's hard though, 'cause you don't want to be rude and shut somebody down, and especially because a lot of the interactions do happen in the waiting room, or in front of other people… it's awkward.

Another participant described her concern that refusing to answer questions would cause clients to feel bad about asking them:

There are a lot of openings. People could say, "Are you getting enough sleep?" You know, "Yeah. No." Whatever the answer is, and then back to them… there's a lot of possibility for shaming or making someone feel bad about a question. You know, so you have to make sure that you don't create something that doesn't need to be created.

One psychiatrist described that clients understandably are curious about the therapist, and she tried to give clients some information, but only as appropriate:

Depending on the question and the appropriateness. I tend in general in my theory and practice, unless it's extremely inappropriate… I try to acknowledge what it's about, and figure out what's behind it. "You're curious about me, you want to understand if I'm like you, you want to identify with me. Let's look at this. Let's understand it." …I think a lot of psychiatrists who were trained, at least in my world where I trained psychodynamically, can often come off as quite withholding and not giving anything of themselves. And so, you know, I would give them a little bit as appropriate… or I'd sort of, you know, answer a little bit vaguely, and then try to spend more of the time understanding – with the nosier patients – why do you want to know so much about this? What is this about for you, and what does this mean for our work?

A similar desire to maintain a balance was described by many participants in relation to their decision to accept gifts. As stated above, ten of the 11 participants who were offered gifts chose to accept them. Of the 11 who were offered gifts, five described that they felt uncomfortable about being offered gifts, even though they accepted them, and three described accepting gifts even when it was against their usual stance, training, or agency policy. Many participants described feeling that, even though accepting the gift made them uncomfortable or went against agency policy, rejecting the gift would be rude and harmful to the relationship. As one patient described, "the reason I accepted [gifts] is my presumption was it would just be too big a rejection -- it's just not worth it with many patients." Another participant described her rationale in this way:

> [The patient] would have been offended if I didn't take it. So mostly that's what guided
> me. Like would this actually be detrimental to the patient and insulting if I don't accept
> the gift?

Another patient who was currently pregnant was working with a mother and child who were approaching termination, and the mother offered to bring the therapist a gift as part of the termination session. As the participant described, she felt uncomfortable and uncertain about accepting the gift, but did not want to reject the family either. When the mother offered to bring a gift, she responded as follows:

> I mean warmly, I said, "Oh my gosh, that is so thoughtful and sweet of you, and really
> not necessary. And these are the ways that I'm planning on having termination go, and
> this is what I'll do for the goodbye party. And let's keep talking about this, because I
> don't know that it needs to focus on the baby, or certainly on giving me a gift. You know,
> seeing you guys every week is such a gift for me." So really sort of deflecting it back and

trying not to outright refuse it, because culturally that would be very rude. So we'll see…

I probably put it too gently and so my guess is that they'll still do something… I think I'll

probably continue to encourage her, maybe we can take pictures together and we can

make each other cards and things like that.

Another participant described the rationale behind her decision to accept gifts in this way:

I took [gifts] because I had talked about it with [a group of colleagues who had also been

pregnant while practicing] in advance, and we decided I would just take them and not

make a big deal about it, because of sort of – pregnancy in our society and how people

want to treat – do what patients want to do for you and people in general want to do for

you. But it always made me so uncomfortable because it's like everything against

everything I learned in training… it always made me uncomfortable.

The one participant who did not accept a client's gift felt uncertain, in retrospect, about how this

decision impacted treatment. After this session, the client ended up not returning to see her

again. In the community mental health clinic where she works, many patients drop out of

treatment prematurely, but she wondered whether the rejection of the gift had anything to do

with this patient dropping out. As she described:

[A patient] did give me a box of clothes and honestly I still have it in my office because I

didn't really – I wasn't prepared for that. It was really early on. And I thanked her and

was like, "I'm not sure." First I was like, "It's unnecessary. Can we talk about why you

wanted to give me the gift? And I appreciate your thought." But she was insistent about

the gift. And I did feel uncomfortable rejecting her, I felt like it would be rejecting of her

to not take it. But I left it like that, like "I'm not sure". And then we never ended up

seeing each other again… So that's where I left off. Which maybe that was something –

maybe that was part of what happened. Maybe she did somehow feel rejected or maybe she didn't want to deal with that conversation. So I don't know.

Not wanting to shift the focus of treatment onto the therapist. Five participants explicitly described some degree of discomfort or worry that the "focus" of therapy sessions would shift onto the therapist, or that clients would feel a need to take care of the therapist, which would cause some degree of role reversal in the relationship. As one participant who works with children and families described:

> [Children] were curious about what the baby was gonna be like, and I would say like, 'I wonder what it was like when you were a baby, and maybe we should ask mommy about that' … There was one client where we got out his baby album and we looked at all the pictures from when he was a baby, and mom reminisced about what that was like, and spoke to him about what kind of baby he was. Those sorts of conversations, which I thought was really nice; I tried to kind of get things to go that way. They started to ask a lot of questions… I actually work with three other clinicians who either just had babies, or are pregnant now… What we've talked about is like, it's the only time in your clinical life where something so personal, like completely interferes with therapy. So in some ways you have to address it, but then you don't want it to be all about your pregnancy. So that was why I would try to get them – 'cause it made sense that they were curious about it, but I didn't want it to be about me.

Another participant who worked in a women's health clinic reported worrying that clients would feel unable to talk about certain issues, including abortion, because of her pregnancy.

> I didn't want them worrying about me, or feeling like they now could not talk about their own issues around pregnancy. 'Cause I also counsel women that are considering abortion.

60

And so most of those women are just one-time sessions at their decision-making and most of those are on the phone so there would be no reason to tell them. The ones that came in, certainly I did not bring it up early in pregnancy, but if they came in for an abortion counseling and I clearly was pregnant I would say to them, "You know what, like obviously I'm pregnant and I don't want you to think that that's going to influence my counseling of you about what you decide to do with this pregnancy." So I would preemptively bring that up because who wants to say, "Yeah I opt for an abortion with a lady that's seven and a half months pregnant." It's a little awkward for them so, like I said, I preemptively struck in those cases.

Feeling as though client behaviors were "normal" or "socially appropriate." A number of participants reported clients responses to their pregnancies seemed to be "socially appropriate," "natural," or "normal." In these situations, participants tended to feel less uncomfortable and not feel as though a boundary was violated. Eleven of 13 participants reported clients offered congratulations or expressed happiness to them, particularly at the time of disclosure of the pregnancy, and many participants felt like this was a "normal" response to discovering that someone is pregnant. As one participant described,

Most [patients] would say what you would say to someone socially. You know, "I hope you're feeling okay," "Congratulations," or, "I'm so excited for you." Many of my patients know me well; I've been seeing them for a number of years. So some genuine just socially appropriate responses.

Other participants felt as though personal questions were normal and acceptable in the same way. Some stated there did not seem to be much of a distinction, in the minds of their clients, between the therapist and other pregnant women in their lives. One participant stated

clients "asked me the same questions they would ask anybody." Another participant who

worked with pregnant women described her feelings about touching and personal questions in

this way:

> I just feel like to some extent it's almost socially normal in our society. It's like, you're
>
> pregnant and suddenly strangers are entitled to touch your stomach in the elevator, right?
>
> … I don't know if it's American society or if it's Westernized society – I don't know. But
>
> there's something about being pregnant where suddenly a stranger is entitled to come up
>
> to you and ask you personal questions about yourself and your family, or touch your
>
> body.

The same participant went on to describe how, because clients share so much of themselves

during therapy, it was predictable that they would ask personal questions about her:

> So for me working intimately with people where they tell me the toughest stuff of their
>
> life, it was not at all surprising to me that I got an increase in questions. So I guess I was
>
> prepared for it. And I also think that people just feel free to go there when you're
>
> pregnant in our culture.

Another participant had a similar feeling that in our society, it is normal for people, therapy

clients included, to be curious and ask personal questions of a pregnant woman. She wondered

whether this curiosity was heightened in the therapist-client relationship:

> Well I think it is pretty natural and normal. I think in society it seems that if people
>
> become aware of a woman's pregnancy, I mean it seems almost like with strangers but
>
> especially with people you might have a relationship with, that most people would have
>
> some questions about the pregnancy. So I feel that the questions are relatively normal,

62

like a normal occurrence… I would speculate, is there added curiosity about a therapist's

personal life?

Another participant felt these types of questions from clients were so normal that she did not

even consider them "personal":

I mean, people ask you everywhere you go, "Is it a boy?" Do you know what it is?

When's it due?" I mean, those are like, the questions that like random strangers think it's

okay to ask you anywhere you go. They were asking me like ten times a day. So I didn't

really consider that personal.

One participant reported that many of her clients asked about the sex of the baby and she

answered the question directly and did not feel as though a boundary had been violated. When

asked why she thought clients asked that particular question, she stated:

Human curiosity, 'cause I think anybody asks the gender when you see a pregnant

woman. Usually the first thing that anybody asks. I didn't take it as any significant

meaning… I didn't see anything deeper in it.

Other participants felt that clients offering gifts was normal, social behavior. These

participants tended to accept gifts with little trepidation or discomfort. As one participant

described:

[A client] giving like, a small token gift … overanalyzing that is a mistake, and

something that some therapists get all worked up about doing, but I completely disagree.

I think that people are just being human, and I think it's sweet, and it didn't change a

thing. And it would have changed a thing if I had acted like – patients don't understand

when you try to refuse a gift. Especially if it's a small little something. You know – they

don't understand.

Another participant felt similarly when it came to gifts. As she described:

People just want to do something nice for you. Sometimes it's nice to act real, and

normal, and not make a big deal about things and over-interpret them. And so I think in

general accepting it just made me a normal person.

Pregnancy as point of connection. On the opposite end of the spectrum from those who

felt unsafe or extremely uncomfortable at boundary violations, some participants reported that

their pregnancy, and the general loosening of boundaries that accompanied it, enhanced the

connection and therapeutic alliance between client and therapist. Several participants stated this

was because they seemed more "real," "human," or "normal" to their clients. For example, one

of the participants who worked in the forensic hospital described that she felt her self-disclosure

around pregnancy led clients to feel respected, which enhanced the treatment:

I think that in some ways, [my pregnancy] kind of humanized the relationship and

allowed [clients] to feel respected. That I wasn't treating them as a criminal and I was

willing to share a little bit of information… It's normal when you know someone who is

pregnant or has a baby, you want to be happy with them, you want to celebrate with them

… So I think giving a little bit of information gave the patients the ability to have that

experience with my pregnancy, normalizing and reaffirming that it's a therapeutic, it's a

clinical relationship, but it is a relationship.

Another participant described a similar sense that pregnancy made her more "real" to clients,

which clients seemed to like:

I'm less of the person who sits in the chair who they otherwise don't know anything

about, and more of the person who's a real person and they have a sense of my life. And

so I think some people really, really like that, they really feel closer to me.

Another participant described the human connection she felt with clients during her pregnancy, which she felt enhanced the alliance and improved the outcomes among her clients:

> … If [clients] get a little more personally connected to you, they see you less like a robot and more of a human being, and more connected to a human being begets this process of being in a relationship, because you are in a therapeutic relationship. And the more human they can experience you -- not that it's about your life or whatever -- but that you are a human being with your own set of whatever's going on in your life, just somehow can encourage connection. And I think when people feel connected, they have better outcomes. Does that make sense?

Another participant felt as though being pregnant and accepting greeting cards from clients was rapport-building in a similar way. When asked how she responded to clients offering her cards, she stated:

> I probably didn't think too much about it, to be honest. I think it's a natural thing to do. Again, I hope – maybe I'm wrong – I hope it was rapport-building, like, I'm sharing something about me with you, which is not going to happen all the time, and you shared that thank you or congratulations. And that's a decent thing people do for people who are in our lives … I don't see how any of that could be harmful which is the most important thing.

Two participants described how pregnancy felt like a point of connection with some clients because the therapist was able to be vulnerable. One participant felt as though her vulnerability around the pregnancy, and her ability to discuss her client's experience of the pregnancy, increased closeness and intimacy in the relationship, which moved the treatment forward:

I think for people with whom there's been an established relationship and who really

have been able to talk about the pregnancy… it feels like it can be sort of a point of

connection… I feel sort of a closeness with those clients, and it feels intimate in some

way… like that it feels like a pretty personal thing to be talking about, but when I am able

to kind of go there and have the conversation, whether I'm disclosing or not, it feels like

a way of really feeling a moment of connection… I think it has something to do with the

way I orient myself. Because it's such a personal thing that's happening, and it's

happening in the room in this physical kind of way, and that can feel really vulnerable I

think. I think in moments when I'm able to orient myself sort of internally to being more

open to talking about the meaning of that in the relationship, and being more open to my

client's experience, that feels like it moves the therapy relationship forward.

Another participant reported that self-disclosure to clients about her fears around pregnancy had

a positive impact on her work with pregnant clients, in particular by normalizing their

experiences. She stated:

I think sharing vulnerabilities and fears with them also was really normalizing, you know

to say, "I too am concerned about pain level during delivery," or "I too am concerned

about loss of sleep," or – I do a lot of sexual dysfunction, so about never having a sex life

with my husband again… You know they would say, "I have all these issues and you're

this far along pregnant. Do you worry about this?" And I would say, "Sure I do." A lot of

normalizing.

Other participants described how the pregnancy made them more "relatable," with female

clients especially. As one participant described, it felt like "I was in their club a little bit now

that I was pregnant; that felt connecting for them." Another participant described:

To me, it's important for our own clients to know we're human beings, going through

normal life events just like they are. So I think to some degree it makes me relatable. So

like, prior to being a mom I think when I was working with moms, especially moms with

babies, that was an un-relatable experience for me. So I think that it enhances my ability

to work with that population. Probably that's why I get so many [clients who are

mothers].

Overall impact of the therapist's pregnancy on treatment

Generally speaking, most participants did not feel their pregnancy had a big impact,

positive or negative, on treatment with most clients. As described above, some participants felt

the need to be stricter with boundaries with certain clients, while others allowed boundaries to

loosen in some cases. Participants did not describe any negative or positive impact of tightening

boundaries, though many described the positive impact of loosening boundaries, when they felt it

appropriate, because it encouraged connection and a productive therapeutic alliance. In this

section, I will describe other ways participants felt their pregnancy either helped or hindered

treatment. These include participants who felt they had an increased understanding of pregnancy

and parenting following their own experience of pregnancy, which in some cases deepened

empathy for clients. Others described changes in their emotional availability to clients as a result

of the pregnancy, in ways that both helped and hindered treatment. Finally, this section will

cover the ways some clients experienced anxiety related to the pregnancy and maternity leave, or

decompensated during the pregnancy. This led some to believe the pregnancy may have hindered

treatment for some clients.

Increased understanding and empathy for clients. Eight participants reported that

they understood pregnancy and parenting better because of their pregnancy, and this has led to

deeper empathy for clients, especially those who are mothers. Most also reported this new understanding made them feel more effective as clinicians, especially for those who worked with young children and parents, or with women who were pregnant or postpartum. As one participant described:

> There could be an additional level through experience. Like I said before, ten years ago I didn't know what it felt like to be a mom… I think that [having a child] probably just provided enough life experience for me to have -- be able to be a little bit more grounded in my understanding and empathy and getting it. And maybe going a little deeper with some stuff that maybe I would have skated over before, not recognized the significance that children can apply. Whether you can't have children, whether you do have children, and how to be in a relationship and have children, and how to be a working mom and have children. So it all became a little bit more clearer to me. So when I'm working with people who have that going on, I probably get it more.

Another participant who worked with children and families reported she thought parents could feel less judged by her following the birth of her child because she more fully understands the difficulties of parenting:

> I find, as a parent, when a professional says, you know, "I have kids and A, B, C and D," I just find that I relate to that person now and I think of that person as human and real. And so I also think that child psychologists -- people have this strange perception that that means we have a parenting book and know what do to, and that means we make no mistakes. And so they often -- parents are nervous that we're judging and I really don't want families to feel that way. And I think for them knowing that I have kids, it's like a code for saying, "I totally get it. You know, I get that you don't always use a nice

speaking voice, and that sometimes you're very frustrated and overwhelmed and you say

things that you don't mean to, and that does not make you a bad parent." Like, I get that.

And I believe I can say that and that they feel connected to me.

Several participants described having more empathy for parents, especially those with few

resources. One participant who works with adolescents described having more empathy for

youth who are parents, and more empathy for the parents of the youth she works with:

I think there's a lot more realization of the difficulties of parenting, especially if I have

youth who are parents themselves… seeing the difficulties that a lot of my youth have

gone through in early childhood and the abandonment issues and abuse as an early

infant… the understanding of when a youth is pregnant, and the skills required for

parents, how difficult it is if you haven't had a solid base, grounding as a young child as

well. So I think in the sense of being pregnant, it's helped me also see those challenges in

a better light.

She went on to describe:

I think it's also made me a lot more understanding of the difficulty of being a parent no

matter what your age is. The challenges that exist. I think a little bit more understanding

if a kid is like, "Ahh, this child is crying, what do I do?" I'm like, "Oh yeah yeah, I

understand." So maybe a little bit more understanding in the struggles that they go

through, and that parents go through as well in raising the children.

Another participant described a similar sentiment:

Becoming a parent and becoming a mother, I definitely think, yeah – you certainly

understand a level of empathy and understanding of life in general. And so definitely it

deepens your ability to understand your patients more. Parenting is really difficult, and

it's hard to get it right, even when you're highly educated and very conscious and do the

best you can. Understanding that people with limitations make the mistakes they do is

much more easier to understand.

Another participant described feeling similarly about her clients who are parents, now that she

has some experience with parenting and understands how difficult it is:

I remember actually thinking, the first week when you're exhausted and tending to the

baby every couple of hours, and I'm thinking, "Oh my gosh, people without the support

that I have, and who don't have the financial resources and the mental resources, and how

do people do it?" So yeah I think it definitely increased my empathy. And I just felt like,

impressed that people have been able – some of my clients have been able to do that.

Especially in a field that has a history of blaming parents for their kids' mental health, it's

kind of easy to do that, and yet it's such a hard job, and I'm just getting started with that.

Another participant described the sense that clients felt as if she understood them better, which

promoted connection. At times, this perceived empathy was helpful to treatment, though it could

also constitute a barrier:

Both being pregnant and doing women's mental health work, and now having a kid and

doing women's mental health work, patients appear to act as if I automatically have more

empathy for them. They seem, there seems to be, and there are people I knew before and

after, so it's a generalization of course, and it's all subjective, but it seems that some of

my patients just felt like it was easier to talk to me about their experience, that I just

would understand. Which in some situations is indeed more accurate. And other

situations isn't true. You know, I don't understand certain other peoples' experiences

better just because of my pregnancy. It doesn't mean that I had a similar experience to

them. But people do presume you understand more. If that makes sense. And so the plus

of that is, you know, I think they feel comfortable and connected and maybe even engage

in a rapport with more ease, and in other situations, I think the negative is, because they

presume I understand they're less likely to describe their own experience and I might

have to push more and say, I might not, I might not – you know I can't read your mind

and I don't presume that our experiences were similar. Can you please tell me really what

was it like for you?

Another participant who works with women with postpartum mood disorders reported she has a

better understanding, following her own experience during pregnancy and in the early weeks of

her child's life, of the importance of regulating sleep for the baby and mother. She now assesses

clients' sleep more carefully and implements a behavioral plan to address any issues. As she

described:

I think I have more knowledge, and I think I also have more of a sense that sometimes –

though I'd always been trained this way anyway, in terms of the behavioral part

postpartum, and that protecting sleep is so important – I think I have more potential just

tips, behavioral techniques and skills that I can help people with right there in the office,

and do an in-the-moment intervention.

Pregnancy impacting the therapist's emotional availability. A number of participants

commented on the ways their pregnancy affected their ability to be present with clients

emotionally. Three participants reported feeling exhausted or distracted during their pregnancy,

which may have affected clients negatively. One participant described it being "hard to focus"

during her pregnancy because, as she stated, "I was uncomfortable and focused on the big thing

before me in my own personal life." Another participant described being less flexible with clients during her pregnancy because she wanted to protect her health:

I was more tired. I was more emotional. I was less tolerant. I cleaned house a little more. You know if a patient did something to upset me or agitate me, or raise my blood pressure, I was much quicker to draw the line or even terminate care, than I would be maybe now. I just didn't have the tolerance for -- you know I had to sort of protect my health… I probably got rid of about five patients with my second pregnancy in private practice just because they had become so stressful… Whereas now, I haven't terminated care with a patient in a while. You know I tend to be more, "Let's meet, let's talk about this, let's do a contract, let's figure this out, let's draw some boundaries." That kind of thing. I didn't have those reserves when I was pregnant.

Another participant was in a training program during one of her pregnancies, and found the demands of the training program on top of pregnancy to be exhausting, which impacted her clinical work:

I guess probably I was more distracted and anxious, so I probably was a little bit more distant and not as present... but some of that was just the exhaustion and stress of working too much, and worry that I needed to work for a certain number of hours so that I could get the maternity leave that I wanted and needed. So I think it probably impacted my patients approximately that way.

Interestingly, two participants who were pregnant at the time of the interview reported opposite feelings, that they were less affected emotionally by the work and in some ways, more able to be present with clients. One participant described feeling "more relaxed" and "less taken

for a ride" emotionally by clients since being pregnant. When asked why she felt this was the case, she explained:

I'm not sure. It could be biological. It could be hormonal. It could be more psychological in terms of feeling like I'm focused on nurturing this human being that I'm growing in my body, and really that being, that feeling like the most important thing. So other anxieties or worries or concerns feel a little bit more distant. I feel more peaceful, I would say is probably the best way to say it. And you know, I'm not entirely sure why. It's something that I've thought about a lot. Is this just biological, or is this about the meaning of this new phase of my life, where I'm nurturing this new person and preparing myself to be a mother? It's hard to know, it's hard to answer that.

She went on to describe how this change has positively impacted her clinical work:

I would guess that there is less interference of my affect that doesn't have to do with the client, if that makes sense… I just I feel a little better. I think it impacts the therapy in that I feel sort of a little clearer. And so a little bit more able to kind of step out of my own needs in any given moment and attend to theirs… it's like this paradoxical thing, where I'm preoccupied with this other person that I'm growing, and that somehow because that's my priority, I'm less worked up about worries and therefore more available in the therapy. Less preoccupied.

Another participant felt a similar sense of being less impacted emotionally by clients during her pregnancy, which she felt was positive for her. When asked how her pregnancy impacted the way she approaches therapy, she replied:

I feel like in general in my work… this sounds horrible saying it, but I feel like I kind of care less sometimes, and sometimes in a good way. That I'm not taking as much of the

weight of other people home with me… I really do personally believe in the mother

stress, and what the mother experiences during pregnancy really is transmitted to the

baby growing… I really want to have a calm pregnancy, an easy pregnancy. I want my

baby to feel nurtured in the womb… I think I've grown up and feel like a mother more,

even while pregnant, that I have to protect my personal life, and my personal boundaries.

And still care very deeply about my clients and still want to work very hard with them,

and I want to be present and I really consciously try to do that. But I feel like at the end of

the day, I kind of say to myself, like, "This is it, this is the end, you're going home now."

I notice… I'm working fewer overtime hours. I kind of let things go. I'm leaving my

notebook and my planner at work sometimes and I'm going home and trying to be done.

And I would say that's not really impacted my one-on-one – I would hope it hasn't really

impacted my one-on-one work with clients. I'm still really present. I'm still really

engaged and I still really want to be there. But at the same time, I feel like I don't let it

get to me. The pain and the trauma that they've experienced, because I just don't want to

have that inside of me while I'm pregnant.

Client anxiety regarding pregnancy and maternity leave. Eight participants reported

at least some clients expressed anxiety about the therapist being pregnant and planning an

absence for maternity leave. Some clients felt like the therapist was abandoning them and

expressed anxiety or anger, while others needed regular therapy or medication management to

maintain stability and were therefore anxious about the break in treatment. Not all participants

described this having an adverse impact on treatment, though some described how some clients

seemed to decompensate during pregnancy. At least two participants described how, in

retrospect, they felt maternity leave was a turning point in the work with some clients, in that

clients were relieved to have them back and became re-invested in therapy. One participant who worked in private practice had two different clients who became worried about maternity leave for different reasons:

> So one young woman… she's going through a lot of transition including a lot disappointment in her life with friends and not being able to form romantic relationships that last. And so she kind of, that's the bulk of what we've been talking about, relationships not being solid and permanent… she did say she was having a lot of emotion about worrying about what that meant for us. And so I had to provide a lot of reassurance that the transition was going to be OK and I would be returning and we'd certainly find somebody to see her in my absence… The other client, she's had some pretty serious symptoms in relation to her bipolar disorder, and so regular counseling is sort of essential for her functioning and keeping her job and stuff like that. So she knew that would be something we have to make sure we put something in the gap. It's sort of like almost, I would describe it like a dependence on therapy. So to get that taken away felt very scary for her.

Another participant who worked in a women's health clinic also reported clients were concerned about the maternity leave. She described:

> The biggest concern was, "How long are you going to be gone? Are you going to come back? Are you going to leave us?" So there was some abandonment stuff that came up for people. And I assured everyone that I was coming back, and they assured me you might change your mind, and I assured them I was not in a financial position to change my mind, and I would be back. So there was lots of back and forth about, "Oh you're going to change your mind and not come back and what am I going to do?"

One of the participants who worked primarily with children reported some children became anxious that the therapist would abandon them or worried they would be "replaced" by the therapist's baby:

Well, I think for kids at least, it seemed a way of understanding where they fit in to this picture and maybe concerns on, "Will I be replaced? Are you still going to like me? Are you going to still be my therapist when you have this baby? Are you going to forget about me? Will you want to help me anymore?" Kind of just understand "Where do I fit into this picture?" and "What's going to happen to me?" And "I was here first, so let me show you all the ways I've been here and how you can remember me or what I have done." That's what I felt like.

The participants who worked in the forensic hospital also reported some clients decompensated during their pregnancy, perhaps related to their anxiety about separation during maternity leave. As one participant described:

The female patient who was on maximum security, she was not very stable. She was very fragile, and as the date of my pregnancy leave came closer, she became more and more fragile and was contemplating stopping her medications… She was one that I had been meeting with for quite a long time and so I think she was anxious about my leaving for my maternity leave, and she also knew that when I came back I would be part-time and would be only able to meet with her once a week when I came back. For her, I think that was difficult.

In summary, the findings of this study suggest the therapist's pregnancy is a unique and often intense period during treatment, which seems to impact the therapist-client relationship in a

variety of ways. Further analysis of these findings, as well as a discussion of their implications

for psychotherapy practice, are included in the following chapter.

CHAPTER V

Discussion

The purpose of this study

This study aimed to add to knowledge in the field about how the psychotherapist's pregnancy impacts the therapist-client relationship. The therapist's pregnancy creates a period in treatment when the therapist's private life is highly visible to clients. No other major event in the life of the therapist, aside from a serious illness, unfolds in such an obvious, physical way that clients witness in every therapy session. This is the first study of the therapist's pregnancy that intentionally studied this issue from a relational perspective. Relational theorists posit that, as human beings, we know ourselves and interact with the world primarily through relationships with others. They also assert that in mental health treatment, the relationship between therapist and client is the central force that drives healing, meaning making, and change (Aron, 1991, 1996; Mitchell, 1993, 1997; Greenberg & Mitchell, 1983; Wachtel, 2008). The present study aimed to understand from the therapist's perspective how the therapist's highly visible pregnancy, and the client's newfound awareness of her personal life, might cause a shift in the therapeutic relationship toward more personal, less professional ways of relating. These new ways of relating include a propensity of clients to ask, and therapists to answer, personal questions, as well clients to offer and therapists to accept baby gifts, among other behaviors. Does the therapist's pregnancy force therapists to take on some of the qualities highly valued in relational theory, including therapist authenticity and some degree of self-disclosure? How do

therapists understand these changes, if they occur, and how do they impact the therapeutic

relationship and the therapy itself?

This chapter reviews key findings of this study and situates them in the body of existing

research on this topic, as well as discusses the ways this study both confirms and contradicts

findings in previous literature. I then discuss the implications of these findings for

psychotherapy practice and offer some directions for future research on this topic.

Key findings

The findings of this study suggest that pregnancy presents an opportunity for therapists

and clients to interact on a less professional, more personal level, though not all therapists

allowed boundaries to shift in this way with all clients. Most therapists report that at least some

clients crossed boundaries in ways they had not done prior to the pregnancy. Boundary-crossing

behavior included clients who asked personal questions about the baby (especially the sex and

name), offered baby gifts, touched the therapist, and commented on the therapist's body. Some

study participants also described a tendency of clients to take care of or nurture the therapist

during her pregnancy, which therapists felt was a role reversal in the relationship. This suggests

that pregnancy might be a stimulus for some clients to want to interact on a more personal level.

In response to these behaviors, therapists tended to act according to the degree to which

they felt uncomfortable, which depended on the type of behavior, the context in which it

occurred, the dynamics of the existing therapist-client relationship, and the client's social history

and presenting problems. In this way, therapist responses tended to fall on a continuum. On one

end of the continuum, therapists felt the need to reassert boundaries concretely when clients were

threatening or extremely intrusive, or had a history of harming children (i.e., the client who

wished the therapist's baby would die, then asked her to hang a gift in the "little brother or

sister's room"). In the middle of the continuum were situations where client behaviors felt less intrusive but were still uncomfortable to therapists, such as clients who asked during the first trimester whether the therapist was pregnant, or touched the therapist's stomach for a few moments too long, or asked the baby's name. In these situations, therapists tended to dodge questions by lying, giving vague answers, or deflecting the question back onto the client. Interestingly, therapists tended not to explicitly address boundaries in these situations, often for fear that clients would feel ashamed or "shut down" by the therapist. Therapists often described wanting to "strike a balance" in these situations between eroding the boundary too much and tightly maintaining the boundary which might seem withholding to clients. Gifts tended to fall in this middle zone on the continuum; therapists felt uncomfortable accepting gifts, but almost always accepted them without addressing the shift in boundaries directly with clients.

On the other end of the continuum were participants who found some client behaviors, including asking personal questions and offering baby gifts, to be predictable, socially appropriate, and innocuous. These therapists tended to answer questions and disclose more information to clients, based on their feeling that questions were not overly personal or intrusive. Further still on the continuum were those therapists who felt that the pregnancy actually engendered a new sense of intimacy, closeness, and connection with some clients. These participants also tended to answer questions forthrightly and accept gifts, and also reported feeling as though some clients could relate to them more as a result of their pregnancy. Some described how they felt vulnerable with clients because of their pregnancy and the high visibility of their private life, and this seemed to allow clients to be more vulnerable and open with them in return. This finding suggests that some therapists and clients may relate on a more personal level during the therapist's pregnancy.

It is also important to note that the therapists interviewed in this study seemed to approach each client on their caseload differently. For example, decisions about the timing and manner in which therapists disclosed their pregnancy to clients were intentionally made, depending on client needs and the dynamic of the relationship. One example of this is the finding that therapists tended to disclose earlier to clients who were struggling with infertility or had anxieties related to abandonment in relationships.

The key findings of this study have some implications for the utility of relational theory in guiding practice during the therapist's pregnancy. The main findings outlined above suggest that at least some clients cross the usual professional boundaries in response to the therapist's pregnancy, by offering gifts, asking personal questions, and in other behaviors. Therapists tend to respond by either allowing the professional boundary to erode somewhat, or by reifying the professional boundary in some way, depending on whether the therapist perceives client behaviors to be appropriate, normal, intrusive, threatening, or otherwise. Relational theorists place a heavy emphasis on therapist authenticity and self-disclosure, and this study affirms that in some cases, therapists who responded authentically and disclosed about themselves perceived a deepening, positive shift in their work with clients. On the other hand, some therapists felt a strong need to reify boundaries to protect themselves, or deflected personal questions and rejected gifts out of discomfort. Of course it is impossible to know how the therapeutic relationship may have improved or deteriorated if therapists had reacted differently in these situations and allowed the boundary to open, but it is important to note that none of the therapists I interviewed perceived any negative impact to result from maintaining or reaffirming the professional boundary. This finding seems to call into question the utility of therapist self-

disclosure and authenticity, qualities that are emphasized and at times even valorized by relational and intersubjective theorists.

Rather than making a determination here about the utility of therapist authenticity and self-disclosure, this study makes clear that questions around authenticity and self-disclosure are complex. Both self-disclosure and authenticity are likely useful in some situations and with some therapist-client pairs, but not all. Relational theory seems to be a useful lens for trying to understand these issues and might give pregnant therapists some alternate ways to look at and think about their relationships with clients during their pregnancy. Relational theory could be especially helpful for therapists to use in processing the intensified transference and countertransference responses that many participants reported occurred with at least some clients during their pregnancy.

Situating findings within existing literature

Several findings of this study were directly in line with those of previous studies on the therapist's pregnancy. As with the present study, previous literature shows the overall impact of pregnancy on treatment can be positive or negative, typically depending on the client, their diagnosis, and their degree of pathology (Fenster, 1983; Byrnes, 2000; Matozzo, 2000). The present study found that most therapists reported a majority of clients were happy and excited, and often expressed sincere congratulations, upon discovering their pregnancy, a tendency that was also found in previous studies (Fenster, 1983; Katzman, 1993; Matozzo, 2000). Additionally, participants in this study reported some degree of role reversal with clients who were solicitous and nurturing toward the therapist during her pregnancy, a tendency also reported by Grossman (1990) and Fenster (1983). Two previous studies found that therapists reported feeling physically vulnerable with some clients during their pregnancy (Grossman, 1990; Byrnes,

2000), which again was replicated in the present study, particularly among those who worked with severely mentally ill populations.

With regards to emotional availability during pregnancy, Grossman (1990) found that therapists reported feeling less flexible in their work with clients, and Fenster (1983) found therapists became irritated by clients more easily and were less psychologically available during therapy sessions. In the present study, surprisingly only three therapists explicitly described this sentiment. This study marks a departure from previous literature in that some participants discussed how during pregnancy they feel more clear-headed and less emotionally affected by clients.

Findings of this study related to boundaries and gifts were mostly consistent with previous studies. Existing literature suggests that pregnant therapists loosen boundaries to some extent, are more willing to self-disclose, and are less concerned about their personal privacy (Fenster, 1983; Grossman, 1990; Byrnes, 2000). This study found the above tendencies to be true, though the degree to which therapists self-disclosed, and how they felt about these disclosures, varied by therapist and within a typical caseload. Almost all participants reported their decisions to self-disclose and reveal private information depended on the client. It seems the therapist's pregnancy definitely provides an *opportunity* to loosen boundaries appropriately; some therapists are more willing than others to use this opportunity, and typically only do so with clients who they are comfortable with.

As with self-disclosure, findings of this study related to gifts are generally in line with previous studies, though with some important distinctions. Like the present study, previous studies have found therapists are commonly offered baby gifts from clients during or immediately following pregnancy, and therapists tend to accept gifts when they are offered

(Fenster, 1983; Bashe, 1989; Fallon & Brabender, 2003). The present study found therapists often felt uncomfortable with gifts, but accepted them anyway. Bashe (1989) described how many participants in her study accepted the gift because rejecting it would be an "insensitive deprivation" (p. 82), and Fenster, Philips, and Rapoport (1986) wrote that their participants felt accepting gifts was a "reparative" gesture because clients "have no choice" but to endure the therapist's pregnancy (p. 65). There was a similar sentiment among the participants for this study, although they seemed to feel less a sense of "owing it" to clients and more that denying the gift would be too harsh or rejecting, and would damage the therapeutic alliance. Also, a number of participants felt as though gifts were innocuous and simply "a decent thing to do for people in our lives." These participants tended not to feel uncomfortable.

Departures from previous findings. There are some areas where the current study did not replicate findings in the existing literature. One major example is the timing and manner in which therapists disclose their pregnancy to clients. A majority of the therapists I interviewed disclosed their pregnancy to clients around the beginning of the second trimester, before clients asked them or found out "through the grapevine." This confirms a previous finding by Byrnes (2000), however it stands in contrast to findings by Katzman (1993) and Fenster (1983). These researchers found that most therapists waited for clients to notice the pregnancy and initiate conversation about it. The difference in these findings might reflect a shift in how and when pregnant therapists disclose their pregnancy to clients, with more therapists disclosing up front before clients ask.

The above shift might be related to recent attention in the field on the therapeutic relationship, possibly tied to the emergence of relational psychodynamic theory and recent research that suggests a strong therapeutic alliance is key to positive client outcomes (Norcross,

84

2002; Lambert, 2004; Wampold, 2001). The participants I interviewed tended to think clients would feel betrayed if they found out about the pregnancy from someone else, and avoiding this rupture in the relationship motivated them to disclose up front. In a similar vein, they tended to feel that rejecting gifts would cause an unnecessary disturbance in the relationship. Fenster's 1983 sample of psychodynamically-oriented therapists were likely trained before relational theory was fully formed or being taught to practitioners, and were taught to be more reticent about disclosing personal information.

At least two other findings of the present study contradict previous findings and possibly suggest changing attitudes about the therapist's pregnancy. First, three studies conducted before 1990 found that a majority of therapists interviewed felt "guilty" about their pregnancy being an intrusion into the therapy (Fenster, 1983; Bassen, 1988; Grossman, 1990). In contrast, Byrnes (2000) found that the predominant emotion of most therapists was happiness and excitement about the pregnancy, and did not find therapists to feel particularly guilty. In the present study, neither excitement nor guilt seemed to be predominant feelings among those interviewed.

Another departure from previous findings is related to acting out behavior from clients. In at least five previous studies, therapists reported clients were more likely to act out during the therapist's pregnancy than usual. Acting out behavior included prematurely terminating therapy against the therapist's recommendation (Berman, 1975; Fenster, 1983); cancelling sessions (Napoli, 1999); an increase in missed sessions, tardiness, and late payments (Bassen, 1988); and even sexual promiscuity among clients (Katzman, 1993). While the present study did not specifically ask therapists about acting out behavior in clients, participants did not typically describe the behaviors above. They noticed some anxiety about abandonment from some clients,

and acting out (i.e., making threats toward the baby) in extremely mentally ill clients, but acting out behavior was generally not a big problem.

Implications for social work practice

The findings of this study suggest the therapist's pregnancy can be an intense period in therapy for both therapist and client. These findings also suggest that therapists can continue to provide meaningful, helpful psychotherapy to most clients that might even be enhanced, and at the very least not seriously disrupted, by the pregnancy. Given that the vast majority of social workers are female (Whitaker, Weismiller, & Clark, 2006), practicing psychotherapy while pregnant, and the complications it entails, is likely to affect many social workers during their careers. To better prepare and support pregnant therapists, trainings could be offered to clinicians and supervisors about this topic. These could review literature in the field and give practitioners a sense of what to expect from clients as their pregnancy progresses. Because a number of decisions must be made around self-disclosure, gifts, and how to handle boundary violations from clients, pregnant therapists could benefit from specialized forums to process their experiences during pregnancy. Aside from supportive clinical supervision, this could include local peer supervision groups of fellow pregnant therapists, or online forums where pregnant therapists can connect with one another. These discussions could occur as part of a larger effort to help prepare and support practicing social workers to effectively deal with major life events, which inevitably occur for most psychotherapists during the course of their careers.

Directions for future research

A larger-scale, longer-term study is needed to reduce the threats to validity in this study described earlier. It would be interesting to replicate this study with a larger, more diverse sample, more seasoned researchers, and with data from interviews of both clients and therapists.

86

Another study could examine, from the client's perspective, what approaches and interventions felt helpful or harmful to them, and how they felt about their therapist's decision to accept or reject gifts or answer or deflect personal questions. It could also ask how clients feel the therapist might be more or less relatable, authentic, or empathic during her pregnancy, and to what extent these qualities matter to them.

As described above, this study departs from previous literature in that it found clients seem to act out less and therapists feel less guilty about their pregnancy than they did 20 and 30 years ago. Other studies could specifically ask therapists and clients whether the pregnancy has a negative or positive impact on therapy. Another study could also look specifically at social attitudes toward women, and particularly women psychotherapists, who work during pregnancy. Are attitudes related to pregnancy changing, and is this in turn causing therapists and clients alike to have less negative reactions to the pregnancy? Are clients less likely to terminate therapy because it has become more socially acceptable for women to work during their pregnancy? Other related research topics could include how the visibility of pregnancy impacts therapy; for example, a study could explore the experiences of men and lesbian women whose wives or partners are pregnant, or male and female therapists who are adopting children. Still another study could investigate how relational approaches to psychotherapy might prove particularly useful to therapists as they go through major life changes such as pregnancy.

Conclusion

This study suggests that the therapist's pregnancy offers an opportunity for therapist and client to connect as human beings, beyond the bounds of the professional, therapist-client relationship. Perhaps pregnancy is such a basic and primitive human experience that it causes therapists and clients to transcend social and professional expectations about how they are

supposed to interact. Pregnancy might afford the therapist and client a period of mutual recognition and understanding, less as client and provider and more as two people who are both going through complex life changes that can simultaneously be joyful, exciting, turbulent, and demanding. This study sheds some light on this unique period in treatment, and more research is needed to deepen our understanding of it.

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Appendix A
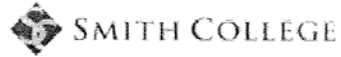
SMITH COLLEGE

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February 7, 2013

Elizabeth Wolfe

Dear Elizabeth,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Vice Chair, Human Subjects Review Committee

CC: Rachel Burnett, Research Advisor

Appendix B

Recruitment Email

Dear [Friends/ Colleagues/Name of potential research participant],

I'm currently working on my Master's thesis, which is an exploratory research study about how the psychotherapist's pregnancy impacts the relationship between therapist and client. I am sending you this email {to ask for your help recruiting participants for the study} or {because you have been recommended to me as someone who might have interest in participating in this study}. I am looking for clinicians who are currently at least three months pregnant and practicing therapy, or have been pregnant while practicing therapy within the past five years. Participants must be a licensed mental health practitioner. If you fit these criteria, I hope you will consider participating in this study.

Participation in the study consists of a 45-60 minute interview with me conducted over the phone or video-phone technology (such as Skype or GoogleVoice). The interview will involve a short series of demographic questions, followed by questions about practicing psychotherapy while pregnant. Interview questions will be provided in advance along with the Informed Consent form. This study has been approved by the Human Subjects Review Committee of Smith College.

If you meet the above criteria and are interested in participating, please contact me via email or phone. Also, please feel free to forward this email to any friends or colleagues who you think might be interested. If you received this email because someone recommended you to me as a potential participant (i.e., sent me your name and email address), that person will have no knowledge of whether or not you participate. I am also available to answer any questions you might have about the study.

Thank you for your time and your support!

Sincerely,
Liz Wolfe

Appendix C

Screening Questionnaire

Please read the following statements and indicate *Yes* or *No* as to whether the statement describes you:

1. I am currently at least three months pregnant and practicing psychotherapy; **or** I was at least three months pregnant while practicing psychotherapy within the past five [or ten] years.
2. I am a licensed mental health professional

To be eligible to participate, you must be able to answer "yes" to both questions. If you answered "no" to either statement, thank you very much for your interest, but you are not eligible. If you would be interested in possibly being contacted at a later date should the qualification requirements change, please indicate (Yes/No) and provide your contact information below. Please feel free to forward my contact information to colleagues who might be eligible and interested in participation.

If you answered "yes" to both statements, you are eligible for participation in this research study, which explores how the therapist's pregnancy impacts the therapist-client relationship. Please provide the following information:

Your name: _____

Contact information (including a phone number, email address, and either a fax or mailing address):

_____

I will be sending you the Informed Consent and a preview of the interview questions. I will need a signed copy of the Informed Consent returned by fax, mail, or email (if you have a scanner) by or before the interview. How would you like me to send this to you? _____

Appendix D

Informed Consent

Dear Participant,

My name is Elizabeth Wolfe, and I am a Master's-level Social Work student at Smith College School for Social Work. I am currently conducting a qualitative research project that explores the impact of the therapist's pregnancy on the therapist-client relationship. The data will be used for my MSW thesis, with the possibility of future presentations and/or publication.

You will be asked to participate in an interview with me over the phone, or using video-phone technology such as GoogleVoice or Skype, at a time convenient to you. Interviews are estimated to last no more than 60 minutes, and will involve a short series of demographic questions followed by more in-depth questions about your experience of practicing psychotherapy while pregnant. Eligibility requirements for participation are that you:

- Are currently at least three months pregnant and practicing psychotherapy; *or* were at least three months pregnant while practicing psychotherapy within the past five years.
- Are a licensed mental health practitioner.

After demographic data is collected, the remaining portion of the interview will be audio recorded onto my computer using standard Apple software (Garageband). I will then transcribe these interviews personally, or if need be, by a professional transcriber who will sign a confidentiality pledge.

Risks to participation are minimal, but include potential distress or discomfort at sharing what could have been difficult experiences during your pregnancy. To minimize these risks, a preview list of interview questions will be provided to you prior to the interview. Please know that you may decline to answer any interview questions at any time. A referral resources list will not be provided. While compensation is not provided for your participation in this study, benefits to participation include an opportunity to reflect on your work and contribute to knowledge in the field about how therapist pregnancy impacts treatment.

Confidentially can be reasonably provided in this research. Advisors to my research will have access to the data for this study, but with your identifying information removed. I will conduct the interviews from a private room in my home. Demographic information collected at the beginning of the interview will not be recorded. The recording will immediately be uploaded to my personal computer that is password locked and stored securely in my home. I will then transcribe these interviews personally, or if need be, by a professional transcriber who will sign a confidentiality pledge. All data (notes, digital recordings, transcripts, etc.) will be kept in a secure location for a period of three years as required by Federal guidelines and data stored electronically will be protected. If the data are needed beyond the three-year period, they will continue to be kept in a secure location and will be destroyed when no longer needed. Please be mindful not to identify clients should you speak of them. In any presentations or publications resulting from this research study, data will be presented in aggregate form and any identifying information in illustrative vignettes or quotes will be carefully disguised.

Your participation in this study is confidential. You may withdraw from the data collection process and may refuse to answer any question at any time. Furthermore, for up to two weeks following the interview you may contact me by phone or email and have your interview transcript and audio recording, and any demographic data deleted. At that time all materials pertaining to you will be immediately destroyed. If you have any additional questions or wish to

withdraw please contact me through the contact information listed below. Should you have any concerns about your rights or about any aspect of this study, you are encouraged to call me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

_____   _____
Participant's Signature   Date

_____   _____
Researcher's Signature   Date

Please keep a copy of this form for your records. Thank you for your time and your participation in this work.

Sincerely,

Elizabeth Wolfe
MSW Candidate
Smith College School for Social Work

Appendix E

Preview Interview Questions

1) How did clients become aware of your pregnancy?
2) What, if any, patterns did you notice in the ways clients responded to your pregnancy?
3) Did clients ask any personal questions following their discovery of your pregnancy? If yes:
   - How did you handle the personal questions raised by your clients? Did you respond the same way to all clients?
   - What happened when you did this?
   - Did you find that there were ways of responding to the personal questions that positively affected the client or the therapy? How?
   - Did you find that there were ways of responding to the personal questions that negatively affected the client or the therapy? How?
4) Did clients offer you gifts during your pregnancy or after your baby was born?
   If yes:
   - How did you decide what to do when clients offered you gifts?
   - Did you respond the same way to all clients? Why or why not?
   - Did you find that certain ways of responding to gifts that positively affected the client or the therapy? How?
   - Did you find that there were ways of responding to gifts that negatively affected the client or the therapy? How?
5) Did you discuss or process with clients the impact of your pregnancy on therapy? If yes:
   - How did you facilitate this conversation?
   - How did clients typically respond?
   - Did you find that certain ways of leading this discussion positively affected the client or the therapy?
   - Did you find that certain ways of leading this discussion negatively affected the client or the therapy?
6) Are there any other ways that being pregnant changed the way you relate to clients?
   - If yes: Can you describe how you have changed?
7) Are there any other ways being pregnant changed the way you understand and conduct therapy? Please describe.

Appendix F

Interview Questions

1) How did clients become aware of your pregnancy?
     If therapist disclosed: When and how did you disclose?

2) What, if any, patterns did you notice in the ways clients responded to your pregnancy?
     - Were there any responses typical of clients of a certain age, gender, race, or DSM diagnosis?
     - Were there any other factors that seemed to predict how clients responded to your pregnancy?

3) Did clients ask any personal questions following their discovery of your pregnancy? If yes:
     - How did you handle the personal questions raised by your clients? What happened when you did this?
     - Did you respond the same way to all clients?
     - Did you find that there were ways of responding to the personal questions that positively affected the client or the therapy? How?
     - Did you find that there were ways of responding to the personal questions that negatively affected the client or the therapy?

4) Did clients offer you gifts during your pregnancy or after your baby was born?
   If yes:
     - How did you decide what to do when clients offered you gifts?
     - Did you respond the same way to all clients? Why or why not?
     - Did you find that certain ways of responding to gifts that positively affected the client or the therapy? How?
     - Did you find that there were ways of responding to gifts that negatively affected the client or the therapy?

5) Did you discuss or process with clients the impact of your pregnancy on therapy? If yes:
     - How did you facilitate this conversation?
     - How did clients typically respond?
     - Did you find that certain ways of leading this discussion positively affected the client or the therapy?
     - Did you find that certain ways of leading this discussion negatively affected the client or the therapy?

6) Are there any other ways that being pregnant changed the way you relate to clients?
     - If yes: Can you describe how you have changed?

7) Are there any other ways being pregnant changed the way you understand and conduct therapy? Please describe.