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Rhyannon Leah O’Heron
Pregnant Queer Clinicians:
An Exploratory Study of the
Countertransference
Experiences of Queer
Clinicians During Their First
Pregnancies

ABSTRACT

This study explores countertransference experiences of queer clinicians in work with adult female clients in a myriad of settings during their first pregnancies. Twelve clinicians with Master’s degrees or higher in the fields of social work, counseling, and psychology participated. In addition, all participants self-identified as queer, lesbian, and/or bisexual women in same-sex relationships. Participants, diverse in age, religion, geographical locations, work settings, and number of years in the field, were fairly homogeneous in ethnic identity, theoretical orientation, and methods used to become pregnant. The qualitative study design, using a flexible, semi-structured interview guide, allowed for an in-depth exploration into the participants’ experiences in a way which empowered participants to help shape the interview through sharing their stories and create knowledge in the field regarding this unexplored phenomenon.

Thematic analysis of the information gathered resulted in five major sections of findings: demographic information, countertransference during first pregnancy, experiences of countertransference with case vignette individuals, reflections on changes post first pregnancy, and supervision. Two pervasive themes across the findings indicated that (1) participants’ therapeutic relationships were each unique making it difficult to compare and speak generally about their experiences; and (2) participants were faced with managing client assumptions about their sexual orientation and

relationship status that emerged as a result of the inevitable disclosure of pregnancy. The study implicated a need for supervision that is sensitive to issues of pregnancy and also to sexual orientation. Increased education, training, and research in the field regarding the countertransference experiences of queer clinicians are also implicated.

PREGNANT QUEER CLINICIANS: AN EXPLORATORY STUDY OF THE
COUNTERTRANSFERENCE EXPERIENCES OF QUEER CLINICIANS DURING
THEIR FIRST PREGNANCIES

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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2007

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CHAPTER I

INTRODUCTION

Little is known of the experiences of queer therapists and the clinical and countertransferential dilemmas they encounter in work with clients. Even less literature and information is available to support the understanding of the experience of countertransference during pregnancy for queer therapists. According to the National Association of Social Workers 2006 study of licensed social workers in the United States, 81% of the profession is comprised of female clinicians. This is a larger proportion than the percentage of women, 51%, who make up the population of the country at large. While neither the NASW nor the United States government make any effort to collect information regarding the percentage of the population who identify as queer; it is estimated that roughly 10% of the population of the United States identify as gay/lesbian (Boslaugh, 2006). Thus, it is also probable that a significant proportion of women in the field do not identify as straight. Increasing numbers of queer women are choosing to have children, given current social trends of improving gay rights, and more information is needed to understand the experiences of these women. Further, in order to expand the current “psychology of heterosexuality” which exists in the research and theoretical basis of the field, acknowledgment of queer professionals in the field and exploration of the issues they face is also necessary (McDermott, 2006). Much of the existing literature on the disclosure of therapist pregnancy focuses on the reactions and experiences of clients

to this new knowledge, and little information exists regarding the countertransferential experiences of the pregnant therapists. Understanding and preparing for possible situations of inevitable disclosure of personal information, such as the disclosure of pregnancy, and the possible countertransference that one might experience as a result is necessary to support the use of this countertransference in the service of the client and for the purpose of deepening the therapeutic relationship.

This study will explore the countertransference experiences of queer therapists during their first pregnancies to further the development of knowledge in the field of clinical social work. The purpose of this study is to explore queer clinicians' experiences of countertransference during their first pregnancies in their therapeutic work with adult female clients. The research question asks, "What are the countertransference experiences of queer clinicians in therapeutic work with adult females during their first pregnancies?" While there are two articles exploring the experiences of countertransference of two pregnant lesbian therapists (Silverman, 2001; Sachs, 1989), there has been no empirical research conducted on this topic area. Thus, one goal of this study is to contribute to the developing body of knowledge on countertransference and queer clinicians, and another is to discuss implications for social work education, supervision, and training on this phenomenon. Having more information about these experiences would not only benefit queer clinicians planning for pregnancy, but could also be of value to supervisors working in the field.

Some use the term queer "as an inclusive, unifying sociopolitical umbrella term for people who are gay, lesbian, bisexual, and also those who are transgender, transsexual, intersexed, and queer" ("Queer", 2006, paragraph 5 line 1). In this study, "queer" will be

used as an umbrella term to define those individuals who identify as lesbian, bisexual, and/or queer. Countertransference will be defined using the broadest available frame of reference to ensure any and all thoughts, feelings, wishes, fantasies, conflicts, anxieties, and/or enactments which are aroused in the therapeutic relationship as a result of the clinician's pregnancy are open to discussion during data collection. Thus, a broad definition of countertransference where all therapist reactions occurring in the bidirectional relational matrix of the therapeutic relationship, as discussed by Fauth (2006), Burke and Tansey (1991), and Marcus and Buffington-Vollum (2005), will be used in this study. The terms clinician, therapist, participant, and social worker will be used interchangeably and hold the same meaning throughout this study.

As there are only two articles specifically exploring the experiences of pregnant lesbian therapists, and both of these articles explore the authors experiences and are not empirical; literature exploring countertransference, therapist self-disclosure, and the impact of pregnancy on the therapeutic relationship will also be reviewed and used to guide the development and analysis of the study. The study is a qualitative study using in-depth interviews with twelve queer senior level clinicians from across the country to explore their countertransference experiences during first pregnancies.

CHAPTER II
LITERATURE REVIEW

Countertransference

Theoretical Literature on Countertransference

Theoretical articles by Fauth (2006), Burke and Tansey (1991), and Marcus and Buffington-Vollum (2005) all reference three areas of historical literature and understanding of the term countertransference. These three schools of interpretation are 1) the classical Freudian and ego psychological understanding of transference as an experience limited to the analyst's unconscious reactions; 2) the totalistic conceptions of countertransference stemming from object relations theory, and the belief that countertransference is all therapist reactions occurring in the bidirectional relational matrix of the therapeutic relationship; and 3) the interpersonal or relational school of thought which sees countertransference as the therapist's 'normal or role-responsive' reactions to interpersonal patterns of the relational phenomenon of the therapeutic relationship.

Burke and Tansey (1991) discuss the implications these differing theoretical perspectives have on therapists' decisions regarding self-disclosure of countertransference. The perspectives on disclosure of countertransference stem from entrance of this material into therapeutic space being seen as:

inevitable but incompatible (Freudian, drive-conflict model), to being narrowly accepted (object-relations, developmental-arrest model), to being welcomed and useful (interpersonal, relational-conflict model) (Burke & Tansey, 1991).

Fauth (2006) goes on to discuss the difficulty conducting research on countertransference as a result of these multiple definitions and understandings of the terms and its use, and advocates for the need to have a “moderate” definition which will enable research in this area to grow. Fauth (2006) suggests defining countertransference as the “idiosyncratic reactions (sensory, affective, cognitive, and behavioral) to clients that are based primarily in the therapists’ own personal conflicts, biases, or difficulties (cognitive biases, personal narratives, maladaptive interpersonal patterns)” (p. 17). Fauth (2006) goes on to state his belief that “extratherapy factors” and resulting personal/professional reactions would and should not be included or viewed as countertransference. However, this suggestion seems to negate the reality that inevitable disclosures, such as pregnancy, would have an impact on the transference experiences in the therapeutic relationship; which seems impossible given the bidirectional, relational nature of therapeutic dyads, which Marcus and Buffington-Vollum (2005) and Sharhar (2004) discuss. Fauth’s suggestion also conflicts with research that explores and discusses the impact and importance of unconscious and non-verbal communication, such as the research of Rapsahl-Leff (2004).

Marcus and Buffington-Vollum (2005) and Sharhar (2004) broaden the understanding of countertransference by applying a social relations perspective and an action theory perspective, respectively, to the term and utilizing these relational models to deepen understanding of the interpersonal nature of countertransference. They assert that

there is a need to understand countertransference through this relational lens, which asserts that the formation of a therapeutic relationship rests on the ability to have a “shared, unique social reality” (Marcus & Buffington-Vollum, 2005, 257) or “mutually orchestrated meaning system” (Shahar, 2004, 8) within the relationship. Thus the use of transference and countertransference to address intersubjectivity and projective identification, as well as to acknowledge the needs of both client and therapist become critical to the deepening of therapeutic relationships.

Goldstein and Horowitz (2003) discuss the potential difficulties that arise when there is a clash between the self-object needs of the client and therapist (e.g. client seeks idealized parent imago, therapist seeks twinship); thus highlighting the importance of managing the therapist’s needs through supervision. Similarly, Shahar (2004) discusses the implications of understanding and utilizing a relational lens to explore issues of transference and countertransference in the therapeutic relationship stating that: 1) there is a need for a better understanding of this phenomenon in order to ensure successful use of the material in therapy and 2) there is a need to recognize the social backgrounds of both client and therapist in order to fully understand and appreciate the transference experiences and their multiple potential sources.

Fauth (2006) suggests useful ways in which to conceptualize the measurement of countertransference that could be generalized to a myriad of studies exploring countertransference. His measurement categories include exploring countertransference origins (unresolved personal conflicts of clinician), triggers (therapeutic events eliciting countertransference origins), countertransference management (strategies for coping), and countertransference effects (influence on outcomes of therapy (Fauth, 2006).

Countertransference of lesbian therapists in work with lesbian clients

Reichek (1993) and Goldstein and Horowitz (2003) both explore the countertransference experiences of lesbian therapists working with lesbian clients. Goldstein and Horowitz (2003), theoretically discuss how lesbian therapists often fall into two camps in regards to self-disclosure and use of countertransference in the therapeutic relationship based on their theoretical orientation: traditional analytic models or relational theoretical models. Traditional analytic models see the therapist's role as that of a blank slate, where therapeutic value is placed on the client's ability to project his/her thoughts, feelings, and beliefs onto the therapist; thus the use of therapist self-disclosure is dissuaded. Relational theoretical models argue against this value system, choosing instead to believe that therapeutic value is found in the ability for client and therapist to share "dyadic reciprocity"(Marcus & Buffington-Vollum, 2005, 257) formed largely through both parties use of self and the transference material that develops in the therapeutic relationship.

Seibold (2005) as well as Burke and Tansey (1991) also discuss the role of theoretical stances, such as those mentioned by Goldstein and Horowitz (2003), in directing disclosures of therapist countertransference and other personal material, such as pregnancy. In the traditional analytic model discussed by Goldstein and Horowitz (2003) little to no self-disclosure is made; it is noted that potential therapeutic issues arise when clients inadvertently discover their therapist sexual orientation. The relational model is that of therapists who choose to disclose up front or at appropriate therapeutic moments. Goldstein and Horowitz (2003) present a somewhat biased view of these two therapeutic stances in which they offer more support to therapists in the relational camp and state a

feeling that therapists in the traditional analytic camp who hold a traditional view of disclosure do so because they may be uncomfortable with their sexual orientation. While current trends are moving in the direction of more relational forms of therapy, this does not render traditional psychoanalysis invalid.

Reichek (1993) approaches the phenomenon of countertransference experienced in lesbian client-lesbian therapist dyads through an empirical study exploring the experiences of 10 self-identified lesbian therapists. The research design is a strength of Reichek's (1993) study. Reichek conducts interviews using an interview guide asking open-ended questions that focus on countertransference as well as specific case examples. Her data is analyzed through categorizing the information and range of responses and, where feasible, correlations with demographic variables are performed. Lortie (2005) and Silverman (2001) reach conclusions similar to those of Reichek (1993), they find that the countertransferential and self-disclosure experiences of the lesbian therapists with their lesbian clients were different from those experiences with other clients. Interestingly, Reichek (1993) also finds that all participants discussed having thought about, discussed, and studied at length the subject of countertransference despite the lack of empirical literature on the topic. A limitation of the study, which Reichek (1993) acknowledges, is that the sample is very homogeneous with participants sharing the same geographical location, therapeutic style, education level, race, and socioeconomic status.

Goldstein and Horowitz (2003) also discuss the possible outcomes of unacknowledged and unmanaged countertransference, including collusion with client's homophobia and avoidance. Despite current progressive social trends, Goldstein and Horowitz (2003) discuss how instances of prejudice and discrimination that lesbian

clinician's may face and have faced in the field, including job loss, having colleagues and supervisors doubt their ability to treat heterosexual clients, and clients not wanting to be seen by an out lesbian therapist among many others leave therapists feeling silenced, scared, and feeling increased anxiety, anger, vulnerability. When therapists are unsupported in the work place and unable to manage and express these feelings they result in a parallel process in their therapeutic relationship where clients ability to explore sexual orientation and process strong feelings is avoided. While the authors spend time exploring the undisclosed therapist sexual orientation and resulting countertransference, the authors neglect to include a discussion of how the disclosure of therapist sexual orientation may also be a result of unmanaged countertransferential feelings and needs/wishes/fears of the therapist as opposed to being purely for the clients benefit. For instance, Statterly (2006) discusses therapists internal struggle with wanting to self-disclose sexual orientation as a way of having their true-selves known. Goldstein and Horowitz (2003) discuss possible clashes that may occur when a therapist need for twinship in the transference relationship is unmanaged, while a client seeks idealization. Goldstein and Horowitz (2003) stress the importance of utilizing supervision to "scrutinize therapist's own attitudes and feelings" (p. 119) and to "manage the boundary between therapist's personal and professional identity" (p178) in order to support the effective use of countertransference and self-disclosure. Maroda (2003) warns that for supervision to be useful and beneficial a therapist must feel able and willing to self disclose countertransference reactions not only to clients but also to supervisors in the

supervisory relationship. “Supervision can provide a more objective view that can enlighten the therapist to possible distractions and misdirections. However, supervisors also contribute heavily to therapeutic impasses and are not omnipotent” (Maroda, 2003, 46-47). This may be a challenge for lesbian therapists who find themselves to be working in prejudice and/or discriminatory systems.

Therapist Self-Disclosure of Sexual Orientation

Another area of the literature which contributes to building a knowledge base with which to approach the subject of countertransference for queer pregnant clinicians is research on queer therapists and issues related to self-disclosure of sexual orientation. Using grounded theory analysis Statterly (2006) explores self-disclosure and countertransference of gay clinicians in work with both gay and straight clients; while Lortie (2005) uses content analysis of interviews with lesbian therapists and heterosexual female therapists to compare use of self-disclosure and countertransference.

In the study Statterly (2006) conducts four focus groups are held with a total of 16 self-identified gay therapists while Lortie (2005) collects data utilizing semi-structured interviews with 6 self-identified lesbian, queer, or gay female therapists and 6 heterosexual female therapists. Statterly (2006) provides no other demographic information about his participants and Lortie (2005) states that all of her participants are white. Statterly (2006) defines three core categories with which to understand the decision making process of gay clinicians regarding disclosure of sexual orientation. These categories are “identity creation, pre-client contact identity management, and client contact identity management” (p.244). Identity creation refers to the impact of the therapist’s experiences of him/herself as a professional, and of the rules of organizational

context on the therapist's use of self-disclosure. While pre-client contact identity management refers to the ways in which therapists consider theoretical orientation as well as their therapeutic understanding of self, client, and the therapeutic relationship to inform their self-disclosure decision-making process. Client contact identity management refers to the therapist's process of struggling internally with a desire to self-disclose sexual orientation in order to be authentic to his/her true self while having to remain thoughtful about the purpose in terms of the bettering the client and/or furthering authenticity, connectivity, and/or role modeling in the therapeutic relationship (Statterly, 2006, 244-245). Through content analysis of interview data Lortie (2005) finds that the self-disclosure practices of queer therapists were influenced by: theoretical orientation, personal experiences in therapy where therapist used self disclosure, personal choice, and positive client responses to use of self disclosure. Thus, both Lortie and Statterly find that some factors impacting the use of therapist self-disclosure resulted from aspects of the therapist-client relationship. Lortie (2005) also finds differences (e.g. frequency, type of client disclosure is made to, directness of disclosure) between the ways in which queer and heterosexual therapists disclosed information about their sexual identity, and attributes this difference to issue related to homophobia/heterosexism.

Through grounded theory analysis Statterly (2006) ascertains that there is not a static model with which to explain therapist self-disclosure, and the researcher concludes that a theory needs to be developed which acknowledges the dynamic nature of the self-disclosure process for queer clinicians. Lortie (2005) concurs with Statterly that there is a need for more research in the area of queer therapist self-disclosure practices.

Additionally, both Lortie (2005) and Statterly (2006) discuss ways in which societal

heterosexism influences the ways clinicians practice self-disclosure of sexual identity. These findings and conclusions highlight the need for more detailed information regarding the self-disclosure practices of queer clinicians, and the potential countertransferential factors that influence or result from these personal disclosures.

Pregnancy and Countertransference

Pregnancy inevitably brings issues of sexuality and the physical reality of the therapist as a sexual being into the room, potentially adding another dimension to the experiences of self-disclosure and countertransference in the therapeutic interaction; experiences which warrant empirical exploration. There is no empirical literature exploring the countertransference experiences of pregnant lesbian therapists, and a limited scope is taken in the exploration of heterosexual therapists' experiences with pregnancy and the resulting countertransference.

One limitation of the literature regarding the countertransference experiences of pregnant clinicians is that both articles (Ulkman, 2001; Raphael-Leff, 2004) use case study analysis as the research method. The studies by Ulkman (2001) and Raphael-Leff (2004) both omit demographic information of the cases explored in their samples, thus rendering the non-dominant view invisible. Raphael-Leff (2004) goes on to make the false assumption that his findings are generalizable to all cultures despite the unidentified sample.

Raphael-Leff (2004) highlights the role non-verbal communication, or "unconscious communication," plays in the therapeutic exchange, and the potential positive and negative impacts this type of communication may have on the therapeutic relationship. Hjalmarsson (2005) also comments on the use of non-verbal communication

and intuition in her clinical work during her pregnancy in experiences where her clients discover her pregnancy as well as her clients' experiences of the fetus being a third person in the therapeutic space.

The findings of both Raphael-Leff's (2004) and Ulkman's (2001) studies indicate that being prepared for the exploration of countertransference during pregnancy is critical to supporting a beneficial outcome of the therapeutic relationship. Ulkman (2001) suggests that this finding has important implications for training both students and supervisors as it may stimulate thought about the possible inevitable personal disclosures that may arise in their therapeutic work. While the samples of the research studies discussed above are limited as all of the therapists were using psychodynamic theory to inform their work, Marcus & Buffington-Vollum (2005) discuss the ways in which countertransference has evolved from being a purely psychoanalytic tradition to being widely used, understood, and explored by therapists utilizing a myriad of theoretical perspectives. This discussion supports an understanding that the findings of Ulkman (2001) and Raphael-Leff's (2004) studies are beneficial for a wide variety of clinician's in the field, as therapist from varied theoretical backgrounds rely on the understanding of interpersonal dynamics in their therapeutic relationships.

Understanding and using client transference during therapist pregnancy

In order to support the management and effective use of the resulting countertransferential reactions, an understanding of the ways in which clients may respond and react to the therapist's pregnancy enables therapists' to attempt to think and plan ahead in ways.

McWilliams (1980) writes about three therapeutic issues which impact the researcher's countertransference during her pregnancy. Hjalmarsson (2005) also explores her experiences working through three of her clients' transferential issues that arise as a result of her pregnancy.

Both McWilliams (1980) and Hjalmarsson (2005) discuss clients experiencing transferential feelings of neglect/abandonment, envy/anger, and excitement. McWilliams (1980) concludes that clients' protectiveness of these transferential feelings, coupled with therapist difficulties managing client regression while pregnant, may lead to the potentially damaging result of mutual collusion of these transferential issues. Client feelings of neglect/abandonment, envy/anger triggered by therapist pregnancy, often place the client in a vulnerable state in which he/she is in need of greater attention and attunement from the therapist but avoids and is protective of verbalizing these feelings. When this client experience occurs in a time when the therapist is experiencing hormonal changes and often turned inward and focused on her pregnancy instead of the client, the time and energy needed to address these transferential issues isn't present, leaving the therapeutic relationship in a precarious position.

A related issue McWilliams (1980) and Hjalmarsson (2005) discuss is the challenge that arises with changes in schedules, expectations, and therapist availability, all of which may impact the transferential experiences of clinician and clients both during pregnancy and after child-birth.

Hjalmarsson (2005) concludes that the therapist's pregnancy has the potential to positively impact the therapeutic relationship through creating a less intrusive and safer space to discuss transferential feelings. In order for this positive impact to occur

Hjalmarsson (2005) suggests that 1) therapists must allow the client greater involvement in the therapist's life as a result of the change in the analytic space that has occurred, and 2) therapists should take an "interactive (reciprocal/relational) approach . . . to effectively work through client's complex feelings" (p.1). While these findings are interesting they cannot be generalized to queer pregnant therapists given the limited scope of the case studies. Seibold (2005) offers a meaningful commentary of Hjalmarsson's (2005) article pointing out that Hjalmarsson never includes a discussion of the impact of her own thoughts, feelings, fantasies, and/or wishes about the disclosure and/or the meaning her pregnancy has on herself, clients, or therapeutic relationships. Seibold (2005) goes on to state the importance of having awareness and insight of these countertransference feelings as pregnancy can be a time when the "therapist's ability to separate her own perceptions from her client's is increasingly blurry" (p. 14).

Pregnant Lesbian Clinicians and Countertransference

There are two articles (Silverman, 2001; Sachs, 1989) that explore disclosure of pregnancy and the resulting countertransference dilemmas for the pregnant lesbian therapists. Silverman (2001) and Sachs (1989) share very different experiences in regards to their self-disclosure and countertransference during their pregnancies. Some of this difference is partially due to societal changes in regards to homosexuality and women's issues between the 1980's and 2000's.

Sachs (1989) describes herself as being one of the first pregnant lesbian therapists at the time of her pregnancy and states her countertransference experiences stemmed from a position of having little to support her through the experience; being that she was breaking new ground and had no peer colleagues or literature to turn to for support in

planning for working through her pregnancy. It is also interesting that while Sachs (1989) describes her theoretical stance as a feminist one, which is more relational in nature, she decides to shift away from this theory to a more traditional analytic stance during her pregnancy. In doing so, she refrained from disclosing her pregnancy until clients asked or commented and did not disclose her sexual orientation. Sachs (1989) neglects to include a reflection or an exploration of the role her countertransference or sexual orientation played in her decision to refrain from use of self-disclosure. Marode (2003) discusses the possible harm that may come from misuse of theoretical concepts to provide a rationale for treatment decisions, and the danger of unmanaged countertransference leading to the therapist re-creation of his/her past in the therapeutic relationship. In discussing her 6 cases, Sachs (1989) notes that 2 of the 6 clients terminated prematurely and she attributes these early terminations to the client's transference and impasses that arose, again neglecting to consider the role she may have played in these therapeutic interactions. Marode (2003) comments on client termination of therapy stating, "therapists significantly underestimate the role of dissatisfaction with treatment and the role of the therapist as central factors in termination." (p. 47). Marode (2003) further discusses the use of self-disclosure of countertransference both in supervisory and therapeutic relationships, as a key tool for working through "treatment grid-locks" (p.44). Sachs' (1989) experiences point to the difficulties that can arise without adequate supervision which would help a clinician acknowledge, manage, and effectively use countertransference in the service of maintaining working therapeutic relationships. Considering the social and political climate and extent of societal homophobia at the time, Sachs' (1989) experience also sheds light on the impacts of

homophobia/internalized homophobia on the decision-making processes in therapy. Silverman (2001) discusses her experiences of countertransference directly. More specifically, she addresses the issues of having the therapist's sexual life enter the therapeutic relationship while pregnant, and the increased feelings of vulnerability and anxiety she experienced as a result of her concerns about the social acceptance of her pregnancy. While Silverman (2001) also describes feeling a desire to avoid her awareness of the countertransference issues she experienced, she decides instead to face them head on, as she is aware of the dangers avoidance may cause. From her own experience, Silverman (2001) concludes that these countertransferential feelings, such as fear and shame, may lead to inhibited affect of the therapist if she feels she must hide parts of herself due to avoidance of exploration of these issues rather than coming to a place of being able to make a clinically appropriate choice to disclose or conceal her sexual orientation. The researcher also discusses the importance of acknowledging feelings of countertransference in relational work with clients because "both members are continuously affecting each other in the subtlest of ways" (Silverman, 2001, 5). Maroda (2003) concurs with Silverman's thoughts on the importance of acknowledging and utilizing countertransference to deepen therapeutic relationships. Maroda (2003) believes that the respect shown to clients through therapists willingness to become vulnerable and discuss countertransferential reactions in therapy can not only provide opportunities for new experiences and growth, but can also be a supportive intervention in moments when therapists feel stuck with clients.

In the article Silverman (2001) discusses two of her cases, one exploring work with a straight client and the other exploring work with a lesbian client. She finds that she is

able to be more emotionally available and involved in the working relationship with the lesbian client. Silverman (2001) describes this difference as being a result of feeling she “was not being emotionally honest or available to” (p.47) her straight client in the way that she was able to with her lesbian client due to the assumptions clients made about her personal life. In addition, Silverman’s personal “concerns about the social acceptance of her pregnancy” (p.49) as a lesbian woman also impacted the “anxiety and vulnerability”(p.49) she experienced with her straight client. The strength of Sachs’s (1989) and Silverman’s (2001) articles is that they begin to shed light on the complex experiences of queer pregnant clinicians navigating decisions regarding self-disclosure and use/management of countertransference. While they are not research studies, Sachs (1989) and Silverman (2001) explore their valuable experiences as lesbian pregnant clinicians. Implications for practice arising from these studies (Sachs, 1989; & Silverman, 2001) support the need for more research exploring the countertransference experiences of queer clinicians. Silverman (2001) also states her belief in the need for more research, education, and discussion in the profession to explore this issue in a variety of settings. The omission of space for the exploration of issues facing queer clinicians and clients contributes to the perpetuation of the dominant social narrative which states that queer identities are unworthy of exploration and devalued; and the formation of a “psychology of heterosexuality” (McDermott, 2006, 195).

CHAPTER III

METHODOLOGY

Research in the counseling professional fields, such as social work and psychology, have historically been and are still, largely based on the experiences of heterosexual people, leaving the voices and experiences of roughly 10% of the population unheard and unacknowledged. Furthermore, as noted in the literature review, research exploring the experiences of queer clinicians' comments on the lack of empirical data available to support the understanding of this population and their experiences of countertransference in work with clients. Thus, one goal of the questions posed to participants of this study was to not only gather information to further the understanding of the experiences of queer clinicians' during their first pregnancies, but also to gather information about their thoughts regarding supervision in relation to this phenomenon in order to support the development of knowledge with which to educate supervisors in the field. Therapy, based on a myriad of theoretical models of practice, places great emphasis on the roles and uses of transference and countertransference in the therapeutic relationship, as they are tools used to effect the deepening of understanding, growth, and change in clients as well as in the therapeutic relationship itself. There is currently no empirical research on the countertransference experiences of pregnant queer clinicians. Thus, the second goal of this study was to pose questions directed at shedding light on these unique and unexplored countertransferential experiences. For the purpose of this study transference and countertransference were defined using the broadest available

frame of reference to ensure any and all thoughts, feelings, wishes, fantasies, conflicts, anxieties, and/or enactments which were aroused in the therapeutic relationship as a result of the clinician's first pregnancy were open to discussion during data collection. In order to elucidate any confusion regarding the myriad of ways in which the term countertransference may be defined and understood, all participants were given a definition of this word. Participants were also asked to self-define the term countertransference to ensure the existence of mutual understanding of this term among participants and researcher alike. All participants provided responses that fit within the definition provided.

Based on existing literature, it was hypothesized that pregnancy poses an added layer to the countertransference experiences of queer women as they are often faced with assumed heterosexuality and placed in a position to decide to disclose or conceal information related to their sexual orientation. Inevitably, with the entrance of pregnancy into the therapeutic space, so too come issues and questions regarding sexuality. Furthermore, first pregnancy experiences were explored as it was hypothesized that these initial clinical encounters during pregnancy would provide the richest descriptions of these first-time countertransferential dynamics. This chapter will explore the sampling, data collection, and data analysis procedures chosen to study this phenomenon.

Sample

Participation in the study sample was limited to twelve individuals who met the following sampling criteria: adults who had 1) experienced a pregnancy while engaging in therapeutic work, 2) held a master's degree or higher in a counseling profession, such as social work or psychology, 3) had clinical experiences with adult female clients in any

kind of social service setting or private practice, and 4) self-identified as lesbian, and/or queer. These identities were not exclusive for participation, but instead offered the range and diversity sought in this study. While the selection criteria did not actively recruit bisexual individuals, due to possible variation in experience, individuals who identified as bisexual in addition to identifying as lesbian, and/or were in a same-sex relationship were included in the study.

The researcher considered using a purposive selection process in order to acquire a more ethnically diverse participant pool. However, all interested participants were fairly homogeneous in terms of race and other socio-cultural factors, thus, a random method was used to select participants for the study in hopes of achieving a representative sample that was not affected by possible researcher bias. Participants of this study were recruited using a variety of non-probability sampling techniques, including snowball sampling and convenience sampling, through posting free advertising flyers in community agencies and around the greater Seattle, Washington area. On-line networking through academic, community, and professional list serves were also used. Special consideration was given to organizations, communities, stores, and list serves used and frequented by queer community members, mothers, and people of color. Additionally, as connections were made with possible participants and others interested in the study, these individuals were encouraged to forward the announcement to other individuals who may be interested in participating. All recruitment materials included the researcher's confidential voicemail phone number, as well as Smith School for Social Work email address.

The decision to make use of these diverse non-probability sampling techniques was made with the expectation that a broad range of therapists representative of diverse

ethnic backgrounds, social identities, geographical locations, and therapeutic modalities would be found to participate. However, despite these attempts to attract a diverse sample from a wide array of differing organizations and communities during the recruitment phase of this research project, the sample of this study is skewed in that it is very homogeneous. While participants came from a variety of states in the northeastern and western United States, all participants identified as Caucasian and all but one employed psychodynamic theories to inform their practice.

The first twelve interested individuals who met sampling criteria and returned a signed informed consent form were invited to participate. One of the participants who returned a signed informed consent and planned to be interviewed did not participate due to scheduling difficulties, and thus the researcher invited another individual to participate, as this person was the thirteenth person to respond to recruitment materials based on date.

All identifying information from individuals who expressed interest in the study and did not participate was kept confidential and destroyed once data collection was completed, including the informed consent of the participant who withdrew due to scheduling difficulties.

Data Collection

Utilizing a flexible, exploratory design, in-depth interviews were conducted to collect rich descriptions of participants' experiences with countertransference during their first pregnancies. In gathering all data, measures to protect the rights and confidentiality of the participants were taken as outlined in a proposal of this study that was presented to the Human Subject Review Board (HSRB) at Smith College School for Social Work

before data collection began. Approval of the proposal (see Appendix A) indicated that the study was in concordance with the NASW *Code of Ethics* and the Federal regulations for the Protection of Human Research Subjects. This exploratory study's design employed semi-structured in-depth individual interviews lasting between 36 and 66 minutes in length. Both in person and telephone interviews were conducted with individuals from across the United States. The intent of this research design was to acquire a diverse sample of 12 participants who would be representative of other queer clinicians in the field who fit the sampling frame, participants who would contribute to developing a relatively unexplored body of literature.

A total of twelve interviews were conducted over a two-month period, three of which were in person interviews. Both practicality and convenience were considered when deciding whether to interview participants by telephone or in person; thus, only participants located within a three-hour driving distance of the researcher's home were interviewed in person. While the interview guide was designed to be as clear and concise as possible (see Appendix B), a limitation of this study is that utilizing both phone and in person interviewing may affect the validity of the study as the context, environment, and ability to connect to participants varied interview to interview. In conducting phone interviews the ability to accurately understand participants' responses differed from in person interviews as non-verbal cues were unavailable for analysis and at times it was difficult to hear participants' responses or accurately interpret participants' silences; thus affecting the ability to accurately compare, and analyze the data collected.

In person interviews were held at a mutually agreed upon time and location. Two of these interviews were held in the participants' work places while one interview was

held in a participant's home. All participants were advised to consider issues of confidentiality and outside noise interference when deciding upon an interview location. Interviews conducted over the telephone were held at a mutually agreed upon time and a phone adapted recording device was used to ensure participants confidentiality. All phone interviews were done while both participants and researcher were in confidential spaces at home or in work offices.

All participants were mailed or faxed two copies of the informed consent form and asked to return one signed copy and keep one for their personal records prior to engaging in the interview. The researcher also read aloud the informed consent information prior to beginning the interview and enabled participants to ask any questions they had about this material. The informed consent information detailed the study's purposes, possible risks and benefits, and ways in which privacy would be protected in the data collection, analysis, and reporting process. It also contained the researchers contact information. Copies of recruitment materials and the informed consent information can be found in Appendices C and D.

Effort to reduce researcher bias lead to two specific events prior to actual data collection: first, colleagues and advisors reviewed the interview guide and next, a practice interview (using the guide) was conducted with an individual who met the sampling criteria. The interview guide contained four sections of open-ended questions 1) participants' current demographic and factual questions and those related to the time during the participants first pregnancies, 2) questions exploring general themes related to their countertransference in practice during their first pregnancies, 3) participants' clinical experiences with a specific adult female client during their first pregnancies; in

this section participants were asked to disguise identifying information of the clients they discussed in order to assure clients' confidentiality, and 4) participants' concluding thoughts, reflections, and suggestions for the field based on the experiences they had and shared.

At times during the interviews questions were clarified and participants were given time to elaborate on questions and provide additional anecdotes. Occasionally, participants were asked to elaborate on ideas provided in response to a specific question in order to obtain a more holistic understanding of the participants meaning and experience.

These twelve interviews were digitally recorded while the researcher took minimal notes during the interview. To ensure confidentiality, participants' names were not used or recorded during the interview process. The researcher then personally transcribed all interviews within a week of the interview date to enhance accuracy, and confidentiality was maintained as only the researcher had access to this raw data. To further ensure confidentiality all identifying information (e.g., names, agencies etc.) were removed in reporting the data. Additionally, participants were assigned a number during data collection and only this number was associated with their data (e.g., data files, notes, transcriptions, etc.). All data were kept separate from signed informed consent forms, and both will be kept in separate private secured areas that only the researcher will have access to until the federally required three-year time period has passed and the data will be destroyed.

Data Analysis

Thematic analysis was employed to examine the data collected from the interviews conducted. As interviews were being conducted, minimal notes on relevant information were taken along with particular common themes and unique responses across interviews. Within a week of completing each interview, the recordings were transcribed in full by the researcher. Once all transcriptions were complete they were explored for commonalities and themes with the intent of gaining a better frame to conceptualize unstructured data and begin to categorize the data into sections of major findings. To complete this task, the researcher employed a process of coding the content of the interviews by question responses and then compartmentalizing emerging commonalities and differences in the words, themes, and issues discussed by participants across the study.

Due to the qualitative method chosen for this research study, the generalizability of the findings may be limited. However, this semi-structured, flexible method of interviewing which promoted the gathering of in-depth narratives from the individuals involved has the potential to contribute to future larger studies that could be designed for greater generalizability of their findings.

CHAPTER IV

FINDINGS

Introduction

Overview of the Study

This chapter contains the findings from interviews conducted with twelve female therapists from across the country. The subject of investigation was to explore queer clinician's experiences of countertransference during their first pregnancies in their work with adult female clients. This chapter is divided into five sections: demographic information, countertransference during first pregnancy, experiences of countertransference with case vignette individuals, reflections on changes post first pregnancy, and supervision.

Demographic Information

Twelve Caucasian female therapists participated in the study: eleven licensed social workers and one registered clinical counselor. Participants' ages ranged from 33 to 50. Participants lived in a number of different geographical locations including: British Columbia, California, Connecticut, Maryland, Massachusetts, New York, and Washington. Participants' identified their religious affiliations as: Buddhist, Christian, Catholic, Jewish, Spiritual, Near Death Experiencer, and four reported no affiliation.

All participants were lesbian identified, were affiliated to the lesbian community, and/or in a same sex relationship at the time of the interview. More specifically

participants identified as (7) lesbian, (4) bisexual and in a lesbian relationship, and queer-lesbian (1). Eleven participants reported being in a long-term partnership.

Five participants reported changes in the breadth of theories they currently rely upon to conceptualize their work from the psychodynamic theories utilized during their first pregnancies. In addition to psychodynamic theories participants were currently using: family systems, relational, feminist, narrative, mindfulness, trauma, EMDR, CBT, DBT, spiritual, and eclectic theories to approach their work.

Participant demographics at time of first pregnancy

The subject of investigation of this study relates to the following demographic information related to the time period of first pregnancies in the participants lives. Eleven participants were licensed social workers and one was a registered clinical counselor nearing completion of her MA in counseling psychology. Their ages ranged from 29 to 42. Almost all of the participants (n = 11) reported utilizing psychodynamic theories as a basis for their work during their pregnancies. Participants had been practicing in the field from 1 to 17 years at the time of their first pregnancies. Participants had their first pregnancy between 9 months and 13 years prior to the research interview; the majority (n = 8) between 2 to 5 years prior to the interview. All participants used different methods of artificial insemination with both known and unknown sperm donors to become pregnant. Seven participants became pregnant within the first four months of trying to conceive. Three participants took longer than one year trying to become pregnant while one spent seven years. Four participants report having medical and/or health related complications.

The average number of years a participant had spent in her work setting was 4.2 years, with a range of six months to eleven years. They practiced in a wide range of settings and often multiple settings (n = 6) during their first pregnancies including: a variety of outpatient and inpatient mental health settings with adults, children, and families (n = 8); private practice (n = 7); maximum security prison, and a lesbian, gay, bisexual, transgender (LGBT) center.

Participants described the climates of their work environments for queer clinicians using several different descriptors: open and accepting (n = 9), tolerant (n = 3) “I didn’t experience homophobia but always felt a difference;” and hostile (n = 3), commenting on “a dynamic of exclusion,” and how “the support staff were difficult I experienced some discrimination.” All participants worked as out queer therapists among colleagues. Two participants were out to all clients, and ten participants were out to one or more clients.

Twelve Case Vignettes Individual’s (CVI’s) Demographics

A section of the interview questions asked to participants of the study were in regards to their work with a specific adult female client, or CVI. Eleven CVIs discussed were identified as Caucasian; the remaining CVI discussed was identified as Puerto Rican. Their ages ranged from 20 to 60, with the majority of CVIs (n = 7) being between the ages of 40 and 45. Six CVIs discussed were identified as lesbians; five were identified as straight, and one as bisexual. Eight CVIs were mothers.

Nine CVIs were reported as being married, partnered, and/or in a relationship(s). CVIs had been engaged in therapy with the study participant for varying lengths of time: one to three years (n = 7), one year or less (n = 3), or more than 6 years (n = 2). CVIs were working on a multitude of issues in therapy: family related issues including conflict

with mother (n = 7); substance use (n = 5); trauma, attachment issues (n = 4); anxiety, sexual orientation, anger management, relationship difficulties (n = 2).

Countertransference during first pregnancy experiences

An analysis of the data revealed two important underlying threads to keep in mind. The first common thread related to the many challenges associated with clients' heterosexist assumptions about their therapists; since the inevitable disclosure of pregnancy brings issues of therapists' sexual orientation and relationship status into the therapeutic relationship. The second common thread apparent in the study was that participants considered each client and therapeutic relationship as a unique experience. Participants frequently noted that they were uncomfortable making generalized statements or comparisons about their different therapist-client relationships. The multiple variables present in each client-therapist dyad made it complicated for participants to think in generalized ways about all clients and relationships.

In looking at countertransference the following sub-sections will be explored: participants' own definitions of countertransference; preparing for countertransference; the impact of pregnancy disclosure on the therapeutic relationships; general countertransferential issues and themes that emerged; and countertransference management.

Participant's own definitions of countertransference

Participants (n = 12) were all in agreement in their definitions of the term countertransference, and their definitions matched that of the researcher. The participants defined countertransference as a result of what the client brings to the therapeutic

space and/or as a result of the therapeutic relationship that develops. Participants described countertransference as “reactions to what the client is bringing up,” “thoughts and feelings related to the client,” “feelings and emotions that come up within myself as a response to my relationship with the client,” and as “the wide range of emotional reactions that I have as a part of the clinical experience sitting in the room with a client.” Participants also commented on the interplay of what the client brings with the therapist’s personal experience:

Countertransference is any thoughts, feelings, reactions that I have towards my clients that could be triggered by my clients and what they bring in but is also based on my own life experiences, issues, and stuff; so I see it as my stuff triggered by what the client brings in or just what’s coming up for me.

Six of the participants noted experiencing countertransference as a more holistic experience including “the energy in the room,” “any reactions the therapist has,” “the totality of our experience with the client,” and “physiological, spiritual” reactions.

Preparing for countertransference

In the second set of questions on the interview guide participants were asked the question: in planning for or in the early stages of your first pregnancy how did you think your pregnancy might affect your work with adult female clients? The aim of this question was to explore how participants planned and prepared for the clinical experiences and countertransference they might face in work with adult female clients during their pregnancies.

All participants (n = 12) responded to this question having had a variety of thoughts and possible concerns regarding the impact of their pregnancy on their clinical relationships and the transference issues that might arise. Participants made general

statements such as, “I new it would bring up all sorts of stuff . . .” and “I thought about all the clients on my caseload . . .” and “ I was worried I would have strong reactions . . .”

Two frequently discussed concerns (n = 6) participants had in planning and preparing for their work pertained to clients’ assumptions regarding therapists’ sexual orientation and relationship status; more specifically, concerns regarding how, when, and how much to self-disclose in response to clients questions regarding therapists pregnancies and personal life issues. One way in which participants voiced these early concerns was through commenting on questioning their feelings of safety and security in the therapeutic relationship. One participant commented “I was worried it would be emotionally and socially unsafe for me and for them,” and another stated “I was dreading the personal questions and just feeling anxious about that and what that would mean to the work.” Participants also voiced these concerns by discussing feeling as though disclosure of their sexual orientation and pregnancy may change the transference dynamics, and the way they were seen and understood as therapists and individuals. “I was wondering how I would be perceived” one participant responded, another reported “I knew my sexual orientation would come up with some people who would ask me about my husband, clients see you as being all together and having everything you want in life.” One participant who practiced openly as a lesbian therapist commented on the role client assumptions and stereotypes regarding lesbians as parents and regarding relationship status played in client responses to her pregnancy,

Clients new I was a lesbian and certainly more and more lesbians are having kids but I still think its not the norm, I imagined they picked up on the fact that I was single so either clients knowing I was a lesbian or assuming that I was single, it may have been a surprise to them that I was pregnant. I don’t know if that was true or not but that’s what I thought about.

Participants who expressed having concerns during the planning and preparation stages of their pregnancy with determining how, when, and how much to disclose to clients provided responses like “I wondered how we’d talk about it and what to do if it didn’t come up,” and “I was unsure of how much I wanted to share and what would be appropriate to share.” One participant discussed her struggle with disclosure decisions in the following way:

I had a set of heterosexual clients who didn’t know my sexual orientation and I was concerned about how that would play out in terms of when or if they had questions about assuming I had a husband, or I got pregnant naturally; or what I would do with those assumptions if they became verbalized

Five participants commented on concerns regarding how disclosure of their pregnancy may affect clients “who wanted to be pregnant” or “who had had an abortion,” and also were concerned about “how clients would respond to the pregnancy in general, how they’d see it as good or bad.”

In the same vein, four participants were concerned their first pregnancies might change some of the transference feelings of identification with female clients who were mothers, lesbians, and/or fat women on their caseloads. For instance one participant commented, “I thought about my connection to other women who had children and relating.” Another participant commented on her thoughts regarding work with a lesbian mother:

I thought there would be an identification with me in some way, or I was curious it would change the way she saw me. All of a sudden I’d be similar to her in a way she wasn’t aware of because she wasn’t aware of my sexuality at the beginning, so I was curious what it would stir up for her to know that and that I was a mother.

Another clinician commented on feeling as though her pregnancy might “inspire and empower” lesbian clients on her caseload who “knew [she] had a female partner.” One participant felt as though “fat” clients might be able to better identify with her; “[she] had suspicions about when [her] body and size changed that a lot of body image stuff and changes in the climate in the room would occur.”

Four participants commented on feeling concerned that their pregnancy disclosure might trigger discussions related to mothering and motherhood issues. A number of participants made statements like “I wondered how it would affect her to know that I was becoming a mother” in relation to work with clients who had strained relationships with their own mothers, or who had had children removed from their care. One participant also commented on her thoughts regarding how clients might view her as a “good or bad mother because motherhood is in the room with you and becomes really relevant.”

A few participants (n = 2) discussed the following issues being considerations of theirs while planning and preparing for disclosure of pregnancy: triggering client abandonment issues, parenting issues, managing erotic transference, fears of client rejection, and concerns about not being emotionally present in the therapeutic relationship in the same way.

Impact of disclosure of pregnancy on therapeutic relationships

In order to ascertain how the disclosure of pregnancy and participants’ countertransference affected their therapeutic relationships with clients participants were asked to: 1) rate the significance of the disclosure of their pregnancies on their

transference and clinical work on a scale of 1 (insignificant) to 5 (very significant) and 2) to discuss the three key ways that their countertransference experiences impacted the therapeutic relationships with adult female clients on their caseloads.

Participants had difficulty using the rating scale to respond to the first question regarding the significance of their pregnancy disclosure as they felt “it was different for every client.” In addition to using the rating scale many participants provided a narrative response explaining their rating choice(s). Thus, a majority of participants (n = 7) chose to respond with ratings between 3 and 4 commenting that this rating represented “an overall average,” or “represented most of [my clients].”

Five participants responded “five, it was quiet significant and neat;” with one participant responding “oh! It was a 5 plus, it was majorly significant.” Only one participant rated her experience as being a 1, or insignificant, with the majority of her clients stating “with two clients it was a five for all the others it was probably a 1.”

This participant, and one other stated similar feelings, mentioning, “at the time I wouldn’t have thought it was as important, in retrospect I can see it had a place in impacting the work.”

In response to the second question, which asked participants about the three key ways they felt their countertransference experiences impacted their therapeutic relationships with adult female clients. The majority of participants (n = 7) commented on feeling that their therapeutic relationships with adult female clients were positively changed by their pregnancies as their relationships with clients intensified and “the pregnancy became a vehicle to deepen peoples commitments to their treatment and a jump start for growth.” A number of participants commented not only on clients’

commitment to the therapy relationship becoming deeper, but also reflected on their own commitment, one participant commented:

It deepened my relationships to clients. I felt I had a whole new landscape to see and utilize and my own emotional field. So because of that I felt I had more to work with and could take more risks with people in terms of musing about emotions and if I had a hunch about something someone was feeling I'd take a risk to say it because maybe before I wouldn't have noticed it in myself and had the opportunity to say it.

Another participant who worked predominately with mothers described this change stating:

I'd always seen the kids as injured, hurt, and in need of my help, I was much more in tuned to seeing the mothers that way too . . . that was a real positive change in the relationships I had with some of the women it deepened the relationships.

Five participants spoke about how the countertransference resulting from their first pregnancies also lead to increased avoidance and distancing in their relationships.

Three of these five participants commented on their own feelings of avoidance and distancing resulting from “ distraction . . . it impaired my ability to be there and be present with the patient,” and from “things I missed or I didn't want to see . . . I would have wanted to be more present.” One of these three participants held deep regret for the outcomes of her increased avoidance as it lead to pre-mature client terminations, she explained:

I was even more defensive because I was doing the nesting thing and wanted a big nice protective padding around myself so I kind of pushed back more than I would have instead of just dealing with the anger and not taking it personally . . . and with none of those people did I talk directly about issues to do with my pregnancy; and I regret that now, I'm sad that that meant that both of those people left and it was really hard for them.

Two of these five participants commented on client's increased avoidance and distancing resulting from the transference relationship that evolved during the participants' pregnancies. One explained this phenomenon as being:

struck by the lack of discussion about it, you know here it was in the room and I would leave openings for it . . . there was a way many clients didn't want to talk about how hard it was for them because they would say 'this is a good thing and I don't want to make you feel bad'.

While the above participant finds the avoidance to be a result of positive and protective feelings that clients held for her as their therapist, the second participant found that avoidance and distancing resulted from "angry feelings" that came "to the floor in the therapy," leading her client to "feel a bit distant, or maybe a bit jealous, or angry somehow that [the client] couldn't have children."

Four participants mentioned how self-disclosure regarding issues pertaining to sex, sexual orientation, and relationship status affected their therapeutic relationships. One of these four participants commented on how her countertransference experiences were connected to "increased possible self-disclosures made."

Countertransference also influenced relationships for three participants through increasing the identification felt between therapist and clients who were mothers. This was described by one of these participants as feeling "mom's were more connected to me . . . and I could identify more with them and understand them differently"

A small number of participants (n = 2) commented on the following impacts occurring in their therapy relationships as a result of their countertransference: pregnancy becoming a "vehicle for clients to address issues", increased anxiety in the relationship, and client's feeling empowered. For one participant her pregnancy became a vehicle for

one client to “recapture some of the joy over her own pregnancy . . . she started to open up and share some of her own experiences with pregnancy,” and for clients to “explore their own childhoods.” A different participant commented on feeling an increase in the anxiety present in her therapeutic relationships including her own anxiety, stating, “it brought out my fears, and questions, and thoughts of how I might screw up my own kid.” A final participant commented on empowerment stemming from the transference relationship that evolved as a result of her pregnancy, she mentions that:

one lesbian client was empowered . . . I resembled someone who pulled some things together that didn't seem outwardly possible to her, she could see more opportunities for herself via what she knew about me during my pregnancy

Countertransference issues and themes that emerged during participant's first pregnancies

Participants were asked to respond to two questions regarding the countertransference issues and themes that emerged during their clinical experiences working with adult women during their first pregnancies. First participants were asked to reflect back on their first pregnancies and identify five major countertransference issues and/or themes they experienced in their work. Then the interview guide asked participants: were these five major issues/themes experienced across the board with all clients, and if not to please explain.

A number of different countertransference feelings were discussed by participants, the most prominently mentioned being anger (n = 7). One participant discussed feeling “angry and hurt” as “a number of lesbian clients [were] saying things suggesting that [she] had betrayed them in some way by taking this heterosexual path”.

Another two participants described angry feelings resulting from feelings of difference and a sense of inequality in their experiences as pregnant lesbian women in comparison to the experiences they imagine straight women go through. One participant discussed her anger regarding her inability to discuss her partner:

I also had anger that I couldn't share my partner's name and her feelings about it; like other women get to say 'oh my husband did this' and 'I wonder if the baby will have his eyes' . . . there's this person, who's my partner and who's going to be the parent, who I had to leave out of all that and I felt angry about it.

Another participant, who worked with mother's involved in child protective services, discussed how her anger lead her to question her thoughts about the world:

I had a really weird anger reaction and almost ironic view of the world, my worldview was skewed. I kept thinking how crazy the world was that it could work in a way that I, who had lots of resources: family support, a loving caring partner, and a real strong desire to become a mother had to work so hard to get pregnant. I had to go through some losses, deal with systems, bureaucracies, red tape, lawyers, all the drama of getting pregnant. Most of the women I worked with had the experience of waking up one day being like 'oh I'm pregnant' and there was a part of me that was just so angry that there were all these women who had all these children they just couldn't care for, and here I was doing shots and all kinds of crazy medicines, peeing on sticks, waking up every morning to take my temperature, having to jump through all these hoops and paying all this money to consult with lawyers so my partner would have legal rights . . . all these kinds of things these women never had to deal with or think about were part of my pregnancy experience.

In addition to discussing countertransference feelings that came up, participants also discussed countertransference issues related to their relationships with clients. One such issue that seven participants directly discussed was managing feelings regarding coming out and disclosing their sexual orientation to clients and responding to client assumptions. One participant reported:

I felt my internalized homophobia a little more intensely than I had because either there was an assumption that there was a father and I was straight so I had reactions to that or assumptions that I was not coupled and that I just got pregnant by accident so I had reactions to that. . . but it wasn't the work of the therapy to get into that, ya know . . . it was hard to work through it in their therapy.

Another participant described how her “original issues coming out,” issues of “finding community,” were triggered during her pregnancy experience in work with lesbian and gay clients whom she feared would feel she “wasn't a true part of the community because [she] was doing a typically heterosexual thing . . . [she] didn't want to be suddenly ostracized and on the outside again.” A final participant discussed feeling “frustrated” and “relieved” by client's assumptions, as “a very personal thing was happening that other people were witnessing and so it wasn't something [she] could ignore;” however, she had decided “not to come out and so [she] felt relieved to have them make assumptions.”

A related theme that participants (n = 7) experienced was feeling a need to be “self-protective” in their relationships with clients. One participant describes her need to self-protect from her feelings of identification with mothers she worked with. These client's parenting experiences triggered her to feel “scared” about making similar mistakes given her empathy and new understanding of parenting and bearing children being an “overwhelming,” “miserable,” and “exhausting” experience at times. A number of participants mentioned feeling “protective,” “the potential for being invaded,” and “feeling exposed” by the questions, assumptions, and comments of clients. Four of these seven participants also discussed how they felt the need to more closely monitor their

professional boundaries. “It was the most personal thing many [clients] had known about me. . . it needed to be known but I still tried to maintain personal boundaries of myself as a therapist,” one participant explained.

Five participants discussed feeling increased concern and worry for clients and how they would manage the disclosure of pregnancy and cope during the participants maternity leave; leading one participant to “want to prematurely or falsely reassure my clients that nothing would be different in terms of my ability to be there for them.”

Countertransference feelings of physical illness, anxiety, loss, and worry also came up (n = 4) in interview responses. A number of participants felt “exhausted” and were managing feelings of physical “discomfort” and sickness during their work with clients. Anxiety that participants experienced related to their concern for clients as well as feeling “overwhelmed” and “stressed” by having to respond to “client’s asking personal questions.” Participants also discussed anxiety related to ending their treatment relationships and going on leave. One, feeling anxiety in relation to unknowns like “when am I going to deliver, will it be on time, do I work until last minute, not work, when do I return to work . . .” Another feeling “a lot of pressure, a need to be more than adequate . . . everyone had more needs as I became more pregnant and ready to leave.” These participants also discussed feeling anticipatory anxiety and fear regarding the loss of their therapeutic relationships during their maternity leaves. “I had fear of people leaving my practice and maybe they wouldn’t want to wait to do therapy with me because I was going to be taking a break,” said one participant. Another decided “to terminate with most of my clients who I had been working with for years because they needed crisis or case management I wouldn’t be available for. . . so I was having a lot of feelings of loss.”

A final participant discussed experiencing “loss” in a different way, through discussing issues of childhood and parenting with clients during her pregnancy, it triggered her to think “back to [her] own childhood and parenting issues with my own mother.”

A few participants (n = 4) commented on feeling increased therapeutic attunement to clients, and also feeling a greater identification with clients. In elucidating the experience of finding greater therapeutic attunement to clients during her pregnancy experience one participant describes how

there was just this incredible heart opening, and I felt I could better use what I was feeling to help folks access what was going on for them it was great really great, not what I expected.

In detailing the experience of identifying with clients in new ways, one participant had

a delicious sense of deeper connection . . . I’d joined this new club, the mom club. . . so it was not at all literal it was this very earthy, deep, beyond words awareness that I shared with these women. I was stepping into a place, not one they had been for a while, but I was welcomed by them and somehow I felt wiser because of it . . . I had a new vision, seeing them in a new way and knowing they were seeing me in a new way it was really quite special; a powerful time, quite intense.

Three participants discussed experiencing increased judgment toward their clients who were mothers and whom participants felt were making poor parenting decisions; one participant remarked feeling her client was “creating a recipe for a child who’d be in distress.” A final three participants discussed the positive experience of feelings in a “more intense,” “palpable,” and “deep” way in their work with clients during their pregnancies.

In addition to being asked to identify the major countertransferential themes that emerged, participants responded to a question regarding if the countertransferential

themes presented above were experienced with all clients. Half of the participants (n = 6) responded in the affirmative, and half (n = 6) reported having “different reactions to different people.” One participant who experienced different reactions with different clients reported “it was different with my gay and lesbian clients because I was out to them so things didn’t come up in the same way” she explained. Five of the six participants who commented on having different reactions with different clients also commented on how these themes were present in varying degrees with different client’s on their caseload making it hard to definitively answer “yes” or “no” to the stated question of whether these themes emerged across the board with all clients. For example, one participant remarked, “all of my reactions were intensified around that time related to the [pregnancy] experience, probably to more or less a degree depending on the circumstances of the people.” Another similarly stated, “ my responses to clients were more extreme one way or the other.”

Countertransference Management

Participants employed a number of coping strategies to manage their countertransference. To acquire information about the ways in which participants managed their countertransference reactions they were asked: how did you manage these experiences?

Participants most frequently report (n = 9) turning to supervision as a way to manage and cope with their countertransferential experiences. One participant remembers, “I was in supervision more frequently than I had been before there was so much going on with me and with clients reactions . . . things were just flying fast so I was consulting with two supervisors at that point.” Another participant recalled how

important and supportive her supervisor had been in helping her manage her countertransference through listening and encouraging the participant to engage in self-care activities:

she was really helpful, she was really able to hear where I was coming from, share in my excitement about being a mom, and encourage me to take good care of myself . . . she really seemed concerned for my wellbeing and my baby's wellbeing, that was really helpful. She empathized and let me talk about my feelings and reactions.

Similarly to the importance of having supervision as a place to go to and discuss the countertransference that was arising in their practice; five participants discussed the importance of having peers, other queer therapists who had experienced pregnancies, to go to for support. One participant commented on a unique experience of having a supervisor who was also a peer and how this helped her to seamlessly navigate her therapeutic relationships and issues that arose because her supervisor was so familiar with her experience of pregnancy as a lesbian clinician:

I had an exceptional supervisor since she had had a baby and was queer she knew the territory so I really processed a lot of what was happening in therapy which made things really smooth with my clients, I don't think my countertransference was uncomfortable for the most part, it was just interesting and something different to be looking at.

Other participants echoed the importance of receiving support from other queer therapist who could understand their experiences of pregnancy in order to prepare for and manage the countertransference they experienced. For instance, one commented on her ability to

receive support and information she was lacking in her supervision from peers, “there wasn’t a lot to read about it or a lot in supervision specifically about being a lesbian so I did talk to other therapists about how it was for them to be doing the work during their pregnancy.”

An equal number of participant (n = 5) greatly relied upon their partners’ support as a means to manage their countertransference experiences during their pregnancies. “I really rely on my partner to process feelings so they’re not coming up in session,” one participant explained. Another participant managing countertransference in her relationships with clients who were mothers, many of who had histories of mistreating their children, reported:

I was able to check in with my partner, and we had a lot of good conversations about what parenting meant to us and what family meant to us and having that context made it clearer for me to see that this is my stuff that I’m bringing to [therapy] relationships and recognizing it was really helpful too.

Group consultation (n = 5) was also a significant means of supporting participants with their countertransference experiences. “I was fortunate to have a consultation group to talk about it,” stated one participant. Another mentioned how she used group consultation to manage her uncertainty with discussing issues of her pregnancy and maternity leave with clients “I took a lot back to supervision group . . .how do you talk to [clients] to give them reassurance but not giving them any certainty about the future . . .I took it step by step.”

Four participants discussed the importance of self-care in managing their countertransference. One participant reported, “using [her] own meditation practice to kind of keep a float and as a container.” Other participants reported focusing on self-care

at home through “taking the time to be together, plan things, and focus on what was happening in our home and make that the most important thing . . .and not bring the work home with me, and have the space to be myself,” and at work through considering “what kind of work is it responsible to be doing, how much do I take on?”

A small number of participants (n = 2) mentioned the importance of discussing their countertransference with clients as a means of managing it. “[Countertransference] was something I had to pay attention to, think about, and part of it was also just working through it with some clients.” Two participants also reported managing and attending to their countertransference through utilizing time management strategies. Both discussed remaining on top of things like “paperwork” so as not to “overload” themselves and focused on “taking it one step at a time.” A final two participants commented on the importance of support from friends and personal therapists in helping them manage their countertransference experiences. Only one participant discussed how she did not manage her countertransference experiences reporting

I don’t think I managed [countertransference] as well as I would now . . . I had a supervisor but I didn’t talk to her about those issues, I probably should have. . . This was the first time I was engaged in long-term therapy.

Thus far, participants’ countertransference has been explored through a wide lens looking at themes emerging in relation to participants’ general therapy practices with adult female clients during their first pregnancies. The next section will move to more narrowed focus exploring participants experiences of countertransference in relation to their work with one adult female client from the time of their first pregnancies.

Experiences of countertransference with Case Vignettes Individuals (CVI)

Each participant was asked to share a personal case vignette of her experiences working with an adult female client, identified here as a CVI. Participants were asked three questions related to their work with the CVI. The first sought to collect information about the role demographic information played in shaping countertransference experiences. The second inquired about other thoughts and feelings that emerged in the context of the therapeutic relationship as a result of the therapist's pregnancy. The final question asked that participants compare their experiences with the CVI to other clients on their caseload during the time of their first pregnancy. Responses to these three questions will be explored in the following sub-sections.

The effects of demographic information

After providing a description of their CVI's demographic information each participant was asked: did any of the CVI's demographics impact the countertransference you experienced? The vast majority of participants (n = 11) responded "yes." The one participant who responded "no" felt that her countertransference resulted from her "own anxiety."

The most frequently cited (n = 5) demographic factor affecting the countertransference participants experienced was their CVIs' "sexual orientation," specifically CVIs' being "lesbian identified." A number of participants explained feeling more at ease and comfortable being out in their work with their CVIs because of their

shared lesbian identity: “I didn’t have any issues being out to [CVI], felt I could be honest and correct her when she made assumptions . . . I felt more comfortable and at ease with her to be myself;” “I felt closer to [CVI] or we were somehow more similar . . . I could understand her and align with her . . . I was comfortable.” Other participants commented on feeling as though this identification to the CVI allowed them to be “role models.” A number of participants also commented on the need for strong professional boundaries as this shared sexual orientation had the potential to “test boundaries” and to be “both positive and negative.” One participant explains:

we had a nice connection. . . it was more of a struggle for me. I needed to stay on my toes in terms of thinking I understood something about [CVI] that I might not understand, I might make assumptions about her because I identified in some ways with her and that could be hurtful to the therapy

Four participants discussed feeling as though their CVIs’ treatment issues affected the countertransference they experienced in the rooms. One participant discussed feelings of anger resulting from her CVI’s “presentation . . . she was concerned with her weight and her children’s weight... I found myself getting angry that she’s teaching her kids to treat their bodies poorly . . .” another participant discussed feeling she could better “understand” her CVI as “some of her depression was family related, it was similar to me personally.” Three participants commented on the length of time in treatment being a factor contributing to their countertransference reactions to the CVI. Two of these participants discussed CVIs being in treatment for long periods of time leading to increased comfort. One explaining how her increased comfort allowed her to be more open with her CVI:

She was one of the first patients I told when I got pregnant I think because she felt safest we'd worked together a long time I had a good handle on her and so she was sort of my practice patient in terms of sharing the news. . . and she knew I had a female partner at that point.

The fourth participant had the opposite experience of feelings “safer because [the CVI] was new.”

Participants' sharing similar class backgrounds (n = 3), ethnicities (n = 2), and coming from similar families of origin (n = 2) as the CVI experienced similar reactions of: comfort and identification, role modeling, and a need to maintain professional boundaries. One participant discussed her process to maintain and understand her professional boundaries and judgment in work with her CVI given their same race, class, and families of origin in the following way:

Did I identify with her, or was I more empathic with her, because I was white like her and she was white like me? Was it that she was financially different from my other clients? Was it that she was so similar to me? All those things were real questions for me it was very intense . . . I think the similarity piece had an impact.

A few other identify factors were discussed as affecting participants countertransference such as age (n = 2) and being a mother (n = 2). While the majority of participants discussed CVIs who were around their same age, two participants discussed experiencing maternal transference to CVIs as a result of their age difference; “I think that contributed to my feeling maternal and protective toward her and worrying how the pregnancy would affect her,” explained one participant working with a younger CVI. The other participant experienced a reversal in the maternal transference and care giving roles in her relationship with a CVI who she had a “ten year plus age difference” with:

at times she was trying to turn the role and be a caregiver for me . . . we had to discuss and redefine the roles and say that's not a place that we go sort of. . . I'm sure there was a part of me that wanted to be taken care of and that awareness of having to stay in a professional role and not be friendly and certainly not in a role where she's taking care of me.

Another two participants discussed their difficulty managing a countertransference reaction of wanting to “distance” and “reject” CVIs who were discussing ways in which they had mothered and mistreated their own children. These participants identify the source of this distancing/rejecting reaction as stemming from their positions of preparing to become mothers and feeling identification with these CVIs over this new identity while also “feeling I've gotta be a better mother than that.”

The effects of the therapist's pregnancy

The most frequently occurring responses participants cited were opposing experiences of increased anxiety (n = 4) and experiences of greater positive transference feelings and reward (n = 4). Participants reported experiencing greater “anxiety” through having increased feelings of “nervousness” and a sense of being “pressured . . . to get a move on [therapeutic work]” as a result of being pregnant. Participants with the opposing experience of feeling “a positive transference” as a result of their pregnancies discussed feelings of “excitement,” “twinship,” and positive “identification” with CVIs, as well as feeling their work became “more rewarding.”

Maintaining and managing therapeutic boundaries was another countertransference experience that arose for a number of participants (n = 3). One participant had to “remind [her]self not to sit around and talk to clients about [her] pregnancy. . .and had to remember ‘this isn't about [her]’.” This participant ultimately

decided she “couldn’t be as objective as she needed to be so [the CVI] ended up working with a colleague.” Two of these three participants experienced testing of boundaries as a result of an erotic transference relationship that emerged. For instance, one participant discussed her experience having to maintaining boundaries with a CVI who “had an intense erotic transference” toward her during her pregnancy through having to “hold the line,” and through “talking about it because it got it all in the room and it deepened the work and we could understand it in a different way.” The other participant discussed her experience with managing mutual erotic transference feelings that emerged:

I was really running on a lot of hormones and my sexual energy was really high. I’d had a very rocky history with my partner, our sexual relationship was really effected by that so I think I was pretty frustrated sexually during that time. . . there was a lot of turmoil and chaos I was trying hard to contain. . . I was vulnerable to that, to [CVI’s] sexual intensions, and pregnancy brings an element of sexuality to the room.

A number of participants (n = 3) discussed struggling with internal tensions regarding disclosing aspects of their identities to their CVIs, and feelings of sadness (n = 3) that arose in connection to experiencing these internal tensions in their therapeutic relationships because of their pregnancies. One participant shares her experience of internal turmoil and sadness over working with a CVI whom she could not be her “true self” with during her pregnancy:

Here I am with my queer family, my trans partner, and sperm donor . . . [CVI’s] projections of me don’t include that. . . she was thinking ‘oh nice married white middle class woman, just like me’. . . dealing with the internal tension of her projections with me and figuring out how to address them, whether to address them. . . there were moments I felt sad that I wasn’t being my one true self, and that there were all these assumptions about my life and family that were so far from the truth but there was no way to address them and that part was difficult for me.

Similarly to feelings of sadness, a few participants shared experiences of feeling physical pain (n = 2) and guilt (n = 2) that were triggered in their relationships as a result of their first pregnancies. “ At times it physically made my heart hurt just seeing [CVI’s] level of longing, which we hadn’t discussed until I got quite pregnant,” one participant explains; and goes on to discuss how “it didn’t seem like it should be so unequal . . .I did feel a little guilty” as she “was so happy, and excited, and full of promise” and was aware that pregnancy “wasn’t going to be anything that happened for [her CVI] anytime soon.” Another participant shared her experience of feeling “annoyed and angry” with her CVI during her pregnancy as her CVI was frequently “in crisis and taking up so much time.” These feelings lead her to experience guilt as her thoughts took her to a place where she was “feeling like for Christ sake I’m pregnant give me a break, those sorts of horrible things.” Another countertransferential experience that occurred for two participants in their work with CVIs as a result of being pregnant was having “a lot of my own fears about mothering triggered.”

The next sub-section will investigate the ways in which these specific experiences mirrored or were vastly opposed to experiences with other adult female clients participants were engaged in therapeutic relationships with at the time of their first pregnancies.

A comparative look at this case in relation to caseload

Ten participants were split in their responses with five stating their experiences were vastly different with each client, and five stating that their experiences with other clients had elements that were similar to the CVI and also had elements that were different. One of the participants who felt her experiences with other clients differed from

her CVI discussed how this was probably a result of both the CVI's issues as well as what was personally triggered for her in her relationship with the CVI:

My experience with her was not the same as others. . . I had more of a need to predict with her what it would be like and I think part of my need to predict was about what she was bringing in and part of it was to do with my own reactions to her and her issues and what that triggers for me. So we talked more about it and it was much more present in the work than with other clients

A second participant felt her experience with the CVI was very different as her CVI "was a mother and all my other clients were LGBT people . . . so the issue of motherhood wasn't as present" with other clients. A number of these participants commented on feeling as if the work experience with the CVI was different because "so many things were different I guess because the work with everyone was so different."

Five participants felt their experiences with other cases had both similar and different elements as the CVI. These participants commented on feeling their work with each individual client differed, but that similar themes and feelings arose across the work with different clients. One participant recalled how "deepening of conversations about sexuality, motherhood, and lesbianism were typical of work with other lesbian clients and other female clients in general." Another participant discussed how the level of "intensity" in the work varied from client to client depending on the issues the clients were bringing to treatment. A final participant discussed how homogeneity in her caseload led to "somewhat similar experiences with 65% of my caseload," but also discussed how her "countertransference varied so widely depending on why [clients] were seeing me, at what level of treatment they were in, how far they'd come, and how insightful they were."

A small number (n = 2) of participants reported having a significant number of very similar countertransference experiences with other clients. One participant explains “it was working with similar countertransference-transference issues and being able to bring up things about being pregnant and peoples’ histories that I wouldn’t have gotten to, at least not in the same way, otherwise;” the second participant echoed “it’s similar in terms of the countertransference stuff.”

The next section will look at the ways in which the participants have integrated and learned from the work experiences they had during their first pregnancies to shape and guide their current clinical work and use of countertransference.

Reflections on changes in clinical work post first pregnancy

This section contains data regarding the ways in which participants have utilized their countertransference experiences to shape their current clinical practice, and the ways their experiences have influenced their thoughts about and use of countertransference in their current work.

Reflections on changes in clinical work

In the concluding section of the interview guide participants were asked to discuss the ways in which they felt their countertransference experiences lead to changes in their clinical practice. One common change noted in participants’ responses (n = 7) was a sense of feeling their experiences helped “season” them as therapists in the field. One participant felt it helped make her “less of a perfectionist” another commented on how she now “asks questions differently, might make decisions differently, and listens differently” because of having “a unique experience [pregnancy] . . . that makes [her] a better clinician.”

Five participants discussed a sense of increased compassion and empathy for clients, particularly client's who were mothers. "I have lived the experience, so I feel I can bring a different level of true compassion and understanding to the work," one participant answered. Another participant explained her experience as such:

We all have our own unconscious we're unaware of. I think of my unconscious as a big ocean and I'm out there paddling a boat saying I know what I'm doing, where I'm going, but I don't cause it's the ocean; so I try to have more empathy for how parents have gotten to the places they are.

A few participants (n = 3) noticed that they became stronger advocates as a result of working through the countertransference experiences that arose during their first pregnancies. One participant discussed the impact of how her changing view of the definition of family affected her work:

It made me more aware of how subjective the idea of family is and I think it influenced my work in that it made me a much stronger advocate with [Department of Social Services] because I think it started to be clear to me that they had the limited perspective I'd once had and sometimes weren't able to see the benefits of different kinds of family arrangements

Similarly other participants found they were able to "challenge more" and be "more assertive and confrontational" in their work with clients and systems.

Another three participants discussed feeling they understood their boundaries in a new way, and shifted their professional boundaries as a result of their countertransference experiences during their first pregnancies. One participant commented on feeling as if she "disclosed more than [she] intended too with lesbian clients" during her first pregnancy and as a result is more "cautious" and now spends "a lot of time and names what is happening [for the client] 'I'm sensing you really want to know more about me' . . . before [she] goes and gives clients all this information." A related revelation another

participant shared was feeling she “learned about [her] needs and boundaries which helps [her] in the present be more open to clients experiences and less afraid of being intruded upon.” A third participant found that her priorities shifted as she became a mother and she has

had to accept that my clients aren’t not a priority, but they’re not *the* priority and when [she] was pregnant [she] was invested in imagining it would be like that but it wasn’t true. . . its grist for the mill in the therapy work. . . [she’s] learned clients can tolerate if [she has] to reschedule . . .and most clients are forgiving.

One participant who faced many complications during her pregnancy leading her to experience feelings of “grief and loss” felt that her practice orientation evolved into a “more mindfulness and being in the moment” practice with clients.

Reflections on changes to use of and thoughts about countertransference

Participants were also asked: have your thoughts about the use of countertransference changed at all as a result of your countertransference experiences during your first pregnancy? One participant did not provide a response to this question, and one participant did not directly answer the question and instead discussed her work with adolescent clients; an important topic worth inquiry, but outside the scope of this study. Despite these two void responses, the countertransference that occurred during first pregnancy does have a significant affect on shaping clinician’s use of and thoughts about countertransference as the majority of participants (n = 10) reported that changes did occur as a result of the countertransference experiences they worked through during their first pregnancies. These ten participants also reported that their changing identity in the world, becoming a mother, also changed the way they viewed and used

countertransference. This sub-section will go on to explore these ten participants responses.

A number of participants (n = 5) reported a deeper appreciation for the therapeutic role countertransference can play in their working relationships. “It’s made me a little less ridged about some things . . . makes me more and less likely to just answer questions or do certain things as opposed to just interpreting, or the opposite for some things I probably feel a little more flexible,” said one participant.

Another felt she learned to “honor countertransference more as one of the most powerful things we have” as her pregnancy experience helped her “actually get that it played an important role” and lead her to this new consciousness in her work. Similarly, a third participant commented on her realization of the importance of countertransference and changes to the way she now addresses countertransference and transference in her work reporting:

I now acknowledge countertransference because I wasn’t really doing that before . . . if there was a little comment they made that I could go ‘oh! There’s something going on between me and this person’ I’d just let it go, but now I talk about how [the therapeutic relationship] is affecting me. . . I see that it’s valuable. If we need to talk about our relationship, so it can be a continuing relationship, then that’s good; lets go there. I used to have clients for a few months now it’s years, and I think they’re staying because we’re getting real work done, and part of the work is how they’re relating to me. . . so I think we can get to real stuff through addressing transference and countertransference and I got that from my pregnancy experience.

Two participants reported feeling less fear of their countertransference reactions.

There was a time I was afraid of [countertransference], and I think I’m definitely not afraid of it anymore; and I think I’m moving further down the continuum away from fear. Having a baby helped, and having those really intense countertransference reactions gave me an experience to use as a benchmark,

believed one participant of her experiences. In addition to moving away from fear, two participants reported now viewing countertransference as “human, natural responses” and something that could be “a real benefit to the work” if “used with an awareness because it definitely influences and impacts the work.”

Participants (n = 2) reported learning things about their countertransference reactions which now help them understand more about how, when, and who to make self disclosures, such as disclose of their countertransference reactions, to.

“As a therapist, I think at 25, I wasn’t disclosing anything and was thinking blank slate, and as I grow as a therapist I’m more comfortable understanding when and how to bring counter- transference into the room and when to self-disclose to the client . . . the pregnancy deepened that understanding,” said one participant. In a same vein, the second participant felt she “gained a lot of experience in how to manage self disclosure and what to think about when you’re thinking about it; trying to anticipate the full range of responses you might hear from clients; what self-disclosure is helpful and what kinds aren’t, how much to disclose, and who, and when, and how.”

The last section of findings in this chapter will offer suggestions for supervisors in the field that participants provided based on their own thoughts and feelings about the supervision they received, or wished to receive, during their first pregnancies.

Supervision

To conclude the interview, participants were asked to share anything they would like for supervisors in the field to know regarding the needs or ways in which to support a queer clinician who is planning for a pregnancy or working in the field while pregnant.

The majority of participants interviewed (n = 7) felt it was imperative that supervisors in the field “acknowledge” and “normalize” the countertransference occurring and the pregnancy experience, and offer a great deal of “safety” and “support” in the supervisory relationship as pregnancy increases the therapists feeling of “vulnerability.” “Clinicians need a tremendous amount of support at that time” said one participant who recalled feeling “way more exposed than [she]’d ever been all of a sudden, way more vulnerable” during her pregnancy experience. Another participant shared the value and importance of feeling supported around “the acceptance of the changes that [she] was going through, and helping [her] find ways of dealing with that as it pertained to work with clients, and validating [her] experience, and giving [her] hope.” A number of these participants also discussed the need for “sensitivity” to, “acknowledgement” of, “normalization” of, and “validation” of the complexity of their situation as a result of their identities as queer women. One participant strongly suggests, “supervisors in the field definitely acknowledge the partner.” Along similar lines, another participant echoes, “be sensitive to issues of sexuality“ especially if there are “work place issues about sexuality.”

Half of the participants interviewed (n = 6) felt it was important to be helped to access information about queer therapists experiences of pregnancy, through referrals to other queer clinicians who have experienced a pregnancy or to written resources. One participant offered this suggestion as she felt that her connection to other therapists who shared in the experience of pregnancy and were lesbians was crucial

heterosexual supervisors, many of them not all of them, don't really get the complicated issues that come up when you're a lesbian therapist and pregnant. . . I worked in a supportive place in a progressive state and still felt like the only people who really got it were other lesbian therapists who were pregnant.

Another participant discussed her experience working with

all straight women, no queer women, who had had pregnancies which said my need for research and talking to somebody who'd been more in my position, and I really didn't have a resource like that which is really why I'm talking to you today, so other people will have that resource, it would have been nice to have

Two of these participants felt it was the field of social work as well as supervisors obligation to queer clinicians to "really have a whole lot of information . . . be educated about what its like, and what peoples' thoughts are, what their needs are, and what their countertransference issues are" because they felt that "it's something that's completely overlooked, something people don't think about, and it's a complicated issue."

As many queer clinicians report facing an added layer of internal tension regarding issues pertaining to their sexual orientation, many participants (n = 5) discussed feeling it would be important for supervisors to be aware that they felt the main supervisory need of queer clinician's during pregnancy is support in preparing for how to respond to client's questions, assumptions, and reactions to the disclosure of pregnancy. Participants suggested supervisors "help the therapist be prepared for the intensity of peoples reactions both to the pregnancy and the lesbianism;" and/or to:

offer support around the identity issues it raises and the projection and assumption that your straight and must be married to some guy because that's not really comfortable for many people who are queer. . . attend to the discomfort that gets raised around identity and peoples assumptions about your identity. . . offer space to explore it . . . a place to sit with it.

Other participants suggested the importance of "helping the clinician figure out ahead of time how they're going to answer all the questions that come up," "talk about it earlier so

you have ample time in supervision to discuss telling clients,” “help people prepare for the enactments,” and “help to explore [therapist’s] affect with a client rather than clinical strategizing” in supervision. Two participants recalled feeling unsupported regarding this issue and felt their work was negatively impacted as a result. One discussed having to “plow through this on [her] own and kind of figure it out as [she] went” because she didn’t receive support around these issues in supervision and found that “there’s not a whole lot written about it.” Another strongly suggests supervisors “bring it up and explore it in terms of relationships to clients and countertransference” as she felt she “missed out on that experience, it would have been a good learning experience to address instead of learning by the school of hard knocks.” One participant commented on the importance of supervisors in the field being aware of “their limitations” and thus be able to “help folks connect with others who’ve had similar experiences.”

Chapter Summary

The findings from a 33-question interview asked to 12 queer clinicians regarding their experiences with countertransference during their first pregnancy were explored in this chapter. A common thread across participants responses to these interview questions was the importance of managing and coping with countertransferential reactions to clients’ heterosexist assumptions about the therapist identity that emerge as a result of the therapist inevitable disclosure of pregnancy. Another common theme emerging across sections of the interview was that each client and therapeutic relationship developed poses its own unique experience for the therapist.

Therapists' thoughts, feelings, and reactions were all elements of the definition of countertransference that participants collectively agreed upon. All participants also unequivocally discussed planning for and thinking about how their pregnancies might affect their working relationships with clients. Most participants struggled with concerns regarding possible self disclosures that would be made to clients as well as assumptions clients would have about their identities during this planning period.

All participants rated the significance of the impact of their disclosure of pregnancy on their therapeutic relationships between a 3 and 5 on a 5-point scale; with 5 participants rating it a 5 or above. Additionally, all participants rating below a five discussed feeling as though it was difficult to choose one number from the rating scale as their experiences varied so widely from client to client.

In discussing the general countertransferential themes and issues that emerged in their work during their first pregnancies participants most readily reported feelings of anger and a need to be self protective in response to client heterocentric assumptions about their sexual orientation and relationship status. Participants were split in answering the interview question about whether or not these themes and issues occurred with all clients, as each therapeutic relationship shaped intricate, intense, unique countertransference experiences. In terms of managing these countertransference experiences, supervision proved to be the most used tool cited by the participants in this study.

Analyzing CVI data it was found that the CVIs' demographic factor most impacting the participants countertransference experiences was the CVIs' sexual orientation. The majority of participants who discussed working with lesbian clients

found they felt increased comfort and identification in their work. In commenting on the role of the therapists' pregnancies entering the therapeutic space and discussion, the main countertransference experiences discussed were opposing feelings of anxiety and feelings of reward. Again, the majority of participants was split and had difficulty comparing their CVIs to other clinical experiences from the time of their first pregnancies as each client and relationship was different.

Next, participants discussed how their pregnancy experiences had changed their current practice and thoughts about the use of countertransference. All participants felt their work was positively impacted as a result of working through their pregnancy experiences as it provided another experience from which to learn and grow leading to deeper empathy and understanding for clients and themselves. There was also unanimous agreement that their thoughts about the use of countertransference were positively influenced by the growth and learning that took place during their pregnancy experiences as they had gained a deeper appreciation for the use of countertransference as a therapeutic tool.

Finally, participants shared their suggestions for improving the supervision of pregnant queer clinicians in the field. Participants all expressed the need for supervisors to be educated about and sensitive to issues pertaining not only to pregnancy but also to sexual orientation; thus enabling them to support, normalize, and acknowledge the pregnant therapists experiences as they relate to her clients. Further, participants felt the most helpful topic to address with therapists in supervision was the issue of managing and responding to client assumptions about the therapist's sexual orientation and relationship status.

CHAPTER V

DISCUSSION

The research question asked, “What are the countertransference experiences of queer clinicians in therapeutic work with adult females during their first pregnancies?” The goal of this study was to gather in-depth information on queer clinicians’ experiences of countertransference during their first pregnancies in order to begin to understand this phenomenon, as this topic is unexplored. This chapter will investigate the major findings as they relate to previous research in the field, and implications for theory, social work practices and future research will also be addressed.

Twelve Caucasian female therapists ages 33 to 50 participated in the study: eleven licensed social workers and one registered counselor from a number of different geographical locations. Participants identified their religious affiliations as Buddhist, Christian, Catholic, Jewish, Spiritual, Near Death Experience, and four reported no affiliation. Participants were recruited using a number of non-probability sampling techniques, and participation required completion of an interview via telephone or in person lasting approximately one hour in length. The demographic factors which seemed to have the greatest impact on the countertransference experienced other than sexual orientation were the number of years of experience in the field at the time of first pregnancy, and the number of years spent working with the CVI. As the longer a participant had been working in the field or with a CVI the more comfortable, open, and able to address and utilize their countertransferential reactions in the treatment they were.

Additionally, a number of participants noted the importance of their relationship status on their countertransference experiences. In some cases partners were sources of support for participants; in other cases lack of sexual intimacy in the participant's relationship contributed to vulnerability to erotic countertransference with clients; and all participants noted clients' questions and assumptions regarding their relationship status being a source of countertransference.

One limitation of this study is that the participants involved were a fairly homogeneous group in terms of ethnicity, education level, and theoretical orientation, among other factors likely making them a sample of like-minded participants. However, according to the NASW 2006 national study of licensed social workers this participant group is fairly reflective of the profession at large which is 81% female and 86% Caucasian. Efforts to recruit an ethnically diverse sample failed. This may be a result of different cultural views regarding the acceptance of homosexual lifestyles and thus the degree to which clinicians of color are practicing openly as queer. Further, all participants noted they became pregnant through use of artificial insemination, a very costly and time consuming reproductive procedure which may be more easily accessible to Caucasian women who statistically have more socio-economic resources at their dispense. The use of non-probability convenience and snow balling sampling techniques may have lead to only participants who were more comfortable and willing to discuss their countertransference experiences as they related to intimate and personal subject matter surrounding pregnancy and sexuality to participate. Further, the impersonal use of phone interviewing to collect much of the data and the lack of personal face-to-face contact may have been more ideal or comfortable for a certain type of participant. Thus, the findings

of this study may have relevance for and be generalized to other white queer clinicians in the field working with adult female clients.

Participants were asked not only for their own demographic information but also to provide the demographics of their CVI as the previous literature indicates that in order to fully understand and appreciate the potential multiple sources of countertransference, successfully gathering these social backgrounds are necessary. It is interesting then to note that most participants chose to discuss a CVI with whom they shared a number of demographic factors such as ethnicity, race, age, and sexual orientation, which was identified as the most salient demographic factor. Similar to previous research in the field by Silverman (2001) and Sachs (1989), a major finding of this study was that pregnancy poses an added layer to the countertransference experiences of queer clinicians who are often faced with assumed heterosexuality. Being a queer clinician also proved to be a complicating factor for participants as they struggled with decisions regarding self-disclosures and how to respond to client questions regarding sexual orientation and relationships status that came up as a result of the participants' pregnancies. The combination of being a queer clinician and pregnant clearly presented its challenges to participant therapists in their work. Other factors that had an effect were the demographic factors of the client, specifically those demographics similar to the participants, such as sexual orientation; and years of experience in the field and length of time spent working with the clients. This finding is congruent with literature on countertransference which discusses the sources of countertransference stemming from what the therapists personally brings to the treatment, what the client brings to the treatment, and the dynamic treatment relationship that develops between therapist and

client. This finding is also important because it lends support to the idea that pregnant queer clinicians must cope with additional challenges in their therapy work; they need to pay attention to how these factors affect their own countertransference issues.

In commenting on the role of the therapists' pregnancies entering the therapeutic space and discussion with CVIs, the main countertransference experiences discussed were opposing feelings of anxiety and feelings of reward. For participants experiencing both of these opposing experiences, it can be understood if one considers how identification can be both comforting and rewarding and also anxiety producing as this identification can lead to loosening of professional boundaries and internal tensions regarding disclosure, creating a need to be more vigilant in their work in this regard. Further, participants commented on feeling increased anxiety and pressure regarding wanting to maintain the same level of involvement and care for clients who they enjoyed working with as their own personal needs and fatigue levels were increasing; another situation producing both feelings of reward and anxiety.

A common theme emerging across the findings was that each therapeutic relationship posed its own unique experience for the therapist. This is supported in the literature. Marcus & Buffington-Vollum (2005), Statterly (2006), and Shahar (2004) describe characteristics of client-therapist dyads as bidirectional and distinct in that each relationship has its own unique shared social reality. This perspective on client-therapist dyads was supported by this study's participants who preferred to provide narrative descriptions rather than to generalize their countertransference experiences in the field during their first pregnancies as each of their therapeutic relationships were so rich and unique. Participants found it difficult to use a 5-point scale to rate the impact of their

pregnancies on their therapeutic relationships, and in making generalizations and comparisons regarding different cases on their caseloads during the time of their first pregnancy. However, ensuing discussions about the use of a rating scale indicated that a case-by-case rating would have been much easier.

Many participants noted countertransference experiences of feeling increased comfort and self-disclosing more with lesbian clients, as opposed to straight clients. In addition, in discussing countertransference arising in work with CVIs, sexual orientation was identified as being the most salient demographic factor impacting countertransference experiences. Participants' disclosure practices and comfort levels differ depending on the sexual orientation of the client, with therapists feeling more comfortable and disclosing more with clients who are in the sexual minorities. This finding is similar to research by Silverman (2001), Goldstein & Horowitz (2003), and Lortie (2005).

A number of prior studies cite the importance of managing and coping with countertransference in order to use it to benefit the client and therapeutic relationship (Shahar, 2004; Rapheal-Leff, 2004; Ulkman, 2001; Hjalmarsson, 2005). This correlates to another thread emerging across the findings; the importance of participants managing and coping with countertransference reactions to clients' heterosexist assumptions about the therapist identity that emerge as a result of the therapist inevitable disclosure of pregnancy. For instance, one participant noted her inability to discuss her pregnancy with her clients as she feared facing rejection from her clients, triggering her own memories of coming out and feeling rejected and struggling to find a sense of belonging. As a result of her inability to manage these countertransference feelings she had a number of clients

terminate treatment with her during her pregnancy. Other participants noted how the treatment relationship was a microcosm of larger society in which their life experiences as queer women were/are unacknowledged and/or looked down upon and their struggle with the feelings of anger, injustice, and internalized homophobia brought up. These participants discussed the importance of seeking support from other queer clinicians in the field who could understand and normalize their experiences and offer sound advice for how to address these complex feelings and issues in treatment.

Therapists' thoughts, feelings, and reactions were all elements of the definition of countertransference upon which the participants collectively agreed and which matched the definition offered by the researcher. Fauth (2006) discusses the importance of having a common definition of countertransference in order to effectively study this phenomenon. All participants also unequivocally discussed planning for and thinking about how their pregnancies might effect their working relationships with clients. During this planning period participants struggled with concerns regarding safety, social perceptions, heterosexism and homophobia they may face based on the assumptions clients would have about their identities, and how these factors would impact their decisions regarding self-disclosures that might be made. These issues are consistent with those discussed by Silverman (2001) and Sachs (1989), Lortie (2005), and Goldsteing & Horowitz (2003).

Feelings of anger, issues of disclosure of sexual orientation and coming out to clients, and a need to be self-protective in response to client heterocentric assumptions about their sexual orientation and relationship status were the most readily reported countertransference issues. These findings are consistent with those of Statterly's (2006)

as this study discussed therapists internal struggle with wanting to have their true-self known, and Goldstein & Horowitz (2003), Silverman (2001), and Sachs (1989) who report feelings of anger, avoidance, anxiety, and vulnerability being prevalent among clinicians who are unable to have their true-selves affirmed as a result of having to manage and work in heterosexist and homophobic environments. Possibly, the feeling of needing to be self-protective discussed by participants in this study and issues surrounding coming out to clients resulted from an inability to feel safe in having their true-selves known and a desire to defend against anticipated heterosexism/homophobia which may trigger participants internalized homophobia, as one participant mentioned, and/or defend against difficult feelings of fear, shame, or guilt, as expressed by Silverman (2001), which might have arose. Further, for a number of participants working with mothers these feelings of anger and self-protection stemmed from a desire to defend against feelings of identification with these mothers who were struggling in their own ability to parent, and the associated fears participants had of becoming similar to these clients and struggling in their own ability to mother their unborn children.

Despite frequently reported feelings such as anger and anxiety, all participants felt their work was positively impacted as a result of working through their pregnancy experiences as it provided another experience from which to learn and grow leading to deeper empathy and understanding for clients and themselves. This finding may be due to the fact that all but one participant discussed ways in which they managed their countertransference experiences through supervision, among other things. The literature points to managing countertransference and effective use of supervision as one of the main predictors of successful outcomes in therapy. The one participant, who reported that

she did not utilize supervision to manage her countertransference experiences, also is the only participant to report that she did not discuss her pregnancy openly with clients and had clients prematurely terminate therapy during her pregnancy. This may have been due to her inexperience in the field, as she was the only participant who was nearing completion of her MA in counseling psychology at the time of her first pregnancy.

Implications for social work arising directly from the participants of this study were suggestions from participants for supervisors in the field. Participants all expressed the need for supervisors to be educated about and sensitive to issues pertaining not only to pregnancy but also to sexual orientation; thus enabling them to support, normalize, and acknowledge the pregnant therapists experiences as they relate to her clients. Further, participants felt the most helpful topic to address with therapists in supervision was the issue of managing and responding to client assumptions about the therapist's sexual orientation and relationship status. Participants stressed the importance of addressing these issues in supervision early in the pregnancy process to enable ample time for exploration of this complex topic.

Participants also expressed frustration with the lack of information they and their supervisors had to offer in regards to countertransference experienced by queer clinicians, and anger with having to at times educate their supervisors about the issues they faced and/or feeling alone in navigating their experiences. Thus, similarly to past research all participants noted a gap in the field in regards to the countertransference and self-disclosure experiences of queer clinicians, especially in regards to inevitable disclosures such as pregnancy. A need for more education, training, and research on the experiences of queer clinicians, which would encourage social workers in the field to challenge their

own heterosexism and homophobia is necessary. Inability to access information on this experience as a result of this gap may be one reason that supervision was so necessary a means of managing countertransference for these participants, who at times specifically sought supervision to manage the countertransference of their pregnancy experiences when they otherwise were not utilizing supervision as a source of support. A large gap in the field also exists in exploring these experiences as they related to queer clinicians of color, as all past research as well as this study are biased in that they almost exclusively explore the experiences of Caucasian clinicians and clients.

While the scope of this study only allowed for an exploration of clinicians' experiences with adult female clients a number of participants were eager to discuss their experiences working with adult men as well as children, adolescents, and families. Further research on this phenomenon with other populations is unexplored and worthy of exploration. Continuing to explore these topics in a variety of settings to enable stronger conclusions to be drawn regarding the needs and experiences of clinicians working in different settings would also be worthy of exploration. A number of participants commented on the role being in a partnership played in shaping their countertransference experiences and it would be interesting to further explore how this factor shapes countertransference experiences of queer clinicians.

Future research should focus on a more diverse participant pool including more variation in ethnicity, age, work settings, theoretical orientation, and years of experience. In addition, varying experiences with a diverse client pool may benefit discussions of the implications of race and racism on experiences of countertransference for queer clinicians during first pregnancy. Future research on such personal subject matter may be more

easily explored with a more diverse sample through alternate means of data collection; utilizing a survey to collect data on this personal subject matter would attract a more diverse participant pool as it would be even more anonymous. Future research focusing on the self-disclosure practices and decisions of queer clinicians during their first pregnancies, rather than countertransference experiences would also add to the field, as these two areas of practice are unique and interconnected. It would also be interesting to explore the experiences of non-birthing mothers who are clinicians and the way in which the role and identity as a queer mother impacts treatment relationships. Similarly, looking at this issue from a gay father's perspective would be interesting and is unexplored.

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APPENDIX A

November 14, 2006

Dear Rhyannon,

The Human Subjects Review Committee has received and reviewed your amended documents. You have done a very thoughtful and complete job with the revisions and we are now happy to give final approval to your study.

One thing I was curious about. You describe your participants as queer therapists who have been pregnant while seeing clients. I was interested in the use of the word queer. I know that it is now the approved term, but are you including anyone more than lesbian clinicians who have been pregnant? If not, is there some reason not to refer to them as lesbians? If you are including others, you probably should be more specific about who you would include in your definition of queer pregnant therapists.

Please note the following requirements:

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

Maintaining Data: You must retain signed consent 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.

This should be a very interesting study. If the therapist is out to her clients, it will raise all sorts of issues about how people might feel about the pregnancy. If she is not out, the pregnancy will lead to all sorts of heterosexist assumptions on the part of the clients, which might be difficult for the therapist. Good luck with you intriguing project.

Sincerely,

Ann Hartman, D.S.W.

Chair, Human Subjects Review Committee

APPENDIX B

Interview Guide

A. Demographic and Factual Questions

1. Current Age:
2. Sexual Orientation:
3. Gender Identity:
4. Ethnicity:
5. Religion:
6. Degrees and Licensures held currently:
7. Current theoretical orientation of your practice:
8. Age During first Pregnancy:
9. How many years of experience in the field did you have at the time of your 1st pregnancy?
10. Degrees and Licensures held at time of first pregnancy:
11. In what type of setting(s) were you working clinically at the time of your first pregnancy?
12. How long have (had) you been working there?
13. Can you describe the theoretical orientation of your practice at the time of your 1st pregnancy?
14. How would you describe the climate of your work setting(s) as a queer employee?
15. In which work settings did you practice openly as a lesbian therapist at the time of your first pregnancy?
16. What method did you use to become pregnant?
17. How long were you trying to become pregnant?

18. Did you have any complications during your first pregnancy which affected your work as a therapist?

B. General questions related to therapy practice during first pregnancy:

1. How would you define countertransference?
2. In planning for or in the early stages of your first pregnancy how did you think your pregnancy might affect your work with adult female clients?
3. On a scale of 1-5, 1 being insignificant and 5 being very significant, how would you rate the importance or impact of the disclosure of your first pregnancy on your transference and clinical work at the time?
4. Reflecting back on your first pregnancy, can you identify five key countertransference issues/themes you experienced in your clinical work?
5. How did you manage these experiences?
6. Were these five key issues experienced across the board with all clients?
If no. . . please explain
7. In what 3 key ways do you feel these experiences impacted therapeutic relationships with the adult female clients you worked with?

C. Questions related to case vignette

Now I would like you to share a case vignette of an adult female client who most stands out in your mind from the time of your first pregnancy who was not diagnosed with borderline personality disorder or psychosis.

8. Please describe your client demographics, including age, ethnicity, sexual orientation, religion, marital status, number of children, length of time in therapy with you, therapy issues, diagnoses?
9. Did any of the client demographics that we just discussed impact the countertransference you experienced? *If yes. . . please explain*
10. What feelings and/or experiences came up for you in the context of your therapeutic work with this client as a result of your pregnancy?
11. Is this clinical example similar to many other cases of work with adult female clients at that time? *If no. . . . please explain*

D. Conclusion Questions:

12. Reflecting back to your first pregnancy did you or have you done anything differently in your clinical work as a result of your countertransference experiences at that time?
13. Have your thoughts about use of countertransference changed at all as a result of your countertransference experiences during your first pregnancy?
14. Do you feel there is anything you would like for supervisors in the field to know regarding the needs or ways in which to support a queer clinician who are planning for a pregnancy or is working in the field while pregnant?
15. Is there anything else you would like to add to this interview?

APPENDIX C

Recruitment Material

Hello my name is Rhyannon O’Heron. I am an MSW candidate at the Smith College School for Social Work in Massachusetts. I am currently looking for participants for a research project which will be used in partial fulfillment of my degree.

The project will explore the **countertransference experiences of queer clinicians during their first pregnancy**. For the purpose of this study countertransference will be defined using a totalistic understanding of the term in which any and all thoughts, feelings, wishes, fantasies, conflicts, anxieties, and/or enactments which are aroused in the therapeutic relationship as a result of the clinician’s first pregnancy are open to discussion during data collection.

If you hold a masters or doctorate degree in social work or psychology, identify as lesbian, queer, or gay, and have been pregnant while engaging in clinical work with adult female clients I would invite you to participate in the study.

You will be asked to participate in an interview lasting approximately 1 to 2 hours in length at a mutually agreed upon location, and at a time that is most convenient and comfortable for you. Your interview will be audio-taped, however, your name will not be said on tape and the information you provide, including your identity, will be coded and remain strictly confidential.

The subject matter of this study has never been empirically explored. Through sharing your experiences you will be able to contribute to a relatively unexplored and important body of knowledge which may have implications for future educational, training, and research opportunities which will benefit queer clinicians and their clients.

I greatly appreciate your interest and would welcome any questions, comments, and interested individuals to contact me at any time at roheron@email.smith.edu
Or (206) 302-2988

Sincerely,

Rhyannon O’Heron BSW, MSW candidate
roheron@email.smith.edu

APPENDIX D

Informed Consent Form

Dear Participant:

My name is Rhyannon O’Heron and I am an MSW candidate at Smith College School for Social Work located in Massachusetts in the U.S.A. I am conducting a research study about the countertransference experiences of queer clinicians in clinical work during their first pregnancies. For the purpose of the study countertransference will be understood to include any and all thoughts, feelings, wishes, fantasies, conflicts, anxieties, and/or enactments which are aroused in the therapeutic relationship as a result of the clinician’s first pregnancy. Thus, I will be talking about these experiences with queer social workers, clinicians, and psychotherapists who hold masters and/or doctorate degrees in social work or psychology in order to get a full picture of their experiences engaging in clinical work during their first pregnancy. The information that you tell me will be used for my thesis in partial fulfillment of the Master’s of Social Work degree at Smith College School for Social Work and for future presentation and publication on this topic.

Nature of Participation

You are being asked to participate because you are a queer clinician who has experienced a pregnancy while engaging in clinical work. You will be asked to share your experiences in regards to your work and countertransference experiences that occurred during your first pregnancy including the negative and positive aspects of pregnancy on your own well being and the effects on the therapeutic relationships you were/are involved in, concerns prior to pregnancy and afterwards, the process of deciding how to make use of pregnancy and disclosure in the therapeutic relationship, and the experience of clients as a result of the disclosure of pregnancy. At the beginning of the interview I will ask you about your gender identity, sexual orientation, current age/age during pregnancy, race/ethnicity, religion, degrees and licensures held, type of work setting while pregnant, type of clients seen, theoretical orientation drawn from in clinical practice, and years of experience at time of pregnancy/currently.

The interviews will occur in late 2006 and early 2007. Each interview will take 1-2 hours to complete. The interview will take place at a mutually agreed upon place and time that provides some confidentiality and isn’t too noisy, such as an office, home, library or coffee shop.

Your interview will be audio taped. I will not say your name while the tape is operating so that you will not be identified by name on this tape. All names of agencies, clients, colleagues, locations, etc. . . provided will be changed to protect confidentiality in any reporting of the data; and I ask that you change identifying information when sharing case material with me. Further, all participants will be assigned codes at the time of the interview which will be used to identify transcribed materials. If another person is hired

to transcribe interview tapes, he/she will be asked to sign a confidentiality form. All audio tapes, transcriptions, and other data materials will be locked, in a storage area which only I will have access to.

Risks of Participation

There is a risk that asking you to recollect and speak about personal subject matter such as pregnancy, sexual orientation, and countertransference may bring up unwanted memories and accompanying uncomfortable affects. At times, it may feel invasive having someone ask questions about such personal experiences. Please tell me if you feel that way so that I can stop the interview and ask if you wish to take a break, skip/decline to answer the question, or stop the interview. Another risk is the possibility that others in the community may see you meeting with me and assume that you are participating in this study. I will make every attempt to find a place to meet where your confidentiality can be maintained. I will not be able to provide a list of supportive resources to you; thus by signing this informed consent you acknowledge these risks, and assert your belief that discussion of the personal subject matter involved in participation will not cause you to experience unmanageable emotional stress.

Benefits

Participation will provide you with an opportunity to share your experiences of being queer, bearing children, and engaging in clinical work. It will also provide you with an opportunity to have your voice heard and to discuss and actively reflect upon the impact your queer identity has on shaping your experiences. Additionally, through your reflections, you may form new insights about your work and use of countertransference which will enhance your ability to use this material and think about it in new ways in your future work. Through sharing your experiences you will be able to contribute to a relatively unexplored and important body of knowledge which may have implications for future educational, training, and research opportunities which will benefit queer clinicians and their clients.

You will not receive monetary compensation for your participation in this study.

Informed Consent Procedures

You have every right to tell me at any point if you do not want to answer a question or portion of a question and we can skip it and move on to another question, or stop the interview for a break, or end the interview completely. Additionally, your participation in this study is completely voluntary and you may withdraw at any time during the interview or up until 3 days after the interview has taken place. There will be no penalties for withdrawing from the study, and no one will know of your interest, involvement, or withdrawal. Upon withdrawal from the study all collected information up to that point will be destroyed.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION; 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.

Signature _____

Date _____

If you have any questions or wish to withdraw your consent, please contact:
Rhyannon O’Heron at roheron@email.smith.edu

Please keep a copy for your records.