THE PREGNANT THERAPIST:
An exploration of countertransference issues and their impact on the therapeutic relationship.

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In pregnancy, there are two bodies, one inside the other. Two people live under one skin.... When so much of life is dedicated to maintaining our integrity as distinct beings, this bodily tandem is an uncanny fact.

-Joan Raphael-Leff
CONTENTS

Acknowledgments ........................................................................................................................................... v

Abstract ....................................................................................................................................................... vii

Chapter One: Introduction ............................................................................................................................... 8

1.1 Aims and Objectives ................................................................................................................................. 9

1.2 Method .................................................................................................................................................... 9

Chapter Two: Literature Review ..................................................................................................................... 10

2.1 The Pregnant Therapist ........................................................................................................................... 11

2.2 Impact on the Therapeutic Relationship ................................................................................................. 12

2.3 Client’s Reactions: Transference ............................................................................................................ 13

2.4 Therapist’s Reactions: Countertransference ............................................................................................ 14

2.4.1 Integration of Personal and Professional Identities .............................................................................. 14

2.4.2 Issues of Sexuality ............................................................................................................................... 15

2.4.3 Fear of Negative Emotions ................................................................................................................. 15

2.4.4 Countertransference Emerging from Childhood Conflicts .................................................................. 16

2.5 Countertransference in the Three Trimesters ........................................................................................ 16

2.5.1 The First Trimester ............................................................................................................................. 16

2.5.2 The Second Trimester ......................................................................................................................... 17

2.6 The Therapist’s Needs .............................................................................................................................. 19

2.7 Conclusion .............................................................................................................................................. 20
Chapter Three: Methodology ................................................................. 21
  3.1 Rationale for a Qualitative Approach .................................................. 21
  3.2 Research Strategy: Interpretive Phenomenological Analysis (IPA) .................. 21
  3.3 Sample .................................................................................................. 22
  3.4 Method of Data Collection – Semi-Structured Interviews .............................. 23
  3.5 The Researcher ..................................................................................... 24
  3.6 Data Analysis ...................................................................................... 25
  3.7 Ethical Considerations .......................................................................... 25

Chapter Four: Findings .................................................................................. 27
  4.1 Theme A: Feeling Exposed ...................................................................... 28
  4.2 Theme B: The Good Enough Mother ....................................................... 32
  4.3 Theme C: Pregnancy as Catalyst: Transference and countertransference ........... 36
    4.3.1 Negative Transference ..................................................................... 37
    4.3.2 Loss ............................................................................................... 39
    4.3.3 Reactions from male clients .............................................................. 41

Chapter Five: Discussion ............................................................................... 42
  5.1 Feeling Exposed ................................................................................... 42
    5.1.1 Discomfort with exposure ................................................................. 42
    5.1.2 Self-disclosure ............................................................................... 44
  5.2 The Good Enough Mother ..................................................................... 46
    5.2.1 Being a “tough task master” on oneself ............................................ 47
5.2.2 Maternity Leave/ Endings ................................................................. 47
5.2.3 Worry about the baby’s well being .............................................. 48
5.2.4 Client’s reactions to the therapist as the perfect mother ............... 49
5.3 Pregnancy as a Catalyst: Transference and Countertransference .......... 50
  5.3.1 Negative Transference ................................................................. 51
  5.3.2 Loss ............................................................................................ 52
  5.3.3 Reactions from Male Clients ....................................................... 52
5.4 Conclusions .................................................................................... 53
5.5 Recommendations .......................................................................... 54
5.6 Limitations ..................................................................................... 54
5.7 Further research ............................................................................ 55

References ......................................................................................... 56

Appendices ......................................................................................... 60
Appendix A Demographic Questions .................................................. 60
Appendix B Interview Guide ............................................................... 62
Appendix C Information Form ............................................................ 63
Appendix D Consent Form ................................................................. 64
Appendix E Sample Analysis ............................................................... 65
Appendix F Master Table of Themes .................................................. 68
LIST OF TABLES

Table 1: Sample Demographic Information ................................................................. 23
Table 2: Superordinate Themes ................................................................................... 27
Table 3: Feeling Exposed – summary of main issues ................................................ 42
Table 4: The Good Enough Mother- summary of main issues .................................. 46
Table 5: Pregnancy as A Catalyst: Summary of main issues ..................................... 50
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**ABSTRACT**

The therapist’s pregnancy has the potential to disrupt or facilitate the therapeutic encounter and an awareness of this potential impact allied with a willingness to work with it can be invaluable for the growth of both client and therapist. Only a small amount of the literature in this area focuses on the therapist’s perspective and so this research set out to explore the therapist’s view of how pregnancy impacted on the therapist and the therapeutic relationship. Three therapists were interviewed, each discussing their experience of two pregnancies while working as psychotherapists. Interpretive Phenomenological Analysis (IPA) was used to analyse the rich data.

Analysis of this data revealed three particularly interesting themes: (1) the therapist’s discomfort with the exposure of her private life, (2) the therapist’s struggle with the need to be ‘good enough’ for her client and her ‘real child’, (3) the therapist’s awareness of her pregnancy as a catalyst for transference and countertransference reactions. The therapists reflected on issues such as self-disclosure, working around the forced break/ending, and their wish to protect their baby from clients’ aggression. They found that willingness to work with the transference reactions evoked by their pregnancy accelerated the work with clients, generating new themes such as loss, loneliness, envy or abandonment from female clients and an increase in sexual material from male clients.

The therapists experienced particular difficulties in working with negative transference and themes of loss; at times feeling guilty about their clients and at times anxious about the well-being of their baby, with these difficulties more prominent in their first pregnancy. The importance of good supervision and support was stressed by all therapists as a way of dealing with these difficulties and gaining awareness of what they felt.

The findings of this research were, in the main, very much in line with the available literature.
CHAPTER ONE: INTRODUCTION

Pregnancy is a time of emotional and physical change that can be a wonderful experience but can also cause anxiety and stress. It’s a transitional time for a woman where she renegotiates her personal and professional identities, adjusts relationships, and develops a new relationship with her neonate while preparing for the experience of motherhood (Fallon & Brabender, 2003). The therapeutic relationship (unlike other relationships) is one-sided in that the therapist is unlikely to share personal life events with clients. However pregnancy is an event that cannot be hidden from the client (Lax, 1969) and as Etchegoyen (1993) puts it “Pregnancy reveals fundamental aspects of the analyst's private life, it confirms the therapist's existence as a separate and sexual being” (p.141).

Pregnancy has significant implications, potentially both disruptive and facilitative, on the therapeutic space (Bassen, 1998) in that the therapist’s pregnancy intrudes on the client’s space, turning it from a dyadic to a triadic relationship, bringing with it an inevitable break or ending to the relationship. However at the same time the therapist’s pregnancy “offers a rich opportunity for emotional growth of both patient and therapist” (Fuller, 1987, p.26). If the therapist is aware of and willing to work with the reactions her pregnancy evokes it can deepen the therapeutic encounter. Therapists may however avoid awareness of the impact their pregnancy has on the relationship because of feelings of guilt towards the client, or their wish to protect their baby (Fallon & Brabender, 2003) and may particularly struggle to deal with strong negative transference or countertransference reactions (Imber, 1990).

It is important to investigate this topic further because many female therapists may go through pregnancy while seeing clients and yet surprisingly, there is lack of literature on this topic - especially that focus on the pregnant therapist reactions (Dyson & King, 2008; Fallon & Brabender, 2003).
1.1 Aims and Objectives

The purpose of this research is to explore the effects of the therapist’s pregnancy on the therapeutic relationship from her point of view.

The specific objectives of the research are:

1. Gain a better understanding of the impact of the therapist’s pregnancy on the therapeutic relationship
2. Briefly explore transference reactions
3. Explore the array of countertransference reactions
4. Address these issues from the perspective of Irish therapists
5. Analyse the data using an interpretive phenomenological approach and develop a summary of themes and reactions experienced by therapists
6. Provide an informative guide for other therapists and their supervisors in relation to pregnancy

1.2 Method

IPA analysis was applied to the interviews of three therapists, each speaking about her experience of two pregnancies while working as psychotherapist.

The analysis process yielded three superordinate themes; the therapists struggle in relation to their exposure of private life; the conflict between being good enough for the client and the baby, and awareness of the impact their pregnancy had on transference and countertransference reactions.

The research was in line with the literature in asserting the importance of the therapist’s awareness of the dynamics her pregnancy might evoke in the therapeutic room.
CHAPTER TWO: LITERATURE REVIEW

When examining the literature on the topic it is surprising to see that until the 1970’s there were only a handful of articles available. Deutsch (1944) considered the psychic disturbance pregnancy could create in a woman’s life; potentially reactivating early conflicts, ambivalence towards the foetus, anxiety and guilt. Hannett (1949) treated pregnancy more like an illness when examining the reactions of her clients to her own miscarriage.

Ruth Lax (1969) was the first to really explore the affects her pregnancy had on the therapeutic relationship and discussed transference and countertransference reactions with examples from six case histories. The reason this important topic may have been ignored is because pregnancy highlights the difference between male and female therapists (Perlman, 1986). Women did not want to make their gender the centre of attention and did not want to admit their guilt about not doing ‘good enough’ therapy because of the intrusion of their pregnancy (McGarty, 1988).

In the subsequent 30 years, there has been a growing literature on the topic with a variety of articles and two books (Fenster, Phillips & Rapoport, 1986, Fallon & Brabender 2003). When examining this literature a number of interesting characteristics become clear:

- Much of the research is based on self-analysis (Lax, 1969; Perlman, 1986; Bienen, 1990; Imber, 1990; Etchegoyen, 1993)
- A smaller number have based their research on interviewing other therapists (Fenster, et al., 1986; Bassen, 1988; Fallon & Brabender, 2003)
- Most of the material in English is published in the USA
- Much of the work has been from a psychoanalytical perspective

Most importantly, the majority of the literature focusses on the impact of the pregnancy from the client’s perspective, where only a handful of articles (Bienen, 1990; Imber, 1990; Dyson and King, 2007) take the perspective of the therapist as its main focus.

\footnote{For the purpose of this literature review the terms client and therapist will be used}
Bienen (1990) explains that this resistance might possibly be due to the therapist’s anxiety of appearing professionally incompetent. Clementel-Jones (1985) suggests that therapists avoid this topic as they are reluctant to acknowledge their responsibility for the therapeutic environment. Imber (1990) proposes that therapists resist awareness of countertransference (in particular intense negative responses) during pregnancy as they are emotionally more vulnerable – “the fantasies, wishes, conflicts and anxieties which being pregnant arouses, both personally and professionally, may result in denial and avoidance of highly charged material with patients” (p.234).

So it seems that there is a real need for more European-based and contemporary research on the topic - focussing on the therapist’s countertransference reaction.

This literature review will consider the available material from the general to the specific and the main focus will centre on the therapist’s countertransference reactions.

2.1 The Pregnant Therapist

Pregnancy raises issues in every woman around self-image, sexuality, maternal identification, redefinition of roles and worries about the developing foetus.

Raphael-Leff, a psychoanalyst who researched the psychological effects of pregnancy and parenthood wrote (1993, p. 15):

While gestating her baby, a woman’s freedom of choice is curtailed. For the duration of the pregnancy she must share her body with another who is always there, even in her most private moments; who interrupts her thoughts and disturbs her sleep, forces her to change her eating, working, and toilet habits, and alters activity patterns of a life time.

In the therapeutic process the therapist’s private condition becomes “public property” (Friedman, 1993). Fenster et al. (1986) describe specific issues the pregnant therapist must deal with, including:

- The exposure of her anonymity and disclosure to the client that she has been sexually active with a man
- Anxieties about client’s responses
- Trying to integrate the therapist and mother roles. In other words, how can the therapist that needs to be the client’s all-available idealised mother be the same to her own child?
2.2 Impact on the Therapeutic Relationship

Pregnancy transforms the therapeutic relationship from a dyadic to triadic where the baby may be perceived as an intruder (Dyson and King, 2008). Bassen (1988) found that pregnancy increased the intensity of both transference and resistance and had either a facilitating, disruptive or not particularly apparent impact on the relationship. The differences were determined by the client’s resistance, the phase of the treatment and by the therapist’s countertransference and technique. Pregnancy was described as “acting like a catalyst, eliciting deeper and more intense material” (p.3). For some clients, issues that had been previously kept out of the treatment were prompted by the pregnancy. Fenster et al. (1986) found that when issues around the therapist’s pregnancy were not properly explored they disrupted the therapeutic process and led to premature termination. Conversely, heightened awareness of transference and countertransference issues often enhanced the therapeutic relationship.

Winnicott (1956) argues that it is normal for women to be self-absorbed and have heightened sensitivity during pregnancy, calling the phenomenon ‘primary maternal preoccupation’ and this effect may cause some distortion of the therapist’s empathic attunement to clients (Uyehara, Austrian, Upton, Warner, & Williamson, 1995). The pregnant therapist may be more emotionally vulnerable but may experience “increased intuition, empathy and nurturing capacity which can impact positively on her work” (Dyson & King, 2008, p.30). Raphael-Leff (2004) suggests the importance of paying attention to the unconscious interaction between therapist and client which a powerful event such as pregnancy brings into the relationship.
2.3 Client’s Reactions: Transference

The pregnancy of a therapist can provoke various reactions from clients depending on their history; whether they were an only child or had siblings, their gender or simply differences in character. Bassen (1988) found that pregnancy provoked a wide range of dynamic conflicts that had previously been kept out of the treatment such as:

- feelings about dependency, loss and abandonment, separation, envy, jealousy and competition, feelings of exclusion, fears and feelings of repulsion about female sexual anatomy and sexuality, wishes and fears of pregnancy,...[and] anxiety and guilt about death wishes toward the foetus and/or the analyst (p.283).

The pregnancy of the therapist therefore evokes deep-seated childhood conflicts, fantasies and wishes. The pregnancy can be an opportunity for the client to re-experience through transference many of his pre-genital and oedipal struggles, and to re-enact his own childhood conflicts (Lax, 1969).

Fallon & Brabender, (2003) divided clients’ responses between

- Reactions that are in the ‘real relationship’ such as anger about the disruption of the treatment or happiness or envy for the therapist’s good fortune.

- Transference reactions that comes from the client’s past or internal conflicts.

They found common themes in the responses such as symbiosis and separation, envy and competition, sexuality, jealousy, and the oedipal triangle. They argue that understanding the client’s response can lead to enhanced empathy and more appropriate intervention.

Clients may also experience greater difficulty expressing negative feelings towards the pregnant therapist due to a social taboo about ‘having to be nice to pregnant ladies’ (Perlman, 1986). The pregnant therapist must pay close attention to transference reactions and be prepared to modify the course of treatment accordingly in order to maximise the positive therapeutic outcome (Cole, 1980).
2.4 Therapist’s Reactions: Countertransference

Pregnancy can provoke a variety of special feelings within the therapist and these internal feelings can either be a reaction to those of the client or can emerge from the therapist’s own unresolved unconsciousness conflicts, hormonal fluctuations, physical changes or social role uncertainty (Fallon & Brabender, 2003).

The therapist may be more defensive than usual due to emotional vulnerability, may resist countertransference awareness or deny its impact on the therapeutic relationship. She may also find it harder to tolerate particularly intense negative feelings such as envy, hatred or destructive fantasies within herself or her clients (Bassen, 1988; Bienen, 1990; Imber, 1990; Nadelson et al, 1974). If the therapist can confront herself in these countertransference issues the growth for the client and therapist is invaluable (Fenster et al., 1986).

The following common countertransference issues can be summarised from the literature:

2.4.1 Integration of Personal and Professional Identities

Pregnancy (particularly the first) raises questions for every working woman regarding the need to integrate her professional and maternal roles.

This issue is particularly magnified for the pregnant therapist who faces a conflict between the need to be “the good enough mother” for her client and for her expected “real child” (Nadelson et al., 1974).

For the therapist who works in private practice further more practical conflicts may be raised around the need to build up her practice and the wish to stay at home with her new born baby. These anxieties continue throughout the pregnancy and postpartum.

Fallon & Brabender (2003) found that many therapists try to manage this crisis by denying the impact pregnancy has on themselves and on the therapeutic encounter, instead attempting to maintain a “business as usual stance” (p.51) They may also deny the guilt and anxiety they feel about doing an inadequate job both at home and in the work with clients.
Ulman (2001) explains that therapists in general and pregnant therapists in particular find it difficult to acknowledge their own humanity and personal needs. This can result in seeing pregnancy as an intrusion on the therapeutic space - particularly for those who work analytically and therefore rigidly try to maintain a blank screen (Fallon & Brabender, 2003). Anderson (1994) emphasises that for effective therapeutic work the therapist must accept her new physical and emotional state, and the reality that it may require her to adjust her work accordingly.

2.4.2 Issues of Sexuality

Pregnancy brings the reality of the therapist’s sexuality into focus. If the therapist is comfortable with these feelings she can use her gender for further exploration of clients’ material and if not then it may result in avoiding relevant signals from clients (McGarty, 1988).

Therapists may feel uncomfortable with issues of sexuality due to personal or cultural views of motherhood and sexuality (Cullen-Drill, 1994). Interestingly, only a small minority of the literature includes reports about increase in sexual transference from male clients (Bashe, 1989). This can be due to the therapist’s own discomfort, leading her to neglect exploration of subtle transference displays (Fenster et al., 1986).

2.4.3 Fear of Negative Emotions

The therapist may struggle to tolerate intense negative feelings such as hatred, envy, or destructive fantasies within herself and from her clients (Bassen, 1988; Bienen, 1990; Imber, 1990; Nadelson et al, 1974). However some therapists did not report any expressions of anger from clients and Fallon & Brabender (2003) speculate that this might be due to the therapist’s complete avoidance of clear signs of anger.

Such avoidance can be due to a number of factors (Fallon & Brabender, 2003):

- The wish to avoid seeing the pregnancy as an intrusion on the therapeutic space
- Her own physical and emotional vulnerability
- Her own unresolved childhood conflicts, particularly sibling rivalry
Bassen (1988) found that therapists felt particularly guilty when working with women who wanted to have children and could not, resulting in the therapist’s desire to hide her pregnancy so as to protect the client but also to protect herself from envy or anger.

2.4.4 Countertransference Emerging from Childhood Conflicts

Lax (1969) found through discussions with colleagues that specific counter-transference reactions were evoked by the therapist’s own childhood conflicts. For example:

- Therapists who expected their clients to be hostile discovered it was connected to their own childhood rage when a younger sibling was born.
- Therapists who felt uncomfortable with male clients noticing their pregnancy had issues with femininity and self-image.
- Feelings of guilt towards the clients originated in intense sibling rivalry conflicts.

She found however, that once the therapist worked out her own childhood conflicts she was able to respond to the client from their own specific infantile psychic reactions.

2.5 Countertransference in the Three Trimesters.

The developing pregnancy in each trimester may bring with it different countertransference issues to consider:

2.5.1 The First Trimester

In the first trimester the pregnancy is normally kept secret from the outside world. Emotionally, the therapist may experience excitement and joy combined with anxiety and fear while physically she may feel fatigue, nausea and discomfort (Fenster et al., 1986). The therapist should recognise that these can affect her emotional availability, and readjust her work if needed so as to minimise their impact on the client (Fallon & Brabender, 2003).

The therapist may feel she wants to tell her clients about her pregnancy or may enjoy having a secret all to herself (Dyson & King, 2008). Some therapists may feel uneasy about keeping a secret from the
client (Fenster et al., 1986), while others experienced a desire to be left alone at this stage, evoking feelings of guilt (Bassen, 1988).

2.5.2 The Second Trimester

The second trimester is generally a more peaceful time, with fewer physical discomforts and less anxiety. This allows the therapist to relax and let the pregnancy generate important issues within the treatment (Fenster et al., 1986). Countertransference reactions at this stage may include increased empathy and intuition for some therapists (Barbanel, 1980). Other therapists reported being more absorbed by their inner lives than in the first trimester and therapists who discovered the genders of the baby were more preoccupied with themselves than those who did not (Turkel 1993).

Self-Disclosure

The second trimester also brings with it issues of disclosure as the pregnancy becomes more visible (Fenster et al., 1986). Therapists are not used to self-disclose and may feel anxious and exposed, and confront questions about when and how much to disclose (McGarty 1988). Some therapists avoid revealing information to clients (some described hiding their pregnancy under loose clothes) which can be for a number of reasons (Fallon & Brabender 2003):

- The therapist’s wish to deny the impact her pregnancy has on herself and the therapeutic relationship
- The therapist’s discomfort with the exposure
- The therapist’s wish to protect her unborn baby

Uyehara et al. (1995) wrote a detailed paper about their focus group’s discussion of how and when to tell the client about the pregnancy. While noting that therapists should be aware that countertransference could potentially interfere with accurate reading of the client’s indication, they recommended clients should be informed of the pregnancy sometime in the second trimester and that preferably the therapist should wait until the client showed conscious or unconscious indication that
they had noticed the pregnancy. They also noted that a number of conflicts created guilt and anxiety within the therapist, causing her to disclose her pregnancy either too early or too late. They included:

- The conflict between the joys of being pregnant and the frustration of its interference with her professional life.
- The conflict between the wish to do well professionally and the desire to be the ideal mother.

Fallon & Brabender (2003) discuss the importance of the therapist sharing information with clients as an empathic reaction to their curiosity and recognition of the therapist as a human. But while doing so disclosure of information should be kept to a minimum, with exploration of the client’s fantasies before it is shared.

**2.5.3 The Third Trimester**

In the final trimester the ‘primary maternal preoccupation’ intensifies (Winnicott, 1956). Women may be more self-absorbed with realistic concerns and excitement about the coming birth and by more primitive fears of life and death while increased physical discomfort and fatigue may also be experienced. All these experiences can interfere with the therapist’s availability to her client and “she may resent the demands and needs of her clients which are pulling her away from her preoccupation with her baby” (Dyson & King, 2004, p.38).

Many women develop ‘nesting behaviour’ in preparation for the coming child and this behaviour can be seen in the therapy room with therapists trying to reach closure with clients, making referrals and updating all their records.

In addition, issues about the reality of the coming separation must be faced by both therapist and client, the therapist may feel anxiety about losing her clients from a practical and emotional level and so setting an ending date is crucial as it provides a framework for clients to work through possible feelings of separation and abandonment (Fenster et al., 1986). The therapist may feel relief at reaching the end of her pregnancy but may also mourn the physical separation from the foetus, and a parallel process can occur in her therapeutic work where she can feel relief and mourning as she separates from her clients (Fallon & Brabender, 2003).
2.6 The Therapist’s Needs

The pregnant therapist needs to find ways to feel supported and contained in her work (Dyson & King, 2004). She must acknowledge that pregnancy is a time of emotional upheaval and the effects it has both personally and on the therapeutic relationship. As a result she may need to adjust her work and she should explore countertransference issues with colleagues, in supervision and personal therapy (Fallon & Brabender, 2003). Imber (1995) asserts the importance of good supervision during the therapist’s pregnancy and the supervisor “may need to function in ways that are out of the ordinary to help the supervisee cope with the added stress set off by a special life event” (p.282). Uyehara et al. (1995) suggest that issues specifically around countertransference guilt should also be dealt with in supervision. They further recommend that supervisors should have a good understanding of the emotional and technical issues of pregnancy, and give examples of two male supervisors that actually intensified supervisees’ guilt by reacting to the pregnancy as an unfortunate event.

Dyson & King (2004) identify personal therapy as an opportunity to confront and work through conflicts and go on to recommend reading around the topic, talking to other therapists who have experienced pregnancy and writing a personal diary.
2.7 Conclusion

Upon examining the literature on the topic it emerges that pregnancy can have a profound impact on the therapeutic relationship. Dyson & King (2004) write that “no other event in the therapist’s life impacts as powerfully on the therapeutic relationship as pregnancy”, and on reading the literature this certainly seems a credible position. Pregnancy can elicit unconscious material from the client which must be worked through and explored in therapy and it also elicits real and unconscious material from the therapist herself - some due to the real psychological and physical effects pregnancy has on every woman, and some in connection to the special nature of the therapeutic work and the therapists’ need to be the ‘all-providing’ mother for the client.

There certainly seems to be a lack of research where the main focus is on the therapist’s countertransference reactions and almost none from a European and Irish perspective. It is hoped that this research will go some small way towards filling that gap.
CHAPTER THREE: METHODOLOGY

3.1 Rationale for a Qualitative Approach

The aim of this research is to explore the impact of the therapist’s pregnancy on the therapeutic relationship with a special focus on countertransference issues. It can be challenging to get a full sense of the therapists’ experiences as they may be avoiding their reactions (Bienen, 1990; Imber, 1990).

Therefore qualitative inquiry is the most appropriate method as it is especially effective when researching complex and subtle material (Brocki & Wearden, 2006) and has much to offer especially around understanding the complexities of the therapeutic process (McLeod, 2011).

The primary aim of qualitative research is “to develop an understanding of how the social world is constructed” (McLeod, 2011, p.3). It allows inquiry of real life topics in a set of flexible and sensitive methods that enables participants’ experiences to be heard while being a challenging, interesting and rewarding activity for both the researcher and the participant (ibid). In qualitative research there is no hypothesis or fixed truth, instead there is an exploration of a wide variety of aspects (Banister, Burman, Parker, Taylor & Tindall, 1994).

3.2 Research Strategy: Interpretive Phenomenological Analysis (IPA)

Interpretive Phenomenological Analysis (IPA) is the particular qualitative approach chosen for this research, as it is “especially useful when one is concerned with complexity, process or novelty” (Smith & Osborn, 2003, p.55).

IPA explores in detail participants’ perceptions, views, and understanding of their own experience (Reid, Flowers & Larkin, 2005). The IPA researcher aims to engage with the person’s reflections on their experience and is effectively a double hermeneutic interpretation process as the researcher is trying to make sense of the participant’s sense-making process (Smith, Flowers & Larkin, 2009).

The individual’s personal perception is important but at the same time the researcher has an active role in the process and aims to gain a full understanding of the participant’s point of view (Smith & Osborn, 2003).
IPA originated in psychology research and has also increasingly been used within counselling and psychotherapy research (McLeod, 2011). It is a recently developed approach to qualitative inquiry but it is drawing on concepts with much longer histories, driven from three major philosophical areas; Phenomenology, Hermeneutics and Ideography (Smith, et. al, 2009).

- Phenomenology strives to understand what it is like to be a human. Husserl, a key thinker in this approach, encourages people to step outside of daily life activities to reflect and examine their experience.
- Hermeneutics gives IPA its basis for interpretation by examining a part from the perspective of its whole and its detail.
- Ideography is concerned with the particular and aims to establish rich detail based on in-depth analysis.

These philosophical underpinnings were very much an integral part of this research. The participants were encouraged to reflect on their experience with clients while they were pregnant. When examining the material emerging from the interviews each detail was examined very closely but also in the context of its whole.

### 3.3 Sample

A purposeful homogenous sample was selected in order to gain detailed knowledge of the specific group studied (Chapman & Smith, 2002) and participants were recruited through snowball sampling (Quinn Patton 2002). The researcher wanted to ensure the ability of the participants to articulate their thoughts and experiences well in order to provide rich data to work with (Baillie, Smith, Hewison, & Mason, 2000) so participants were specifically recommended through a number of contacts. Three therapists were selected in order to allow sufficiently in-depth engagement with detailed examination of similarities and differences (Smith & Osborn, 2003), according to the following original criteria:

1. An experienced qualified working psychotherapist who had seen clients while pregnant.
2. The pregnancy having occurred within the last two years.
3. The pregnancy can be the first or a subsequent pregnancy.
4. Approximate age group should be from 26 to 44 years of age.
The actual sample selected was suitably homogenous as can be seen in the table below. The therapists’ average age was 38, two of the therapists had been pregnant in the last year while one had been pregnant in the last three years. As it happened, all therapists experienced two pregnancies, both occurring while they were seeing clients, this especially contributed to the richness of the data, as they were able to compare between the pregnancies. The principal difference was the therapist’s orientation which while adding to the variety of the data at one level, also showed that all psychotherapists encounter similar issues regardless of their orientation.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Years Working</th>
<th>Years Accred.</th>
<th>Orientation</th>
<th>Qualification</th>
<th>No of Preg.</th>
<th>Time since last Preg.</th>
<th>Clients Per Week</th>
<th>Length of Leave</th>
<th>General Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah</td>
<td>42</td>
<td>12</td>
<td>5</td>
<td>Psycho-analytic</td>
<td>MA</td>
<td>2</td>
<td>3 Yrs.</td>
<td>10-15</td>
<td>2 wk. before 8 wk. after</td>
<td>Facilitating Disruptive</td>
</tr>
<tr>
<td>Linda</td>
<td>39</td>
<td>9</td>
<td>5</td>
<td>Family therapy-systemic</td>
<td>MA</td>
<td>2</td>
<td>1 year</td>
<td>4</td>
<td>1st – 1 yr. 2nd – 3 months</td>
<td>Facilitating Disruptive no affect</td>
</tr>
<tr>
<td>Kathy</td>
<td>33</td>
<td>8</td>
<td>5</td>
<td>Psycho-dynamic (Spec. in couples)</td>
<td>MA</td>
<td>2</td>
<td>4 months</td>
<td>15</td>
<td>6 weeks</td>
<td>Facilitating Disruptive no affect</td>
</tr>
</tbody>
</table>

Table 1: Sample Demographic Information

3.4 Method of Data Collection – Semi-Structured Interviews

Therapists may be more defensive than usual about revealing countertransference issues in pregnancy (Imber, 1990). Therefore a method of interviewing where rapport can be built between the interviewer and respondent so as to encourage openness, self-reflection and honesty is important. Semi-structured interviews were specifically chosen because they provide the researcher with a set of guiding questions that can be modified during dialogue with participants (Smith, & Osborn, 2003). Kvale & Brinkmann (2009) assert the importance of the interview process in obtaining descriptions of the interviewee world in order to interpret its meaning.

For this reason there was close attention in creating rich open ended questions that allowed the participants to deeply reflect on their experience of being pregnant while they practiced

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2 See Appendix A for a set of demographic questions asked prior to the interview
psychotherapy. The interview guide was informed by the literature review and the researcher’s own interest in the topic (Lofland & Lofland 1995). It was then followed by a consultation with the researcher’s academic supervisor to ensure all the themes were covered and to discuss appropriate ways to approach the interview process.

Each participant was met in a private room, at her workplace to ensure there were no distractions. The interviews lasted approximately sixty minutes where initially each participant filled in a form comprising of a set of demographic questions followed by in-depth, open ended questions (Quinn Patton, 2002). The participants did not receive a copy of the questions before the interview so as to ensure spontaneity and authenticity on the topic.

The researcher used therapeutic listening skills to elicit participant’s stories (McLeod, 2011) and encourage them to talk at length (Smith et al, 2009). The interview guide was not followed mechanically and if necessary, new questions were improvised in response to therapists’ answers or comments. So as to assist with establishing and maintaining rapport, the interviews were recorded and only transcribed at a later date. However notes were taken immediately after each interview in order to capture the experience of how the therapist responded to the questions.

3.5 The Researcher

Brocki & Wearden (2005) recognise the researcher’s centrality to analysis and research and thus urge IPA researchers to state their own preconceptions, beliefs, and aims prior to the analysis stage. The researcher had been pregnant and experienced her own countertransference issues while seeing clients. Specifically, issues of guilt around taking a break for maternity leave and keeping a secret from the client were prominent. On one hand the fact the researcher had been through a similar experience helped, as it provided insight and understanding of the material, but on the other hand the researcher had to be aware of differentiating her own experiences from those of the respondents.

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3 See Appendix A
4 See Appendix B
3.6 Data Analysis

IPA involves a detailed case by case analysis of individual transcripts (Chapman & Smith, 2002) where the researcher has an interpretive relationship with the transcript (Smith, & Osborn, 2003). The researcher actively engaged with the data by listening to it, transcribing it, reading and re-reading and using a close line by line analysis (Smith et al, 2009). Particular attention was made to non-verbal communication such as a pause or a laugh in order to capture and make sense of the participant’s personal experience (Larkin, Watts & Clifton, 2006).

Smith et al, (2009) welcome new ways of analysis, so once the data was transcribed it was copied into an Excel spreadsheet where each paragraph was numbered and then closely analysed to include line by line analysis, the researchers interpretation, and emerging themes. This provided a very clear graphic representation of the data, which greatly assisted throughout the process of analysis, and helped in identifying both connections across emergent themes and in creating a superordinate list of themes. These steps were performed on each transcript separately and each transcript was approached as if it was the first one in order to respect its individuality. In the final stage, connections were made across cases which eventually produced a Master Table of themes (ibid.).

Following the hermeneutic circle theory it can be seen how the whole of each interview was analysed into parts and then brought together to form a new whole at the end of the analysis (Smith et. al, 2009). This helped to develop “an organised, detailed, plausible and transparent account of the meaning of the data” (Harper and Thompson, 2012, p.104).

3.7 Ethical Considerations

While undertaking this research three basic ethical principles were considered following the Belmont Report (Zimmerman, 1997). Participants were treated fairly, respectfully and the benefit of this research was evaluated in respect to any possible harm.

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5 See Appendix E
6 See Appendix F
7 The hermeneutic circle aims to "understand any given part you look to the whole, to understand the whole you look to its parts" (Smith et. al, 2009, p.28)
The following principles, following Silverman’s (2004) three main ethical considerations, were specifically applied:

1. Informed consent where participants were fully aware of the purpose of the research and any possible risks
2. Confidentiality of information and anonymity of respondents
3. Voluntary participation

All these principles were addressed in this research as follows:

1. Participants were given an information sheet⁸, and signed an informed consent prior to the interview⁹. The participants were briefed by the researcher before the interview both verbally and by e-mail regarding the subject of this research and the nature and terms of their participation.

2. Participants were informed that their confidentiality and anonymity would be maintained while explaining that there are limits to confidentiality. To maintain anonymity care was exercised in storing the confidential information. In addition all identifying material was removed from the data presented in this research.

3. Participants were clearly told that they were free to choose what information to disclose and of their right to withdraw from the investigation at any stage.

The process of supervision in this research provided an important place for the researcher to reflect and examine ethical issues (Harper and Thompson 2012) so as to ensure accurate and objective presentation of the material.

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⁸ See Appendix C
⁹ See Appendix D
CHAPTER FOUR: FINDINGS

The aim of this research is to focus on the experience of the pregnant therapist, and how she felt her own countertransference issues impacted on her relationship with clients. While the three interviews yielded very rich data on a variety of aspects relating to the general impact pregnancy has on the therapeutic relationship, the researcher selected themes that focus on how the therapist experienced herself in the relationship. The researcher used her own psychotherapeutic skills to interpret the data and following IPA methodology, a triangular process (Smith et al., 2009) occurred where the interaction of raw data from the participants with the researcher’s close analysis yielded the development of the following three superordinate themes:

<table>
<thead>
<tr>
<th>Feeling Exposed</th>
<th>The Good Enough Mother</th>
<th>Pregnancy as Catalyst: Transference and countertransference</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I had a desire to take my belly off and leave it with the secretary downstairs”</td>
<td>“I became a tough task master on myself”</td>
<td>Negative Transference</td>
</tr>
<tr>
<td>“Sharing your stuff to a level you don’t normally”</td>
<td>“It was very sad I was crying my eyes out …leaving my baby behind”</td>
<td>“It was horrible, hard to listen to”</td>
</tr>
<tr>
<td>“The therapy room is so exposed”</td>
<td>“I wonder if it has any effect on my daughter”</td>
<td>“She had to talk about her story because I had a bump.”</td>
</tr>
<tr>
<td>“If I was exposed then my baby was exposed”</td>
<td></td>
<td>Loss</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I basically sucked in”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I can deal with loss if it’s not loss for my gain”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I felt guilty”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reactions From Male clients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“All of a sudden the flirtations started with me”</td>
</tr>
</tbody>
</table>

Table 2: Superordinate Themes

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10 Which can be seen in the Master Table of Themes in Appendix E
4.1 Theme A: Feeling Exposed

All three therapists spoke about feeling exposed in the room, which was experienced as discomfort as it changed the normal engagement between therapist and client. Some therapists felt an urge to protect themselves or the baby from the client, while some clients tried to use the pregnancy to break the boundaries of the therapeutic relationship. The therapists had different attitudes in relation to sharing information about their pregnancy and the degree of facilitation /disruption it introduced to the client work. Both Linda and Sarah\(^{11}\) felt irritated that generally speaking, a woman’s pregnancy seems to make her public property. Sarah illustrated her anger and surprise at this by using words like “shocking”, “tricky” and “strange” a few times through her long discussion about “people outside” or “people on the bus” touching pregnant ladies or attempting to give advice.

Par. 142 **Sarah:** “You would have the experience on the bus and, you know, there would be the questions and the-this and the-that, and that's all exciting. And you know its peoples’ excitement and their experience, or whatever it might be… but- it's really kind of nothing to do with you! [Laughing and sounding annoyed] or the worst you know; people touching you, I found that shocking… I found that shocking!” \(^{12}\)

Linda recalled a similar feeling:

Par. 140 **Linda:** “That always fascinates me even from my point of view…that there is something about a pregnant woman that the boundaries change and that you can touch them? [Surprise in voice- laugh]”

It can be seen from the transcripts that the two participants felt uncomfortable with their body becoming public property where anyone might touch it. At another level it could be inferred as the woman’s desire to keep people out of her pregnancy so she could be in a complete state of symbiosis with her baby where no one else intrudes. So how does that affect the therapy room that by definition needs to be exposed?

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\(^{11}\) All the names have been changed to maintain anonymity
\(^{12}\) Transcripts notation used in quoted extracts (Smith et al., 2009, p.120):
- \(\ldots\) Significant pause
- \([\ ]\) Material Omitted
- \([her]\) Explanatory material added by the researcher
In relation to the therapy room, all therapists expressed the feeling of wanting to keep the pregnancy to themselves in some way. For Linda it was mostly around her first (unexpected) pregnancy. She felt very protective about it and wanted to keep it to herself but felt she had no choice but to eventually disclose it to clients.

Par. 126  **Linda:** “It just, it felt very precious [ ] it was something that I wouldn't have control over it once it was out”.

When she did tell clients she felt “uncomfortable” as it was “sharing your stuff to a level you don’t normally” and it “invites a level of inquiry about you”. Linda was able to work with the exposure, to use it in the room when appropriate while managing to maintain boundaries.

Par. 136:  **Linda:** “[ ] Which has two sides to it I think. I think it can be ok, not ok but it can be ok in the room at times, for there to be a switch or, eh... because it, you can use it, em, but I suppose it is a very uncomfortable place for a therapist to be. Because the definitions are usually the other way around, and you want to be clear that this time is their time and not your time.”

Linda’s hesitancy might indicate that even though she felt she was able to manage the “switch” in the room for the therapeutic process it was not easy and was uncomfortable for her.

Sarah who works analytically expressed a different approach which necessitated keeping the therapist as a real person out of the room so as to allow transference to develop. This increased the conflict around the exposure her pregnancy brought into the room.

Par. 26:  **Sarah:** “so you become em [ ] much more how do I say, present in the work in a sense of the physical sense than maybe that you would before, because of the fact that your body is physically changing”.

As a therapist Sarah tried to “*stay in [her] position*” but for many female clients it became a way to “*try and bypass the therapy and say something to you that is more personal*”.

Sarah believed it was extremely important to work with whatever reactions her pregnancy brought up for clients. However in order to allow the transference to evolve naturally and not direct the client in any way, she didn’t tell clients she was pregnant and addressed the fact by only saying she would be taking leave.
Par. 38: **Sarah:** “because it brings you into the therapy in a way that I thought was somehow outside of the therapeutic relationship or could be in a sense that I am a, that I am saying something about myself in a personal capacity”.

The researcher, who is not analytically trained, wondered about the theoretical basis for not telling the client about the pregnancy. Is it a way of trying to avoid the unavoidable, i.e. the reality that pregnancy brings into the relationship?

Kathy voiced a very different opinion:

Par. 150: **Kathy:** “Of course they had the right to know because I am human! I have sex, get pregnant, go mad! If they don’t know that then why should they trust me with their story?”

But while she was very open to using her second pregnancy in the therapeutic work, she felt protective with her first:

Par. 43: **Kathy:** “[ ] there was plenty of jokes around it but even the jokes were very censored, they were only where I was comfortable, about getting bigger… and I was fine with that”

She explains that even though she told clients she was pregnant she avoided it, and as a result “there were definitely opportunities missed”. When exploring the possible reasons for the avoidance, there seems to be a desire to keep the image of her pregnancy and prospective motherhood perfect, and the fear that once it was exposed in the room clients could burst that bubble.

Par. 122: **Kathy:** “[ ]I made myself… but it was hard work, so I was trying to look like an earth mother or something but it was fucking exhausting, and like under all that make up there was a load of broken veins and sweat that I wasn’t comfortable with”.

Here Kathy is speaking about her efforts to maintain a perfect image for herself and hide the imperfections. If her pregnancy was exposed in the therapy room clients might uncover these imperfections. Later, when reflecting on her ability during her second pregnancy to stay with the story of a struggling mother, she looked back on her inability to do so on the first pregnancy:

Par. 132 **Kathy:** “[ ] I remember one day [she] described how the child was hysterically crying. She was breastfeeding, but also needed to go to the toilet and that chaos… and I think if she had said that on my first pregnancy I would have been frightened”.

Kathy worked openly with the various reactions her second pregnancy brought into the room - but only after confirming her baby was doing well. During the first four months of her pregnancy the
survival of the baby was uncertain and as a result, this time she wished to protect the exposure of her pregnancy for the baby’s sake:

Par. 94: Kathy: “I found it difficult to be in the therapy room because the therapy room is so exposed you know for the therapist and the client, as it should be! But if I was exposed then my baby was exposed, and I could manage myself, but how could my baby manage… that was difficult… em very difficult! [laughing] you know when I started to show, I felt ok but before that for the first four months… it was awful!”

Once Kathy learned that her baby was safe she openly used her pregnancy in the room in the transference relationship with clients but at the very end of the interview she reflected:

Par. 180: Kathy: “If I was to get pregnant again I would do it differently again,[ ] If I was honest I would be a little bit more contained”.

When asked to clarify ‘contained’, she explained:

Par. 183: Kathy: “It became a joyful thing for most people in the therapy room… so my clients would have been thrilled for me and that was lovely but I think next time if I was going to have a baby I would just be careful that they are not hitching their wagon to my star in a way… because they were – oh my god that’s brilliant news… so they watched the baby grow but then they don’t get to see it they don’t get to share it with you… so I would be a little bit more contained in it”

So there is a sense here that her second pregnancy and Kathy’s personal life became too much of a shared experienced with clients, when in reality they couldn’t actually share the experience of the baby’s birth and growth.

In conclusion, all therapists felt discomfort with the exposure of their personal lives in the therapy room. This discomfort emerged from a number of reasons; the possible role reversal the personal disclosure might cause, the wish to protect their baby from the client, or their wish to keep their pregnancy to themselves by keeping intruders out of it.

They dealt with the exposure in slightly different ways, depending on their style and therapeutic approach. The exposure of the therapist’s humanity and personal life affected the work with clients, and it could be inferred that there needs be careful consideration of how much to share with clients.
4.2 Theme B: The Good Enough Mother

All therapists demonstrated a conflict between the desire to be the “good enough mother” in relation to both their clients and their unborn baby. These difficulties were specifically demonstrated in relation to maternity leave or when there was a concern for the baby’s well-being.

All the therapists discussed various physical issues they experienced especially in the first and last trimester:

Par. 7: **Linda:** “I was well… well… With both of my pregnancies for the kind off… three months in the first and five months of my second I was quite sick… morning sickness… morning noon and night sickness”

When asked how she felt being so sick and still seeing clients she answered:

Par 9: Linda: “It was not too bad… I was ok…”

Par 14: **Sarah:** “Em… my pregnancy was eh… good in sense that there were not particular health problems but, eh other than, I had back problems and that was something that eh, continued from my first it was sciatica”

When asked at a later stage if her physical state interfered with her work she said

Par 206: **Sarah:** “Physically I wouldn’t have been you know, doing cartwheels or anything but I felt I was still able to work”

Par. 35: **Kathy:** “To a point that like I worked up to the week I had Tom and I was massive… but I was light on my feet because I wasn’t showing it”

In all the transcripts it can be seen that the therapists tried to play down the physical impact pregnancies had on them, and made certain to emphasise that even though they were not always feeling well it did not impact on the work with clients.

Linda conveyed a sense that she worked hard to show clients that she was still fully there for them by becoming a “**tough task master on myself**” to prove clients they were not getting a “**winding down therapist**”. When she was finishing up for maternity leave she made sure to “**package up a goodbye**” for her clients so they would not feel abandoned.
Par. 188: **Linda:** “I probably would have given myself, put myself under a lot of pressure to do that extra bit for people before I finished up… I think it comes with the territory of being a therapist…wanting to do the best you can for clients”.

Interestingly many clients didn’t turn up for the very last session:

Par. 169: **Linda:** “A few people just disappeared! Do you know, after many many months of positive good work when it came to actually doing: ‘right this is what we’ve done and this is where we have gotten to’, ‘where do we go from here’, ‘what does the future hold’ and that kind of stuff…they didn’t come in…”.

Here Linda sounds hurt and annoyed that her clients didn’t appreciate all her efforts to end the sessions nicely. The researcher wondered about the reason clients didn’t turn up to the very last session. Could it be that they were angry, feeling abandoned, despite the therapist’s efforts to show she was still good enough? Perhaps they didn’t feel able to voice this anger against a pregnant woman? When asking Linda about it she said she didn’t think the clients were angry and that perhaps the need to end nicely was more on her part than that of her clients. However, later in the interview she did say that “mentally you are detaching and putting everybody down for a little while” so perhaps she projected being the “winding down therapist” despite her best efforts.

Unlike Linda’s clients, Sarah mentioned a client who did get to express anger about feeling abandoned:

Par. 54: **Sarah:** “She was furious, absolutely furious…. em… that ah, that I was pregnant and that I hadn’t told her and em… that I was going to be going and that there was going to be somebody else essentially that I was caring for.”

Sarah worked with this response in the therapeutic relationship and the client did come back after the maternity break. There was a sense though that she expected to have to bear quite a lot from the clients so as to be the “good enough mother”. As she said later in the interview:

Par. 220: **Sarah:** “So it’s not about stopping that - it’s allowing it to come out, even if it’s terrible… you know so that you have to bear the pain or the uncomfortableness or the anxiety, that’s the price you have to pay”.

Interestingly with Kathy, even though she “avoided very obvious signs in the therapeutic relationship” while pregnant, and expected some clients to “punish” her by not coming back after her short maternity break, they did all come back. Wondering about it, she explained:
Par. 71: **Kathy**: “I suppose luckily [ ] clients that were with me had been with me for a very long time. So they had the, they had got to voice that pain at a different time, I think that helped! It must have! There had to be a reason they came back!

When they did come back there was more of a discussion about “how it felt [for the client(s)] knowing that I had a baby at home”. Kathy was also very conscious about taking a short maternity leave as not to unduly disrupt client work:

Par. 168: **Kathy**: “I think I would have felt like it was too much about me if I took anymore… and that’s my stuff… so I managed to avoid really addressing it by complying with it… so… and making it work”.

She expressed her sadness about choosing to return to work after just six weeks:

Par.166: **Kathy**: “Yeah … it was very sad I was crying my eyes out when I came in to work leaving my baby behind [ ]”.

Linda on the other hand took one year off after her first pregnancy. While she valued having the year to “live her life” she found it very disruptive to her work with clients and was why she took only twelve weeks on the second:

Par. 77: **Linda**: “The first time around I took off a year because my father passed away immediately after I had my son…so I was like right… my family needs me, I need to be at home…and what I found with that, because I had started my own private practice a year before I had my son, it took me, another year…. It was like starting again”.

Sarah took eight weeks maternity leave and felt it was a good length of time. She was also a little different from the others in that also felt it was actually helpful for her to come back to the work with clients as it gave her some time for self outside of the demands of home and baby:

Par. 206: **Sarah**: “I think felt that very helpful in me being, in in…taking up the, the kind of therapy again, for myself, also having a space outside of the demands of being present for the baby all the time, they are very, very different things obviously, but I felt it was a good…it was a good kind of combination or something?”.

Linda at times felt that the therapeutic work took away from her time to be the good enough mother to her baby:

Par. 17: **Linda**: “There were times in the pregnancy where I suppose personally you would feel that I wished I had more time for myself to connect with the pregnancy. You know because…it’s busy and you spend a lot of your time focussing on other people”.

Sarah wondered if what her baby heard in the room had any effect on its development:
Par. 77: **Sarah:** I wonder if it has any effect on my daughter for instant [laughing], [ ] I often noticed that when I was working she was very quiet so there wasn’t that kind of moving around which I always find very interesting [laughing]… Whether she was listening or asleep or what you know but there wasn’t that kind of you know near the end, you are being bashed around the place, always very quiet… so… I don’t know [laughing].

It sounds like the therapist is concerned, or feeling some guilt about having her baby in an environment that may be hostile or unsuitable for her baby and wonders if it might have any effects on the child’s further development.

Kathy was especially anxious when there was uncertainty around her foetus well-being, her guilt and worry about what the client can do to the baby is more evident in the text:

Par. 91: **Kathy:** “There was quite a lot of anxiety in the early stages of my pregnancy and that really affected me in how I was in the process with clients because I had a desire to take my belly off and leave it with the secretary downstairs before I went to work with clients…and it was because they could change it, take it, hurt it very different…so it was less about the client but more about me protecting my baby”.

The therapists also commented about how clients perceived them to be the perfect mother to their baby but how in reality they struggled with motherhood:

Par 154: **Linda:** “[ ] She saw that I was going to be so calm and earth mother. You know, isn't it great for your child… you should see the level of disorganisation I have in my life [laughing]!”

Par 112: **Kathy:** “I tried to explain to her, and I thought it was important to explain to her, that this was work that I couldn’t fall apart… that I was tired, and I wasn’t finding parenthood any easier than she did, but I represented that woman that can do it all”

Par 215: **Sarah:** “It really separates mother in reality… from how perhaps your patients set you up as mother, you really you really kind off get the idea of eh, the transference being nothing to do with you in a sense of who you are in reality because you have these two very different eh… worlds”

In conclusion this theme illustrates the conflict therapists have in finding the balance between being good enough for their baby and for their client. The unborn baby and the client are both in the room intruding on each other’s space and both seeking attention from their literal or figurative mother. This also raises issues around the therapist’s self-care and attention to her own physical needs.
4.3 Theme C: Pregnancy as Catalyst: Transference and countertransference

All therapists recognised their pregnancy impacted on their work with clients, which was at times facilitating and other times disruptive depending on the client and the therapist’s own awareness of the transference/countertransference relationship.

Sarah explained the reason pregnancy provokes transference reactions within clients:

Par. 173 **Sarah:** “The body of the woman, the body of the mother is bang in the room [laughing] with the patient which is going to provoke a lot of anxiety”.

Both Sarah and Linda experienced more reactions from female clients centred on themes of abandonment, jealousy and loss and also some strong negative transference. Kathy on the other hand noticed reactions from female and male clients. She argued that all the reactions from females were around loss, where with men it depending on their age - younger men saw her as a more motherly, for older men she became more sexualised.

The therapist’s countertransference responses were different depending on: the client, their therapeutic approach, and/or whether it was their first or second pregnancy.

All therapists said that it was harder to work with negative transference on the first pregnancy because of their own anxiety. The following three subordinate themes will be further explored:

1. Negative transference
2. Loss
3. Reactions from male clients
4.3.1 Negative Transference

One of Linda’s clients developed a strong negative reaction to her first pregnancy. The client, an older lady that lost her adopted young adult daughter to drugs, came for bereavement counselling. When Linda was late into her pregnancy the lady started telling her stories about babies that died before birth:

Par. 90: **Linda:** “In the end when she’d be putting on her coat and getting ready to leave the room she'd say, wait till I’ll tell you something... And inevitably it would be that when someone she knew when she was pregnant and got to nine months and the baby didn't make it….and all sorts of things…”

Linda in the countertransference felt “horrible” and that it “was really hard to listen to”. The first time it happened she was “holding [her] stomach waiting for movement”. Linda explained that her own reaction was so strong because it was her first pregnancy and also because she was at that time “in and out hospital with scares”. Linda, working with her supervisor, became aware of her change in attitude to her client:

Par. 98: **Linda:** “It also made me have a reaction to her, that I had to work with through in supervision in terms of… you know, part of me didn’t like her that much for doing that [laughing…] She was a frail elderly woman who had been through really tough times. Suddenly she had this sharp edge to her”.

Linda’s laughter may indicate that she is uncomfortable admitting her own negative feelings towards the client, but she is identifying the benefit of being able to work it through in supervision. The negative transference from the client and the countertransference reaction from the therapist impacted the therapeutic relationship in both a facilitating and a disruptive way:

Par. 103 **Linda:** “[ ] In one sense it took some of her frailty away…. It made me be able to challenge her harder than I was, em, which I am not sure was such a bad thing...in terms of my approach may have got a little tougher with her [ ] it meant that she had to talk about her relationship with her daughter and some parts of her story were in an accelerated way because I had a bump”.

The client did not come back to therapy after the maternity break; Linda reflected:

Par. 114: **Linda:** “Had I not been pregnant would she have continued to see me? I think she probably would. Had I not been pregnant would we have gone to a lot of the hurtful places for her? I don't know whether I would have brought out a lot without my pregnancy”.

37
So Linda is aware that her pregnancy accelerated the therapeutic relationship as she became more challenging, but maybe Linda challenged the client slightly too much (because “parts of her didn’t like her very much”) and this might have been a contributory factor as to why the client didn’t return.

Sarah also expressed difficulty in working with a client that had strong negative transference: The client became aggressive and felt betrayed by the therapist’s pregnancy. The therapist became a very “maternal figure” to the client, which provoked work around difficulties in relationships with her children, siblings and mother. In this way, the pregnancy was a catalyst for the work around these themes and continues three years later. At another level it was also disruptive as the client said she felt guilty saying certain things because “you are not supposed to say these things to a pregnant lady”.

When Sarah was asked about how she felt in response to the negative transference she said:

Par. 72: **Sarah:** “I think the fact that it happened on my second pregnancy I was a lot more prepared like if it happened on my first pregnancy [laughing] when I hadn’t as much experience either… that I would have found it difficult. But at times I found it difficult”.

Here Sarah expresses her difficulty in a somewhat hesitant way. It was difficult to get a sense of exactly what she felt in the room because Sarah conveyed a strong separation between herself as a person ‘outside’ and as a therapist in the room. For example when asked how she felt in response to hearing “terrible stories about childbirth or losing babies” she said:

Par. 184: **Sarah:** You have to, you have to, listen to the words of your patient…. so afterwards it may kind of you know resonate. And that is when you deal with that, outside the room. But in the room you can’t sit in there with a look of horror on your face… [laughing].

Sarah referred a few times during the interview to the importance of supervision and personal therapy in her ability to not bring in any of her own feelings into the room:

Par. 169: **Sarah:** “So anything that I’m coming out with, in terms of me personally that I would struggle with, I would have that place to speak about it”.

The researcher understood the real value of Sarah’s on-going support in her ability to separate her own reactions from the ones of her clients but did wonder about the viability of really fully separating the person from the therapist.
4.3.2 Loss

Kathy felt that her pregnancy brought up themes of loss for every female client:

Par. 56: **Kathy:** “Well I think to every female client it did because if they had children it was loss because the children were getting older… if they had children and they were even my age you know it was loss because they remember what it felt like being pregnant, so you lost another piece of yourself by not being… and then obviously the clients that hadn’t there was a fear that they couldn’t or they knew they couldn’t… so it was always about loss”.

Kathy in her first pregnancy avoided clear signs of transference reactions from female clients because she was too frightened to work with their loss; she found it difficult to work with loss while she was clearly “gaining”:

Par. 61: **Kathy:** “I think I’m ok with sitting in the shit and the ugly bits with clients… but to feel like you’ve just won the Lotto and you are hearing their sad stories was very difficult”.

She also noted “there were definitely opportunities missed”, with clients because of her avoidance of those issues. She specifically told about her struggles with one client who couldn’t have children:

Pars. 9-25: **Kathy:** “I basically sucked in [ ] I just felt like I was doing it for the client , so my pregnancy wasn’t impacting on her process[ ] and we grieved for her lack of babies, as if I wasn’t pregnant [ ] so it was unfortunate… because she stayed with me to the next pregnancy and the difference was immeasurable …and I felt very sad that I never gave her the chance to voice her rage… so because I was sucking in… she was politely avoiding it too”.

Working on this issue in supervision she said “sucking in” could have been a way to either protect herself or protect the client. She argued that it was mostly about protecting the client, but drawing on other things Kathy said in the interview there could have been a sense of also wanting to protect herself and keeping the perfect image of her first pregnancy.

Sarah also spoke about feeling particularly guilty while she was working with a woman struggling with a series of unsuccessful IVF treatments;

Par. 150: **Sarah:** “There was one there was one em…that that I found, I found it difficult personally, em she, she couldn’t have children… she was going for IVF, and em I was obviously pregnant and em, I found that difficult, I found myself feeling guilty eh

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13 This issue was discussed in more detail in the previous theme (Theme A: Feeling exposed)
because of, and I am wondering I suppose what … was happening for her in it, she never once mentioned the fact that I was pregnant”

Here Sarah sounds very hesitant; there is a sense of uncertainty about her own feelings and the feelings of her client. Interestingly the therapist’s pregnancy was completely ignored by the client. When Sarah said she was going on leave the client responded “Enjoy your holiday!” Sarah felt the client was too defensive around this issue and protected herself by not actually seeing the reality of her therapist’s pregnancy:

Par. 156: **Sarah:** “So there was a complete refusal to acknowledge the fact that I was pregnant and I wasn’t, I felt that it wasn’t my place, because she was obviously very defended… it was an extremely painful for her but she was trying to go through or trying to deal with and, you know, I felt that my saying I am pregnant would be too much… for her it was obvious!”.

Sarah mentioned a few times through the interview that she felt guilty about this client, and while the researcher understands the theoretical rationale for not over challenging the client’s defences, there may also be a question of the therapist also need to protect herself from dealing with this very real situation.

Linda also spoke about how her pregnancy changed the work with a client that was single:

Par. 154: **Linda:** “She was quite guarded … and compartmentalised about what bits of her life that she was here to talk about, and you know, what was on the table and what was off the table… My pregnancy brought more of her questions about her life and future to the room”.

When asked how Linda felt about it she said:

Par. 157: **Linda:** “No, not guilt. I am… No I suppose I would feel that I would have had a connection to the feelings that she was expressing in the room and she was talking about loneliness. You know that’s really what she was talking about, you know, I think we all experience loss and loneliness. And the feeling of being alone and she was connecting with something that was really quite core [ ] for her. It just came in the door… In a very unusual way… and I think that was what she needed”.

Linda didn’t express guilt in this case as she was able to connect with the feelings the client expressed, this can possibly be that the case was different, the client was single but was not actively trying to have children and couldn’t.
4.3.3 Reactions from male clients

Interestingly Kathy was the only therapist who spoke about reactions she experienced from male clients - possibly because she also works with couples so is more attuned to various responses from men. She said that while younger male clients responded to her pregnancy by seeing her as a more motherly figure, her older male clients responded by being more flirtatious and seeing her as more sexualised. She particularly spoke about one client - an older man who had not had a sexual relationship with his wife for eight years and avoided that fact in therapy. But suddenly because she was pregnant “all of a sudden the flirtation started with me and it was easier than to bring up the need for a sexual relationship, or the important of desire”.

When asked how she felt in response she said:

Par. 116  **Linda:** “I suppose I don’t see it as a threat. In fact that I know what I represented and it’s while some of it was real in the relationship, It’s not real in the bigger issues outside of me, so they wouldn’t be attracted to, em, or they may not be attracted to me if they knew all of me, and if they knew that I’m not Oprah, you know [laugh] with all the answers em…”

Here it can be see that Kathy was able to work with the sexual reactions her pregnancy elicited from the client and separate herself as a person.

In conclusion, the first two themes represented the therapists’ countertransference as evolving from their own feelings and the change of status that their pregnancy made in the relationship with clients. However in the last theme the therapists’ reactions were a direct response to their clients’ transference. The importance of their awareness to all the reactions their pregnancy evoked can be clearly seen, as it means they can use them in the work with clients. Such awareness can greatly facilitate the therapeutic process whereas avoiding those issues may be disruptive. Support and supervision has great importance in gaining this awareness.
CHAPTER FIVE: DISCUSSION

This research aimed to gain an understanding of the therapist’s experience of her pregnancy in the therapeutic relationship. To this end, the transcripts of three therapists were analysed using IPA, leading to the development of three superordinate themes around the therapist’s countertransference.

Fallon & Brabender (2003) explain that countertransference issues can be raised by the therapist’s own reaction to her pregnancy or as a result of the client’s transference. The first two themes in the research: ‘feeling exposed’ and ‘the good enough mother’ arise from the therapist’s own reaction to the change her pregnancy brings to the relationship. The final theme ‘pregnancy as a catalyst: transference and countertransference’ however focuses on the therapist’s response to the reactions of her clients.

5.1 Feeling Exposed

The pregnancy reveals aspects about the therapist’s private life which changes the normal interaction between therapist and client. This brings about a wish to keep the pregnancy private, a need to protect the baby and questions regarding self-disclosure. The following table represents a quick summery of the main issues that were found in relation to this theme and will be explored in more detail in the subsequent sections of this broad theme:

<table>
<thead>
<tr>
<th>Summary of issues raised by the Participants</th>
<th>Linda</th>
<th>Kathy</th>
<th>Sarah</th>
<th>In Literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discomfort with the exposure of their private life</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Wanting to keep their pregnancy private from people and/or clients</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Experience of a “switch” in the therapeutic relationship</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Acceptance of switch as a way to show human aspects of therapist</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Wanting to protect the unborn baby</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Issues around how much to disclose to clients</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Disclosing very little</td>
<td></td>
<td></td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Disclosing a lot</td>
<td></td>
<td></td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Disclosing too late/too early</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance of pregnancy in therapeutic relationship</td>
<td></td>
<td>√</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Issues more prominent in the first pregnancy</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

*Table 3: Feeling Exposed – summary of main issues*
5.1.1 Discomfort with exposure

All three participants in this research felt discomfort with the exposure of their private lives and the “switch” it caused in the therapeutic relationship. This very much matches descriptions in the literature about the therapist’s discomfort with her private condition turning into “public property” in the therapeutic space (Fallon & Brabender, 2003; Friedman, 1993; Fenster et al., 1986; McGarty, 1988).

There are a number of possible reasons for this discomfort:

- The exposure of the pregnancy brings the focus of the therapist’s gender and reveals the fact she has been sexually active (McGarty 1988). This reason was not directly identified by any of the participants in the research.
- The client or the outside world may seem to intrude on the mothers’ phantasy of being in complete symbiotic relationship with her baby (Dyson and King, 2007). This could be seen in Sarah’s and Linda’s wish to be left alone and not be touched or given advice from people in general.
- It changes the normal balance between therapist and client, as therapists normally try to maintain anonymity in the therapeutic space (Ulman, 2001). This issue was expressed by all the participants in the research.

It may be particularly difficult for those who work analytically and try to maintain a “blank screen stance” (Fallon & Brabender, 2003), to deal with this exposure of their private lives. Sarah who works analytically discussed the need to stay in her position and not let the reality aspect of her pregnancy interfere with the transference and discussed clients’ desire to become more personal and “bypass therapy”. The literature tends to disagree with this position by arguing that pregnancy becomes clearly visible and is a reality that cannot be avoided in the relationship (Friedman, 1993). Ulman (2001) claims that “the exposure introduces into the therapy a moment of human sharing of vulnerability that has the potential to enrich the treatment”.
5.1.2 Self-disclosure

The participants’ reported desire to keep their pregnancy private, raised questions around when and how much to disclose to clients. Each therapist behaved differently, and also exhibited differences in behaviour between first and second pregnancies. This is reflected in the literature particularly in Uyehara et al., (1995) who dedicated their paper to the topic of self-disclosure. In most of the literature there seem to be a recommendation to tell clients about the pregnancy sometime around the second trimester while preferably waiting for conscious or unconscious recognition of the pregnancy from clients (Uyehara et al., 1995; Fallon & Brabender, 2003; Fenster et al., 1986). This reflects the decision to disclose the pregnancy by two participants – Kathy and Linda. Sarah on the other hand represents a minority view in this research and in the literature in that she never actually told clients she was pregnant, but was however very open to working with the transference reactions her pregnancy brought up for clients. Bassen (1988) though still recommending telling clients about the pregnancy reflects this point of view by saying that directing the clients attention to the pregnancy is actually a way of avoiding the impact of their pregnancy on the transference countertransference reactions. She found that therapists who told about their pregnancy too early worked less productively with the transference, and their pregnancy was seen as more disruptive then facilitating.

Uyehara et al., (1995) found that in many cases the therapist’s own countertransference may interfere with the decision of when to tell clients. This is demonstrated by Linda who told clients late in her first pregnancy as she wanted to protect her own privacy and told clients very early on the second pregnancy as she wanted to be organised. Kathy also behaved differently with her two pregnancies; with her first while disclosing it in the real relationship she completely avoided it in the transference relationship while with her second she was open to work with the transference but in hindsight felt she actually shared too much with clients.
Fallon & Brabender (2003) discuss reasons why therapists may disclose too much or too little to their clients: Disclosing too much information can be due to the therapists own excitement, her desire to gain sympathy in order deflect anger from clients, or to avoid the guilt about having something clients don’t have. Kathy often discussed her difficulty in working with clients’ loss when she was clearly so happy and that might be the reason why she shared too much with clients in her second pregnancy. She explained that in some way her pregnancy became a joyful event for clients in the room but once the baby was born they were no longer a part of it. A very similar scenario is described in Fallon & Brabender (2003).

Disclosing too little information can be due to the therapists desire to deny the impact pregnancy has on herself and the therapeutic space, a wish to protect the baby\textsuperscript{14}, or her discomfort with the exposure. Kathy during the first few months of her second pregnancy expressed the wish to leave her “belly” outside the therapy room in order to protect the baby from the client.

\textsuperscript{14} The issue of denial of the impact pregnancy has on the relationship and the wish to protect the baby will be further discussed under the next theme.
5.2 The Good Enough Mother

Both the client and the baby wish to see the mother/therapist as the perfect all-providing mother. In the most primitive phantasy they both wish to be in complete state of symbiosis with the mother/therapist. But with the therapist’s pregnancy the baby and the client intrude on each other’s space (Dyson and King, 2007). Winnicott (1965) explains that the mother/therapist have to provide a “good enough” environment for the baby/client to feel secure and develop to its best potential. But how can the therapist/mother find the right balance between being good enough for both and at the same time consider her own physical needs (Nadelson et al., 1974)?

All the participants in this research demonstrated a struggle in this area. The following table represents a brief summary of the main issues that were found in relation to this and will be explored in more detail in the subsequent broad sections of this theme.

<table>
<thead>
<tr>
<th>Summary of issues raised by the Participants</th>
<th>Linda</th>
<th>Kathy</th>
<th>Sarah</th>
<th>In Literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict around the need to be good enough for client and baby</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Pressure on self to do the best for clients while ignoring some of own physical needs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Clients terminating as a result of the pregnancy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Reactions of jealousy and abandonment from clients</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Taking a short maternity break to not disrupt client work</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Satisfaction with being back at work as a way to get a break from baby’s demands</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Disruption of maternity break on client work</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Worry/guilt about the baby’s well-being</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Wanting more time with baby</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Clients perceiving therapist as the perfect mother for their baby</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Table 4: The Good Enough Mother- summary of main issues
5.2.1 Being a “tough task master” on oneself

The therapists interviewed seemed to be putting pressure on themselves to do the best they could for clients while at time ignoring some of their own physical needs.

None of the therapists changed their work load as a result of their pregnancy and while all expressed different physical issues such as feeling sick, having back problems (Linda), sciatica and difficulty talking towards the end (Sarah), feeling sick (Kathy), they all insisted that it did not disrupt their work in any way. Fallon & Brabender (2003) found that it is common, particularly for first time mothers, to deny that their physical state has implications for their work. This could be a way of managing the crisis of integration of the maternal and professional roles by denying the impact pregnancy has on the therapeutic encounter. It might also be an attempt to deny the guilt and anxiety they feel about doing an inadequate job both at home and in the work with clients (Uyehara et al., 1995). Anderson (1994) emphasises the importance for the therapist to recognise she is not ‘superwoman’ and that her physical and emotional state may require her to change her work.

5.2.2 Maternity Leave/Endings

Fenster et al., (1986) refer to the “nesting behaviour” woman experience towards the end of their pregnancy and a mirroring process that occurs for therapists as they try to reach closure with clients before they go on maternity break. With Linda this behaviour was very evident as she worked really hard to “package up a goodbye” for each client. Interestingly however, many clients did not come to the very last session and did not return after the break. Dyson and King (2007) argue that the therapist may unconsciously wish to get rid of clients whose demands may be distracting her from her preoccupation with her baby. It’s possible that Linda worked hard to reach closure with her clients because she was so excited to be finishing work and have time with her baby and her clients may have gotten a sense of that.

Bassen (1988) spoke of the therapist’s guilt about taking maternity leave and disrupting client work. All the participants were in favour of taking a short maternity break so as to cause little disruption and Linda and Kathy discussed the conflict of leaving their baby at home. Balsam (1974) refers to the
need to be back at work as an intrusion on the “mother-child symbiotic dyad”. She explains that first-time mothers in particular may feel they want to spend more time at home after the birth and if the therapist’s desire to stay with her baby diminishes her emotional availability she should reassess her return to work (Fallon & Brabender, 2003). This is evident in this research with Linda who felt she needed to stay at home longer and took a year off with her first baby but felt the financial and practical side effects it had on her private practice. Sarah described a different perspective saying that in some ways it was good to be back at work away from the demands of the baby. Fallon & Brabender (2003) explain that this may cause guilt for the new mother that she is leaving her baby behind while enjoying her work. Feelings of guilt may also be directed towards the client if the therapist feels she is not as flexible as she was prior the birth of her baby.

5.2.3 Worry about the baby’s well-being

It is evident in the literature that many therapists worry about the well-being of their foetus, and feel the need to protect it, particularly in reaction to negative and aggressive transference from clients (Bienen, 1990; Imber, 1990; Etchegoyen, 1993; Fenster et al., 1986; Fallon & Brabender 2003). This research yielded similar results with the therapists expressing their concern about what the baby heard in the room: (Sarah), wanting to leave the baby out of the room because the client can hurt it, (Kathy) and waiting for movement from the baby to see he is ok (Linda). Dyson and King (2007) found that therapists feel more vulnerable about their baby particularly when there are concerns about the baby’s health, and this was evident in the transcripts of both Linda and Kathy. Therapists may try to avoid strong negative transference because of their wish to protect their baby (Bassen, 1988; Bienen, 1990; Imber, 1990; Nadelson et al, 1974) and both Linda and Kathy expressed difficulty with working with strong negative transference. Sarah seemed to be most prepared to work with her clients’ aggression as she felt extremely supported in her personal therapy and supervision.
5.2.4 Client’s reactions to the therapist as the perfect mother

Clients can present various transference reactions to the therapist such as envy, jealousy, feelings of abandonment, (Bassen, 1988; Fenster et al., 1986; Fallon & Brabender 2003) and this was particularly evident in the transcripts of all the participants in this project. Interestingly all the therapists also mentioned how the clients perceived them to be the perfect mother for their new baby. Fallon & Brabender (2003) stress the importance of exploring these expressions of idealisation as they most likely cover up the client’s rage about the therapist’s abandonment of them.
5.3 Pregnancy as a Catalyst: Transference and Countertransference

Pregnancy acts like a catalyst to transference material from clients and a countertransference response from the therapist; it may elicit new material or deepen the work. This can be facilitating or disruptive of the work, depending on the client, the therapist’s style and her awareness of the transference and countertransference relationship. This was highly evident in most of the literature (Bassen, 1988; Dyson and King, 2007; 1988; Fenster et al., 1986; Fallon & Brabender 2003; Lax, 1969) and in all the participants’ transcripts.

The following table summarises the issues emerging in this theme and will be explored in more detail in the subsequent broad sections of this theme.

<table>
<thead>
<tr>
<th>Summary of issues raised by the Participants</th>
<th>Linda</th>
<th>Kathy</th>
<th>Sarah</th>
<th>In Literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy as a catalyst to transference</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Pregnancy both disruptive and fascinating of client work</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>More reactions from female clients</td>
<td>√</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Reactions from male around sexuality</td>
<td></td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Reactions from younger male – motherly figure</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All reactions from female – Loss</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Therapist difficulty working with negative transference</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Therapist guilt/ difficulty working with loss/ particularly clients that cannot have children</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Separation between therapist role and personal life (?)</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Avoidance of pregnancy in therapeutic relationship</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Table 5: Pregnancy as A Catalyst: Summary of main issues*
5.3.1 Negative Transference

Both Linda and Sarah spoke about clients presenting with strong negative transference and aggressive reaction to their pregnancy. Stories about babies dying were prominent in both transcripts and are a common phenomenon in the literature. Fuller (1985) explains it as acts of hostility towards the therapist/baby which masks an unconscious phantasy for the baby’s or therapist’s death, and asserts the importance of exploring them with clients. However, many therapists tend to avoid dealing with the negative transference reactions as a way of protecting themselves and their baby or of denying the impact their pregnancy has on the therapeutic process (Bassen, 1988; Bienen, 1990; Imber, 1990; Nadelson et al, 1974). It is important to explore these issues in supervision as avoiding them may result in premature client termination.

Kathy clearly avoided clients’ reactions to her first pregnancy in order to protect clients and to maintain a perfect image of her pregnancy and imminent motherhood. However, contrary to the literature, all of her clients came back after the break. She explained this by saying that the clients had been with her for a long time and were able to express their pain when she came back from the break. Sarah, though admitting it was difficult, seemed very capable of dealing with negative transference and even more so during her second pregnancy - with the important aid of supervision. Linda felt she was more able to challenge her client in reaction to those signs of aggression but there was a sense that she still found it difficult, and possibly challenged the client too much which might have been the reason for the client’s termination of therapy.

While the literature states that therapists try to avoid awareness of transference and countertransference reactions particularly regarding negative reactions (Fallon & Brabender, 2003) the research showed a greater willingness on the part of the participants to work with transference and countertransference reactions. Only one participant (Kathy) clearly stated she avoided awareness of client’s reactions, and only during her first pregnancy. The other two participants (Linda and Sarah), and Kathy on her second pregnancy, while encountering difficulties with regard to some very difficult clients were generally open to working with the various dynamics their pregnancies evoked. All the participants expressed the importance of good supervision as support in the process.


5.3.2 Loss

All the therapists particularly emphasised the difficulty of working with clients who didn’t or couldn’t have children; a scenario also addressed in the literature. Bassen (1988) found that therapists felt guilty about having something to be envied, and tried to hide their pregnancy not only in order to protect these clients, but also to protect themselves from their rage. This coincides with Kathy’s difficulty in working with loss while she was clearly gaining and her wish to “suck in” her pregnancy especially when working with a woman who couldn’t have children. Interestingly, the woman who did remain a client got a chance to express her envy and rage during Kathy’s second pregnancy.

Sarah also felt particularly guilty working with a woman who had been through IVF treatments and Sarah’s pregnancy was completely ignored in the relationship. She explained that the woman was too defended to recognise the pregnancy. Uyehara et al. (1995) mention cases where discussing the pregnancy should be avoided with particular clients, but that in such cases it should be clearly explored that this is done to protect the client and not the therapist’s sense of guilt.

5.3.3 Reactions from Male Clients

Only one participant (Kathy) discussed reactions from male clients. She found that particularly for older men that she became more sexualised. This also coincides with the literature; Fallon & Brabender (2003) found that only a few therapists reported reactions from men with a particular sexual content. This small number can possibly be explained by therapists’ discomfort with the issue of sexuality thus causing them to neglect exploration of subtle transference displays (McGarty, 1988). Furthermore, therapists may be particularly uncomfortable in exploring erotic transference while they are pregnant due to cultural views around motherhood and sexuality (Cullen-Drill, 1994).
5.4 Conclusions

There is a high correlation between the findings of this research and the reviewed literature. All three therapists found that their pregnancy impacted on themselves, the client and the therapeutic relationship in both facilitating and disruptive ways. Their pregnancy raised new countertransference issues; some emerging from their own physical and emotional changes, some in relation to the change of balance in the therapeutic relationship, and some as a direct reaction to clients’ transference.

The therapists seemed to particularly struggle with the exposure of their private lives and the change of balance in the therapeutic relationship because these two issues raised questions about how much the therapist should reveal about herself as a real person in the room. Two participants argued that revealing aspects about themselves facilitated the relationship as they were able to relate to the human aspect of the therapist and one participant argued that the revelation of the therapist as a real person might influence the therapeutic process and thus interfere with the transference.

Therapists also seem to struggle with the fact that both their clients and their baby intrude on each other’s space and faced the question of how they might provide “good enough” environments for both. This in turn raised issues around maternity leave, the need to protect the baby and the need to be available for the client while paying attention to the therapist’s own physical needs.

Other countertransference reactions emerged directly as a result of the client’s transference. The therapists found it difficult to deal with strong negative reactions of envy, anger, abandonment and loss, and while in some scenarios they avoided working with these reactions, in many other scenarios they did explore the clients’ reactions, which proved to be extremely beneficial to the work.

This research shows the importance of the therapist’s awareness of the conflicts and changes her pregnancy can bring into the therapeutic relationship and working through these conflicts means she is better able to deal with clients’ reactions and can use her pregnancy to deepen the therapeutic process.
5.5 Recommendations

A number of recommendations crystallised both from the literature and the findings of this research\textsuperscript{15}:

1. Awareness of the impact the pregnancy can have on the therapeutic relationship and willingness to work with it in the room
2. The importance of good supervision and support particularly in exploring countertransference issues therapists may avoid
3. Attention to her own physical and emotional needs and realisation she is not superwoman

5.6 Limitations

The interviews yielded a lot of good data including a number of themes that were not included in this project because of a restriction in word count.

Therapists may be very defendant regarding exploration of countertransference issues particularly those which evolved in their own childhood conflicts. The one hour interviews did not provide enough time to truly dig in deep to this material.

The sample selected was not entirely homogenous, the therapist were practicing different approaches to psychotherapy which may have contributed to some additional differences in their views. Furthermore the researcher herself was trained in a humanistic integrative approach which impacted on her interpretations - particularly of the analytic point of view.

The researcher was also pregnant while seeing clients and was not entirely objective in the analysis process.

\textsuperscript{15} This is a summary of the most important points relevant to this particular research, a wider list of recommendations can be found in Fallon & Brabender (2003 pp. 83-91)
5.7 Further research

This research has focussed on the experience of the pregnant therapist and how she perceived it impacted on the therapeutic relationship. While more difficult, it would be very interesting to research this aspect further by also interviewing clients and hearing their perspective.

Another aspect which this research only touched on would be to explore the effects new motherhood has on the therapist and the therapeutic relationship.
REFERENCES


Harper, D. & Thompson A.R. (2012) *Qualitative research methods in mental helath and psychotherapy, a guide for students and practitioners* UK: John Wiley & Sons Ltd.


Appendices
APPENDIX A

DEMOGRAPHIC QUESTIONS

Please fill in the information below:

<table>
<thead>
<tr>
<th>Initials:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
</tr>
<tr>
<td>How many years have you been working as a psychotherapist?</td>
</tr>
<tr>
<td>How long have you been accredited? With whom?</td>
</tr>
<tr>
<td>What is your therapeutic approach?</td>
</tr>
<tr>
<td>What is your qualification? (Please circle)</td>
</tr>
<tr>
<td>Number of pregnancies?</td>
</tr>
<tr>
<td>How many pregnancies while you were working as a psychotherapist?</td>
</tr>
<tr>
<td>How many clients per week did you see while you were pregnant?</td>
</tr>
<tr>
<td>How long since your last pregnancy?</td>
</tr>
<tr>
<td>What was the length of your maternity leave? (how much time did you take before and after the birth)</td>
</tr>
<tr>
<td>In general terms what effect do you think your pregnancy had on the therapeutic relationship? (Please circle the most suitable answer)</td>
</tr>
</tbody>
</table>
APPENDIX B

INTERVIEW GUIDE

Impact of pregnancy on the therapeutic relationship

1. Could you tell me a little about your last pregnancy…
   (Prompts- Physically/ emotionally / psychologically)
2. Did your work with clients change as a result of your pregnancy?
   (Prompts- Practical level – maybe less work load/ therapeutic style)
   a. At what stage did you notice that the pregnancy began to impact upon the work?
3. How was the pregnancy disclosed to your clients?
   (Prompts -Did you tell the client/ did they notice themselves/ when and how)

Transference reactions

1. What reactions did you experience from clients in relation to your pregnancy?
   a. Did you notice differences in reactions within your client group i.e. borderline/ male/ female/ other
   b. Did the nature of the work or themes change as a result of the pregnancy?
2. How would you describe your client’s reactions? (Negative/ positive/ both)
3. How did you respond to your client’s reactions in therapy? (explored/ tried to ignore)

Countertransference reactions

1. How did you feel in response to your clients reactions?
   a. Were there any particular reactions from clients that were difficult to deal with?
2. What other feelings (positive and negative) did the pregnancy evoke within you in relation to client work? (countertransference reactions)
   a. How and when did you become aware of your feelings?
   b. What effect did your reactions have on the therapeutic relationship?
      (Prompt - hindered/ facilitated/ no effect)
3. Did you experience a difference in your reactions/ feelings across the three trimesters?
4. Some therapists noticed that their reactions were somewhat related to their own childhood conflicts can you see any link?
   (for example- feelings of guilt towards clients resulted in sibling rivalry conflicts)
5. Were there any specific reactions from yourself/ clients around taking a break/ ending?
6. How long was your maternity leave and did it have any impact on your relationship with clients?

Supervision and support

1. Did you get any support as a pregnant therapist?
   (Prompt - from colleagues/ personal therapy/ supervision)
2. How did you find supervision in particular?
   (Prompt - supportive/ not supportive/ indifferent)
3. What advice would you give other pregnant therapists?

General

1. In general terms do you think your pregnancy had a facilitating, disruptive or no effect at all on the therapeutic relationship?
2. Do you think that being pregnant/ becoming a mother impacted upon how you work as a therapist after the birth? Has it changed your relationship to the work?
3. Is there anything else you would like to add that you feel is important to his subject?
My name is Ranite Hacham-Lynch and I am currently undertaking a BA in Counselling and Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which is concerned with the impact of the therapist’s pregnancy on the therapeutic relationship.

What is Involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) ________________________________

Signature _________________________________________________________

Date   /   /
APPENDIX D
CONSENT FORM

Protocol Title:

An exploration of the therapist’s pregnancy and its impact on the therapeutic relationship

Please tick the appropriate answer.

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

☐ Yes ☐ No

I understand that my participation in this study is entirely voluntary and that I may withdraw at any time, without giving reason.

☐ Yes ☐ No

I understand that my identity will remain confidential at all times.

☐ Yes ☐ No

I am aware of the potential risks of this research study.

☐ Yes ☐ No

I am aware that audio recordings will be made of sessions

☐ Yes ☐ No

I have been given a copy of the Information Leaflet and this Consent form for my records.

☐ Yes ☐ No

Participant ___________________ __________________________
Signature and dated Name in block capitals

To be completed by the Principal Investigator or his nominee.

I the undersigned, have taken the time to fully explained to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/her to ask questions on any aspect of the study that concerned them.

__________________________ ____________________________
Signature Name in Block Capitals Date
## APPENDIX E
### SAMPLE ANALYSIS

<table>
<thead>
<tr>
<th>Line no.</th>
<th>Original transcript</th>
<th>Close line by line analysis</th>
<th>My thoughts</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>162</td>
<td>Em... yeah (pause) I think as well, em... I think that endings were less structured then I would have been generally in my work around the time when I was finishing up to go on maternity leave. I suppose I would be quite structured about organizing endings sessions kind of neatly packaging up a goodbye do you know or a and so long for now or a transfer meeting or whatever, things like that...</td>
<td>Endings- less structured I would be quite structured- neatly packaging up a goodbye</td>
<td>wanted to neatly package it for herself - know for self that clients are ok so she wouldn’t feel bad for taking a break for self</td>
<td>endings self/client taking a break guilt good enough mother</td>
</tr>
<tr>
<td>163</td>
<td>But what I would say compared to other times in my work, finishing up for maternity leave was messy...</td>
<td>messy compared to other times</td>
<td>Messy interesting word, everything for her is always structured so messy is probably quite bad</td>
<td></td>
</tr>
<tr>
<td>164</td>
<td>So you are saying that the finishing up for maternity leave would be more messy than normal endings that you do?</td>
<td>More messy then normal?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>165</td>
<td>Yeah yeah yeah, and nearly that, I am not sure, it’s a sense I have...but nearly that rather than me leaving some of my clients they chose just not to continue ....</td>
<td>Rather then me leaving some of them chose not to continue</td>
<td>big words - chose not to continue - couldn’t face the fact she was leaving, clients didn’t want to make an ending that is neatly packaged</td>
<td>Endings Client reactions</td>
</tr>
<tr>
<td>166</td>
<td>So maybe there was a sense that you didn’t want to feel that you are ending with the clients. Could that be a reason or ?</td>
<td>Is it you not wanting to feel real ending?</td>
<td>Trying to understand is it about her or the client?</td>
<td></td>
</tr>
<tr>
<td>167</td>
<td>No no no, if it was me... I would be very structured in ending in some way of having some kind of a full stop or a comma... (laughing)</td>
<td>No no no very structured in ending a full stop or a comma</td>
<td>Her desire was be very structured for self, feel that she can put a full stop or comma so she can now concentrate to own life</td>
<td>Endings Good enough mother</td>
</tr>
<tr>
<td>168</td>
<td>But maybe you felt that that wasn’t really an ending. Or you didn’t want it to be a real ending?</td>
<td>Did you not want to end?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>169</td>
<td>For me it brings me back to the postcard from my client because for a few people they just disappeared! ... Do you know, after many many months of positive good work when it came to actually doing: “right this is what we’ve done and this is where we have gotten to” ”where do we go from here” what does the future hold” and that kind of stuff...they didn’t come in...(voice becomes quitter)</td>
<td>a few people just disappeared many months of positive work wanting to summarise they didn’t come in</td>
<td>she sounds hurt by the fact they didn’t come in after all the good work they did together disappointed she didn’t get closure for self seems like the client didn’t want this closure she wanted</td>
<td>endings taking a break clients reactions therapist need</td>
</tr>
<tr>
<td>170</td>
<td>They didn’t wait for the very last session?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>171</td>
<td>No! yeah...</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>172</td>
<td>Wow!</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>173</td>
<td>Not all of them but some of them Some of them didn’t.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Line no.</td>
<td>Original transcript</td>
<td>Close line by line analysis</td>
<td>My thoughts</td>
<td>Theme</td>
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<tr>
<td>174</td>
<td>Cause they knew you were going on maternity leave. And maybe they couldn’t handle it or something. Or they were angry?</td>
<td>Were they angry?</td>
<td>Am I asking too much of a direct question…</td>
<td>endings taking a break clients avoiding anger? Therapist avoiding clients anger Wanting to be good enough</td>
</tr>
<tr>
<td>175</td>
<td>Yeah or... Maybe ... Or they didn’t need to do that ending piece the way that I had a need to... obviously box things off when I finish things... But obviously they didn’t have a need to (sounds a little confused or angry...) ... Do you know...</td>
<td>no It was my need to box things off maybe they didn’t need that</td>
<td>Some hesitance in words Yeah / or / maybe Confusing - why didn’t the need that? She is really rejecting my suggestion of anger, not wanting to see the possibility To me it does sound like some sense of feeling abandoned or angry as why else they just wouldn’t turn up to the very last session</td>
<td></td>
</tr>
<tr>
<td>176</td>
<td>Whereas they would come in to the last therapeutic session as such and I would say “well look our next session is going to be our last. We’ll be looking at what was valuable and where do I go from here, and is there something else you need from me...</td>
<td>come in for last therapy session but didn’t come for wrap up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>177</td>
<td>And they didn’t come in? Wow... And that wouldn’t happen to you in other endings with clients.</td>
<td>Happened before?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>178</td>
<td>No, No No...</td>
<td>No</td>
<td>Only happened when she was pregnant, then must be something to do with the pregnancy, the fact they maybe felt they were forced to finish</td>
<td></td>
</tr>
<tr>
<td>179</td>
<td>So that is interesting.</td>
<td>happened in both pregnancies</td>
<td>Interesting again happened in both pregnancies- must be related to it</td>
<td></td>
</tr>
<tr>
<td>180</td>
<td>In both of my pregnancies I noticed that...</td>
<td></td>
<td></td>
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<tr>
<td>181</td>
<td>Is there something they didn’t say or was there some anger or something... I wonder ?</td>
<td>Anger?</td>
<td>I am asking again about the anger</td>
<td>endings taking a break clients avoiding anger? Therapist avoiding clients anger Wanting to be good enough</td>
</tr>
<tr>
<td>182</td>
<td>Yeah could have been...or it’s different... you are not saying our work is complete ... You are saying I am leaving my work...</td>
<td>Yeah could have been you are not saying our work is complete You are saying I am leaving my work...</td>
<td>she is leaving them before work is complete so they chose to leave her and not give her the benefit of this warp up some guilt from therapist?</td>
<td></td>
</tr>
<tr>
<td>183</td>
<td>Yeah...And that’s hard cause it’s kind of an ending that was forced on the two of you, you know... It’s not that it came to a natural end and it is natural to come and try to finish it and package it... But maybe in this case it can’t be packaged because it is not the end.</td>
<td>Forced ending - cant be packaged?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>184</td>
<td>Yeah yeah, Exactly, exactly. So... there is something in that. You know I would wonder and I don’t know if you were doing the other side of it. Of what do clients think... but I would wonder whether clients think about whether or not you have their full attention on the last...</td>
<td>I wonder what clients think or not you have their full attention on the last...</td>
<td>Not sure did clients feel they didn’t have her full attention? Maybe she felt herself she couldn’t give them her full attention and tried hard to package up a goodbye to compensate...</td>
<td>clients reactions endings Goof enough</td>
</tr>
<tr>
<td>Line no.</td>
<td>Original transcript</td>
<td>Close line by line analysis</td>
<td>My thoughts</td>
<td>Theme</td>
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<tr>
<td>186</td>
<td>Do you know I would wonder what their feedback would be... because... it is obvious that you have many balls up in the air...sort of speak (laughing)</td>
<td>it is obvious that Many balls up in the air...</td>
<td>It was difficult for her She was trying to juggle between a lot of things</td>
<td></td>
</tr>
<tr>
<td>187</td>
<td>And did you ever feel that from any clients that you were kind of feeling that you are not</td>
<td>Felt pressure in self - not from clients I think it comes with the territory of being a therapist I would put myself under some pressure but I don’t think I felt that from any of my clients...</td>
<td>put the pressure on self to be perfect Didn’t feel it from clients</td>
<td>good enough mother for clients pressure on self</td>
</tr>
<tr>
<td>188</td>
<td>No, no, no I probably would have felt it in myself. I probably would have given myself, put myself under a lot of pressure to do that extra bit for people before I finished up... do you know... I think it comes with the territory of being a therapist...wanting to do the best you can for clients. But yeah I would put myself under some pressure but I don’t think I felt that from any of my clients...</td>
<td>They feel they are winding down therapist... unsure - in one hand clear signs winding down, wanting to take a break neatly package everything and forget about clients, but in another level feels bad about these feelings and putting self under pressure to not feel that</td>
<td>good enough mother for clients pressure on self Therapist reactions</td>
<td></td>
</tr>
<tr>
<td>189</td>
<td>But I would wonder em.. you know (pause) it’s like anybody finishing up with a job... they are winding down... so They feel they are winding down therapist...</td>
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</tbody>
</table>
### APPENDIX F

#### MASTER TABLE OF THEMES

<table>
<thead>
<tr>
<th>Theme</th>
<th>Key ideas</th>
<th>Lin</th>
<th>Sar</th>
<th>Kat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling exposed</td>
<td>• Boundaries</td>
<td>33</td>
<td>91</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>• Touching</td>
<td>123</td>
<td>136</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Not wanting to tell</td>
<td>136</td>
<td>130</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>• Advice giving</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Changes balance between therapist and client</td>
<td></td>
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<tr>
<td></td>
<td>• Makes therapist more human</td>
<td></td>
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<tr>
<td></td>
<td>• Having sex</td>
<td></td>
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<tr>
<td></td>
<td>• Reality</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Therapist not expert, has life struggles as well</td>
<td></td>
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<tr>
<td></td>
<td>• Psychoanalytic view- not bring therapist in real way as disrupts with transference</td>
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<tr>
<td></td>
<td>• Protective around first pregnancy</td>
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<td></td>
<td>• Joke around it but only to the point I was comfortable</td>
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<td></td>
<td>• Protective second pregnancy because of scare</td>
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<tr>
<td></td>
<td>• First pregnancy wanted the image of being perfect so couldn’t bring in to the room</td>
<td></td>
<td></td>
<td>118-126</td>
</tr>
<tr>
<td></td>
<td>• Not brining self in a personal capacity into the room so to allow transference, distinction between therapy and outside world</td>
<td></td>
<td></td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>For baby</td>
<td>10-12</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Wanting to protect baby</td>
<td>54</td>
<td></td>
<td>91-95</td>
</tr>
<tr>
<td></td>
<td>• Leave it outside of the room</td>
<td>79</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Time to connect with baby</td>
<td>89</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Good to be busy way of avoiding struggles with baby</td>
<td>31</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Maternity leave- length</td>
<td>77</td>
<td></td>
<td>206</td>
</tr>
<tr>
<td></td>
<td>• Crying when back from leave</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Worrying about baby</td>
<td>17-27</td>
<td></td>
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<tr>
<td></td>
<td>For client</td>
<td></td>
<td>54-70</td>
<td>181</td>
</tr>
<tr>
<td></td>
<td>• Giving yourself to someone else</td>
<td>67</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• High expectations from self regarding organising things for clients</td>
<td>77</td>
<td></td>
<td>36-40</td>
</tr>
<tr>
<td></td>
<td>• Maternity leave how long</td>
<td></td>
<td>78</td>
<td>164</td>
</tr>
<tr>
<td></td>
<td>• Knowing therapist has a baby at home</td>
<td></td>
<td>209-215</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Wanting to look perfect in the pregnancy as if its all easy?</td>
<td></td>
<td></td>
<td>122</td>
</tr>
<tr>
<td>Avoidance of issues that come up as a result of pregnancy</td>
<td>• I avoided it</td>
<td></td>
<td>5-30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• “Difference immeasurable”</td>
<td></td>
<td>23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Telling about preg Kathy first - not inviting, second inviting inquiry</td>
<td></td>
<td>103</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• First preg – wanted the image of being perfect so couldn’t bring in into the room with clients</td>
<td></td>
<td></td>
<td>118-126</td>
</tr>
<tr>
<td></td>
<td>• Importance of awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theme</td>
<td>Key ideas</td>
<td>Lin</td>
<td>Sar</td>
<td>Kat</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
</tbody>
</table>
| Working with the transference             | • Strong negative reaction from client  
• How did therapist handle it  
• Disruptive/ facilitating?  
• When working with negative transference it can deepen the work  
• Male transference/ sexuality/ motherly  
• Couples reactions to return from leave  
• Client dumping negative feelings of hating her child, hating his need, chaos if she said it on my first I would have frightened but in my second I could hear it | 82-117 | 38-56 | 135  |
|                                           |                                                                                                                                                                                                            | 72   | 77    | 181-187 |
|                                           |                                                                                                                                                                                                            | 135  | 48-50 | 109  |
|                                           |                                                                                                                                                                                                            | 181-187 | 155-161 |
|                                           |                                                                                                                                                                                                            | 112-117 | 112-117 |
|                                           |                                                                                                                                                                                                            | 131-132 | 131-132 |
| Pregnancy catalyst to work                | • Client had to talk about hurtful things because I had a bump  
• Client came for complex family issues very contemporised about what we can talk about or not but suddenly other issues came into the room pregnancy brought her to talk about being single  
• Therapist feeling well, summer baby, happy – positive about it – felt came in to the room much less even to the point that clients forgot about it  
• Use pregnancy as when to end therapy  
• Awareness of pregnancy and reactions it will produce | 116  | 57-63 | 237-241|
|                                           |                                                                                                                                                                                                            | 151-161 | 174  |
|                                           |                                                                                                                                                                                                            | 237-241 | 5-7  |
|                                           |                                                                                                                                                                                                            | 24-29 | 105- |
| Loss/ gain                                | • Female clients bring up a lot of loss  
• Avoiding themes of loss as a result of her pregnancy because of trying to protect self/ baby  
• Avoiding the loss because trying to protect client  
• Avoiding it because too difficult to deal with  
• Loss/ gain  
• Difficulty, clients trying to conceive  
• Being ok with sitting with loss while you are in a very good place | 155-160 | 139-167 | 9-63 |
<p>|Emergence of themes of loss as a result of the pregnancy |
|Therapist reactions to themes of loss |</p>
<table>
<thead>
<tr>
<th>Theme</th>
<th>Key Ideas</th>
<th>Lin</th>
<th>Sar</th>
<th>Kat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endings</td>
<td>● Therapist anxiety around endings</td>
<td>54-70</td>
<td></td>
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<td></td>
<td>● Endings less structured than normal</td>
<td>162-</td>
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<td></td>
<td>● Therapist tried to be very structured – packaging up a goodbye</td>
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<td></td>
<td>● Messy</td>
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<td></td>
<td>● Rather then me leaving some clients decided not to continue</td>
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<td></td>
<td>● People disspread after months of positive work</td>
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<td></td>
<td>● Use of preg when to end therapy</td>
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<tr>
<td>Fantasy about the kind of mother I really am</td>
<td>● Client’s perception of ideal mother to baby</td>
<td>45</td>
<td>209-</td>
<td>105-</td>
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<tr>
<td></td>
<td>● In reality not the perfect mother at all</td>
<td>155</td>
<td>215</td>
<td>109</td>
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<tr>
<td></td>
<td>● Saw me as being calm – you should see the level of disorganisation I have in my life…</td>
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<tr>
<td>Self Care Physical well being</td>
<td>● Do back flips and all sorts of things for clients and they are ok</td>
<td>7-10</td>
<td>16-20</td>
<td>1-7</td>
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<td></td>
<td>● Had sore back – didn’t look after it well when sitting with clients as get lost in their narrative</td>
<td>20</td>
<td>179a</td>
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<td></td>
<td>● How therapist felt physically</td>
<td></td>
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<td></td>
<td>● Tired, back problems</td>
<td></td>
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<td>Financial aspect</td>
<td>● When to take on new work</td>
<td>71a</td>
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<tr>
<td>Telling about pregnancy</td>
<td>● Disclose or not?</td>
<td>32-38</td>
<td>36-41</td>
<td>99-103</td>
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<td></td>
<td>● When?</td>
<td></td>
<td>152</td>
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<td></td>
<td>● Differences between first and second</td>
<td></td>
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<td></td>
<td>● Linda- late on first early on second</td>
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<td>● Kathy- not inviting inquiry on first, very personal and inviting on second</td>
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<td>● Clients have the right to know- makes therapist more human</td>
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<td>● Not telling as to not direct therapy and demand a response from client</td>
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<td>Supervision</td>
<td>● Male supervisor became more protective</td>
<td>110</td>
<td>169-</td>
<td>170</td>
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<td></td>
<td>● Felt safe protected in supervision</td>
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<td>173</td>
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<td></td>
<td>● Importance of being able to analyse what she felt</td>
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<td>● Importance – using it a s a tool; not feeling judged, able to say certain things</td>
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<td>228-</td>
<td>172</td>
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<td></td>
<td>● Another friend not good supervision</td>
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<td>230</td>
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<tr>
<td>Experience of motherhood</td>
<td>● Understood woman more valued woman, understood how hard it is</td>
<td>193-</td>
<td>209-</td>
<td>122-</td>
</tr>
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<td>● Recommendation to other therapist supervision / support/ personal therapy</td>
<td>197</td>
<td>215</td>
<td>127</td>
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<tr>
<td>Recommendation-advice</td>
<td>● Recommendation to other therapist supervision / support/ personal therapy</td>
<td>110</td>
<td>283</td>
<td>170-</td>
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<td>183</td>
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