DUBLIN BUSINESS SCHOOL

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BREAKING BOUNDARIES: AN EXPLORATION OF THE EXPERIENCE OF THE PREGNANT TRAINEE THERAPIST

THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE BA COUNSELLING AND PSYCHOTHERAPY

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Wheels within wheels, wombs within wombs,
Oscillating figure/ground as perspective turns:
Mother-daughter-me - cord-links on a chain,
Each uniquely storied
Nestling Russian-doll, dowried
Sorrow-sweet fruition cursed with Eden-pain

- Joan Raphael-Leff
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ABSTRACT

The aim of this study is to explore the experience of pregnant trainee therapists. It seeks to explore how pregnancy impacts on clinical work, personal notions of identity and motherhood, and on the overall training experience. A sample group of five participants were interviewed using semi-structured qualitative methodology and the data gathered is analysed and presented according to the procedures of Interpretative Phenomenological Analysis. A far reaching clinical impact is reported, with both facilitating and disruptive elements such as increased attunement and transference, physical discomfort, issues around disclosure and containment, heightened counter-transference, and increased need for preservation and protection. Personal impact on the self includes struggles with changing identity, the re-emergence of old conflicts, and a reworking of parental relationship among others. The findings also include issues particular to participants’ training experience. All the individuals in this study feel there was a lack of information and support. Some highlight the inter-connectedness of the training and new motherhood experience. The findings are discussed in relation to the existing literature and recommendations are made for training institutions and future pregnant trainee therapists in relation to this issue.
CHAPTER 1: INTRODUCTION

1.1 A time of change

A woman discovers she is pregnant. Having taken root in the uterine space the miniscule, fertilized ovum will have a far-reaching influence in drawing the woman into the depths of her psychic space, tap-rooting powerful unconscious representations from her inside story which begin to pervade her dreams, fantasies and emotional life. (Raphael-Leff, 1993, p.7/8).

These deep-rooted unconscious narratives are simultaneously refracted outward into the external world, and in the female therapist’s case; on into the therapeutic space. Etchegoyen (1993), notes that pregnancy is unique in that it brings with it an external reality that is “powerful, undisguised and clearly visible” (p.11). In fact Bueno (2009), asserts that no other single event in the female therapist’s life will impact as significantly on the therapeutic relationship as pregnancy. Wiesenthal (2008), states that pregnancy alters both the psychotherapist’s physiology and psychology; thereby impacting on technique and efficacy.

Bearing this in mind then, consider the trainee therapist, undertaking the long and arduous road to qualification; juggling work, family, college commitments, as well as a deep and challenging exploration of their own psyche. Karter (2002), describes psychotherapy training as unrelenting. Once the trainee begins client work they have a new and significant commitment and responsibility towards their clients; which must be managed and maintained despite what major life events come along for them personally. If we add into the mix then perhaps what could be described as one of the most challenging and life-changing experiences in our lifetimes - having a child; we might begin to have an inkling of how those two forces together might bring with them their
own *unique* set of challenges – peculiar to them only. Pregnancy creates significant disturbances in *all* pregnant women. These will impact on the functioning, being and practice of the female therapist, and subsequently have profound implications for the client, the therapeutic relationship and the therapist herself; most noticeably at a time when many therapists are in the early stages of their training or career, and are lacking comprehensive experience or confidence (Guy, Guy & Liaboe, 1986).

### 1.2 Summary & Rationale

“Pregnancy is at times a tool to promote growth and at times a wrench in the fragile alliance” (Levin & Simonis-Gayed, 1994, p.199). It challenges the therapist’s ability to hold on to the psychoanalytic attitude and to provide adequate containment (Etchegoyen, 1993). The principle behind this research project is to explore the issues which arise, endeavour to become aware of the therapist’s own feelings and conflicts, and consider how we might anticipate and prepare for the changes in the dynamic in order to maximise the positive therapeutic possibilities of this new climate. Specifically, it attempts to explore how it affects the trainee in particular; who is perhaps only finding her feet in the therapeutic process and going through a sharp learning curve.

### 1.3 Aims & Objectives

Overall in the literature it is notable that there is a scarcity of research in relation to the frequency of this phenomenon; and specifically there is almost nothing written about the particular experience of the trainee. This study hopes to broaden the research in providing an in-depth look at the experience of the pregnant trainee therapist in Ireland; and provide
more information to help maximise therapeutic efficacy and her overall training
experience as she navigates through her pregnancy and training simultaneously. It aims to
reduce anxiety around potential issues facing pregnant trainees as they progress through
their training and client work, by informing them through the lens of other trainees’
personal experience.
CHAPTER 2: LITERATURE REVIEW

2.1 Introduction & Overview

The therapist’s pregnancy as a clinical dilemma is a relatively new concern in the therapeutic literature. Prior to Lax’ article on the transference and counter-transference implications of the analyst’s pregnancy in 1969, there were only a handful of other references. Deutsch (1944), emphasized both introversion and the reactivation of early conflicts in relation to pregnancy (as cited Cole, 1980); while Bibring described pregnancy as a profound psychological and somatic disturbance caused by the intrapsychic reorganization of becoming a mother (1959). From this time on the subject of pregnancy garnered more interest, the majority of which though focused on the client’s reactions to the therapist’s pregnancy rather than the therapist’s viewpoint. Nadelson, Notman, Arons & Feldman (1974), established areas of concern, including early developmental and oedipal conflicts, increased maternal transference, and feelings of abandonment, loss and envy; while Paluszny and Posnanski (1971), examined categories of patient reaction to the therapist’s pregnancy (as cited, Cole, 1980).

Much of the literature states that a therapist’s pregnancy causes an impact on the therapeutic relationship but there are variations as to whether it facilitates progress or hinders it. In Fenster, Phillips & Rapoport’s study (1986), 95% of therapists felt their pregnancy enhanced the treatment process while at the same time contending that pregnancy increased difficulties with resistance. Furthermore, 77% had a client terminate unexpectedly during pregnancy or post-partum. Bassen’s retrospective study of 13 analysts asserted that pregnancy served to heighten the clients characteristic styles of
defence and that an inhibiting effect on the treatment could be linked to a short or tenuous relationship to begin with (1988). All of the analysts Bassen interviewed felt their pregnancy had a facilitating impact on treatment. Perlman (1986), examined the special kind of attunement that can occur between therapist and client and also emphasised the vulnerabilities specific to pregnancy such as fear or anxiety relating to the baby’s welfare.

However, despite these there continued to be an overall dearth of literature comparative to the frequent and common occurrence of motherhood. McGarty (1988), proposed that the female therapist may be reluctant to make her gender central to the treatment due to more traditional notions that decried its’ importance. Indeed, even in the mid 1990’s Turkel writes about the continuing paucity of literature on the subject, despite its’ profound implications for the analytic relationship. She suggests this may be due to the female therapist’s denial in the face of the limitations pregnancy may bring to the analytic space and the reluctance to admit “that the therapist is not a superwoman” (1993, p.3). Wedderkopp (1990), ascribed the therapist’s denial as collusion with the client’s denial of the pregnancy, and links it to anxiety and guilt at the analytic breach posed by the pregnancy and ensuing maternity leave (as cited Dyson & King, 2008).

Only two core books could be found by the researcher; ‘The Therapist’s Pregnancy: Intrusion in the Analytic Space’ by Fenster & Rapoport (1986); and ‘Awaiting the Therapist’s Baby: A Guide for Expectant Parent-Practitioners’ by Fallon & Brabender (2003). Thus it is to be noted that the references cited span over several decades as there are not enough in the last ten years to provide adequate background material for this study. Chandler (2008), reminds us that the therapist’s pregnancy
touches on on every single important aspect of the therapeutic process: self-disclosure, attachment, identity, termination and the transference-counter-transference matrix.

The pregnant therapist may find that her inner life varies more intensely than before. At times her inner life may be so full and active that it is hard for her to attend to the patient. At other times it will be a rich background against which to react to a patient while monitoring her own associations and careful responses. At other times it will be quiescent and the therapist may feel calmly receptive. It is a question of balancing one’s own needs and feelings vis-à-vis the patient (Chandler, 2008, p.1).

Let us examine some of these main themes in some more detail.

2.2 The Elephant in the Room: disclosure & boundaries

“The shared psychoanalytic boundary fluctuates with that of the uterine space, raising issues of shared occupancy, usurpation and crowdedness” (Raphael-Leff, 2004, p.5).

Pregnancy is a non-verbal communication which impinges upon the anonymity of the analytic space and draws attention to the fact that the therapist is a sexually active being with a personal world and life outside of therapy. The very real physical presence of the baby soon makes itself known, infringing on the space in a unique way, and bringing with it a host of conscious and unconscious psychological and emotional connotations. Fenster et al. (1986) describe it as “a concrete, irreversible and evocative impingement” into the treatment (p. xii). The carefully constructed therapy space of just two becomes a new dynamic, a triad of sorts, with all that that entails. Previously carefully maintained boundaries are broken and the therapist is confronted with a host of related decisions about disclosure and interpretation.

Stuart (1997), comments from personal experience on the conflict she felt to simultaneously announce and conceal her pregnancy from her clients. Fenster et al. (1986), interpreted the push to disclose as an expression of the therapist’s narcissistic
pleasure in her experience and wider self-absorption at this time. There is little consensus about when is the best time to disclose; some believe disclosure should only occur when the client notices (Fuller, 1985), whereas others suggest disclosing earlier (Fenster et al. 1986; Benedek, 1973, as cited McGarty, 1988). Fallon & Brabender (2003), emphasize that early disclosure is important for certain populations e.g. borderline patients. In fact Stockman & Green-Emrich (1994), argue that treatment by the pregnant therapist of some client populations is potentially harmful; e.g. those with eating disorders. Bassen (1988), argues that early disclosure decreases the potential of working with the transference. Bueno on the other hand, decided on early disclosure in order to allow her clients the benefit of as much time as possible to work through the issues raised (2009). Uyehara, Austrian, Upton, Warner & Williamson (1995), recommend that the therapist disclose the pregnancy at some point during the second trimester; and also advocate the separation of the announcement of pregnancy from that of the maternity leave. “Combining the two obscures the exploration of the symbolic meanings that the pregnancy may have for the patient” (1995, p.17).

Diamond (1992), notes that the identification issues raised by pregnancy and their subsequent affects on the boundary between therapist and client, may in fact predispose the therapist to self-disclose more than usual. This can be due to feelings of guilt, excitement, the desire to deflect anger (Fallon & Brabender, 2003); or indeed due to their conviction of the importance of the therapeutic use of the real relationship to foster trust and rapport (Fuller, 1987). Conversely, disclosing too little may be due to denial of the potential impact of pregnancy, discomfort with exposure or indeed a desire to protect the child (Fallon & Brabender, 2003). Waldman (2003), reflects that these boundary
shifts, both internally and in the therapeutic space, if monitored and learned from; can bolster the sense of therapist’s attunement regarding non-verbal communication and the wider issues of attachment and containment. Lastly, Dyson & King also note there may be credible reality concerns which impact upon the timing of the therapist’s disclosure, such as fear of miscarriage for e.g. or a desire to wait for the results of amniocentesis (2008). Uyehara et al. (1995) also refer to other reality concerns such as the possibility of medical complications or premature birth. Overall, it is crucial to tailor disclosure according to each client, based on their own pathology and tolerance.

2.3 The Mother Within: changing identity & role

“Pregnancy is a profound experience where a mother is born psychologically as much as a baby is born physically” (Dyson & King, 2008, p.39). It is a maturational juncture which profoundly impacts on identity, character and sense of self. Raphael-Leff (2004), comments on how pregnant women grapple with many procreative anxieties, such as those around formation; (will the baby be normal); containment (internal occupation & exposure); preservation (protecting & nourishing the fetus); transformation (seed into baby, daughter into mother, fantasy into reality); and separation (miscarriage, loss, labour & birth). Absorption in these anxieties form the everyday background of the pregnant woman. “On a deep unconscious level, the pregnant woman hovers between internal and external worlds, at a crossroads of past, present and future; self and other” (Raphael-Leff, 1993, p.33).

Diamond (1992), contends that the pregnancy may also affect the balance of the therapist’s professional identity. Both personal and professional identities will be
revised and reorganised accordingly as the therapist struggles to integrate this new maternal role into and alongside her existing roles of daughter, wife/partner, therapist, friend etc. (Fallon & Brabender, 2003). Furthermore, the childbearing period in a therapist’s life frequently coincides with her training or a period of active career building (Turkel, 1993). She must struggle to solidify her professional identity while keeping this separate from her nascent maternal one. Her existing identity and defences will be challenged as she wrests with questions such as ‘can I be both a good enough mother and a good enough therapist’? Common manifestations of this conflict are denial, anxiety, guilt and anger (Fallon & Brabender, 2003).

Cullen-Drill (1994), maintains that pregnancy involves a certain regression for the pregnant woman, where she recapitulates her infantile relationship with her mother (as cited Dyson & King, 2008). Balsam reflects that is it only when a woman becomes a mother herself that she becomes more fully acquainted with her own internal mother, “and carries with it positive and negative effects on a woman’s subjective sense of self” (2000, p.2). For example, Lester & Notman (1988), postulated that the presence of poorly assimilated maternal introjects could have a negative impact on the new mother’s ability to identify with the mother; i.e. the experience of self as a mothering object would be lacking. Thus the ‘mother-within-the mother’ is determined by the woman’s earliest experiences with the maternal object.

Dyson & King (2008), write of the pregnant mother’s slow withdrawal to an interior psychic space, at once identifying with her own mother on one level, and on another narcissistically with the child within. Bueno (2009), comments on the fact that this increased internal focus can have negative repercussions in the therapist being less
available to her clients; however, increased intuitive and empathic capabilities can impact
positively on the work. Stern (1995) coined the phrase “motherhood constellation” to
bring into focus a complex discourse operating on three levels: the new mother’s
discourse with her own mother as mother to herself, the internal discourse with self as
mother, and a further discourse with the baby (as cited, Balsam, 2000). Jung contended
that “every woman extends backward into her mother and forward into her daughter” (as
cited Balsam, 2000, p.12). The transition to motherhood then, and the new mother’s
interaction both with foetus and infant bear the imprint of the nature and quality of her
own maternal representations as internalised from her own experience with mother
(Diamond, 1992). Significantly, Diamond goes on to point out that

the therapist’s re-alignment of self-image in conjunction with that of the maternal
introject in turn undoubtedly affects both the form and content of transference and

Which brings us neatly to the next section.

2.4 Transference

This recapitulation of maternal identification may heighten the possibility of increased
maternal and erotic transference in the work. In fact there are a host of transferential
reactions, well documented in the literature, Guy et al. (1986) assert that clients may react
with

symbiotic desires, genuinely warm and tender reactions, role modelling, identification with the baby, infantile feelings and wishes, a revival of childhood memories, new attempts to ‘test’ the therapist, increased dependency needs, denial and resistance, ambivalence about sexuality, and hostile fantasies about the death of the therapist during delivery (p. 297/8).
Feelings of loss, abandonment, envy, jealousy and exclusion are common as well as increased maternal identifications and sibling rivalries (Wiesenthal, 2008). Fallon and Brabender see pregnancy as a “route to the patient’s increased self-understanding” (2003, p. 20). Thus the therapist’s pregnancy provides a stimulus, but the way in which the client responds will be dependent on their own internal conflicts.

The therapist’s pregnancy can evoke strong feelings for the client around attachment, loss and security.

The foetus ... becoming increasingly visible to the client … will be helpless at birth and dependent on the analyst in ways the client can only fantasize about (Hjalmarsson, 2005; as cited Chandler, 2008, p.2).

Dyson & King (2008), develop this further in the shift from dyad to triad, where the baby may reactivate conflicts of sibling rivalry through either hostility towards or identification with the baby. This experience of an “alien presence” can cause the client to withhold “both content and affect” (Chiaramonte, 1986; as cited Stockman & Green-Emrich, 1994, p.459). Reaction formation is another possibility if the client is too uncomfortable with their aggressive feelings; plastering over them instead with the opposites of concern and a sense of over-protectiveness towards the therapist (Nadelson et al. 1974).

Acting out can be a common form of reaction to therapist pregnancy and helps prevent the client from dealing with the underlying emotions tied to the event. E.g. weight gain, silent sessions, cancellation or unexpected termination, promiscuity or cessation in using birth control, unplanned pregnancies/abortions (Wiesenthal, 2008). The therapist’s pregnancy may arouse fears around sexual competence, erotic feelings towards the therapist or indeed a sense of competition towards her partner for some male
clients. Similarly, homosexual clients may experience inhibition or frustration as a result of the therapist’s pregnancy (Rubin, 1980). It is important the therapist be cognisant of the impact of her pregnancy on her clients and their potential transferential reactions lest she misinterpret them; and also so that she may respond sensitively, using the transference as an artiber for change. To conclude, it has been found that the intensified transference in turn heightens the countertransferential reactions and most contemporary thinkers today will “no longer speak of transference in isolation from countertransference” (Hirsch, 2008, p. 27).

2.5 Counter-transference

The conflict between listening to the client and listening to the therapist’s own internal desires is a pervasive one (Hirsch, 2008). Moreover, the therapist’s pregnancy may cause clients to experience intense feelings at the very time the therapist has most difficulty processing them (Fallon & Brabender, 2003). Bienen (1990), notes there has been much reticence observed in the literature regarding the disclosure and discussion of counter-transference; and postulates this hesitation may be due to anxiety around professional capabilities. Fenster et al. (1986), suggest it may be due to the therapist’s difficulty with her increased sensitivity to any difficult material or inhibition caused by the magnified counter-transference. Raphael-Leff (2004), draws a parallel between pregnancy and therapy in relation to the unconscious dialogue of growth, union, and ultimate separation reflected in both. She warns that

a clash may emerge between the very real demands of attending to the patient in her care and the call of the interior, which, in extreme cases, may lead to miscarriage of the one to preserve the other (p.5).
Similarly Dyson and King (2008), note that due to the therapist’s increasing feelings of vulnerability, it may be particularly challenging to countenance any hostile or aggressive feelings from the client. In particular issues around abandonment and envy towards the foetus were found to be among the more difficult to deal with (Fallon & Brabender, 2003). McGarty (1988), illustrates her difficulty with her client’s transferential rage: “We choose to bring ourselves into the arena of our patient’s intense emotional reactions. We do not choose to put our children there” (p.4). Moreover, the therapist may deny her client’s feelings of aggression towards the infant as they touch on her own conflicts or ambivalence around the pregnancy (Dewald et al., 1993). In order to acknowledge repressed aggression or hostility in the client towards the baby the therapist must be able to accept such feelings in herself. Imber (1990), discusses her defensive reaction formation response of sympathy and concern towards the client in relation to the anxiety she experienced as a pregnant therapist; “at that moment I was trying too successfully to detach myself from my basic angry reaction” (p.7).

As the pregnancy progresses, primary maternal preoccupation (Winnicott, 1984), escalates with its’ accompanying withdrawal and sharpening focus on the baby. The therapist may need to see herself as nurturing and sustaining. This focus on ‘life-giving’ makes it hard to deal with destructive or depriving issues on the part of the client (Bueno, 2009). Indeed, the fast approaching termination in the work and the client’s potentially painful feelings around the separation may bring on a ‘crisis’ in the client’s life. This can be particularly frustrating for the therapist who may begin to resent the client’s demands, as she experiences an ever growing absorption with the baby (Dyson & King, 2008). Additionally, the pregnancy can bring up themes of loss for the client,
which again may be difficult for the therapist to notice or pursue due to her own counter-transferential fear of loss (Guy et al., 1988).

One of the primary counter-transferential reactions cited across all of the research is the therapist’s fear of being less present in relation to the client. Bassen (1988), found evidence of increased self-absorption, guilt, pre-occupation with the baby, and distance from the client. Penn (1986), warned of the importance that the therapist’s guilt not obscure or overshadow the client’s full transferential reaction. As Diamond (1992) commented, it is crucial to treat “the pregnancy as simply one more irritant in the shell of the patient’s psyche which may produce the pearls of transference” (p. 341). Etchegoyen (1993), observed that the work demanded persistent and gruelling working through of issues on her part in the counter-transference. It is crucial therefore the pregnant therapist be constantly vigilant of her own counter-transferential responses, so they do not interfere with or cause harm to the therapeutic process through misperceptions, distortions or errors. In order to do this to the best of her ability, strong supervision and supports are an absolute must.

2.6 Supervision & Supports

Pregnancy engenders both a psychological and physiological crisis in a woman, and as such her increased vulnerability further highlights the importance of amplified support and containment in her work as a therapist. Guy et al. (1986), suggest that pregnancy dictates an increased need for both personal therapy and supervision. Personal therapy aids the working through of the unresolved conflicts which may re-emerge at this time, along with questions of identity and impending issues of motherhood. It can also provide
an important resource in terms of support and nurturance. If the therapist is more aware of her internal conflicts and changing self she will be more open to those of her clients (Fallon & Brabender, 2003). Supervision is a vital aid in recognizing and disentangling the complex and intricate issues arising in the transference-countertransference / reality matrix; and increasing the supervisee’s awareness of obstacles that may affect the work.

Uyehara et al. (1995), advocate that supervisors have an extensive understanding of the issues involved and their impact on the therapist, client and relationship, so they can better support the therapist. There is the possibility that the pregnancy may cause difficulties in the supervisory process itself (e.g. transference / counter-transference, lack of empathy, overly protective attitudes); and male supervisors in particular may not be wholly aware of the physiological aspects of the pregnancy (Bassen, 1988, Turkel, 1993). Fenster et al. (1986), chronicle how many pregnant therapists reported feeling more reserved and distant in supervision; with heightened sensitivity as regards perceived criticism. Bassen (1988), reported that several analysts in their study supposed they would have benefited from more active supervision.

Further support can be garnered from books, articles and colleagues who have already gone through the experience. Dyson and King (2008), also advise keeping a journal and exploring the area with other therapists who are parents. Wiesenthal (2008), points out that over 50% of psychiatric residents in America are of child-bearing age; yet there is little taught on this subject in training programs or indeed reported in the supervision literature. She suggests case-based discussion for all involved in training programs to improve clinical sensitivity in this regard. Bueno explained
I was critically aware of my heightened permeability to … projections, my flimsy defence system and my desperate need for extra supervision and support from colleagues (2009, p.2).

In fact, Uyehara et al. (1995), declare that training institutes should consider these issues when setting their curriculum. Karter (2002), states there is a clear need of “a support network geared to looking at the personal and professional concerns and difficulties that students regularly encounter during training” (p.29).

2.7 Conclusion

Fallon & Brabender emphasize the importance of anything that will aid the therapist anticipate and more fully understand the processes involved (2003). Additionally, the therapist’s trainee status may add further complication in that they are less experienced or well versed in transference and counter-transference elements; thereby having a greater need of expert supervision.

The combination of neophyte status and accommodation to the frame required by altered physical state are likely to create therapeutic complications and a greater number of technical errors than might otherwise occur (Fallon & Brabender, 2003, p.7).

Uyehara et al. (1995), suggest that supervision act as a kind of safety net for the trainee if difficulties arise. “When supervisors were attentive to these issues, candidates were likely to regard the clinical impact of their pregnancy with interest rather than anxiety” (1995, p.14). Levin & Simonis-Gayed (1994), recommend the therapist be aware of her own limitations, be prepared to deal with client’s questions, and set a date for maternity leave early in order to mitigate anxiety. Fallon & Brabender’ research showed that some therapists felt a sense of regret at not seizing the full opportunity presented by their pregnancy (2003). Rivera (1997), in a case study examining treatment of a female
prisoner during her own pregnancy remarked how her pregnancy made her “more aware of my limitations as a therapist” (p. 43). If viewed in the right light, pregnancy can be seen as the special and infrequent therapeutic opportunity that it is.
CHAPTER 3: METHODOLOGY

3.1 Research Strategy & Design:

This research project is an explorative study in which the participants’ own experiences and perspectives will be examined. As such, the methodology chosen was a qualitative analysis; as these methods give a more complete understanding of a subject. Quantitative methodology typically seeks to quantify and measure a subject by a number of specific variables, and as such it is unsuitable for a more indepth understanding of human experience. Qualitative methodology is a more exploratory strategy, which aims for detailed data and accepts that the interpretative nature of the approach means that the researcher plays a central role. There is no fixed hypothesis or clear agenda, rather an exploration of a wide variety of aspects of the study. “Qualitative research is part of a debate, not fixed truth” (Banister, Burman, Parker, Taylor & Tindall, 1994, p.3). This study used one of the most common qualitative data collection methods (semi-structured interviews), as a means of exploration. Crucially, this allows for a more flexible approach that can incorporate new directions and aspects of the topic as and when they may come up during an interview. A number of initial more structured demographic questions were asked to ascertain certain details. Following that, a series of open ended questions were asked in order to encourage the participant to produce lengthy and detailed descriptions of their experiences. Finally Howitt & Cramer (2008), propound that the “key feature of qualitative data is encapsulated in the phrase ‘richness of data’” and this is certainly evident in the wealth of material garnered in this study (p.299). Please see Appendix 2 for the list of questions covered.
3.2 Pilot Study:

A pilot study was carried out using a set of questions drawn up with reference to the relevant literature on this subject; divided into three topics of interest. The purpose of this was to ensure all themes were adequately covered, investigate if the questions were comprehensible; and to familiarise the researcher with carrying out an interview. This was to prove invaluable. Not only did the researcher gain experience in conducting an interview but it was instrumental in terms of feedback from the participant. After the pilot interview the researcher felt that the order of questions should be revised; and this was strongly reflected by the interviewee’s comments. The order of questions was amended accordingly and a number reworded entirely to allow for greater coherency. This redrafted interview schedule was submitted once again to the pilot interviewee for their input; and their recommendations were taken on board with a further reordering of the topics covered. Some of the language in the questions was again reworded and made more simple and direct. The researcher felt these changes were significant in improving the potential richness and depth of the study.

3.3 Research Sample:

A small sample of participants was recruited from among the student population of a third level college. The researcher approached a wide range of training institutions in order to get as wide a population as possible, but due to varying circumstances this wasn’t possible (e.g. institutions refusal of involvement/ respondents lay outside the specified criteria) and as such the sample is from one institution alone. The criteria for participation were female students of Counselling and Psychotherapy, having been
pregnant whilst training and completing clinical work during the last two years. Five participants, ranging in age from 29-36 years took part. The sample was drawn from across three years of training therapists, in order to maximise confidentiality.

3.4 Research Procedure:

The researcher initially contacted the participants through email, explaining the nature of the study and requirements involved. Upon agreement in participation, a date and time was set to meet, in a location convenient to the participant. All interviews took place in private, in a multitude of locations e.g. the participant’s workplace, home, and others in a reserved meeting room in the training institution. Each interviewee was given an information sheet introducing the interviewer, explaining the purpose of the study and requesting their consent to participate (Appendix 1). Each interview was then recorded using a dictaphone and later transcribed in full.

3.5 Analysis:

An Interpretative Phenomenological Analysis (IPA) was used to interpret the interviews. IPA is essentially concerned with life-changing events and centres on understanding personal experiences of the world rather than providing definitive answers. IPA is unique in that it aims to explore an individuals’ perception of their own experience and to give a taste of that persons own private world as they encounter it. It acknowledges that such a study is in part created by not only the participants involved but the unique perceptions and interpretations of the researcher. Smith & Osborn describe it as “the participants trying to make sense of their world; the researcher trying to make sense of the
participants trying to make sense of their world” (2003, p.51).

The interviews were recorded, transcribed and analysed according to IPA methods (Howitt, 2010). Each transcript was read through repeatedly and thoroughly in order to familiarise the researcher with each participant’s particular style and manner of elucidation. The transcripts were then worked through time and again, at first noting significant passages, descriptions, and emotions that emerged and then beginning to draw these into patterns, themes and newly emerging strands which were noted in the margins. Each transcript was treated in this way separately, and then compared and contrasted to each other. A table of super-ordinate themes and sub-themes was then developed to reflect the richness of material complied (see Table 2).

3.6 Ethical Considerations:

The role of informed consent in research is crucial. Essentially, it means that potential participants should understand what they are agreeing to before they actually agree to it (Howitt, 2010). Participants should be given full and detailed information about the study, it’s consequences, the extent of confidentiality and the incentives or benefits (if any) of taking part. The name of a third party that can attest to the bona fides of the researcher should be provided as well as the participants right to withdraw (Howitt, 2010). The researcher compiled a participant consent form with these factors in mind. This form detailed both a description of the study as well as an outline of the ethical contract between researcher and participant (see Appendix 1). The researcher also provided a phone number and email address should the participant have any further queries. It should be noted that one participant who had originally verbally agreed to take
part in the study withdrew due to personal reasons. The researcher then found another participant to replace her.

Confidentiality is a key ethical consideration and as such it was ensured that the transcriptions of each interview were coded by number, kept separately from the demographic details; and all identifying features were obscured. Specifically, confidentiality was important in this study as participants were sourced from the training institution and as such the researcher felt it was more important than ever to protect participant’s identities and obscure details. Pseudonyms were used in the results and discussion section to maintain confidentiality. Furthermore, because participants are from a range of different years which includes both current and graduated individuals, the researcher took the decision to situate all comments in the past tense so as to further disguise any identifying characteristics.

Lastly, it is important to consider the researcher’s own participation in the research process. It is essential to acknowledge the impact of the interviewer, from the initial construction of the research question, to the gathering of participants, and the completion of the interview itself (Banister et al., 1994). The researcher wishes to recognise the potential impact of the above constraints. Carrying out such a study while within the organisation evidently meant that some participants were acquainted to the researcher. Ethically, it is important to acknowledge that as such the researcher recognised that some of the form and content of the interviews could be influenced by this, but would contend that it had a positive impact in terms of a more open engagement.
CHAPTER 4: RESULTS & DISCUSSION

4.1 Participant Details:

Five participants took part in this study, ranging in age from 29-36 yrs old. All were first time mothers and all were in their final two years of training at the time. There was a variation in the amount of time each worked with clients up until the birth of the baby. Please see Table 1.

Table 1: Participant Details

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>NO. OF MONTHS CLINICAL WORK</th>
<th>NO. OF PREGNANCIES</th>
<th>NO. OF WKS BEFORE BIRTH FINISHED CLINICAL WORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amanda</td>
<td>36</td>
<td>12 months</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; pregnancy</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Deirdre</td>
<td>36</td>
<td>18 months</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; pregnancy</td>
<td>5 weeks</td>
</tr>
<tr>
<td>Jill</td>
<td>29</td>
<td>15 months</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; pregnancy</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Karen</td>
<td>35</td>
<td>8 months</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; pregnancy</td>
<td>5 weeks</td>
</tr>
<tr>
<td>Maeve</td>
<td>31</td>
<td>7 months</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; pregnancy</td>
<td>3 weeks</td>
</tr>
</tbody>
</table>
4.2 Qualitative Results:

The five participants were asked questions which explored their experience of pregnancy and new motherhood whilst undergoing their psychotherapy training. Four superordinate themes emerged through the analysis of the transcribed interviews which are as follows:

- 1. The Impact in the Clinical Space.
- 4. Advice for Other Pregnant Trainees.

Please see Table 2 which includes the superordinate results and their subordinate counterparts. The results will be presented and discussed together through the various themes. Due to the relative limitations and remit of this paper it should be noted that the researcher selected the richest passages from the large volume of material that best demonstrated the themes.
### Table 2: Master Themes & Sub-Themes

<table>
<thead>
<tr>
<th>MASTER THEME 1</th>
<th>MASTER THEME 2</th>
<th>MASTER THEME 3</th>
<th>MASTER THEME 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Impact in the Clinical Space</td>
<td>The Impact on the Self</td>
<td>In Relation to the Training Institute</td>
<td>Advice for Other Pregnant Trainees</td>
</tr>
<tr>
<td><strong>Sub-themes:</strong> Facilitating</td>
<td><strong>Sub-themes:</strong> Identity shift</td>
<td><strong>Sub-themes:</strong> Information</td>
<td><strong>Sub-themes:</strong> Self-care</td>
</tr>
<tr>
<td>“am more attuned”</td>
<td>“takes over self”</td>
<td>“helpful to be prepared”</td>
<td>“buy yourself flowers”</td>
</tr>
<tr>
<td><strong>Disrupting</strong></td>
<td><strong>Re-emergence of issues</strong></td>
<td><strong>Not Feeling Heard</strong></td>
<td><strong>Prepare</strong></td>
</tr>
<tr>
<td>“Can definitely say I wasn’t 100% there”</td>
<td>“can of worms”</td>
<td>“like talking to a brick wall”</td>
<td>“trust your gut”</td>
</tr>
<tr>
<td><strong>Containment</strong></td>
<td><strong>Relationship with own mother</strong></td>
<td><strong>College &amp; baby intertwined</strong></td>
<td></td>
</tr>
<tr>
<td>“overstepping boundaries”</td>
<td>“baggage hits current reality”</td>
<td>“wouldn’t have one without other”</td>
<td></td>
</tr>
<tr>
<td><strong>Disclosure</strong></td>
<td><strong>Deeper impact e.g. illness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“feel more congruent”</td>
<td>“post-natal depression”</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Counter-transference</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“emotions magnified”</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Preservation &amp; Protection</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“holding back”</td>
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</tbody>
</table>
4.3 The Impact in the Clinical Space:

There has been much contention in the literature as to whether the therapists’ pregnancy facilitates or disrupts the process but one thing remains clear; it has a resounding impact (Bueno, 2009). In fact many of the studies have found conflicting reports in their own results; e.g. Fenster et al. found that 95% of therapists petitioned delared their pregnancy had enhanced the process while at the same time contending it had also increased resistance (1986). Bassen’s study (1988), cited heightened defences while Perlmans’ recounted both the possibility of a deeper attunement with the client and conversely a vulnerability that could potentially be inhibitory (1986). Chandler (2008), reminded us that the therapist’s pregnancy touches on every single important aspect of the therapeutic process; and indeed this is reflected in the multiplicity of sub-theme clusters emerging in this first master theme. All participants spoke about the influence of their pregnancy in the therapeutic space, which took on a wide variety of different expressions which will now be explored as sub-themes.

Facilitating:

As evidenced in a number of previous studies in the literature the therapist’s pregnancy can have a facilitating impact (Perlman, 1986, Bueno, 2009, Diamond,1992, Fallon & Brabender, 2003). Three of the participants believed that their pregnancy and new motherhood furthered the work. This was expressed in a number of different ways.
Deirdre spoke of how she “felt eh really grounded ... more comfortable in my clinical work”. She compared it to early days of training when she was “really afraid of getting it wrong” but “when I found out I was pregnant, that dissipated. I became ... like less in my head and more in my body”. As evidenced in Perlman’s study (1986), she felt a deeper attunement with the client. “There’s a richness to my empathy now that wasn’t there before” and due to the “intensity of emotion” that she experienced she can now “sit better with all types of emotion”.

Waldman (2003), reflected on a deeper attunement resulting from the wider issues of attachment and containment. Karen echoed this; “when I do go back to work ... it will have helped me be a better counsellor because when I was doing all that developmental work in college it was all theoretical where as now ... it all makes so much sense ... will really take on an added dimension”.

The likelihood of increased transference is well documented in the literature, and if recognised can be worked with well (Guy et al., 1986). Fallon and Brabender regarded pregnancy as a “route to the patient’s increased self-understanding” (2003, p.20). Amanda explained how she felt her pregnancy had facilitated the transference with a client; “there was one client who had ... lost her daughter at 21 to drugs and eh I was always aware that in the transference that I was her daughter ... and when I became pregnant I found that that just brought her into a much deeper place in her grief ... and that was an amazingly intense thing to experience in transference with somebody ... I
don’t know if we’d ever gotten that deep if I wasn’t pregnant you know so I think that worked for that client”.

Disrupting:

Disruptions in the therapeutic space were expressed in a number of ways.

Karen spoke of the constant internal distraction; “in some sessions the baby would be very active, like start kicking me and so that was …. hard to take my focus off the baby and keep it on the client”. This ties in with Bueno’s description of an increased internal focus that can signal negative repercussions in terms of availability of the therapist to the client. Amanda commented “the tiredness was what affected it the most … like almost out of body tired, and it took a lot of effort to stay grounded and present”.

As was evidenced by Nadelson et al. (1974), Jill experienced transferential difficulties in relation to one client who developed a strong reaction-formation to her pregnancy, becoming solicitous and overprotective. “Even if I shifted around in the chair in the room … em he would stop what he was saying and ask if I was okay you know with a … worried look and .. you know so it was, it was definitely at the forefront of his mind. And I think it affected his .. his process”. She also spoke of the debilitating influence on the work whereby he held back on material because “he was very much of the opinion that I was supposed to be in a very positive place ... and he didn’t want to give me any negativity”.
**Containment:**

Pregnancy is a non-verbal impingement upon the analytic space (Fenster et al., 1986). All participants noted fluctuations with boundaries and containment. Waldman (2003), asserted that these boundary shifts can provide important learning in relation to the client and indeed it should be added, the therapist.

**Amanda** refers to the “power shift” in relation to boundaries; “it felt like I was asking them to include me and the pregnancy in their process ... so it was a big step into the unknown, especially when you’re training you know it’s all kind of unknown anyway”.

She continued; “I felt more of myself was exposed to the client – it kind of tainted the relationship with a friendliness”.

Fallon & Brabender (2003), referred to the heightened difficulties that may be experienced by certain client populations. One of **Karen’s** clients “would try and overstep boundaries a lot … she had a borderline personality disorder and … her boundaries were extremely loose and she, she was constantly pushing them”.

Diamond (1992), asserted that shifts in boundaries may pre-dispose the therapist to self-disclose more than usual. **Jill** spoke of how her clients “all started to ask me questions … things that would have been very personal”. She wondered: “how do I em ... manage it without blocking them off? So it was trying to find a balance between you know a certain amount of information to keep the kind of human side of it going and the relationship going em”.

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For Deirdre, this resulted in a clarification of personal boundaries: “I think being pregnant for me made me quite aware of boundaries … I felt really contained … really rock-solid. The boundaries I think become so clear because you really want to protect from the negative feelings … like a filter”.

Disclosure:

As seen in the literature there is much dispute as regards the best time to disclose. Fuller (1985), advocated only disclosing when the client notices while Fenster et al. for example advocated disclosing earlier (1986). Bassen (1988), argued that early disclosure reduces the benefit of working with the transference. In this study, most participants felt it important to disclose earlier than perhaps their supervisors advised and some felt very strongly in relation to this. This was more reflective of Fuller’s theory that the therapist may highlight the importance of the use of the real relationship to foster trust and rapport (1987). All participants without exception expressed a feeling of relief on disclosure and the importance of disclosure in relation to congruence.

In keeping with Fallon & Brabender’s (2003) findings on the importance of early disclosure for the borderline patient, Karen decided to disclose early. “My supervisor said you don’t need to tell her yet … I kind of went with my gut instinct and felt that she’d like to know because .. I knew that she found endings difficult so I wanted to give her the time to prepare for it and in the end it was definitely the right thing to do … I felt awful you know when I was in there and she didn’t know I really felt like I wasn’t being
honest and genuine and I felt like I was keeping something from her and I’m sure that was in the room you know in some unconscious way”.

Bueno emphasised early disclosure to allow for enough time to work through the issues (2009). **Jill** made the decision to disclose at twenty weeks in order to do just that; “that gave me kind of three solid months where I could, I suppose bring things to an end very gradually”. Furthermore, “I felt more I suppose congruent that I did disclose rather than let them wonder … em … certainly one of my clients … wouldn’t have been comfortable in asking me em … and it would have kept with them and perhaps preoccupied their minds as well em … you know it does affect them very much so … from my own point of view I am pleased that I told them”.

*Counter-transference:*

Bienen (1990), noted a reticence in the literature as regards the disclosure and discussion of counter-transference; and it is interesting that in this study when participants were asked to talk about their counter-transference around their pregnancy; they all without exception stated they didn’t have any. Subsequently however, these counter-transferential reactions emerged in the interview in other ways. Perhaps this initial reluctance may relate to what Fenster et al. (1986), described as the therapi(st)’s difficulty with their increased sensitivity to any difficult material caused by magnified counter-transference reactions or more simply put, their anxiety around professional capability (Bienen, 1990). Overall, there were more generalised counter-transference reactions such as anxiety and
guilt at the impact of the analytic breach as well as more specific reactions more personal to the individual.

One of the primary counter-transference reactions cited in the literature is the therapist’s fear of being less present. (Diamond, 1992). Maeve struggled with this: “I felt I let my client down because I wasn’t totally available … I was conscious I was protecting something else … and do you know that was in the room I could feel it and I’m sure my client did as well at the time”.

Bassen (1988), found evidence of increasing self-absorption and guilt as highlighted in the following passages. Jill: “I felt like I was abandoning him after he’d … he’d started to get a little more positive and gain a little more confidence. I almost felt inclined to apologise in some … sessions … so em, I suppose there is an element of guilt involved in finishing up before they are ready”.

Stockman & Green-Emrich (1994), reported the therapist’s heightened sensitivity. For Amanda, her counter-transference was twofold; “I was afraid they wouldn’t be able to let themselves go because they’d be afraid of hurting me or the baby so that was a big concern”. She also spoke about how “all your emotions are magnified” which led to “a struggle to stay in the role of therapist”.

Fenster et al. (1986) described the therapist’s fears for the baby. For Deirdre these fears were exacerbated by her client’s struggles with their autistic child: “My biggest fear was
there would be something wrong with my baby … the fear was there anyway …em, but to see somebody whose life was so affected by it and how they couldn’t transform it in any way … that was really sad. The therapeutic sessions were heavy … they were deeply sad and hopeless and I felt that, yeah”. That client eventually pulled back and terminated the therapy prematurely. “She’d given up on the therapy … I think the pregnancy made it a way of her being able to block me off. I was really really disappointed”.

Preservation & Protection:
Dyson & King (2008), chronicle the pregnant mother’s slow withdrawal into an interior psychic space while Bueno (2009), reminds us of the potential negative connotations of this withdrawal for the therapeutic relationship. Participants spoke of a sense of distance from the client at times, where they were holding themselves back. They largely attributed this to a sense of protection and preservation for self and baby. This could also relate to a difficulty in acknowledging aggressive or hostile feelings from the client due to an increased vulnerability (Dyson & King, 2008). This is evidenced in the following passages.

According to Jill “there were a couple of occasions where I did hold back .. because, for myself … I didn’t want to go there. It was really about my stress levels and … not affecting the baby”. Raphael-Leff (1993), reflected on the absorption and pre-occupation of the mother to be. Jill spoke of how she “wanted to wrap myself in a bubble and just keep myself there for nine months”.

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Maeve actually stopped work with clients as she decided she’d “had enough … of the anxieties and the fears of this person … was transferring onto me unconsciously … I just had to protect myself and the baby at that point … for safety reasons I stopped the client work”.

Karen questioned “I wonder how good I was as a counsellor at the time … like my priority was protecting the baby you know what I mean? … Which probably adds to my opinion that I should have finished up earlier you know? And given my client the opportunity to start with another counsellor who would …. have had their full attention because obviously looking back my client did not have my full attention”.

4.4 The Impact on the Self:

Wiesenthal (2008), highlighted the huge impact of pregnancy on the psychotherapist’s physiology and psychology. Cole referred to it as a unique life juncture involving an intrapsychic reorganisation (1980). More simply put, it had an enormous consequence for the self. All participants spoke about the impact of their pregnancy personally, in terms of relationship to self and to others such as their own mother.

Identity shift:

Participants noted that with impending motherhood came a corresponding internal shift in terms of identity, roles and priorities.
Fallon & Brabender (2003), described a revision and reorganisation of both identity and priorities. Maeve explained “when you’re pregnant the baby … just completely completely takes over the whole self …. Your priorites change .. you will come second the whole time”.

As Dyson and King propounded, “a mother is born psychologically” (2008, p.39). Jill concurs: “It has affected the sense of who I am ... in other ways it’s given me another role … it’s like a new identity for me”. Amanda spoke of a loss and refinding of self: “ It was almost like I had to give up all of myself, my identity … I actually had to just let it all go … I had to actively go out there and pull myself back together and have a reality of my own again”. She added “it felt like five years of life was lived because of the depth of feeling and thinking that went on”.

*Re-emergence of issues:*

In the earliest writing on this subject Deutsch (1944), emphasised the reactivation of early conflicts in pregnancy (as cited, Cole, 1980). For all participants there was a revisiting of certain issues, for some this was more marked than others.

Maeve alikened it to opening a “can of worms”; where “it’s huge can’t really tell how big it is, it’s bigger than your whole self … it’s like a tsunami wave you’re in the middle of it and big turmoil ... I suppose I wasn’t ready for it”.
For Amanda it was also huge, she called it an “emotional maelstrom”. “It was like my own personal process and my therapy and my history all just came up … like on a rocket in the last six weeks so yeah it was really good timing that I had decided to stop seeing clients when I did – because it could have gotten very messy I think”.

Relationship with own mother:

Cullen-Drill (1994), maintained that pregnancy involved a recapitulation of relationship with one’s own mothering experience. All participants revisited their own relationship with mother in some way.

For Amanda particularly it was huge, an early lack in mothering experience was exacerbated by a further lack of support when she had the baby. “What came up for me was em … the feeling of not having good enough mothering”. She went on; “I have to say it made me a little bit bitter. I knew it was going to be tough … you know our family was very dysfunctional and … it took me long enough to … deal with that … and I just wasn’t ready to go backwards again and I did have to go backwards … into … feeling pain and feeling alone and … you know feeling unsupported … and now it was being supported by an actual experience of feeling unsupported so it was like your baggage …. Baggage hits your current reality … And like literally like it was batten down the f****** hatches like for psychological warfare you know”.

Stern (1995), wrote of the “motherhood constellation” whereby there is a discourse on three levels relating to the inter-connectedness of self, own mother and baby. In
considering her own relationship with mother and how she herself was containing her own baby Deirdre achieved a new understanding of her mother and their ambivalent relationship: “I’m … so much kinder to my mother now and … I’ve put the big stick down I was beating her with. It’s really changed how I feel about my mother. I felt like I blamed her for a lot and there's a sense that I didn't want to forgive her ... But now, now I just, (sighs) it all melted away and I just love her and I'm not angry with her and that's like that's actually amazing for me to say because I was angry at her for years like and ... raged. I suppose she has been a container and I suppose an adequate container, but I didn't want to see it that way... or the child in me didn't want to see it that way. And I suppose after having a child myself, the child in me receded”.

For other participants it deepened an already existing bond. Maeve commented how “you’re re-thinking the whole thing it just throws a different light onto the mother daughter relationship” whereas Jill described it as “a positive thing … that’s brought us a little bit closer”.

Deeper impact: e.g. illness

Raphael-Leff (1993), reflected on how the foetus influences the pregnant woman and draws her into the depths of her psyche, “tap-rooting powerful unconscious representations” (p.8). Two participants commented on a further deeper impact of pregnancy and new motherhood on self and specifically what they understood as unconscious links or affects on outward physical manifestations.
Maeve’s issues were two-fold in this regard with a wider impact both on herself and baby. Firstly her child was born “with a hernia which I felt came from the client work – the negativity and the stress of the client work I felt myself yeah – because the body holds everything”. Furthermore, she disclosed she had suffered from post-natal depression which she linked to early trauma being revisited. “I remember em the lecturer telling us after you have a baby everything just leaves the body … that's how it felt … all those years of trauma that had been trapped in the body just left … and then suddenly you're faced with it … It was just like.. BAM – and then you're thrown into the depths of trauma … everything like that happened in my life …it was horrific … and I’m still dealing with it”.

Raphael-Leff (2004), drew a parallel between pregnancy and therapy in relation to the unconscious dialogue of growth, union and ultimate separation. Karen spoke of how she believed her earlier miscarriages were linked to her work with one client in particular: “Before I got pregnant I had … a client who had a lot of physical disabilities and he was one of triplets - I had two miscarriages before this baby and like I … I finished with him and I found I was eight weeks pregnant you know like seven weeks later or something and … I don’t know I just felt that … it was just some connection with it you know he was one of triplets then this baby was like my third pregnancy and I thought that really he took a really huge amount of energy and eh …I just felt the timing of that … I just finished with him and then I found out I was pregnant and like the pregnancy worked and I just I don’t know just there was something around that”.
4.5 In Relation to the Training Institute:

Fallon & Brabender (2003), highlighted the importance of the therapist being aware of her internal conflicts and the issues that may arise in relation to pregnancy. Uyehara et al. (1995), stressed the importance of good supervision in this highly specialised area while Wiesenthal (2008), points out that there is actually very little taught on training programs of this nature. Participants spoke about the impact of their pregnancy in relation to their training experience and explored areas in which they may have been supported or aided.

Information:

A number of the participants felt there was a severe lack in information around this area which they would have felt beneficial.

Karen commented on the mutiplicity of pregnancies in her year and in others; “given the amount the age group yeah there should be something put into the program like because we’re dealing with clients and stuff and the impact that it has and it’s really important that you protect yourself”. She went on; “I was googling trying to find a book to read on it and I couldn’t find it but I desperately wanted to … hear about other people’s experiences and how it impacted on them … it would have been really good ... to have some knowledge around it, definitely”.

Amanda explained; “I didn’t realise the transference and counter-transference were magnified so much – and I remember … one night … my therapist saying oh yeah it’s well known that the transference in em with pregnant women is huge it’s just so intense
… I went f*** - f*** nobody is looking out for me. I’m looking out for myself here but the college isn’t and my placement isn’t”.

Deirdre also highlighted; “there’s very conflicting information depending on who you talk to … I think the college needs to have a stance … this is how we treat it, this is what we advise you to do, here is the information on it, here is the research on it, here’s what you may experience in the therapeutic space”.

Not Feeling Heard:
Some participants felt their particular wishes, decisions and instincts around their pregnancies and college and client work were not fully heard by and respected by the college.

Deirdre commented on the gulf between advice and instinct around disclosure: “I've heard people say that they've been told not to say anything and eh then that goes against how they feel and if you're going to be in there like that it's confused - people are feeling like they are not being genuine and for somebody to continually tell you to go against how you feel em and and completely not listen to what you're actually asking is to me ... quite shocking”. She felt this was down to a conflict in approach, between a person-centred approach and a more analytic one. “The course is I think it’s quite confused itself … a lot of the skills trainers I think are psychoanalytical and they seem to have a completely different view as to how you treat the client to person-centred … I have found the psychoanalytical approach is not humanistic in the way that we would see it to be and
that doesn't seem to have you know the same respect for the client”. For this participant, regard for the client and the importance of being human and congruent was a huge part of her impetus in disclosure.

Amanda too was quite exercised in this regard: “I felt a lot of pressure from (college) to split or do something … I went through all of the ins and outs of it with my therapist and my supervisor and … I felt really confident that I could and I knew it wouldn’t be f***** easy but em … yeah I found … I found like I kinda had to constantly battle to prove – I just thought f*** them they’re not gonna tell me that being pregnant is not going to allow me to perform … Like it’s a psychotherapy course but they don’t f****** listen … like I felt unheard, really unheard. Em and I’m not trying to slate anyone but they didn’t listen …. because it was like talking to a brick wall”.

College & Motherhood Intertwined:

An interesting note is that for a few participants they found their college and motherhood experience were deeply intertwined and connected.

Lester & Notman (1988), postulated that poorly assimilated maternal introjects could have a negative impact on the new mother’s ability to identify with the mother.

Amanda’s approach was to use her training experience and learning to form the basis of a maternal introjection. This was done in two ways, the internalisation of a trainers encouragement: “I found that that feedback I internalised that and it was like the mother voice that I didn’t get from my mother telling me that I was doing good and that just
drove me and brought more out of me and kept me going and that was the momentum and the determination that got me through the course”. She also spoke of internalising learning in relation to mothering. “Well to be honest with you if I hadn’t done the course I would have been screwed (laughs) – the way I studied was I’d always take the theory and integrate it emotionally … so I felt that em you know I’d kind of internalised all these theories and it kind of actually helped me to be a mother! … I would never have known how to do that em and I never had the experience of my mother doing that for me so the course … seriously helped me to be a mum. It was great, it was a blessing really”.

For **Karen** she attributed a lot of her personal development to the course: “I think if I hadn’t have done the degree and I hadn’t have done all that personal therapy I don’t know what type of person I would be. Like I, I dread to think what type of mother I would be … so … yeah I think that all, that all that training has been amazing”.

For **Deirdre** too “it's been terribly interconnected … I think it really laid an amazing foundation for me to like just be this person who helps my baby unfold and I think I'm doing that? I'm the person I wanted to be in the life I wanted (laughs) and that's that's all got to do with this course and having a baby and I don't think I would have had one without the other”.

**4.6 Advice for Other Pregnant Trainees:**

The increased vulnerability and change precipitated by pregnancy underscores the importance of increased support and containment for training psychotherapists. For
example Guy et al. propose there is an increased need both for personal therapy and supervision (1986). Dyson & King (2008), suggested keeping a journal and also exploring the area with other therapists who are parents. Karter recommended a support network to look at common difficulties arising during training (2002). Having gone through the experience of pregnancy and training to be a psychotherapist the participants offered advice from their own perspective. These are divided into two sub-themes, regarding the area of self-care and the need to be prepared.

**Self-care:**

**Maeve** recommended to “really look after yourself … buy yourself flowers I used to do that every week” and she emphasised her “biggest thing … at the end I wasn’t able for my clients … so I think when you come to that point within your client work it’s best to pull out and say … you can’t cope or you’re deferring it for a while”.

**Deirdre** highlighted the importance of considering how long to take off and when to return to practice. “I went back … way too soon … like there’s a period of time that’s really necessary and I think we’re inclined to move away from that sooner than … is advisable I would say … Em and yeah I think it’s really important as a new mother to just … stay with that for as long as you need to and just really trust your gut”.

**Prepare:**

**Karen** admonished “just be aware that it does change the therapeutic relationship and just be really gentle with yourself and you know be … very careful to protect yourself
when you go in to see clients … to give yourself enough time eh before you know your
due date … and probably read a book on it to get some information and have a bit more
of an idea of what’s happening and you know how you might feel”.

Finally, Amanda cautioned; “I don’t think that you can under-estimate how absolutely
opened up and laid bare you get from pregnancy when you’re doing a course like this em
… it’s like a tightrope. Do not let anybody sideline you … do it, do not let the college tell
you how to how to proceed with your degree when you’re pregnant that would be my
over riding thing … cause that was, that’s where I felt let down”.
CHAPTER 5: CONCLUSION & RECOMMENDATIONS

5.1 Research Findings

By and large the findings of this study are for the most part reflective of the wider literature and research in the field. The impact of pregnancy is seen clearly both in the clinical sense and the personal one in a variety of different ways. Three participants felt their pregnancy had facilitated the work in terms of a deeper attunement and an increased transference that proved beneficial. However, the disrupting influence of pregnancy was more considerably documented. This included physical discomfort, internal distraction, magnified counter-transference, difficulties in containment and an increased need for preservation and protection which resulted in a distancing from the client. Personal impact on the self included struggles with changing identity, the re-emergence of old conflicts, a reworking of parental relationship and indeed in two cases a deeper impact in terms of a physical or emotional connotation e.g. a hernia, or post-natal depression.

This study has sought to add to the literature in terms of the affect of this life-changing event on the trainee therapist. As such it also details the issues particular to them in relation to their training experience. One of the primary and significant findings is the fact that all the participants in this study felt they lacked the relevant information and support in this field that would have aided them in their journey and their client work. Furthermore, there is evidence that these individuals felt unheard by the training institution as regards their personal and professional decisions and this raises the issue of the validity of personal experience and the respect of that. Lastly, the findings highlight
the inter-connectedness of the training and new motherhood experience for training therapists and how one informs the other.

This study has provided an indepth analysis of the experience of five pregnant trainee therapists in Ireland today; and it is hoped that these findings give a better and deeper understanding of the processes involved which will better enable us to anticipate and work with issues in this area as they arise, ensuring that we can optimise pregnancy as a therapeutic catalyst for effecting and facilitating change.

5.2 Strengths & Limitations of the Study

As with all studies of this nature there are both strengths and limitations involved. The advantage lies in its in-depth exploration of five individuals’ experience that has yielded such rich and abundant data. It is a testament to the legitimacy of IPA as a meaningful and significant method of analysis in the exploration of human experience. A quantitative approach would not have yielded such abounding and valuable results; which reflect and communicate the individuals’ experience so aptly. Conversely, part of its disadvantage then is that it reflects the experience of five individuals only. Moreover, the nature of IPA lends itself to subjective interpretation of the subjective experiences of an individual, and as such it is coloured by each of our biases, prejudices, interests and leanings – both the participant and the researcher. The researcher attempted to gain a wider sample of training therapists across a range of institutions but this did not prove possible at this time and as such it should be acknowledged that this study is limited to one training institution only.
5.3 Recommendations to Training Institutions

Briefly, there are a number of possible recommendations that emerge from the study which could be of benefit to training institutions as regards the pregnant trainee therapist in the future.

- The provision of information in this highly sensitised and specific area; be it in the form of a class as part of a skills training module, or indeed simply some literature. Hopefully this study can provide some part of that information sought by such individuals.
- The provision of, or at least access to more specialised supervision in this area.
- A support group between pregnant training therapists set up and run by the training institution could provide invaluable support for the pregnant trainee.
- A coherent and considered policy of how the training institution believes areas such as disclosure should be addressed; thereby reducing increased stress caused by dissent among internal and external supervisors and different theoretical grounding.

5.4 A Personal Perspective

On a personal note I have found that the exploration, execution, and completion of this research project has provided me with a deep and valuable insight into both the experience of pregnancy and its impact on the psychotherapeutic process. As someone who wishes to have my own family it has been a fascinating and rewarding learning that hopefully I may put to good use one day! Throughout my six years in training I have observed many pregnant training therapists and marvelled at their tenacity, determination
and commitment as they balanced huge personal and professional challenges simultaneously. It is a testament to the human spirit, to courage, fortitude and inner resolve that they could and would do both concurrently. I would like to dedicate this thesis to all the pregnant therapists and friends with whom I trained.
REFERENCES


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APPENDIX 1

PARTICIPANT CONSENT FORM:

**Title of the study:** Breaking Boundaries: *an exploration of the experience of the pregnant training therapist.*

**Researcher:** My name is Janice Toomey and I am a 4th year undergraduate student in Dublin Business School. I am conducting a research study as part of a Degree Programme in Counselling and Psychotherapy.

**Research Supervisor:** Susan Eustace

**Purpose of the study:**
This is an exploratory study, which intends to ascertain the impact of pregnancy on the trainee therapist. I will ask questions about your changing identity and roles, your experience of your pregnancy in the therapeutic space, and in the area of your overall training experience. You will not be identified in the results or in any part of the finished project, and all answers given will be treated in the strictest confidence. You may refuse to answer any question throughout the interview without prejudice. The interview will take approximately 40 minutes and will be given breaks as needed. Additionally, excerpts from the interview may be made part of the final research report, but no identifying characteristics will be included in the report. Participation in this study is completely voluntary, and you may stop the interview at any time, or withdraw your participation.
The recording will be destroyed following data collection.

Under the Freedom of Information Act (1997), you have the right to access records containing personal information. If the need arises you may contact me regarding this.

Please sign this form to show you have read and understood the contents:

The purpose and process of this study has been explained to me, and I agree to participate. I understand that my participation is voluntary and I can stop the interview or withdraw my participation at any time.

______________________________________________ (signed)
______________________________________________ (signed)
_______________________ (date)

If you have any further questions please contact me at 087 8189187
or e-mail at jaolto@yahoo.co.uk.

Thank you very much for your time,

Janice Toomey.
APPENDIX 2

INTERVIEW GUIDE

Demographic Questions

1. Age at last birthday
2. Age child
3. Place in training when pregnant during client work – 3rd/4th year
4. No. of months of client work while pregnant.

Interview Questions

CLINICAL WORK

1. In your experience, how did your pregnancy affect the therapeutic work?
   (Prompt – strengthened/weakened alliance? Facilitating/disrupting?)
2. Could you describe your counter-transference reactions at this time?
3. How would you say your pregnancy impacted on your functioning as a therapist? (Prompt – emotionally / practically / psychodynamically).

IDENTITY

1. How did pregnancy affect your sense of self?
   (Prompt – changing roles / juggling the professional v personal etc.)
2. Can you describe your emerging sense of self as mother?
   (Prompt – internal sense of motherhood – what does being a mother mean to you)
3. How did your pregnancy affect your relationship with your mother?

(Prompt – What came up in relation to your own mother)

TRAINING

1. What was it like being pregnant during your training?

2. How do you think training institutions could help trainee therapists regarding this area/issue?

3. What would your advice be to other trainee therapists who become pregnant during their client work?

OVERALL

Have you anything else overall to add, that I may have missed?