Pregnancy of a therapist serves as a strong stimulus in transference reactions. With more women entering the workforce, and therefore, more pregnant therapists conducting therapy, more attention needs to be focused on this issue so that turmoil, acting-out, and possible self-destructive behaviors of clients can be minimized.

The PREGNANT THERAPIST

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Pregnancy of a therapist causes some remarkable reactions in the therapeutic milieu. With the increased numbers of women in the workforce, it stands to reason that there are more pregnant therapists working now than in past years. Yet, little has been published concerning the topic of a therapist’s pregnancy as a transference stimulus in the therapeutic relationship. This fact is puzzling, however, since I noted strong transference reactions of clients to my recent pregnancy.

Hannett (1949) underscores the fact that clients’ reactions to a personal event in the life of their therapist offers an opportunity to examine the elements that enter into the clients’ transference. Why then is the literature so meager concerning pregnancy as a transference stimulus, an obvious major personal event? Perhaps because pregnancy is an aspect of human sexuality and thus considered a taboo topic, few have written about it. The paucity of material on the pregnant therapist also could be due to the fact that until the recent Women’s Liberation Movement such women-centered issues were not given much attention. Or, perhaps authors have been hesitant to write about potential conflict areas resulting from a woman’s pregnant state because doing so would be in contrast to the congratulatory, “all wonderful” image of pregnancy perpetuated in American media and culture. The lack of information on the subject could also be due to the fact that most authors and therapists are male.

Benedek (1973) delineates “four worlds” of the pregnant therapist. The world’s evolve in the therapeutic situation resulting from issues that are raised by a therapist’s pregnant state. This article is focused on Benedek’s “first world,” which encompasses reactions of clients to the therapist during her pregnancy.

Dynamics of Transference

Nunberg (1951) feels that transference is a projection onto the therapist of the client’s internalized unconscious relations with his first libidinal objects. During treatment, the client externalizes emotions and ideas belonging to the repressed unconscious objects of his past by projecting them onto the therapist, who is a mental representation of the unconscious objects in the external real world. The therapist is represented within the patient’s ego. The repressed objects, which are projected onto the real therapist, are a part of the client’s past, usually stemming from childhood experiences, and thus are unreal. In the transference situation the client is trying to substitute a real object (the therapist) for unreal objects (repressed material from his past).

Transference occurs as the therapist’s request for free associations or details of past experiences stimulates the client to reproduce repressed experiences. Besides the mental images that are brought to the client’s mind’s eye, the accompanying emotions surrounding the past experiences also surface. “These old and yet new, actual emotions try to attach themselves to the only real object available, the psychoanalyst, and to find an outlet in wishes, fantasies, and actions directed towards him” (Nunberg).

Transference invariably arises during therapy. Freud (1959) attributes much power to the phenomenon of transference, describing transference using war-time terminology. He refers to the battle that ensues when the therapist, in aiming at unearthing the transference process, “delves into the hiding places of the withdrawn libido.” The battle of transference is the struggle between therapist and client, reality and unconsciousness, and Freud felt that “eventually all of the patient’s conflicts must be fought out on the field of transference.”

A client’s transference reactions to the therapist’s pregnancy may be in relation to real and fantasy aspects of his situation. The transference may be based in his character structure developed in the early stages of his life and/or present life situation. The psychoanalytic view of transference sees the client displacing his feelings, attitudes, and opinions from a significant person or idea of his early life experiences onto the therapist. An expanded view of the transference process would include all aspects of the patient’s relationships with the therapist, including aspects that are reality-based. An example of a transference reaction of displacement of unconscious feelings would be anger shown toward the therapist as a result of resurfaced feelings of sibling rivalry. A more reality-
based transference reaction in response to a therapist's pregnancy may be feelings of sadness or anger experienced by an infertile client.

In uncovering the transference, the therapist re-educates the client, helping the client to see how they are living the past in the present through the transference situation. The therapist needs to distinguish the reality-based aspects of the client's transference from the inappropriately transferred aspects (Clarkson, 1980). Once the patterns of transference have been identified by the therapist, she should confront the client with the information based on the client's ability to gain insight.

A positive outcome of a transference situation is that the client is able to test reality better than before the transference occurred. Through revival of the repressed material of the transference situation, the ego gains direct access to its earlier experiences. As the therapist helps the client become aware of the transference situation, the client becomes able to examine his feelings in relation to the situations of his earlier life. When the client accepts the dynamics behind the transference situation, he loses the incentive to project the unconscious material onto the external world. The client will be less apt to distort reality in future experiences after gaining understanding of the transference situation. The role of the therapist in the transference situation then, is to teach the client reality-testing.

Transference Reactions Evoked by Pregnancy

Balsam and Balsam, in their chapter "The Pregnant Therapist" (1974), point out that simply due to the fact that a therapist's pregnancy has a visual aspect, the enlarged abdomen, some kind of reaction is necessarily evoked in clients. Even before the therapist's pregnancy is noticeable, a highly sensitive schizophrenic, borderline, or psychotic client may perceive the therapist's pregnancy as indicated in direct questions to the therapist or in the client's inclusion of pregnancy-related topics during therapy sessions. The therapist should be alert to masked allusions to her pregnant state and should deal with the allusions directly as they come up in therapy to prevent snowballing of transference reactions.

Clients have been known to develop symptoms of pregnancy (e.g., amenorrhea, nausea and vomiting, enlarged abdomen, even pains simulating labor) as a result of identifying with the pregnant therapist (Paluszyn, 1971). Identifying with the therapist's pregnant state can result from a client's unconscious desire to be pregnant or, conversely, a fear of becoming pregnant. Strong dependency ties to the therapist, with accompanying desires to be like the therapist, can provoke such transference reactions as the aforementioned somatic manifestations or possibly behaviors such as wearing loose maternity-type clothing or shopping for baby items. Material the client presents in sessions may center around babies and the birth process and being a mother.

The fact that the therapist has a private life can no longer be ignored by the client who is faced with accepting his therapist's pregnancy. Lax (1969) points out that while it is beneficial in
therapy for the therapist not to impose on clients aspects of her private life, maintaining the anonymity and neutrality a therapist is taught to maintain with her clients, pregnancy cannot and should not be ignored. The therapist's pregnancy presents a reality stimulus to the client. The therapist must enable the client to respond to the reality stimulus in the manner determined by his psychic constellation and current life situation. The obvious changes of the therapist during her pregnancy force the client to view her as a real person. Frequently, clients view their therapist as they viewed their parents, as static persons in whom changes are not acceptable (Nadelson, 1974). Clients must accept the therapist as a growing individual when the therapist is pregnant.

The impact of sexuality implied by pregnancy may trigger transference reactions. The client must face the therapist's sexuality. The client has to deal with the reality that the therapist not only has engaged in sexual intercourse, but also has a close relationship with someone other than the client. Transference reactions may include a resurgence of the client's fears of impotency, ideas that the therapist is bad because the client learned earlier that sex is bad, or fears of having impregnated the therapist, to name a few possible reactions. A positive transference reaction might be that the client opens up on the topic of his sexuality. He may now view the therapist as "safe" because she is clearly someone else's sexual partner. The client may be freed of fantasies that the therapist would make sexual demands of him and thus be open to discussing sexuality issues.

Resurgence of Oedipal conflicts can be a typical reaction to a therapist's pregnancy. Intense transference material may surface as the therapist is now viewed in her maternal state as a mother substitute. It is not uncommon for mental health clients to view their therapist as a mother figure; certainly a pregnant therapist is more likely to induce such a reaction.

Sibling rivalry issues can arise as the client sees himself in competition with the unborn baby for the therapist's attentions. Repressed feelings that the client felt as a child when a younger sibling was introduced to his family can be projected as transference elements. Paluszny and Pozanski wrote about a client who felt in sessions with his pregnant therapist that it was like having three people in the room instead of two. Balsam and Balsam tell of a client who became guarded in therapy sessions, withholding information because he feared the therapist's baby, after being born, would break the bond of confidentiality and tell others his secrets.

Fear of abandonment is a common cause of transference reactions with the pregnant therapist. Such reactions may be based in the client's past, such as with clients who were abandoned at an early age, or reality-based in that the therapist's pregnancy necessitates termination with the client—even if only for the time period of a short-term maternity leave. Fear may be manifested in behaviors such as increased demands, tardiness, or other testing behaviors. The client may abruptly terminate therapy in an attempt to "leave" the therapist first.

Lax, writing about the reactions adult clients had to her pregnancy, stated that male clients tended to deny her pregnant state until the fact that she was pregnant became unavoidable. At that point, a minor turbulence in the transference occurred and isolation was employed as the mechanism of defense. Lax's female clients acknowledged her pregnancy much sooner and profound transference storms were evoked. For several of her clients, recognition of their therapist's pregnancy was painful because repressed conflict issues surfaced. The author found her clients reacting to her pregnancy in accordance with the aspects of the pregenital and oedipal conflicts that were most significant in the development of their pathology. Hannett's clients reacted to her pregnancy in relation to incidents of their past. The author noted that the clients who had the strongest transference reactions made the greatest therapeutic gain from the therapy experience.

Case Reports
In the following case examples, both clients had been in therapy with the author for approximately 18 months. Both young men, aged 29 and 31, respectively, are identified as chronic schizophrenia who experience recurrent short-term inpatient hospitalizations. I first met the clients in my role as Discharge Coordinator to the inpatient facility where the young men were hospitalized. Upon their discharge, I became the clients' outpatient therapist at the local community mental health center. During the first nine months of contact, I met with the clients on a nonregular basis, mainly providing case management services (eg, assisting the clients in securing community residence placement).
Nine months previous to my maternity leave, I began meeting individually with the clients on a more regular basis (approximately once a week), providing psychotherapy to the clients.

In each session, my pregnancy appeared to have great influence in stimulating transference reactions. In Jim's situation, the transference reaction was more obvious, and began during the author's first trimester, before her pregnancy was noticeable. In the sessions with Earl, the transference reaction seemed to formulate during the latter part of the therapist's pregnancy and was at first less easy to recognize. Jim, who experienced the more obvious and easy to understand transference reaction, did not profit as much from the therapeutic experience as did Earl, whose transference pattern was more complex.

Early in the third month of pregnancy, before I had disclosed to others that I was pregnant, Jim asked if I was pregnant. At some level, Jim was able to sense the pregnancy, despite the lack of visual clues. A week after confirming the fact that I was pregnant, Jim announced at the onset of the session that he wanted a change of therapist. He said he just could not see me while I was pregnant, "It just wouldn't be right." He said he would resume sessions when I was no longer pregnant and asked me to get a replacement therapist for him who was young and attractive. Jim came to his next two sessions as though he was on social visits, his conversation centering on surface issues. When asked if he could remember his mother being pregnant, Jim at first said he could not, but later added that he did remember his mother pregnant, saying also, "Yes, I have a younger sister. We're the best of friends." When asked to discuss his reasons for requesting a new therapist, Jim would not respond directly and would terminate sessions early. In preparing Jim for termination, I informed him of my plans for maternity leave and my last day of work months in advance. Two weeks after discussing future termination, having not seen Jim since, I received a call from the director of the housing program in which Jim resided. Jim had abruptly left to go to Las Vegas, halfway across the country. He had left after cashing his monthly SSI check (the only money he had), taking with him a sleeping bag and a few clothes. The director had asked Jim to call his therapist and discuss his plans for leaving. Jim apparently angrily told the director, "She has no control over my life," and refused to call.

On the day I had told Jim would be my last day of work, he appeared at the mental health center. Interestingly, he arrived just minutes before a planned baby shower was to begin. Jim was very angry. His presentation immediately changed from social talk concerning his experiences in Las Vegas to his psychotic recurrent themes of the Devil trying to take his soul over and his power to combat the Devil as he took on the role of "Justice." Jim dramatized his presentation by pounding on the wall and banging the desk with his fist. Jim escalated in his acting-out behavior, never before witnessed by me, to the point that other staff persons intervened to check that I was not being assaulted by the client. After a lengthy display of Jim's acting-out behavior, I asked Jim if he realized I would soon be finished with work because I was leaving to have my baby. Jim's affect changed to one of sadness as he somewhat hesitantly acknowledged the fact. The next day, Jim was hospitalized following an evening of psychotic acting-out behavior at the community residence.

In understanding Jim's transference reaction, it is necessary to focus in on Jim's affect and the defenses he used to deal with his massive anger. When Jim first learned about my pregnancy, he was polite and congratulatory, and in the next few sessions, his behavior was as if on a social visit to a friend. This behavior was an attempt to disguise his massive anger towards the therapist, which became apparent anyway, when he asked for a new therapist. Jim insisted the new therapist be a young, attractive female, since he wanted the author to know he was no longer interested in her. The love/hate disturbance with his therapist reflects his unconscious ambivalence towards his mother.

Jim's abrupt trip to Las Vegas can be viewed as a flight from the therapist. Jim found it necessary to leave the area because he was unable to express his massive anger and was possibly afraid of violent impulses towards the therapist. Not able to deal with termination with the therapist, Jim's trip can be seen as his denial of the need to terminate and his expression of having control, of choosing to be the one who was abandoning the other.

The statement Jim made in regard to remembering his mother being pregnant and he and his younger sister being "best of friends" was an obvious reaction formation to the unconscious contempt he may have for his sister, first experienced as sibling rivalry when Jim was a child. The reaction formation is a defense against the unconscious imagery evoked by seeing the therapist pregnant and reliving some of the anger towards his mother for bringing another child into the world, an intruder into the symbiotic ties of the schizophrenic relationship with his mother. It was certainly no coincidence that Jim returned on the therapist's last day, psychotic, and thus able to express his anger towards the therapist.

Earl's recognition of the therapist's pregnant state was not clear until the therapist was well into her second trimester. Earl discussed in a session a dream/fantasy he had had that he was a prize stud at a horse farm where it was
his job to "get pregnant all the pretty fillies." I asked Earl if he realized I was pregnant. With almost a sigh of relief, Earl responded, "Well God Bless 'ya." Some minutes later he introduced, "I didn't get you pregnant, did I?" Earl was relieved to learn that he indeed did not get the therapist pregnant. From this point on, Earl's material, though extremely bizarre in its presentation, concerned sexual issues. Earl referred to periods in his life when others indicated to him that he was homosexual. Some Oedipal transference occurred as Earl worked through memories of being strongly attached to his mother and hating his father for taking his mother away from him and putting Earl in a mental hospital.

Earl's behavior became bizarre as he attempted to sort out his feelings concerning his sexuality. On one occasion he confided that he was wearing a pair of underpants belonging to a female resident of his community residence and that he was doing so because it felt as though he was making love to her. Earl collected several soda bottles, hiding them in his closet and under his bed after urinating in them. Upon the discovery of the bottles by a staff member of the community residence, Earl inappropriately announced that evening to the household at the dinner table, "Okay, so I've been jerking off upstairs." He reportedly made the announcement in a proud manner, as if he wanted all to be aware of his sexual prowess. A few days before the initial session with me, it was reported to the community residence staff by members of the community that Earl was inappropriately entering bars in town, soliciting men, dressed in full women's apparel. When I spoke to Earl about this behavior, Earl explained that since he had been unable to get a girlfriend acting as a male, he was trying to get a boyfriend and that maybe he was homosexual. Earl also admitted that he would like to be a woman because then he too could have a baby.

Despite Earl's bizarre acting-out behavior stimulated by transference reactions to the therapist's pregnancy, Earl made much therapeutic gain during the last months of working with the pregnant therapist. Once Earl was freed of fantasies that he had impregnated the therapist, he opened up and was able to talk about, for the first time, the issue of his sexuality. As some of his fantasies and behaviors were discussed in therapy sessions, Earl showed an ability to test reality more effectively than ever during his year and a half of treatment. For the first time, Earl was able to talk about his relationships with his parents and work through some issues that surfaced as earlier Oedipal conflicts, and libidinal attachments to his mother were evoked as stimulated by the therapist's pregnant state.

It is clearly evident that both cases demonstrate that pregnancy of the therapist serves as a strong stimulus in transference reactions. More attention needs to be focused on this issue so that turmoil and acting-out and possible self-destructive behaviors of clients can be minimized and the dynamics of the transference better understood.

References