Spiritual Care Resource Center

The article below was published in the New York Times Couch series about psychotherapy. The article highlights the issues rabbis, as therapists, ought to consider when counseling about fertility issues. Just as people may hold a rabbi in the role of symbolic exemplar where they will project their expectations back upon themselves based on what they think a rabbi may believe, so too they may project their beliefs about the rabbi's experience with (in) fertility. This is particularly true when the rabbi may be in the midst of his/her own personal fertility journey as well. This article is important for understanding how to balance protecting and sharing our personal lives in our work and keeping ourselves honest and whole as we encounter others.

The Pregnant Therapist

By Jessica Zucker April 28, 2015

Olivia sat across from me in my sunlit office, shadowed in grief. She'd been trying to get pregnant for years, and had been coming to see me for nearly all of them. After three miscarriages and two unsuccessful IVFs, she spoke softly of her strained marriage, wringing her hands in her lap. I shifted my weight from one leg to the other, listening intently; she shifted her eyes toward the window. But no amount of diversion could hide what sat between us: my unmistakably pregnant belly.

As a psychologist who specializes in women's reproductive and maternal mental health, I hear countless heartbreaking stories from women struggling to get pregnant, coping with perinatal anxiety, grieving miscarriages, contemplating terminating pregnancies and weathering postpartum mood and anxiety disorders. Somehow, during my pregnancy, my own anxiety didn't spike. I remained steady.

Understandably, my patients wanted to know about my pregnancy; a third entity had entered the consultation room, altering the therapeutic dynamic. They peppered our sessions with questions like "How do you feel?" (especially during first trimester, when I glowed olive green), and "What are you having?" (I didn't know). They wondered aloud how my impending motherhood would affect my work life.

Olivia expressed concern that I would lose the pregnancy and pressed me for details about my status and symptoms. "Thank you for checking in," I'd respond. "I feel fine." Then I'd turn the focus back to her. Together we explored the feelings my pregnant belly evoked for her: her envy of my seemingly "easy" go of it, her fear that my pregnancy would end badly, her fantasy that my being a specialist in reproductive health somehow made me "immune" — that "probably nothing bad would happen" to me.

My baby was born that fall.

Traditional psychoanalytic theories envision the therapist as a blank slate on which patients project their thoughts and fantasies, a distant expert interpreting the patient from behind an inscrutable facade. Patient's concerns are seen as problems the doctor can "fix" through psychological suturing. Contemporary psychoanalytic viewpoints, by contrast, have given rise to a very different understanding of the therapeutic alliance, one in which the relationship itself is ultimately what's curative. But the therapist's quasi-anonymity remains a central tenet. Patients might inquire about a therapist's personal life, but unless it benefits the patient's growth to

answer the question directly, the therapist usually explores what the question means to the patient.

So when my body changed shape and my protruding belly filled the consulting room, the traditional therapeutic construct got turned on its head. Pregnancy asserts the therapist's presence and shatters her privacy in a way that nothing else does. My baby bump represented different things to different patients: an active sex life, a certain relationship status, a desire to raise a family. And as my patients often told me, it stimulated longings that stemmed from their own maternal lines.

Four years later, pregnant for the second time, I miscarried at 16 weeks. After a day of bewildering bleeding and foreboding cramps, the baby emerged in the bathroom while I was home alone. I found myself in a psychological haze of despair that is still in the process of lifting from my psyche. One day obviously pregnant, the next I was a deflated, empty vessel.

I wondered how the change in my physical and mental presence would be experienced by my patients. Olivia, for one, chose not to return to therapy for a while. She said that my late-term miscarriage represented her "biggest nightmare" come true. "If a late pregnancy loss happened to you," she explained, "it means it could happen to me."

I speculated that my miscarriage might potentially strengthen some of my patient interactions, because I now understood their grief from a corporeal, not simply a theoretical, perspective. But I also recognized that my miscarriage might accentuate my vulnerability in ways that could hinder the therapeutic process. Would my patients be inhibited from freely discussing what might now, in the face of my fresh pain, seem like mundane details of their daily lives? I feared that they might want to protect me, comfort me, run from me or shield themselves from my anguish.

Processing this particular type of trauma was not something I had learned about en route to completing my doctorate. Even the textbooks that I'd read about pregnancy complications never mentioned the therapist — *her* pregnancy — or how to address within the therapeutic dyad her obvious loss of a pregnancy. I would have to learn this as I went.

Olivia returned to my office three months later, newly pregnant. In one session, near the end of her first trimester, she paused in thoughtful silence — and then whispered, "I'm worried that what happened to you will happen to me."

Several months later I got pregnant again. The beginning of this pregnancy coincided with Olivia's last trimester. I, like Olivia, was now angst-ridden and plagued with uncertainty, despite evidence that the baby was healthy. This time around, Olivia seemed particularly attuned to my eyes. "You look worried," she'd say tenderly.

I reassured Olivia that fear was inevitable given loss — grief knows no timeline. With glassy eyes and a deep sigh, she said that hearing me talk about my residual worries eased the sense of isolation that surrounded her miscarriages, allowing her to feel less alone. She was growing less afraid of losing again. Soon thereafter, Olivia gave birth to a healthy baby boy.

I continued, while pregnant, to hear agonizing stories of pregnancy complications. Far from a pristine therapeutic dyad, my patients and I haphazardly made our way through a maze of human emotions.

In the winter I gave birth — and took a much-needed maternity leave. When I returned to my office, I wept as I entered the consultation room, tears of relief, an emotional exhale following so many anxiety-laden months. Back at work, no longer preoccupied with pregnancy, I felt a sense of renewal and a sturdiness that I hadn't substantially embodied in over a year. I was more fully there, deeply present. I had missed this.

Recently, a new patient, Maya, came to me, 10 weeks pregnant. Fifteen minutes into her first session, while describing sleepless nights filled with fear about becoming a mother, she paused, glanced at my bookcase, and then looked back at me: "Can I ask — are you a mother?"

There was a time when I would have reflexively asked Maya what my maternity might mean to her. But instead I considered revealing a small but profound piece of my life. What I hope to offer my patients now, in both subtle and demonstrative ways — shared and silent — are the arduous lessons learned through personal pain and reflection. Far from a blank slate, but no longer a focal point of the therapeutic relationship, I've landed somewhere in between, a much more ideal middle ground.

"Yes," I began my reply to Maya. "I have two children."

Jessica Zucker is a clinical psychologist in private practice in Los Angeles.
Details have been altered to protect patient privacy.