



Research Article

Parallel pregnancies: The impact on the supervisory relationship and art therapy practice

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ABSTRACT

This paper explores a unique circumstance of simultaneous pregnancy within an art therapy supervisory relationship, and the impact of the supervisee therapist's pregnancy on treatment with adolescents in art therapy. At the time of their parallel pregnancy journey, the co-authors served as art therapists, with the first author supervising the second author, at a residential treatment facility for adolescents with histories of severe trauma, abuse, and neglect. The existing literature is relatively silent on the topic of the art therapist's pregnancy, as well as the impact of pregnancy on the clinical supervision relationship. Therefore, the authors utilized a reflective developmental model of supervision in which support, mutual inquiry, and education were critical in navigating the unique challenges specific to the three trimesters of pregnancy. Special attention is paid to description of practical issues that arose; including pregnancy disclosure, managing boundaries both with clients and in supervision, and maintaining self-care. Two case examples illustrate the impact of the supervisee therapist's pregnancy on relational dynamics with adolescents, and client artwork. As women comprise the majority of practicing art therapists, the authors conclude that there may be a critical need for increased research, guidance, and support for art therapists in the under-explored area of the impact of pregnancy on therapeutic practice.

Introduction

The topic of therapist pregnancy and its impact on clients in treatment relationships entered the psychoanalytic literature when Van Leeuwen in 1966, followed by Lax (1969), published the first accounts describing the impact of their own pregnancies on the transference and counter transference dynamics within the analyst-analysand relationship. Since then, the topic of therapist pregnancy has been explored with increasing, yet still sporadic, frequency in the larger canon of psychotherapy literature (Al-Mateen, 1991; Dyson & King, 2008; Fenster, Phillips, & Rapoport, 1986; Korol, 1995; Latza, 2006; McGourty, 2013; Nadelson, Notman, Arons, & Feldman, 1974; Naparstek, 1976; Paluszny & Posnanski, 1977; Stockman & Green-Emrich, 1994; Turkel, 1993).

Therapist Pregnancy: Intrusion in the Analytic Space (Fenster et al., 1986) was the first full-length book devoted to the topic. Though its subtitle seemingly framed the introduction of the therapist's pregnancy into the clinical dynamic as problematic and fraught with difficulty, this foundational work remains one of the most comprehensive resources available that addresses clinical dynamics and practical issues related to the impact of the therapist's pregnancy. A predominant focus was the range of reported transference reactions that a therapist's pregnancy

may likely elicit, including: Feelings of rejection, betrayal, loss, and abandonment; Envy of the therapist, the therapist's partner, or the unborn child (sibling rivalry); Identification with the baby/ resurgence of infantile wishes and needs; Sexual identity issues and/or concerns related to body image; Acting out (e.g. missing sessions, premature termination of therapy); Idealization or devaluation of the therapist.

Since the publication of the Fenster et al. (1986) volume, several authors (Dyson & King, 2008; Guy, 1987; Imber, 1995) have more closely examined the impact of pregnancy on the therapist herself. Shifting away from a characterization of a therapist's pregnancy as *intrusion*, these works placed more focus on the positive impact that a pregnancy may have both on the therapist herself and in therapeutic work. "Pregnancy may be considered a normal crisis in a woman's life that, although stressful, also has the potential for promoting significant emotional growth and psychic integration" (Imber, 1995, p. 283). Dyson and King (2008) postulated that the pregnant therapist may experience "increased intuition, empathy and a nurturing capacity which can impact positively on the therapeutic work (p. 28). Regardless of whether a therapist's pregnancy is seen as *intrusion* or *opportunity*, undoubtedly it introduces a unique set of circumstances into the clinical dynamic. Pregnant therapists may be tempted to adopt a *business as usual* approach at this time in their work with their clients. Imber

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(1995) described this as a defensive response in reaction to heightened vulnerability, concluding that it is usually more counterproductive, and potentially harmful, than it is helpful.

A search of the art therapy literature found only two articles (Hurdman, 1999; ter Maat & Vandersyde, 1995) and one book chapter (Skaife, 2012) with the topic of the art therapist's pregnancy as the primary focus. Hurdman (1999) and ter Maat and Vandersyde (1995) both focused on clinical themes that emerged in clients' art making and clients' transference reactions to the pregnant art therapist. They found many of the same transference reactions described by Fenster et al. (1986) to be common, such as feelings of loss, abandonment, envy, or denial. As both articles described art therapy work with adults experiencing chronic mental illnesses, instances of magical thinking apparent in either the artwork or the dynamics of the therapeutic relationship were noted. For example, ter Maat and Vandersyde (1995) described a client whose imagery and statements made apparent a fantasy of responsibility for the therapist's impregnation. Further, they highlighted the importance of therapist self-awareness around countertransference reactions so that practical and logistical issues impacted by the pregnancy might be appropriately discerned and addressed. Skaife (2012) also focused on transference and countertransference reactions elicited by her pregnancy, but with emphasis to client reactions within a group therapy context after her return from maternity leave.

Each of these sources examined the impact of the therapist's pregnancy on an adult population, as was also the case for each of the previous articles cited. A literature search on the impact of therapist pregnancy in clinical work with adolescents did not yield a single source. Furthermore, none of the art therapy sources and only a handful of articles in the psychotherapy literature (Baum, 2009; Goldberger et al., 2003; Imber, 1995; Itzhaky, 2002) explored the impact of pregnancy within the supervisory relationship. Situations of simultaneous pregnancy between therapists and clients have been explored (Al-Mateen, 1991; Goz, 1973), however case reports of simultaneous supervisor-supervisee pregnancy have not yet been documented. Consequently, this paper seeks to contribute to several under-explored areas: the unique impact of simultaneous pregnancy within the supervisory relationship and the impact of therapist pregnancy on treatment dynamics with an adolescent client population.

Therapist pregnancy and the supervisory relationship

A review of the literature on therapist pregnancy relative to supervision (Imber, 1995) revealed that pregnant supervisees typically experienced their supervisors to be either avoidant of the pregnancy, or generally unsupportive. This ranged from simple ignorance and/or lack of awareness to their needs, to outright hostility stemming from what supervisees perceived to be their supervisors' countertransference feelings of envy or other negative bias to the pregnancy. Thus, Imber concluded that a therapist's pregnancy justifies a higher need for supervisory support around four core areas: (a) managing anxiety, (b) increasing self-awareness, (c) building self-confidence, and (d) building clinical skills.

Baum (2009) examined supervisors' responses to their pregnant social work student supervisees, based on the supervisees' personal perceptions. While the sample size was small ($N = 10$), her analyses found three ongoing modes of professional reactions to supervisees' pregnancies: (a) avoidant, (b) educational, and (c) therapeutic. Supervisors perceived to operate from an avoidant mode, the majority at 6 of 10 participants, did not address or were dismissive of the supervisee's pregnancy in terms of possible impact on clinical work, even when brought up by the supervisee herself. Educational reaction patterns were seen in two of the supervisors and were "based on a professional perception that pregnancy has an influence on the clients as well as on the therapist" (p. 15). These supervisors utilized educational and reflective processes to help supervisees understand the implications of pregnancy on therapeutic dynamics, and as such, were encouraged to explore their

own emotional responses to the clinical work in order to yield a more meaningful learning experience. The last mode of reaction, therapeutic, consisted of an intensive focus to the pregnancy by the supervisor, even when the supervisee preferred not to discuss it. Though some level of therapeutic activity is part of several well-known models and approaches to supervision (Bernard, 1997; Ekstein & Wallerstein, 1972; Frawley-O'Dea & Sarnat, 2001), Baum maintained that any therapeutic focus to the pregnancy should be for the purposes of learning and skill development, and should not be confused with therapy itself.

An investigation of supervisors' countertransference responses to their pregnant supervisees produced similar findings (Goldberger et al., 2003). In this study, supervisor reactions consisted of distancing at one end of the spectrum to over-identification at the other, analogous to the avoidant and therapeutic approaches, respectively, identified by Baum (2009). Concurring with Imber (1995) and others, Goldberger et al. concluded that pregnant therapists may need higher levels of support, advice, and reassurance at this time in their professional lives, making good supervision especially crucial.

Supervisor pregnancy and the supervisory relationship

Only one article was located that explored the impact of the supervisor's pregnancy within the supervisory relationship (Itzhaky, 2002). This qualitative study analyzed perceptions and reactions of 42 supervisees to supervisors' behaviors. Among the findings, 71% of supervisees reported feeling aware of the supervisor harboring a "secret" in the first trimester before the pregnancy disclosure was made, with a majority of supervisees reporting feeling hurt and frustrated at what they experienced as decreased attention to their needs. These feelings usually resolved once supervisors disclosed their pregnancies, yielding perceptions of improved therapeutic alliance on the part of supervisees. A range of other reactions were also reported, including anger, neglect, and discomfort. Itzhaky speculated that a supervisor's lack of openness contributed to a supervisee's negative reactions, thereby recommending that supervisors be proactive in broaching the impact of their pregnancy on the supervisory relationship.

A simultaneous pregnancy journey in the supervisory relationship

In the following section, I (Miller) explore the unique circumstance of simultaneous pregnancy that transpired between myself and my art therapy supervisee (Giffin) from the angle of the supervision relationship. This discussion is organized in accordance with the three trimesters of pregnancy, with special focus to issues of pregnancy disclosure; managing interpersonal boundaries and self-care; and facilitating closure in clinical relationships. Most importantly, I highlight a reflective developmental approach to supervision in which support, mutual inquiry, and education were paramount in navigating the impact of the parallel pregnancy experience within supervision and in art therapy work with clients.

1st Trimester: Navigating disclosure and establishing a mutual educational process

Pregnancy is most commonly demarcated in accordance with three trimester stages. It is common practice in many parts of the Western world to keep a pregnancy private throughout the first trimester until comfort increases regarding the viability of the pregnancy (Ross, 2015). However, an array of physical symptoms, such as nausea, vomiting and extreme fatigue, can make pregnancy difficult to hide, even though external changes are not yet visible. On a psychic level, the internal reality of the pregnant woman may heighten as self-immersion and attunement to internal shifts occur. Anxiety may peak physical and emotional vulnerability becomes elevated, which may coincide with conflictual feelings as the pregnant woman considers a shift from a career-focused identity to one that will also encompass future

motherhood (Imber, 1995).

My supervisee and I first became aware of each other's pregnancies during a regular weekly supervisory session. This supervision session occurred towards the end of the first trimester in my case, and for Giffin, at the start of her second trimester. Though she had prepared to disclose her pregnancy during this session, my disclosure was unanticipated and earlier than planned. I had planned to inform her at the start of the second trimester, however, what transpired instead was an impromptu disclosure authentic to the unique situation at hand. The atmosphere within the supervisory space was genuinely celebratory, while also reflecting an aura of disbelief at the unusual nature of the circumstance. After the surprise faded, I gave more serious thought to the impact this would have on our art therapy clients, the residential milieu, and the supervisory relationship. I sought support and guidance from my own supervisor, as well as began searching for articles related to therapist pregnancy and the impact of pregnancy related to supervision. As mentioned previously, these literature searches resulted in very few hits.

In our next supervision session, I invited my supervisee to join me in the quest for clinical resources specific to art therapy. We were surprised to find only two articles (Hurdman, 1999; ter Maat & Vandersyde, 1995) that examined the impact of the art therapist's pregnancy in a practice-based context, given that women have comprised the majority of art therapy practitioners, educators, and researchers throughout the field's development (Elkins & Deaver, 2015). The few articles we found became invaluable sources of guidance. Of the three supervisory approaches described by Baum (2009), I began operating from an *educational* mode with respect to the mutual inquiry and problem-solving that our simultaneous pregnancy circumstances required, but which was grounded within a *reflective developmental* supervision framework.

While reflective processes are part of many different supervision models, an explicitly reflective developmental approach regards reflection as "inherently developmental" (Bernard & Goodyear, 2018, p. 37), promotes *reflection-in-action* (Schön, 1983) around what might be, and is both "continuous and focused" towards the goal of supervisee learning and skill-building (Rønnestad & Skovholt, 2013, p. 149). It is often practically structured in relation to a specific trigger (Neufeldt, Karno, & Nelson, 1996), or *critical event* (Ladany, Friedlander, & Nelson, 2005), which serves as the catalyst for reflection. In our case, the parallel pregnancy circumstance seemed to serve as such a critical event, with the three trimester stages of pregnancy corresponding to the "definable beginning, middle, and end, during which a *task* or *series of tasks* is addressed" in supervision, as denoted by Ladany and co-authors (p. 5).

Having begun the disclosure process between ourselves, we continued to search the literature specific to pregnancy disclosure with clients in the treatment milieu. A majority of the sources found concerned the process of pregnancy disclosure in work with adult clients (e.g., Dyson & King, 2008; Goldberger et al., 2003; Korol, 1995). The authors generally concurred that the optimal time for pregnancy disclosure was before the end of the second trimester, or no later than approximately six months into the pregnancy, to ensure ample time for addressing potential transference themes and reactions. This provided our initial framework for the timing of disclosure. However, we predicted that it would be difficult to maintain flexibility in the timing of pregnancy disclosure from client to client given that the milieu nature of the residential setting seemed to complicate pre-existing clinical guidance.

Dyson and King (2008) noted that the therapist's pregnancy is usually disclosed to the client in one of four ways: (a) the client consciously notices and indicates it through words or actions, (b) the client unconsciously notices and the therapist helps the client bring it to conscious awareness (i.e., may show up in art or other non-verbalized actions), (c) the therapist discloses before client notices and client acknowledges it, or (d) the therapist discloses and the client denies the

pregnancy, avoiding or repressing it from conscious awareness. However, these findings imply a disclosure process that is closed to outside interaction or involvement.

Within the residential treatment setting, our adolescent clients engaged in all daily activities within a closely supervised community of peers, staff, and clinicians. While we honored clients' complete confidentiality regarding the content of clinical issues surfaced in therapy (except concerning issues of self-harm, harm to others, etc.), our adolescent clients frequently did not treat information disclosed in the therapy session either by themselves or by the therapist in the same manner. Hurdman (1999) described a similar culture of information sharing when working with adult clients in a day treatment unit, and resolved to maintain more control over the timing and method of disclosure by revealing her pregnancy in a community meeting attended by all staff and clients once she began to show at the end of her fourth month. However, circumstances prevented this in our setting. We also anticipated that disclosing at the same time would promote conflation of our two separate circumstances as one, which indeed was borne out by the small uproar that ensued when word spread that we were both pregnant. "The entire art therapy department is pregnant!" or "there must be something in the clay!" were just a few of the statements made in jest by our clients or our colleagues. Thus, we maintained individual autonomy regarding when and where we chose to disclose our pregnancies, with attention to the clinical guidelines previously discussed.

2nd Trimester: Managing boundaries, self-care, and professional identity shifts

In the second trimester, the pregnant woman may begin to feel some relief from fatigue or other physical symptoms, coinciding with increased visibility of the pregnancy. Decreased internal preoccupation and anxiety may also be common, as well as an increase in feelings of pride and contentment in oneself and the pregnancy. Emotional shifts may correspond to no longer needing to harbor the pregnancy as "secret," as the circle of individuals let in on the news becomes wider (Dyson & King, 2008; Ross, 2015).

As supervisor, I aimed to create a supportive and consistent supervisory space where self-reflective exploration to the impact of Giffin's pregnancy on her work with clients could safely occur. This included special attention to the importance of self-care while managing professional boundaries and navigating identity role shifts, as well as a closer consideration of transference and countertransference reactions stirred up by our disclosures, first to each other, and then with staff and clients in the milieu as the pregnancies became more visible. Rosen (1989, as cited by Korol, 1995) advised to "take the cue from the client and be careful not to over-emphasize an event that is of major significance to the therapist, but may not be as relevant to the client" (p. 161). I encouraged mindful reflection as to potential transference reactions that her pregnancy disclosures might have elicited with clients, while also encouraging self-monitoring for any automatic assumptions lacking in critical reflection.

We also invested time reflecting on the impact that therapist pregnancy had on dynamics within the overall milieu, including optimal ways of handling comments, questions, or other interactions that crossed professional boundaries. For example, we shared with each other our frustration and surprise at the amount of energy involved in constantly negotiating boundary crossings, particularly attempts made by clients and staff to comment about or touch our changing bodies without permission. These experiences provided a vehicle for each of us to openly voice and examine our differences not only in relation to our pregnancy experiences, but also with regards to clinical decisions, approaches, and other areas of professional identity development. Having achieved increased clarity around our own emotional reactions, we were better able to discern that questions and comments on the part of clients, staff, or other clinicians usually stemmed from understandable anxiety with regards to how the overlap in our maternity leaves would

impact continuity of services for the adolescent residents.

During this trimester, the boundary breaches that occurred within the milieu paralleled a loosening of boundaries within the supervisory relationship, but one that we acknowledged and maintained awareness of as our pregnancies progressed. To this end, boundary crossings were not boundary violations, as these were fundamentally moored in an attitude of respect and empathy for each other due to the co-shared nature of many of our experiences—physically, emotionally, and professionally. Mutuality of experience was perceived by both supervisor and supervisee to deepen the supervisory alliance. A practical aspect of this included the necessity of flexibility on both our parts in order to accommodate regular or unexpected healthcare appointments. Additionally, whereas we had previously held to a more formal and structured style of supervision—one that often moved along at a quick pace due to a treatment culture in which unexpected crises were a frequent occurrence—the shared experience of pregnancy necessitated a loosening in this stricture. Allowing time and space for commiseration and sharing of our respective pregnancy experiences was found to strengthen feelings of trust and mutuality within the supervisory relationship, thereby building a solid foundation on which clinical issues could be processed more openly and effectively.

3rd Trimester: Planning for closure with clients and in the supervisory relationship

In the final trimester of pregnancy, many women experience increased physical discomfort and fatigue as their growing shape makes sleep and other bodily functions difficult (Davis, 1996; Nazik & Eryilmaz, 2013). Bursts of energy and excitement are common, often resulting in preparatory “nesting” behaviors. Hence, the last trimester is characterized by the anticipation of new beginnings—new dreams, expectations, concerns, and fears—as well as intensifying anxiety due to the unknowns of labor and the birthing experience. Primary maternal preoccupation and withdrawal may also intensify as the onset of birth draws near.

As we entered the final months of our pregnancies, the focus in our clinical supervision shifted to the process of closure and saying goodbye—to clients, colleagues, and each other. Though Giffin intended to return after a 12-week maternity leave, residents were frequently discharged or transferred to other facilities with minimal notice. Her post-maternity plans carried the potential for change as well. According to research consulted (Dyson & King, 2008; Hurdman, 1999; Stockman & Green-Emrich, 1994), it is preferable to set an exact date for ending (or referral/transfer, if possible) in order to decrease client anxiety and impact positively the course of the remaining treatment. “Failure to set a date could be seen as colluding with the client’s denial of the impending arrival of the baby and the consequent separation of client and therapist” (Dyson & King, 2008, p. 38). Consequently, I advised Giffin to set a final ending date in collaboration with each of her clients that held no promise of return, staggering the dates so that therapeutic closure would occur approximately two weeks in advance of her estimated due date. This allowed us to more carefully examine the impact of closure and termination in light of clinical themes and gains specific to each client, thereby avoiding processing themes of termination in a global and less differentiated manner. In addition, several weeks without formal client contact allowed Giffin the time to say goodbye to colleagues and complete other logistics.

Closure within our supervisory relationship transpired over several weeks, and with added meaning given the uniqueness of our simultaneous pregnancy journey. The unexpected parallel experience had added novel elements of experience, learning, and mutuality to the supervisory process. It foregrounded a level of transparency, authenticity, and risk-taking on both ends that may not have occurred as early on in the supervisory relationship otherwise. As supervisor, my primary concern was to provide a supportive supervisory environment in which continuous reflection was applied to clinical challenges, concerns, and

successes towards the aim of building Giffin’s clinical skills and professional identity. Additionally, the parallel experience provided a unique frame for our work together by enabling a depth of reciprocal understanding, empathy, and interpersonal attunement within the supervisory space.

Impact of Supervisee’s pregnancy on client treatment in art therapy

In the following section, I (Giffin) discuss the impact my pregnancy had during the course of art therapy treatment with two different adolescent clients. These cases provide vivid illustration of the ways in which my pregnancy contributed to therapist-client relational dynamics and client creative processes, with specific focus to the unique challenges presented at each trimester stage and how these served as a catalyst for growth within treatment.

Case example #1

The first trimester of my pregnancy coincided with my introduction to working with Ashley (pseudonym) and our exploration into new roles. For Ashley, that of adolescent, and for me, a pregnant therapist and mother. At 12 years old, Ashley was one of the youngest residents at the treatment center. Ashley had a history of self-injurious behavior and suicidal ideation following severe physical and sexual abuse by her stepfather. Ashley engaged in individual art therapy over the course of six months, which was used as an adjunctive method of treatment in support of her overall goals in the milieu. These included learning to express feelings connected to her trauma history, learning and effectively utilizing coping skills, and building interpersonal skills. She showed an immediate affinity for the creative process, as demonstrated by the enjoyment and ease with which she approached art making.

In the early stages our work together, a number of themes emerged. Especially prominent were themes pertaining to adolescent development, such as physical and sexual changes, as well as feelings of abandonment and rejection resulting from experiences of family loss. Ashley attempted to assert her maturity by expressing adult-like subject matter while concurrently conveying a desire to be nurtured and mothered. She requested reassurance after each mark she made on her paper, at the same time as she sized me up with questions like, “What are you wearing?” and “Do you have a boyfriend?” Consequently, I felt propelled into a maternal role through her persistent boundary testing.

As my second trimester approached, I sorted through my feelings about the personal and professional impact of becoming a mother, while Ashley explored her relationship to her own mother. Ashley stated that she wanted to create a piece of art for her mother to show her appreciation and “not because it was a holiday or special occasion.” She glued various images conveying messages of “love” onto a large bright pink poster board (Fig. 1). While she spoke of love and forgiveness, Ashley literally covered up feelings of disappointment that her mother did not protect her from her stepfather as expressed in a handwritten letter she glued to the piece.

The covering up continued throughout my second trimester. For me, it took the form of baggy sweaters, and for Ashley, wrapping up her artwork. She devoted several sessions to creating elaborate wrapping papers, cards, and bows for artworks that she planned to gift to her mother. At the same time that her creative process focused on themes of covering and containment, her actions suggested that she felt increased safety and trust in the therapeutic relationship, and simultaneously appeared to be engaging in safe risk-taking by exposing a more vulnerable side of herself. For example, she began to store art work made at school in the art therapy office, sit closer to me in the treatment space, and seek my advice regarding peer conflict.

In our next sessions, Ashley created a flower using sculpting media and paint (Fig. 2). The process of paint mixing appeared cathartic and self-soothing for her, while seemingly providing a means for contained



Fig. 1. Untitled.



Fig. 2. Ashley's flower- Untitled.

regressive exploration. Ashley gave considerable attention to the process of applying paint to the stigma, the flower's sex organ. This process began with light colors as if to mute it, then evolved to bright colors as if to highlight it, and ended with a layer of black, as if to negate it. After numerous paint applications, the stigma snapped off the flower. Ashley tolerated the break and sought my support to repair it with glue and repaint it. The multiple layers of paint that she used to cover the stigma was reminiscent of her layering of glue to cover the letter to her mother. In considering the stigma as a sex organ, and having an awareness of her history, I contemplated whether she had aimed to cover the symbolic evidence of the trauma in the same way she covered the literal evidence of her letter to her mother. If her mother didn't see the letter, she wouldn't have to explain to her what happened. If the phallic stigma didn't exist, there would be no means to harm her.

After consultation with my supervisor, I disclosed my pregnancy to Ashley towards the end of my second trimester. Ashley assessed my

physical appearance, stating bluntly that I would “get fat,” and reminisced about her mother's pregnancy with her younger siblings, referring to them as “the evil children.” Ashley's statements conveyed several of the transference reactions discussed by Fenster et al. (1986), including potential projection of body image concerns and possible feelings of envy or rivalry triggered by memories of her mother's pregnancies. During this discussion, Ashley painted a symbiotic, womblike image (Fig. 3), working methodically to create a symmetrical pattern consisting of two mirroring shapes surrounded by various dots. As she painted, Ashley voiced aloud her frustration with the “many” people leaving her due to pregnancy, asking “Who will take care of me?” The phrasing of this inquiry seemed to affirm her perception of me as a maternal Fig. 1 validated her feelings, and aimed to shape this as an opportunity for her to experience loss in an adaptive, empowering way. With time in our session remaining, I invited Ashley to collaborate on a drawing with me as a way to offer nurturance and visually confirm



Fig. 3. Untitled.



Fig. 4. Untitled.

the therapeutic alliance that she now questioned.

In my final trimester of pregnancy, Ashley fluctuated between extremes of anger, avoidance, and admiration while navigating the anticipatory loss due to my impending departure. In one session, she stormed off suddenly, though announced self-reflectively that it was easier for her to leave mad than sad. In another, she shared reasons why she thought I would be a great mother. This relational push and pull aligned with Hurdman (1999) perceptions of the “intensification of the ambivalent mother-child relationship” (p. 238) that she experienced while pregnant in her work with clients. Emphasis was placed on providing emotional support and safe reflective space to her experiences of loss, as well as identifying ways to incorporate the creative arts into her program at the residence and beyond. In one of our last sessions, she completed a box for her flower, padding it with layers of tissue paper to ensure that it wouldn’t break, and opted to keep the top open in order to let “fresh air in,” a decision that seemed reflective of her increasing awareness to the importance of self-care (Fig. 4).

In our final session, Ashley’s tone was somber, quiet, and she avoided eye contact. I presented Ashley with a card and gift of art supplies, affirming and encouraging the capacity for self-expression I witnessed in her. Initially feigning disinterest, she set aside the art supplies and card without reading it, saying that she received a similar gift from a previous therapist that she subsequently threw away. I acknowledged our ending as one loss in a pattern of many for her, and clarified my intentionality in selecting the art supplies specific to my understanding of her needs and interests. She then began to experiment with the art supplies, stating she would not throw them away after all. This final exchange spurred one of the most significant therapeutic processes in our work together: it encouraged her to directly address difficult feelings surrounding losses, while pairing a new narrative to the loss that she was now experiencing due to the ending of our relationship.

Ultimately, Ashley demonstrated major growth throughout the course of art therapy as she worked to attain authentic insight into connections between her artwork and life experiences. Her creations became progressively less defended and representative of a wider range of emotion. She departed from images primarily identified as “happiness” and “beauty.” In their absence, themes of desire for nurturance and safety emerged in the artwork, which paralleled the transformation in the therapeutic relationship.

Case example #2

At the start of my second trimester of pregnancy, I (Giffin) also began working with Michael (pseudonym) in individual art therapy. Michael was a 16-year-old boy with a history of gang involvement and



Fig. 5. Michael’s painting of the flag of Puerto Rico.

difficulty managing anger triggered by feelings of loss and abandonment in connection with his family. His goals for art therapy included learning to identify and process feelings connected to his trauma history; developing emotional regulation and anger management skills through creative processes; and increasing his understanding of interpersonal boundaries. Throughout four months of art therapy, Michael demonstrated a high level of investment and thoughtful planning in his art making process.

Despite Michael’s reported history of poor impulse control, he presented as gentle and composed in our sessions. Each session typically began with Michael methodically brushing his hair, all while enthusiastically discussing his creative ideas. As with Ashley, Michael’s creative work revolved around themes of family. In our first session, he painted an image of the flag of Puerto Rico (Fig. 5), sharing with me the comfort it provided him throughout his life. The flag was tucked under his crib as a baby, and years later, he continued to carry it with him at all times. I viewed this disclosure as a courageous act of vulnerability, as it likened the flag to a transitional object similar to a teddy bear or blanket, while also conveying a strong desire to connect with his cultural background.

During the start of our second session, I formally disclosed my pregnancy even though I was aware Michael already knew. He was nearby a few days prior when another client asked if I was pregnant. He responded in a manner that appeared protective of me, telling the resident, “Leave her alone.” Somewhat surprised by the bravado of his reaction, I considered whether Michael wanted me to experience him as strong and mature, capable of keeping me safe. I revisited this interaction when formally disclosing in our session, and offered time for questions and reflection regarding how this might impact our work together. Though he appeared uncomfortable, he briefly explored his cultural values related to the importance of showing respect for women and mothers before transitioning back to his art. His restraint appeared to reflect both discomfort and an awareness of client-therapist boundaries.

In this way, my pregnancy disclosure facilitated an opportunity for Michael to practice self-regulation skills in accordance with his treatment goals, underscoring Hurdman (1999) mention of the potential for therapist pregnancy to yield positive benefits for the client. Moreover, though Michael’s reactions of ambivalence might be attributed to his experiences of inconsistent parenting (similar to what occurred with Ashley), in his case, cultural variables appeared to play a distinct part. Both the protectiveness he exhibited towards me and his subsequent discomfort with the disclosure might be interpreted as transference reactions stemming from learned cultural gender norms. In response, my countertransference reactions prompted reflection in supervision to the importance of my own self-care and privacy due to the heightened self-protectiveness and increasing fatigue, both physical and emotional, that I felt as I constantly navigated the boundaries between personal



Fig. 6. "Family comes first" plaque.



Fig. 7. Background environment for "Family comes first" plaque.

and professional.

In subsequent sessions, Michael created a plaque using sculpting material and paint, which he titled "Family Comes First" (Fig. 6). He carved the words "Mom and Dad" in the center and surrounded them with his siblings' names. Michael's application of paint highlighted the word "Mom," which muted the other names into the backdrop. After completing this piece, Michael painted an environment (Fig. 7) for the plaque. It began with bright, fluid strokes, and contained imagery similar to the plaque: a light blue ocean, a bright blue sky, and a warm yellow sun. As Michael's comfort and commitment to the piece increased, the color scheme of the sky evolved to incorporate deep hues of purple, which seemed to embody an internal shift towards a deeper, darker mood state. I wondered whether the progression of color in the imagery began to reflect increasing authenticity of the wider range of his experiences related to his family. As his earlier artworks displayed only positive familial associations, did his art now reveal inner ambivalence related to experiences of negligent parenting? In this regard, the piece felt honest and hopeful. His layering of paint appeared to serve a function of deeper emotional processing as opposed to covering feelings up, which occurred just after my own "uncovering" signified by my pregnancy disclosure.

As the second trimester of my pregnancy came to a close, I was visibly pregnant. There was buzz in the residential milieu as both adolescent clients and staff alike frequently stopped to ask me questions about the sex or proposed name for my baby. I maintained personal boundaries without appearing dismissive. My belly presented as a third person in the therapeutic space. There was no hiding it or its physical implications. Interestingly, Michael transitioned from exploring themes of family in his creative process to sorting through thoughts and feelings about romantic relationships in tandem with creating artworks for various girlfriends.

Towards the end of our work together, Michael's artistic style returned to that of his earlier works. For his final art piece, his process began much like previous paintings in terms of color scheme and subject matter. However, this painting differed in the placement of a fiery sun at its center and a prominent division in the bright blue ocean beneath it. The sun—a source of warmth, nourishment, and protection—had shifted from his usual upper left corner placement and was now front and center. The once murky water was now vibrant. As Michael's treatment (and my pregnancy) came to an end, we were both beginning new chapters. He titled this piece, "Best Art Therapy Painting"



Fig. 8. "Best art therapy painting".

(Fig. 8), and asked me to display it in my office.

Overall, the development of a strong therapeutic alliance was imperative to providing a safe space for Michael to process themes of family, culture, and romantic love through his creative process. Through the art therapy relationship, Michael demonstrated his resiliency as a leader and caretaker, both of himself and as demonstrated by the protectiveness he showed towards me. Michael was highly invested and engaged throughout the course of art therapy. It is likely that the physical representation of my pregnancy, combined with the time constraints it placed on treatment, served to accelerate progress towards goals in the areas of relational skill-building and adaptive, emotional management.

Discussion and conclusion

This paper explored a unique circumstance of simultaneous pregnancy within an art therapy supervision relationship and the impact of the supervisee therapist's pregnancy in art therapy with adolescents. A *reflective developmental* model of supervision was emphasized in which support, mutual inquiry, and education were critical in navigating the unique challenges presented specific to each trimester stage of pregnancy. Issues of pregnancy disclosure, boundaries, and self-care were discussed, and two case examples illustrated the impact of the supervisee art therapist's pregnancy on client relational dynamics and artwork in a residential treatment setting for adolescents. In describing the professional impact of a very personal part of the supervisor and supervisee therapists' lives, the authors had three primary goals in mind.

The first was to emphasize use of a reflective developmental approach to supervision (Bernard & Goodyear, 2018; Ladany et al., 2005; Neufeldt et al., 1996; Rønnestad & Skovholt, 2013; Schön, 1983) that openly considered and explored the impact of therapist pregnancy within clinical art therapy relationships and the overall treatment milieu. The importance of support, mutual inquiry, and education as part of this approach, as recommended by Baum (2009), Goldberger et al. (2003), and others, was underscored in this case by the rare nature of the parallel pregnancy experience for both supervisor and supervisee. As a result, each required consistency of support and guidance in order to ensure ethical and competent clinical and supervisory performance. This involved a collaborative effort to discern best practices from previous literature in order to apply these in art therapy work towards the aim of effective clinical practice. It also involved outside consultation and supervision to support the supervisor. However, most critical was continuous reflectivity to the impact of pregnancy on the clinical and supervisory work, which served to strengthen the supervisory alliance, build clinical skills, increase self-confidence, and promote practices of self-care at a time when these were crucial.

Second, the two case examples aimed to engender a viewpoint of therapist pregnancy as a generally normative circumstance that, when navigated in a thoughtful and well-planned manner, can serve as a catalyst in positively impacting the clinical work. Because prior art therapy literature (Hurdman, 1999; ter Maat & Vanderysde, 1995) has foremost featured a discussion of adult clients' negative transference reactions, this may have inadvertently corroborated the

characterization of therapist pregnancy as an intrusion (Fenster et al., 1986). Though the art therapist's pregnancy certainly placed time constraints on treatment, this combined with its physical representation in the therapeutic space, was experienced to positively impact the therapeutic work by precipitating a more expedient, honest, and authentic exploration of themes specific to each client's treatment needs and goals. Moreover, in the case of Michael, cultural variables were deemed significant in understanding his reactions to the therapist's pregnancy disclosure, an area not addressed in previous literature.

Finally, the authors aimed to highlight a topic that is still largely under-explored in the professional literature, especially within the field of art therapy. As the vast majority of practicing art therapists are women, with 94% of respondents from a recent member survey of the American Art Therapy Association having self-identified as women (Elkins & Deaver, 2015), this is somewhat surprising. Perhaps the co-occurrence of art therapy's pioneering years with second-wave feminism of the sixties and seventies, which centered largely on reproduction rights and women's rights in the workplace, has had an ironic impact: "Some influential feminist voices that were otherwise quite insightful almost exclusively saw motherhood as a trap to women's advancement, one that should be avoided by whatever means possible" (Gaskin, 2011, p. 17). As the field sought to establish itself, art therapists may have collectively refrained from exploring the impact of child bearing to avoid evoking associations with traditional gender roles. Regardless, art therapists who become pregnant while engaged in clinical practice have had little to refer to for guidance as they navigate the intersection between the two. Consequently, the authors aimed to shine a spotlight on the topic of the art therapist's pregnancy by detailing their own experiences in order to stimulate further research and discussion around best practices in an area considered to be of certain relevance to a large proportion of practicing art therapists and, hopefully, of increasing interest to the art therapy field overall.

Coda

Miller and Giffin each gave birth to healthy baby boys within four weeks' time of each other. Giffin initially resumed working at the residential treatment facility following her maternity leave, after which she eventually moved on to pursue work as an art therapy clinician and consultant in private practice and school settings. Miller relocated to pursue a graduate art therapy educator position at the same time as working towards her doctorate. Though Miller and Giffin are no longer in a supervisory relationship with each other, they maintain a close connection as art therapy collaborators and friends, who frequently share recent family photos.

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References

- Al-Mateen, C. S. (1991). Simultaneous pregnancy in the therapist and patient. *American Journal of Psychotherapy*, 45(3), 432–444.
- Baum, N. (2009). Supervisors' responses to pregnant supervisees. *The Clinical Supervisor*, 28, 3–19.
- Bernard, J. M. (1997). The discrimination model. In C. E. Watkins Jr. (Ed.). *Handbook of*

- psychotherapy supervision* (pp. 310–327). New York, NY: Wiley & Sons.
- Bernard, J. M., & Goodyear, R. K. (2018). *Fundamentals of clinical supervision* (6th ed.). New York, NY: Pearson.
- Davis, D. C. (1996). The physical discomforts of pregnancy. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 25, 73–81. <https://doi.org/10.1111/j.1552-6909.1996.tb02516.x>.
- Dyson, E., & King, G. (2008). The pregnant therapist. *Psychodynamic practice*, 14(1), 27–42. <https://doi.org/10.1080/14753630701768958>.
- Ekstein, R., & Wallerstein, R. S. (1972). *The teaching and learning of psychotherapy* (2nd ed.). New York, NY: International Universities Press.
- Elkins, D. E., & Deaver, S. P. (2015). American Art Therapy Association, Inc.: 2013 membership survey report. *Art Therapy: Journal of the American Art Therapy Association*, 32, 60–69. <https://doi.org/10.1080/07421656.2015.1028313>.
- Fenster, S., Phillips, S. B., & Rapoport, E. R. G. (1986). *The therapist's pregnancy: Intrusion into the analytic space*. Hillsdale, NJ: Analytic Press.
- Frawley-O'Dea, M. G., & Sarnat, J. E. (2001). *The supervisory relationship: A contemporary psychodynamic approach*. New York, NY: Guilford Press.
- Gaskin, I. M. (2011). *Birth matters: A midwife's manifesta*. New York, NY: Seven Stories Press.
- Goldberger, M., Gillman, R., Levinson, N., Notman, M., Seelig, B., & Shaw, R. (2003). On supervising the pregnant psychoanalytic candidate. *Psychoanalytic Quarterly*, 72, 439–463.
- Goz, R. (1973). Women patients and women therapists: Some issues that come up in psychotherapy. *International Journal of Psychoanalytic Psychotherapy*, 2(3), 298–319.
- Guy, J. D. (1987). *The personal life of the psychotherapist*. New York: John Wiley & Sons.
- Hurdman, C. M. (1999). Clinical issues and client reactions arising from the art therapist's pregnancy. *The Arts in Psychotherapy*, 26(4), 233–246.
- Imber, R. R. (1995). The role of the supervisor and the pregnant analyst. *Psychoanalytic Psychology*, 12(2), 281–296.
- Itzhaky, H. (2002). Enlisting the supervisor's pregnancy to facilitate the supervisory process. *Families in Society: The Journal of Contemporary Human Services*, 83(2), 189–196.
- Korol, R. (1995). The impact of therapist pregnancy on the treatment process. *Clinical Social Work Journal*, 23(2), 159–171.
- Ladany, N., Friedlander, M. L., & Nelson, M. L. (2005). *Critical events in psychotherapy supervision: An interpersonal approach*. Washington, DC: American Psychological Association.
- Latza, T. (2006). *The use of the therapist pregnancy in the psychodynamic treatment of a young girl with fears of abandonment*. (Unpublished doctoral dissertation). Chicago, IL: The Chicago School of Professional Psychology.
- Lax, R. F. (1969). Some considerations about transference and countertransference manifestations evoked by the analyst's pregnancy. *International Journal of Psychoanalysis*, 0, 363–372.
- McGourty, A. (2013). The pregnant therapist and the psychotic client: A phenomenological understanding of the impact of the therapist's pregnancy on the therapeutic process. *European Journal of Psychotherapy and Counseling*, 15(1), 18–31.
- Nadelson, C., Notman, M., Arons, E., & Feldman, J. (1974). The pregnant therapist. *American Journal of Psychiatry*, 131, 1107–1111.
- Naparstek, B. (1976). Treatment guidelines for the pregnant therapist. *Psychiatric Opinion*, 13, 20–25.
- Nazik, E., & Eryilmaz, G. (2013). Incidence of pregnancy-related discomforts and management approaches to relieve them among pregnant women. *Journal of Clinical Nursing*, 23, 1736–1750. <https://doi.org/10.1111/jocn.12323>.
- Neufeldt, S. A., Karno, M. P., & Nelson, M. L. (1996). A qualitative analysis of experts' conceptualization of supervisee reflectivity. *Journal of Counseling Psychology*, 43, 3–9.
- Paluszny, M., & Poznanski, E. (1977). Reactions of patients during the pregnancy of the psychotherapist. *Child Psychiatry and Human Development*, 1(4), 266–274.
- Rønnestad, M. H., & Skovholt, T. M. (2013). *The developing practitioner: Growth and stagnation of therapists and counselors*. New York & London: Taylor & Francis.
- Ross, E. J. (2015). 'I think it's self-preservation': risk perception and secrecy in early pregnancy. *Health, Risk & Society*, 17, 329–348. <https://doi.org/10.1080/13698575.2015.1091922>.
- Schön, D. (1983). *The reflective practitioner: How professionals think in action*. New York, NY: Basic Books.
- Skaife, S. (2012). The pregnant art therapist's countertransference. In S. Hogan (Ed.). *Revisiting feminist approaches to art therapy* (pp. 237–254). New York & Oxford: Berghahn Books.
- Stockman, A. F., & Green-Emrich, A. (1994). Impact of therapist pregnancy on the process of counseling and psychotherapy. *Psychotherapy*, 31(3), 456–462.
- ter Maat, M., & Vandersyde, A. (1995). The pregnant art therapist. *American Journal of Art Therapy*, 33(3), 74–83.
- Turkel, A. R. (1993). Clinical issues for pregnant psychoanalysts. *Journal of American Academy of Psychoanalysis*, 21(1), 117–131.