

Transference in a Pregnancy and Postpartum Group and Reflections on Female Development

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ABSTRACT. The psychological experience of pregnancy has been of increasing interest to therapists and is thought to include a developmental crisis in which the woman reworks her sense of herself and her significant relationships. Beginning as a community outreach program during Operation Desert Storm, a support group for pregnant and postpartum women met over a period of 28 weeks. During that period, the group members, in working through their transferences to the male and female therapists, progressed from devaluing themselves and feeling inferior to men to valuing and enjoying their femininity and reproductive abilities. In light of this occurrence, I challenge the classical theoretical understanding of female development and discuss alternatives.

FEMALE PSYCHOLOGY HAS UNDERGONE a great many changes in recent years (Chehrazi, 1987), and the concept of pregnancy and a woman's availability for therapeutic work during it has been reexamined (Goldberger, 1991). In analytic thinking, female development was traditionally considered to be a variation of male development. Freud (1905) understood girls to be psychically indistinguishable from boys until genital difference was discovered, at which time the girl's development would hinge on her negotiation of her penislessness and resolution of penis envy. The wish for a baby was thought to replace the missing penis and provide the mechanism for successful female development (Freud, 1925). Freud later acknowledged his theorizing about femininity to be incomplete (1932). Two of Freud's contemporaries disagreed with him, proposing early awareness in girls of female genitalia (Horney 1933) and an equivalent castration anxiety in girls—fear of loss of or damage to her female genitalia (Jones, 1932). Recent writers (Galenson & Roiphe, 1971; Kleeman, 1971) have documented an early awareness of vaginal sensations. Stoller (1976) described a pre-oedipal experience of femaleness that he called primary femininity. He thought that little girls entered the oedipal stage with a sense of

themselves as feminine and then assumed a sort of defensive masculinity out of which they were able to resolve the oedipal conflict and emerge with a more complex femininity.

Pregnancy, however, was surprisingly overlooked in early analytic theory, and very little was written on the subject. Benedek (1959) attributed this exclusion to Freud, who felt that pregnant women were in a blissful state of having their wish for a baby (penis) gratified and so were unavailable for and not in need of psychoanalytic therapy. Goldberger (1991) analyzed this position and found the opposite to be true because of her reflections on her own analytic work with pregnant women. That is, although her women patients were narcissistically involved during their pregnancies, they actually developed intense transferences to the analyst and the fetus that were not only analyzable but seemed to unearth some primitive affects and self-representations that might have otherwise been unavailable. Goldberger also found that despite some women's delight in their pregnant state, pregnancy actually seemed to be "a time of emotional disequilibrium that facilitates accessibility to some of a woman's deepest conflicts." Benedek (1959) described pregnancy as a time that reactivated intrapsychic processes from the mother-child relationship. Bibring (1959) considered pregnancy along with menarche and menopause as developmental crises during which unsettled conflicts from earlier phases would be reworked, and, based on her findings in her longitudinal study of pregnant women, she thought that the outcome of the crisis of pregnancy would be significant for the woman's ability to function in the next phase—motherhood.

With these considerations in mind, my colleagues and I, when we were urged to provide some sort of community assistance during Operation Desert Storm, chose to begin a support group for pregnant and postpartum women whose husbands were at war. We were both personally and professionally interested in the psychological experience of pregnancy and embarked on this journey, uncertain of what would be the outcome. We kept detailed process notes in the hope that what did emerge would answer some of our questions about this interesting developmental stage in women. What conflicts would be reworked? What transferences would emerge? What would fecundity represent intrapsychically?

My co-therapist and I advertised and prepared to lead an 8-week group for such women. Initially, we recruited only 3 women who were interested in such an experience, although we knew of the existence of many more who would have been eligible. We were unsure about embarking on such a project with only 3 participants, but the women insisted that they were willing and interested, and so the group began. During the 6th week, I had decided I would like to continue the group beyond 8 weeks and open it to all pregnant and postpartum women eligible for care at our facility, to include active duty women, dependents, and women who had not been directly affected by Operation Desert

Storm. By then, membership had expanded to 8, with an average attendance of 5. My original co-therapist, a male resident, was unable to continue the group beyond the 8 weeks. He was replaced by another man, a psychiatric clinical nurse specialist. The additional 20 weeks of the group were conducted and documented in the same fashion as the original 8 had been, with new members added. As one might expect, analysis of these notes revealed many themes. For the purposes of this article, I limited the focus to the gender-related themes that are manifested in the transferences to the male and female co-therapists.

What appeared to occur was an enactment of a basic conflict of women—that of acknowledging, accepting, and enjoying the vicissitudes of femininity and reproductive capacity versus assuming an inferior position in which they devalue their roles, needs, and generative potential. This conflict was manifested through the process of the group and the transference reactions to the male and female therapists. A developmental milestone seemed to be achieved as the women moved from the devaluing to the valuing position during the 28 weeks they were studied.

Results and Discussion

The first manifestation of gender-related material came early on in the initial 8 weeks of the Desert Storm portion of the group, when the women expressed resistance to venting anger about their husbands' deployment. They felt they did not deserve to have needs or feelings that the group might address because their husbands were the ones fighting the war and therefore deserving of all the supportive efforts. They carefully explained the concept of "perfect Army wives" who suffer in silence and support their men. For several sessions, there was palpable anger that was not directly expressed despite encouragement from the co-therapists. However, during that time, they unanimously expressed the wish for a baby boy with the explanation that they all had daughters and their husbands all wanted sons. If these pregnancies resulted in their having boys, they would be able to stop having babies. Whereas, if girls were born, the whole detestable process would need to be repeated. Interestingly, this latter issue was raised the first time the male therapist was absent from the group.

The notion of female inferiority flourished as the terms of continuing the group beyond the original 8 weeks were negotiated. The male co-therapist, who was about to graduate, terminated with the group, and his last day was met with fears of abandonment. Certainly, his leaving replayed feelings about the women's husbands leaving, but additionally, there was concern about whether the group could go on without the male therapist. The female therapist's ability to lead the group was in question, even though the replacement for the departing male therapist had been named.

The introduction of the second male co-therapist was met with mixed feel-

ings. His welcome was cordial, but he was quickly confronted with the sentiment that “all men leave, and you will, too.” His comments revealing his own experience in fatherhood were received as normalizing and yet also served as a segue for the group to begin venting anger at their husbands who were viewed as unsupportive. Concurrently, the issue of tubal ligation arose, with graphic talk of having tubes tied off, burned off, ripped out, and so on. In other words, devaluation of and alienation from their feminine organs and reproductive capacity were presented in tandem with the material about anger at the male therapist/their husbands. It seemed that hidden in all this talk was also their wish for closeness with these men.

My absence during the 12th week elicited their transference to me as the female therapist. The women wondered whether their children would worry when they were hospitalized to deliver their new babies. They seemed to be voicing concern for how the group would fare without a female therapist. My return the next week was greeted with the expressed wish that I become pregnant, and they fantasized that I had been absent in order to do so. My co-therapist and I assumed that their concern was an attempt to identify with me as the female therapist, but we also wondered if my childlessness was somehow threatening. Maybe I couldn't have a baby. Maybe I wasn't a real woman. Perhaps they really wanted a mother to see them through their pregnancies. Not coincidentally, the next week the wish for and fear of having a “madonna” experience was presented, meaning that glowing state of completely fulfilled woman/motherhood.

For the next two meetings, the male therapist was absent. The group's anger at men returned with a vengeance. They resented the fact that their husbands were unable to understand what they were going through. They demanded more support. When I, the female therapist, mentioned that I found it interesting that there was so much anger on a day when the male therapist was absent, they responded by saying that if he were there, he would claim to be the perfect husband, somehow sticking up for all men. At this point, the group reflected on their conclusion that it did not matter what the men did because they as women had been raised to assume all the caretaking roles anyway. When it was suggested that they might have some say in how much responsibility they assumed for this caretaking role, they seemed to hear that they had in part become their own oppressors. That session seemed to represent a milestone for the women. However, in the next session with the male therapist absent, one of the original members terminated, and the existence of the group again came into question. Boundaries were discussed, and the group's purpose was debated. Their ambivalence about whether they needed the group surfaced. They were also reacting to the issues raised in the previous session. At this point, my competence as the therapist in the group was again in question. The fact that all this happened in the absence of the male therapist seemed to echo

the departure of the first male therapist. Could this group function with female leadership only? Their devaluation of me as the female therapist seemed to be a projection of their devaluation of themselves and another enactment of becoming their own oppressors.

With the return of the male therapist, the atmosphere in the group intensified. The women compared notes on how they were being regarded as secondary to the fetus. They expressed open resentment at how the doctors focus on their pregnant bellies and barely make eye contact. Helplessness and loss of control elicited tears all around, a first for this group. Then, what proved to be a very positive shift began to occur. Through their tears, they provided support for each other, comforted each other, and seemed to bond. They made it clear that they all understood something about each other that others who had not experienced what they had could not. This bonding that I observed continued in the next session, which focused on labor and delivery, epidurals, nursing care, and so on. Afterward, I commented on the warm, nurturing sense I had had of the group that day. The male therapist stated he had been bored and could not wait for the hour to end. The male therapist had been excluded from these very female issues.

My inclusion was short lived. In the following sessions, the women continued to strengthen their cohesion, mentioning how motherhood fosters this bonding between women and how they had noticed that even on the bus, when catching another mother's eye, they felt a certain connection. They mentioned for the first time their awareness of their husbands' jealousy of their involvement in the pregnancy and their ability to reproduce.

In the 21st week, the male therapist was absent again from our session. This time, the group talked about relating sexually with their husbands during and after pregnancy, labeling the issue as something they absolutely could not discuss with the male therapist. I intervened to suggest that there were ways to talk to men about these topics, and I challenged the group to test these methods with the male therapist. By doing so, I was perceived somehow to be defending men. In the next session, despite the male therapist's return, the group confronted both therapists because they considered the therapists incompetent to meet their needs. They explained that by virtue of being a man, the male therapist could not understand. They let me, the female therapist, know that my being childless and showing my ignorance of the difference between female:female and female:male relationships were proof enough that I was also inadequate.

I was given another chance the next week when the male therapist was again absent. This time the group brought up similarly sexually charged topics such as breast feeding and their concern about admitting that it is sometimes sexually stimulating. After my normalizing comments, they pursued even more delicate subject matter, discussing anorgasmia and asking questions about normal

female sexual responses. This session seemed to be their attempt to draw me in as one of them. It was clear that they viewed this material as special and uniquely feminine.

The male therapist returned to a group that began inquiring about the nature of his communication on sexual issues with his wife. Interpreting this demand as a request for technique, the therapists modeled some direct discussion, suggesting that women could teach their husbands how to meet their needs. The group replied with the response, "Men are such babies—why should we have to teach them?—We're not their mothers!" Their response seemed to express their wish to be partners to their husbands and mothers to their children. From then on, they appeared to view the male therapist with more interest and less anger. The focus shifted from adversarial male:female relationships to their expanding identities as wives and mothers. They had overcome much of their own feeling of inferiority, and a new acceptance of themselves and their roles emerged.

As my departure from the group drew near, the women continued to consolidate their sense of themselves as feminine and powerful. I announced that I would be leaving the group to go on to further training and that another female resident would be taking my place. During the 2 weeks before she would start, the male therapist would run the group alone. Attendance was quite poor during that period, and those who did come seemed to express the anxiety of the whole group. An attempt that was aborted to devalue the group and abandon it was quickly overshadowed by the group's verbal affirmations of the work done in the sessions and their expressions of gratitude to me as the female therapist. In my last session, an active-duty woman who had orders to go unaccompanied to Turkey in a few months confessed that she had come to regard her infant as a crybaby. The group interpreted this to mean that she was doing so in order to make parting from the child less painful. Their interpretation seemed to convey the sense that if they devalued the female therapist or the group, they might miss the therapist less or be less affected by the change. The depth of their feelings was striking. Were these the same women who did not deserve the group and needed to have baby boys to justify their existence?

As the group was processing being left in the male therapist's care, an interesting discussion ensued. Some of the women had indeed delivered male infants, and they began to compare notes on the care of baby boys. Anecdotes about newly circumcised penises, the care of uncircumcised penises, and the surprising spontaneous erections were shared. These stories were told with much giggling and devious looks at the male therapist. Finally, they apologized to him for not considering his feelings in their discussion of such a delicate subject. This exchange was interpreted as their way of reworking their relationship with the male therapist. They seemed to devalue him and remind him of their powerful position as mothers of these male infants. And yet, they were

forging a bond with him as someone with whom they could discuss delicate matters. They expressed genuine affection for him.

When the notion of counseling this group had first been discussed, a female supervisor warned me that having a male co-therapist working with an all female group would impede a distinctly feminine process. Although this may be true and worth testing, it does seem clear to me that the process, which did result in transferences to both the male and female therapists showed the women reworking their identities as women and mothers. If Bibring (1959) and Benedek (1959) were correct in viewing pregnancy as a developmental crisis during which old conflicts are renegotiated, then what seems to have happened in this group is that, through their transferences to the therapists, the women addressed their important relationships with both males and females while reworking their sense of themselves.

Bibring also thought that the process of pregnancy as a developmental crisis was quite complex and was aware that at any point in the integration and the adjustment that was occurring complications could arise. For instance, a woman would naturally be reworking her relationship with her husband or with men in general. If some additional stress in that area were to come along, that reworking would probably be intensified or made more difficult. The woman might become symptomatic. In this group, the women were probably set up to have issues with men beyond what one might expect, given that the group formation identified them as the pregnant wives who might need extra support because they had been left behind during war. However, the entire process of this group cannot be explained as simply a reaction to husbands' being deployed overseas.

The transference reactions to the male therapists embody something beyond anger at men. Early on, the wish for a baby boy was unanimous, which seemed to express something akin to Freud's formulation of girls working through their penislessness. Furthermore, it seemed to me that their wish for a penis was transferred to the male therapist because they seemed to need his presence to validate the group and their participation in it. Even when they presented an obvious angry transference of their feelings toward their husbands to the male therapist, there also seemed to be a sense of their own devaluation, as though being without a penis themselves and without possession of their husbands' or the therapist's meant, by extension, that they were of little value. Freud's ideas of penis envy do seem to fit here; yet, his ideas about the role of pregnancy were not played out. Their pregnant bellies were not adequate penis substitutes. The evidence for this conclusion lies in the way in which their transferences to the male therapist changed. The women began to see him less as needed for survival and more as a substitute equal partner with whom they could work out difficulties. Suddenly, the intimate topics that had been forbidden could be discussed. In the end, they began to treat him as a son, somewhat condescend-

ingly pointing out their power as mothers of infant boys. In their comparison of themselves to him, they found themselves not missing something but possessing something different—the ability to mother and all that that signifies. They realized that they had something different and powerful and were not lacking something.

Developments also occurred that related to the women's reworking their own identities as women. Bibring et al. (1961), Benedek (1959), and Deutsch (1945) all agreed that the main task in pregnancy is examination of the woman's relationship to her own mother; this examination involves the resolution of child-mother conflicts and an identification with the mother as the daughter becomes a mother herself. Here, it is useful to consider the transferences to the female therapist. At first, especially during the transition of the male therapists, there was a great deal of concern about having a woman run the group, as if to say that the other female role models in their lives would not have been capable of this and so neither was she. They transferred their fears of female incompetence to the woman therapist. Were these concerns learned from their mothers and the identifications they were making with her as they assumed her role? What is interesting is that through the process of bonding and finding power and value in their roles as women and mothers, their transference reactions to me the female therapist changed. They began to see my impact and leadership as desirable and resisted expressing their depth of feeling about it.

Nancy Chodorow (1978) has written extensively about the differing ways in which boys and girls are mothered and has noted that girls are mothered to become mothers. To state her views another way, mothering behavior is part of the socialization of little girls. Over the 28 weeks of the study, the women in this group seemed to change in their views of themselves as mothers or mothers-to-be. At the beginning of the group and well into the second male therapist's tenure, the women devalued themselves and the female co-therapist, implying male superiority as evidenced in their statements about the preferred nature of baby boys. Perhaps their socialization as women contributed to this beginning position. Did their mothers view themselves as being in an inferior position? Did the women in the group learn to see themselves in the same way through identification with their mothers? It is interesting that this portion of their self-images surfaced near the beginning of the group, when most were in the early phases of their pregnancies and just starting their metamorphosis into mothers. As the group progressed, they also became alienated from the male therapist, deemed both therapists incompetent, and began to claim power and recognize adequacy within themselves as they embraced their femininity. In other words, they began feeling inferior but ended sensing their equality or even superiority.

Given that these women were reworking their identities as women and mothers, how can we make sense of the shift that occurred? A possible explanation

of this shift comes from a paper by Elizabeth Mayer (1991) in which she discussed these two positions and proposed that there are actually two developmental lines for girls that should be considered in the analyses of women.

To arrive at such a conclusion, Mayer presented a case of her own in which the problem of a woman who seemed to have a castration complex because of her sense that being female meant being inadequate or missing something crucial. The analysis proceeded with diligent interpretations of this conflict but without symptomatic improvement. They seemed to have reached an impasse until Mayer began to understand the patient's problem as "anxiety over wishes to be successfully female, not depression over being unsuccessfully male." She saw her patient's passivity and inhibition as the result of her fear of losing something specifically feminine, not from her fear of having lost something masculine. From these observations, she proposed that, in addition to the Freudian understanding of female development—understanding women in terms of what they are not—there should be a parallel theoretical line of development that accounts for women grappling with what they are. In addition to developing in terms of not being men, women develop in their sense of themselves as being women or primarily feminine.

In her paper, Mayer assigned these two lines of development specific affect/defense configurations as described in detail by Renik (1990). Renik reflected on his own analytic technique and found that when he identified inhibitions or lack of pursuit of instinctual gratification, he was usually dealing with anxiety or symptoms designed to guard against a calamity that might occur. Moreover, he found that when he was dealing with depression or symptoms generated because of a calamity that had already occurred, the defenses consisted of enactments of wishful fantasies or attempts to attain what was lost by magical means. Mayer noted that her patient manifested both depression and anxiety, although depression seemed to be the primary affect related to her sense of herself as unsuccessfully masculine. Anxiety surrounded her attempts to be successfully feminine.

Extrapolating from Mayer and Renik, I felt I could reasonably explain the inferior view of themselves that the women assumed early in the group in terms of their depression over being unsuccessfully masculine and the eventual concerns over their new roles in terms of anxiety over being successfully feminine. Early in the process, when the women were devaluing themselves and their needs, they expressed a wishful fantasy for baby boys, as though somehow the maleness of their offspring might replace their lost penises. This wish would serve as a defense against their depression over being abandoned by their husbands or the male therapist. Later in the process, after working through the implications of their transferences to both therapists, the women began to talk of their inhibitions in dealing with their husbands, their sexuality, and their children. These themes clearly manifest anxiety about their roles as women.

So, as with Mayer's patient, our work would not be complete until it had been understood from both points of view. These women were not only dealing with not being men or feeling inferior to men, but were also struggling with what it meant to be women. The developmental task during pregnancy is twofold. Women's development probably proceeds along both lines through all the milestones.

Thus, through examination of transferences to male and female therapists, we observed women in the group negotiating and renegotiating their development as women along two parallel axes. Perhaps, with two female co-therapists, the same sort of process might not have occurred, and the women might not have been able to address both sides of themselves as readily as they did in this group.

Recently, the field of female psychology has been changing and expanding. A great deal is now being written, but the difficulty is in applying what is known in principle to the clinical situation. In reporting and discussing the process from this group, I have attempted to summarize the theoretical and apply it to the clinical. From the many dissenting views about female psychology, I have chosen to present those that seem correct to me. There are two camps: one that would use the theories pioneered by Freud and his followers and make modifications based on newer data and those who feel that Freudian theory has female inferiority embedded in its core and so would throw the baby out with the bathwater (Lerman, 1987). Based on my observations from this group, I would have to agree with the former position. Further research needs to include the collection of more empirical data that can then be shown either to support or to refute these evolving ideas about female development.

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