Motherhood and the Clinician/Mother's View of Parent and Child

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Researchers have explored many factors that might influence how psychotherapists think of or behave with their clients. Individual characteristics of the clinician, such as theoretical orientation, personality characteristics, sex role biases, or liking of the client have been studied most often (Hersen, Michelson, & Bellack, 1984). A second, less common, research area has been that of exploring how the clinical situation affects the practitioner. For example, burned-out clinicians might conceptualize their clients in a more critical manner (Farber, 1983). A third possible area that might influence the behavior and experiences of therapists has been relatively understudied, namely, whether the clinician's experiences outside the clinical situation systematically affect what happens within it.

The emphasis in the psychotherapy literature follows from implicit assumptions about how personal and professional life interrelate. The two areas of experience are assumed to be distinct. Personal and professional roles do not generally interpenetrate or influence each other. If the areas do interpenetrate, this is most often because there is a problem. Thus, research that has addressed how personal roles might influence therapy has tended to focus on episodic occurrences-that is, events that intrude on an ongoing therapy and create a potential or real problem. Pregnancy, for example, has been one of the more studied of the events in a clinician's personal life that might influence therapy, as when researchers have explored the range of client responses to this violation of therapist anonymity (Guy, 1987). When the effects of other typical experiences associated with adult development have been studied, they are also most often treated as problems, intrusions on therapy that might warrant examination.

This chapter describes the results of research in which women report that two of their social roles -namely, maternity and the professional role - do interpenetrate. Experience as a mother results in personal change that is brought to the clinical situation. It is not that maternity creates a problem in conducting therapy or intrudes as an episode on the professional role in a way that must be dealt with. Rather, how the clinician experiences conducting therapy is altered in an ongoing, rather than an episodic, manner.

This research was conducted from the perspective of "transformational research" (Crawford & Marecek, 1989). To avoid interpreting the experiences of the clinician/mothers in terms of preconceived categories, especially those derived from research on largely male samples, the clinicians were asked to describe their experiences from their own point of view and were regarded as informants. Such preconceived categories may include the ideas that work and personal roles do not interpenetrate; if these two areas of experience do affect each other, it is because there is a conflict or problem: personal life is inferior to professional experience and knowledge; motherhood is devalued. The research method was phenomenological. A representative sample of clinicians' met once with the author for a face-to-face interview. They were asked to discuss each of a set of topic areas. For example, they were asked whether being a mother

had influenced their experience of conducting therapy in any way; if so, they were asked for specific examples. The interviews were tape-recorded and transcribed. The results can be best thought of as a composite case study of the range of experiences of the women interviewed.'

Why might maternity be expected to influence clinical experience? Paradoxically, although not emphasized in the literature, anecdotally it is common for clinicians to say that they bring the fruits of their own experience to therapy. Clinicians, for example, who have worked through how to deal with their anger might say they feel greater empathic understanding of the dynamics involved in this issue. Parenthood might be expected to have similar effects because it is a major life experience, involving pervasive changes in the clinician's emotional and social life. The clinician becomes a member of the group of "parents," experiencing events from the parental, rather than from the child's, point of view. Further, in a society such as ours, in which most adults have little experience interacting with young children until they become parents themselves, parenthood involves a profound shift in one's knowledge base about parenting and about early childhood.

In addition, maternity might be expected to exert enduring, as opposed to episodic, effects if maternity is a stage of adult development. The concept of "adult development" involves the hypothesis that adults, no less than children, experience periods of developmental change (Levinson, 1978). The stages of the adult life cycle consist not only of events such as the development of long-term relationships but psychological changes as well. Theoreticians and researchers from a broad range of backgrounds have with increasing frequency been asking whether becoming a parent has an effect on the parents themselves (e.g., Benedek, 1952; Erikson, 1963; Koumans, 1987; Partridge, 1988). If motherhood does involve psychological changes, it is plausible to think that these changes might influence how the psychotherapy situation is perceived.

This chapter explores the phenomenology of how becoming a mother influenced clinicians' perceptions of clients and the experience of conducting therapy. The clinicians in this study lived in two-parent households, and 72% of them had at least one preschool-age child. The mothers were primary caretakers of their children. In only one case did the father provide child care while the mother worked, and the mothers rated themselves as providing the majority of routine care. As reported elsewhere (Derry, 1990), this sample of mothers overwhelmingly elected part-time employment while their children were preschoolers, but they did not differ from a comparison group of nonmothers when basic job attitudes such as commitment, satisfaction, and professional aspirations were evaluated statistically.

Seventy-two percent of the clinicians worked in private practice (rather than institutional) settings, and 64 % worked fewer than 30 hours per week. Ninety-six percent of the clinicians rated their theoretical orientation as psychodynamic, either entirely (36%) or as part of an eclectic style (64%). The eclectic therapists most commonly combined dynamic with cognitive/ behavioral or family-oriented techniques. Ninety-six percent of the clinicians reported that they treated adults; 44%, children; and 88%, couples or families.

INCREASED EMPATHY: AN EXPERIENTIAL SHIFT

An almost universal effect of having children, as reported by the mothers, was a subtle but pervasive effect on attitudes in interactions with clients: 88% of the mothers stated that they felt greater empathy, understanding, or emotional knowledge about parents. The clinicians thought differently about the early memories of adult clients reconstructing the past; they thought differently about individual adult clients or couples who were parents; and they thought differently about the parents of a child in treatment. Almost every clinician, whether she became a mother when finishing graduate school or after 10 years of clinical experience, felt a sense of having gained experiential knowledge:

> Respondent 17: Having a child, in terms of helpfulness as a psychologist, is very much like having been through therapy. Theory is one thing; intimately experiencing it is another.

The most general and common change reported by the mothers was a felt difference when doing therapy. It felt different to hear clients discuss parents or parenthood when the clinician could relate to this material experientially. This shift could enrich the experience of conducting clinical work:

> Respondent 11: (in response to interviewer's asking whether "increased empathy" meant the increased detail in her understanding of issues that she had described): No, it's also the level of passion, it's the level of intensity, it's knowing and feeling the emotional impact of what it's like to have children.
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> Respondent 21: I was not concerned ... with whether [becoming a mother] would enhance my work life. It turns out that it has.... I think [if I were not a mother] the work would be much drier.

The clinicians varied in interpreting how this experiential knowledge was integrated into their overall style. Some clinicians believed that their conceptualizations and interventions (as opposed to how it felt to conduct therapy) were affected a great deal by increased empathy; others believed there was little effect. In general, changes in general theoretical orientation, such as adapting or discarding a psychoanalytic viewpoint, were rare. Some clinicians did believe that their development in a chosen theoretical direction was furthered when observations of their children confirmed their beliefs. However, many clinicians believed that although their understanding of parents' experience changed, they were not aware of doing anything very different in the therapy situation.

Yet what was striking to the interviewer was that even when clinicians stated that they were not doing anything different they typically could give a concrete example of how they were thinking differently. In one striking example, a clinician discussed a female client who had decided to give up custody of her son to her ex-husband. The clinician believed that before having had a child herself she would have felt critical of this client for abandoning her son. Instead, she was more accepting. She better understood the client's experience in dealing with a very difficult situation, and she focused on the possible advantages for all concerned in the new arrangement. Yet this therapist believed that her changed perspective was not reflected in her interactions with this client!

DIFFERENTIATION OF VIEWPOINTS OF PARENT AND CHILD

Whether clinicians believed that their conceptualizations and interventions were affected a great deal or very little by increased empathy, almost every clinician could give an example of how her thinking about a specific client was different. These specific examples of "increased empathy" varied but reflected similar themes. The similarity of themes was a second uniformity in the data. Whether clinicians believed that their increased empathy had a broad effect on their interactions with clients or that their attitude change had little effect, when the range of responses of the clinicians was inspected (for what clinicians mean when they say they feel increased empathy), the responses fell into a general pattern: Clinicians were more identified with the position of parent than that of child, and/or the clinicians better differentiated between the two positions. These results will be presented as a composite case study: No one clinician exemplified the entire pattern, but the responses of each clinician were facets of these themes.

The old view, stated in an extreme form, was an expectation that parents should be "good parents" (understanding, sympathetic, patient) who gratify their child's needs. If the child's needs, as defined by the child, are not met, the parent has in some way failed and is judged in a critical manner. If a parent experiences feelings such as anger that interfere with being sympathetic and understanding, the parent is judged critically, and attributions of pathology might be made to account for the parent's lapse in performance. On the other hand, after having children themselves, the clinicians are more likely to perceive the behavior of parents from the parent's point of view, rather than from the point of view of how the behavior affected the child. The child's perspective on what motivates the parent is better separated from the parent's viewpoint. Parents are judged less harshly; the clinician is less likely to feel critical of the parent or attribute pathology. The parents' feelings are comprehensible, and the pressures on the parent are perceived more clearly. The clinician might also perceive more clearly how the child is contributing to the interaction or that certain conflicts reflect normal, inevitable processes between parent and child.

One component, then, of the shift in attitude that clinicians experience when they become mothers is that idealism about parenthood is deflated:

> Respondent 23: After you have children, it is very humbling, and suddenly you realize that it's much more difficult, how much phenomenally more difficult, it is to be a parent than you can ever conceive of.

The clinician who sees in herself less than perfect parenting might be more willing to accept that imperfection as part of the normal course of things.

> Respondent 8: 1 can see that parents can be caring and still make mistakes, as I can already see the kinds of mistakes I'm making that I don't really want to be making. So I'm not as hard on parents.
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> Respondent 7: I see in myself the conflict between knowing probably the doctrinaire, appropriate thing to do or the right kind of discipline to use ... and then the fact is that I've run out of energy or patience at the time, so I do something that I know is probably not wise.... If I weren't on the inside of it and 1 saw a parent do that,

I might think, "They know better, why don't they stop and think." ... Theoretically, I knew that it was true, but there's nothing like being there a few times to be reminded what that's like.

Even when parents are well-motivated, the clinician might also believe that child rearing is not the science that she previously considered it:

Respondent 23: Kids aren't going to respond all the time, whereas, before, I thought there was some kind of magic answer. If the parents were doing the right thing, the child would respond appropriately.

The clinician has intimate knowledge of the range of emotions associated with parenting, and having experienced them in herself, she is more likely to perceive these feelings as being basically normal, for example, the strength of the attachment bond to the child and the central importance of children to their parents:

Respondent 11: The main thing I've learned that's surprised me in having a kid is how passionate an experience it is, how intense it is, and how high the highs are and how low the lows are and how incredibly strong the bond is. I think it's really hard, I think you almost have to take it on faith, if you don't have a child, how incredibly strong those feelings are.

Parents also experience other feelings, such as the desire to protect one's child, rage when children are frustrating, sadness when children separate:

Respondent 25 (speaking about child abusers that she works with): [After having a child I was] more empathetic and less angry ... I understood more about the reaction, about the intensity of their anger toward their child. I still didn't understand how they acted on it.... Before, I would have denied that that feeling [of anger] was very universal because I would never have those feelings. That's what I thought.

The clinician who has experienced parental feelings from the inside might be more likely to view these feelings as understandable or comprehensible in clients. The clinician might perceive how even behavior that appears pathological can start out in a motive or feeling that is natural for a parent to have. By identifying with this starting point, the clinician may feel less need to attribute pathology or to judge the parent. This does not mean that the clinicians do not perceive that the behavior might have a negative effect on a child or that they do not encourage introspection or behavior change.

One clinician, for example, who worked on an adolescent inpatient unit, found that when clients were restricted for misbehavior their parents would sometimes intercede for them, requesting that the restriction be lifted instead of supporting the clinical staff in setting limits. Before becoming a parent herself, the clinician would typically be angered by these requests. She would wonder why the parents were colluding with their children in sabotaging treatment. After becoming a parent, the clinician was no longer angered. She could understand how a parent could be motivated by a desire to protect a child. The clinician still made the same intervention, namely, increasing the parents' understanding of and cooperation with limit setting. What had changed was her anger and her need to

attribute pathology to the parents.

Even when the clinician believes that the parent is experiencing significant pathology, this identification with the starting point of the process--the feeling of the parent-can result in less anger:

> Respondent 21: 1 certainly understand that you can get very, very frustrated with a child and wish to be punitive and be punitive. So I feel much less judgmental. I address the issues and what they mean to the patient. And sometimes end up by saying "I think it might be better if you did not do that behavior." I am talking about someone who is very disturbed. For example, I have one patient now who, when she gets very withdrawn and absorbed, hits her child and makes the child go away.

In addition to identifying with the feelings of parents, a second aspect of increased empathy is a more detailed understanding of the situation of parents. The clinician now knows that parenting is a difficult, stressful job:

> Respondent 11: 1 have a client now who has a one-year-old who hasn't started sleeping through the night yet.... Before I had [my son] I would have thought, "My god, that's awful, this guy must be tired," but I wouldn't have the hands-on knowledge of what it feels like to never have eight uninterrupted hours of sleep and how tired you are and the stresses on your marriage and how angry you get at the kid and how guilty you feel.

This appreciation of the stresses of parenting can sometimes bring the clinicians to a focus on here-and-now problems, rather than on how a client's family history has produced psychopathology:

> Respondent 19: Rather than just imagining that a lot of [the client's] difficulties, or almost all of them, stem from her own impoverished family, I'm now fusing that with the legitimate difficulties of parenting.

The clinician might better appreciate the stresses of multiple roles, a mother's need for nurturance, or the stresses of being at home with the kids:

> Respondent 23: School vacations. 1 notice a difference in the women I see [during] the week the kids are home. They're much more stressed.

> Respondent 22: I have empathy for what mothers are going through, who are working and have to manage and don't have enough time for themselves.

> Respondent 1: 1 give couples assignments to have time alone together. I know from my own experience that this is important.

> Respondent 14: I respect women who stay home with their kids more than I did before.

The increased empathy with the feelings and situations of parents can result in a clinician hearing in a different manner the adult client's memories of his or her past. The clinician might recognize that she had previously identified with the child's point of view:

> Respondent 7: Before I had children, it was much easier for me to identify with the kid's point of view ... and sometimes to have trouble understanding why parents did what they did or where they were coming from or why it made sense to them.

> Respondent 16: 1 feel that I have more of an empathic understanding of the difficulties of being a parent. And 1 guess, in my work, I had a tendency to identify with the child more, and to see the parents as the people with the problem.

In being less identified with the child, the clinician might be more likely to separate out the perspective of the parent from that of the child:

> Respondent 2: I probably am better able to figure out what parental motivation, or parental activity, might mean. I may be less likely to hear the patient's concerns about parents as, "Gee, aren't they awful," but rather as the patient's perception of the parents. And recognize that there's another side of the story. And how to recognize those differences. And also make room for the differences in perceptions.

> Respondent 4: If patients are disappointed or angry with their parents, I hear it from a point of view of wondering what it would be like to be that person's parent, and what the parent's pressures are, or why the parent might not be sympathetic or listen. I can still see how [it] feels to be the patient, but I also might wonder more if there's a reason for the mother being this way in how [the patient] presents this to her. In their relationship has there been so much conflict that it's hard for the mother to be sympathetic, or what are her pressures or problems?

Separating out the points of view of parent and child, rather than being identified with the child's perspective, can result in a different sense of the dynamics of relationships. The clinician might feel that she has a more systemic view of relationships. She might move away from a simple causal model in which parents act and children react:

> Respondent 4: 1 feel [being a parent] has added to my appreciation of the complexities of the relationship over time.

> Respondent 21: [Having my own children] modified some of my views about rebellion.... I used to have more of an attitude that parents "do things" to children ... like sometimes they withhold certain things ... and it was very important for the children to speak up ... and sometimes I would feel like I was fighting along with the kids.

For some clinicians, this altered sense of causality involved an altered philosophical stance. The clinician might no longer believe that there always is a right and a wrong way to do things. In diagnosis, this might involve a less doctrinaire stance toward using theory or diagnostic categories. In child rearing, this might involve a sense that there isn't always a right answer to every situation:

> Respondent 14: I'm not sure I'm doing anything different than I would have if I had seen these [clients] a few years ago [before having her child], but I think it's just harder for me to think in pat sorts of ways. I think I just have a better appreciation for, you know, that there aren't any easy answers and it's an incredibly complex relationship and intense relationship.

INCREASED UNDERSTANDING OF CHILD DEVELOPMENT

Another way the clinicians were alike was in a common belief that their basic understanding of child development deepened (65% explicitly stated this). As was found in their understanding of parental psychology, clinicians very rarely made an observation that challenged the theories that they held, with the same exception that was seen with parents: their idealism was deflated. As discussed above, this was manifested in a greater

tendency to perceive children as actively contributing to relationships rather than as passively suffering the effects of parental behavior. Children can be willful and misbehave, their behavior can help to shape the behavior of parents, and they might be born with constitutional factors that shape relationships.

Increased understanding of child development could inform the recommendations clinicians make to parents. Clinicians often felt that their recommendations were more practical or that their recommendations had greater credibility with parents who were patients:

> Respondent 15: Before, I would rely on just what I read in books in terms of giving feedback to parents, in terms of things that they could do. Now, I can choose from information that I give, information that I feel would be useful, versus information that I feel would be impractical.

The greater understanding of child development also could inform the clinician's understanding of adult clients reconstructing the past:

> Respondent 13: 1 work with a number of patients with borderline personality disorders and I have a much richer appreciation of what it must have been like to have parents unavailable during those early developmental stages around rapprochement time.... What I try to do with some of the healthier folks is to create a picture of what it might be like to try to separate and to discover there isn't that steady or supportive person there.

Whether working with adult clients reconstructing the past or with children, the clinician might vary from what she had been taught by developing a less idealized view of childhood. In part, this was related to increased empathy with parents. The clinician might be less likely to identify with the client as having been victimized by the parent. The clinician might now believe that children can be demanding and willful, to want things not in their own interests, and to misinterpret the motivations of parents:

> Respondent 8: I think it's always been hard for me to see the parts of patients that are willful or stubborn or just downright demanding, that I've always taken their side, quite a bit. And as I see in my children, whom I can still love, an awful lot of demanding, willful, stubborn stuff, it helps me to gently point those things out to my patients.

> Respondent 4: I guess I can see the perspective that the [patient's] demands are very unreasonable or unrealistic. And maybe what the patient needs to do or can do in therapy is separating better so they don't expect those kinds of things from their parents.

The clinicians also might give greater credence to the idea that the parent's control of the relationship is constrained by the child's constitutional factors:

> Respondent 12: One thing I think I took very literally was that parents create their children.... I see now that [my daughter] came to us with some real constitutional factors.... I think that, before, I felt the parent must have been doing something bad. And now I see that kids are born with certain predispositions. And it isn't anybody's fault.

IMPLICATIONS

The psychotherapy literature has emphasized the independence of personal and professional life. When interrelationships between the two areas have been explored, the emphasis has been on carryover from professional to personal life (as when burned-out clinicians are emotionally distant from their families) or, at most, on episodes in which personal life intrudes on professional life (as when pregnancy intrudes on the therapy situation). In this study, however, an experience in personal life produced an enduring change in the phenomenology of clinicians conducting psychotherapy.

Whether clinicians had children while in graduate school or after 10 years of clinical experience, almost every clinician (88%) reported an experiential shift. It felt different to hear clients discuss their parents or their parenting because the clinician could now relate to this material experientially. This increased empathy for the position of parents enriched how it felt to do therapy, in the sense that the clinicians felt more affectively connected to the material or understood the material in greater detail.

Some clinicians believed that the effect of their increased empathy was confined to a few clinical situations, whereas other clinicians believed that their thinking about clients had been affected a great deal. The clinicians thus differed in how the shift was integrated into their overall style, but a second uniformity in the data was that most of the examples they gave of increased empathy were aspects of the same themes: the clinicians were more identified with the position of parent than that of child, and/or the clinicians better discriminated between the two positions.

Elaine Heffner (1978) has written: "It certainly is not new or startling to find that women feel the desire to take care of their children. What is new is the number of' women who are startled by such feelings" (p. 11). Even among these psychotherapists, whose professional competence is in the area of family relationships, the emotional realities of mothering are something to be learned. Perhaps this is in part because, in this culture, very few women have experience with young children before become mothers themselves. As parents, the clinicians were exposed to nuts-and-bolts information about childhood and parenting not previously understood. Perhaps this also reflects the cultural devaluation of mothering: although motherhood is held up to women as their most important role, paradoxically, it is not culturally defined as a powerfully significant experience.

Motherhood is also inadequately defined culturally as a major life transition. In the workplace, maternity is often thought of as an episode or intrusion. When a woman becomes a mother, the issue most discussed might be maternity leave or how long employment must be interrupted before normal duties are resumed. However, when a woman becomes a mother, her responsibilities and situation are permanently altered. In this research, maternity is perceived to be a life transition psychologically, a permanent change in perspective.

Maternity resulted in an enduring change in how the clinicians experienced conducting psychotherapy. The pattern of changes observed is most consistent with the hypotheses that (1) the clinicians had experienced developmental change that affected how they viewed the therapy situation, and/or (2) the clinicians experienced a change in reference group.

Developmental change is suggested by the clinicians' better discrimination between the positions of parent and child, rather than solely identifying with the child's perspective. Further, the clinicians might develop a perspective that integrates both points

of view. Change in reference group is suggested by the clinicians' change in basic viewpoint to that of a parent. In being less idealistic about parents, the clinicians are more forgiving of the parents' limitations; in being less idealistic about children, they are clearer-eyed about the negatives in children.

The change in perspective associated with maternity is one of increasing psychological differentiation, not one of increasing psychological fusion. That is, the stereotypic mother is understanding, sympathetic, patient, someone who gratifies her child's needs, someone who perceives her child's needs as opposed to her own point of view. What these clinicians describe, on the other hand, are experiences of separating out the perspectives of parent and child and seeing both in a more realistic manner. This is, after all, as it should be. Interconnectedness, or intimacy, requires a sense of oneself and the other as separate but related. (If children really do lack a sense of this separation, that is no reason why their parents, who are adults, should identify with their perspective.)

In perceiving the experiences of parents from their own perspective, some clinicians report that they attribute less pathology or feel less anger. The clinician might perceive how motivation begins with a universal feeling or motive or understand the parents' own constraints and pressures. This has implications for understanding the sources of "mother-blaming." For these clinicians, blaming the mother was associated with an overidentification with the child's perspective and a lack of differentiation of the perspective of the mother.

Some of the changes that the clinicians report are changes that, one would hope, occur developmentally for all individuals and for all clinicians: gaining more maturity in seeing and accepting parents realistically and becoming less dependent on doctrinaire theoretical formulations. It should be stressed that no implications should be drawn from this study about the maturation of nonparents or fathers. We don't know whether these groups develop in similar ways, drawing on different experiences, or develop in different ways. We also have no data about whether mothers and nonmothers differ in their clinical interventions and style, much less their effectiveness.

The conclusions that we can draw are phenomenological. The experience of the clinician/mothers is enriched by increased empathy, and in the structure of their lives, parenthood is intertwined with the experience of developmental change.

NOTES

1. Twenty-five mothers who were actively practicing psychotherapists were randomly selected from lists of all licensed psychologists and all members of a clinical social work group listing three North Carolina towns as their address. To be included in the study, participants had to be currently employed, with a minimum of 3 years of clinical experience, and had to be living in two-parent households containing at least one child under the age of 14.

2. The interview method was similar to that used in other studies exploring the phenomenology of respondents (e.g., Cherniss, 1980; Piotrkowski, 1979). Each clinician met once with the author for a face-to-face interview. She was asked to address each of a set of topic areas, and was asked further questions as needed to clarify or amplify responses. The range of themes that were present in the data was described and organized

into a coherent set of categories. Information about interactions with clients that occurred at any point in the interview was studied. The results reported are not quantitative; they describe the range, not the frequency, of responses. To ascertain reliability in the few cases in which it was desirable to report response frequencies, the author and a research assistant independently coded a subset of cases from the codebook developed by tile author, with an interrater agreement of at least 90%.

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