Contents

Pregnancy and the Psychiatry Resident: Implications for Psychotherapy and Supervision

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The literature suggests that a therapist's pregnancy can influence therapeutic efficacy. During residency psychotherapy training, pregnancy raises key issues, such as the resident's experience of pregnancy, disclosure to patients, and increased sensitivity to transference-countertransference, as well as overt and covert responses from supervisors, colleagues, and staff. Examining these events is relevant since increasing numbers of psychiatry residents are women (1, 2) and pregnancy during residency is common (3). The following is the case of a female patient with borderline personality disorder who became pregnant coincident with her resident-therapist's pregnancy.

"Lara," a 32-year-old unmarried woman, expressed concerns about a nonmonogamous relationship with her boyfriend. She described problems with trust and disclosed traumatic experiences with an abusive mother. She had been diagnosed with moderate depression with features of borderline personality disorder.

"Dr. A," a 33-year-old married psychiatry resident, offered Lara psychotherapy to focus on relational issues and insight. Two months into therapy, Dr. A became pregnant. During the first trimester, Dr. A was preoccupied with the viability of her pregnancy, was anxious about disclosing it to her patients, and felt guilty for considering maternity leave just as a precarious alliance was forming. During the second trimester, Dr. A's anxiety diminished as she disclosed her pregnancy to her psychotherapy supervisor and colleagues and received empathic support.

Dr. A wondered when to disclose her pregnancy to her patients. Weeks later Lara disclosed her pregnancy and her ambivalence about having a child. Dr. A explored Lara's feelings, yet worried that prematurely disclosing her own pregnancy might influence Lara. Dr. A shared with her male supervisor "Dr. Z" her affective responses to pregnancy and her countertransference with Lara. When Lara became pregnant, Dr. Z had acknowledged a parallel rise in Dr. A's anxiety, as well as his own. Dr. Z initially advised Dr. A to not disclose her pregnancy until Lara noticed it.

Lara never spoke about her own pregnancy. Weeks later Dr. A experienced heightened anxiety when Lara revealed abortion plans. Dr. A agreed to disclose her pregnancy before Lara's planned abortion. However, Lara cancelled her next appointment and terminated the pregnancy before further contact.

Several sessions after Lara's abortion, Dr. A disclosed her own pregnancy. Lara congratulated Dr. A, but expressed anger and feelings of abandonment and cancelled subsequent sessions. Dr. Z suggested that Dr. A call Lara to explore Lara's feelings. After this supervisory consultation, Dr. A phoned Lara, urging her to return to therapy.

Upon her return, Lara's sessions were replete with previously unexpressed early sexual and relationship issues. Dr. A noted negative transference elements of maternal rejection and abandonment, which paralleled her countertransference, stimulated in part by their shared pregnancy experience. Dr. Z's supervisory intervention encouraged sustained therapeutic involvement during a difficult phase of negative transference for both Lara and Dr. A. Lara agreed to follow up with another therapist, and Dr. A remarked that their last session ended positively.

Pregnancy changes the psychotherapist's physiology and psychology (4, 5) and may influence therapeutic technique and countertransference with patients (1, 4). Reports suggest that therapists are more preoccupied during the first and third trimester (4, 6–11) and more intuitive and empathic during the second trimester (4, 12).

Specific Issues for Residents

Residents commonly deny the impact of their pregnancy on patients, staff, their learning experience, or even themselves (3, 8), and the same may be true for staff. Collegial and supervisory support

toward the pregnant resident may vary (7), as others may view the resident as less invested in medicine or selfish for not postponing her pregnancy (3, 8, 13–15). Challenges occur upon workforce reentry, when the resident must balance workload, on call duty, child care, and breastfeeding issues (14), as well as integrate her role as wife and mother with that of physician (13).

Disclosing Pregnancy

There is little consensus about the disclosure of pregnancy. Many psychotherapists believe disclosure should occur when the patient recognizes the pregnancy (13). Others suggest disclosing the pregnancy earlier (16, 17), at least 7 months prior to the due date (12), since patients may not notice (13, 18). Early disclosure is suggested when treating patients with borderline personality disorder, like Lara, who tend to react strongly and negatively (16, 19, 20). In psychiatric training, it seems advisable to disclose pregnancy to the supervisor so transference-countertransference issues can be addressed.

Patient Response to Therapist Pregnancy

Patient responses may vary with diagnosis, relationship dynamics (19), and investment in therapy (13), encompassing good will toward the therapist, anger (1), premature termination, suicide attempts, unplanned pregnancies, increased substance use, abortions, missed or late appointments, promiscuity, unprotected sex (21), and memories of childhood or their own reproductive history (7, 16, 17). Feelings of loss or abandonment, envy, exclusion, increased maternal transference (7, 17, 22), and sibling rivalry (7, 17) are common. Pregnancy may render the resident-therapist physically and emotionally vulnerable (19), reviving powerful longings in patients (10, 16, 20, 22), as well as sexual feelings toward the therapist (7, 15, 22), which may hinder exploration of underlying conflicts in psychotherapy (17). If the pregnant therapist is aware of her reactions and empathically understands her patient, the pregnancy event can enhance the treatment process (1, 6).

In Lara's case, themes of abandonment, trust, and negative maternal transference were stimulated by the patient's pregnancy and further provoked by Dr. A's pregnancy disclosure. In this case, exploring transference-countertransference in supervision facilitated the therapeutic progress. Interestingly, the supervisor and Dr. A conjectured that Lara implicitly sensed the therapist's pregnancy. The supervisor's sensitivity to pregnancy was heightened by a pregnant family member, which he disclosed to the therapist.

Teaching, Training, and Research Considerations

Over one-half of residents in North American psychiatry programs are women of reproductive age, and one-half of these women plan pregnancy (15, 23), yet the issues of pregnancy and residency appear to be rarely taught in training programs or reported in supervision literature. Since residency is a common time for pregnancy (13), it is reasonable to expect case-based discussions for residents, clinicians, and psychotherapy supervisors to enhance clinical sensitivity toward resident pregnancy and its impact on training. This is an area of considerable importance which merits further discussion, teaching, and study.

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Recovery: Where Are We?

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Background: There is an increasing emphasis on mental health systems becoming recovery oriented. Before we can work on improving an existing system, however, we have to understand where it currently stands. The objective of this study was to assess staff attitudes and knowledge about recovery at a community mental health center in Brooklyn, New York. **Method:** The author used the Recovery Knowledge Inventory to measure staff attitudes and knowledge about recovery from severe mental illness. **Results:** Staff (N=74) had the highest knowledge about the role of peers in recovery and the need for patients to develop a positive identity beyond that of a patient. Staff also understood their own role and responsibility and their patient's role and responsibility in the recovery process. Staff was less comfortable in having realistic expectations regarding recovery of patients. Staff was least knowledgeable about the course of the recovery process. **Conclusions:** Participants were knowledgeable about some aspects of the recovery process but lacked knowledge about two vital domains of recovery. These aspects involve 1) having hope that recovery is possible for patients with varying levels of symptoms and 2) knowledge that the recovery process more often involves multiple relapses rather than a straightforward, linear course of steady improvement. Lack of knowledge about these aspects might lead to a lack of hope in the treatment atmosphere and hinder the recovery process.

The term recovery has been defined and used in numerous ways. It has been regarded as a complete cure from active symptoms of mental illness (1, 2) to having a complete life in spite of existing symptoms of the illness (3–5). The concept of a complete cure comes from the medical model of treating illnesses that are capable of complete resolution. Over the past few decades, the medical community has seen an increase in chronic illnesses and often focuses on symptom management. In some illnesses, such as in strokes, physical rehabilitation is an accepted practice and neurologists are familiar with these rehabilitation strategies. For mental illnesses the counterpart is psychosocial rehabilitation. Unfortunately, many psychiatrists are unfamiliar with this treatment model and available referral resources. The concept of recovery as quality of life in spite of symptoms involves social, economic, and personal aspects, in addition to symptom management (5, 6).

There are many definitions of recovery. Since the President's New Freedom Commission on Mental Health (7), there have been many papers on definitions of recovery and the conceptual model of recovery (3, 4). The following definition includes all the aspects of recovery: "Recovery is a process involving a redefinition of one's illness as only one aspect of a multidimensional sense of self—capable of identifying, choosing and pursuing personally meaningful goals and aspirations beyond or despite the illness" (8).

The recovery model as conceptualized by Jacobson and Greenley (3) has a set of internal and external conditions. Internal conditions include factors like hope, healing, empowerment, and connection (4, 9, 10). The external factors that define recovery include human rights, a positive culture of healing, and recovery-oriented services. Human rights can be described on the broader society level as encompassing all cultures and beliefs. A positive culture of healing refers to the cultural milieu in which services are offered, whereas recovery-oriented services are the actual services provided.

Even though there has been a growing body of work on recovery in the last 30 years, the work on measuring recovery-oriented services has just started, as mental health systems are increasingly encouraged to become more recovery oriented (4). Before we can work on improving an existing system, we have to understand where it currently stands. The aim of this study was to assess staff attitudes and knowledge about recovery at a community mental health center in New York. The study also was designed to see if there were any differences among staff based on their roles in the department.

Method

This study was conducted at a community mental health center in Brooklyn, N.Y. This center has two inpatient units with a total of 70 beds. This center also provides outpatient services and a more intensive day treatment program. The Recovery Knowledge Inventory (8) was used to measure staff attitudes and knowledge about recovery from severe mental illness.

Staff in the outpatient department, day treatment program, and inpatient unit, as well as residents that float through all sections of the psychiatry department, were approached. Informed consent was obtained and participants were requested to complete the Recovery Knowledge Inventory. As various definitions of recovery exist, staff was provided with the definition of recovery as given in the Recovery Knowledge Inventory.

The study sample included 74 staff members working in the psychiatry department at the Maimonides Medical Center in New York. Staff members included those staff working with patients, such as mental health workers, nurses, psychologists, and psychiatrists. The Institutional Review Board at the medical center approved the study.

The Recovery Knowledge Inventory was developed by a group of researchers at Yale University in 2006 who felt that the evidence base for recovery was not enough to help move the mental health community toward recovery-oriented care. Bedregal et al. developed the measure as part of a statewide initiative in Connecticut to be more recovery oriented. It is composed of 20 questions in four empirically validated domains. Factor 1 concerns roles and responsibilities in recovery, factor 2 concerns the nonlinearity of the recovery process, factor 3 concerns the roles of self-definition and peers in recovery, and factor 4 concerns expectations regarding recovery. Reliability analysis (Cronbach's alpha) estimates for the four components are 0.81, 0.70, 0.63, and 0.47, respectively (8).

We calculated mean scores for staff on the four factors of the Recovery Knowledge Inventory using the scoring method suggested by its creators. We used analysis of variance (ANOVA) and post-hoc Tukey's tests to compare mean differences between groups.

Results

Staff had the highest knowledge about the role of

Table 1: Staff Scores on the Recovery Knowledge Inventory										
	All Staff (N=74)		Day Treatment Staff (N=17)		Outpatient Program Staff (N=9)		Inpatient Staff (N=27)		Residents (N=21)	
Factor	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Factor 1 (roles and responsibilities in recovery)	3.5	0.62	3.66	0.63	3.56	0.69	3.57	0.60	3.52	0.67
Factor 2 (nonlinearity of the recovery process)	2.41	0.56	2.62	0.62	2.46	0.31	2.39	0.64	2.25	0.45
Factor 3 (role of self definition and peers in recovery)	3.97	0.52	4.19	0.53	3.76	0.34	3.91	0.61	3.97	0.41
Factor 4 (expectations regarding recovery)	2.92	0.86	3.12	0.70	2.94	0.77	3.00	1.02	2.64	0.79

peers in recovery and the need for patients to develop a positive identity beyond that of a patient (factor 3). Participants had the highest mean score of 3.95 (SD=0.52) on this factor (Table 1). Factor 3 included statements such as, "The pursuit of hobbies and leisure activities is important for recovery."

Staff was also comfortable with understanding their own role and responsibility and their patient's role and responsibility in the recovery process (factor 1). Participants had the next highest mean score (3.58, SD=0.62) on factor 1. Factor 1 included statements such as, "People with mental illness/substance abuse should not be burdened with the responsibilities of everyday life." This question was reverse scored.

Staff was less comfortable in having realistic expectations regarding recovery of patients (factor 4). Participants had the third highest mean score (2.92, SD=0.86) on factor 4. Factor 4 included statements such as, "Not everyone is capable of actively participating in the recovery processes." This question was reverse scored.

Staff was least knowledgeable about the course of the recovery process (factor 2). Participants had the lowest mean score (2.41, SD=0.56) on factor 2. Factor 2 included statements such as, "Symptom management is the first step toward recovery from mental illness/substance abuse." This question was reverse scored.

We subdivided all staff by the section they worked in into outpatient staff, inpatient staff, day treatment staff, and residents. Residents were seen as a separate category as they rotate through all these sections. All the participants' scores had the same trend: a maximum score on factor 3, followed by factor 1, then factor 4, and then factor 2. Results on the ANOVA showed that there were no significant differences among the various groups on the four Recovery Knowledge Inventory factors (p>0.05) (Table 2).

Discussion

Even though recovery is a process that consumers must struggle with, mental health providers play a vital support role by providing the right conditions (6). This study is a step toward clarifying what aspects of recovery are known and acceptable to staff and delineating which factors need more

education among mental health providers. Participants in this study were knowledgeable about some aspects of the recovery process but lacked knowledge about two vital domains of recovery.

The results of our study are similar to those of the authors of the Recovery Knowledge Inventory. The psychiatry department staff felt more comfortable with factors 1 and 3. This means that the staff is probably knowledgeable about and accept 1) the role of peers in recovery, 2) the role and responsibilities of the staff and the patient, and 3) the need for patients to develop a new definition of self beyond being a patient.

Staff that participated in this study scored low on factors 2 and 4. These aspects of recovery involve 1)

Table 2: Results of the ANOVA					
	Sum of Squares	Mean Square	F	df	p
Factor 1					
Between groups	0.193	0.064	0.159	3	0.924
Within groups	28.274	0.404		70	
Total	28.467			73	
Factor 2					
Between groups	1.281	0.427	1.376	3	0.257
Within groups	21.731	0.310		70	
Total	23.012			73	
Factor 3					
Between groups	1.338	0.446	1.704	3	0.174
Within groups	18.332	0.262		70	
Total	19.671			73	
Factor 4					
Between groups	2.455	0.818	1.100	3	0.355
Within groups	52.058	0.744		70	
Total	54.514			73	

having hope that recovery is possible for patients with varying levels of symptoms and 2) knowledge that the recovery process more often involves multiple relapses rather than a straightforward, linear course of steady improvement. Lack of knowledge about these aspects might lead to a lack of hope in the treatment atmosphere and hinder the recovery process. Also, in spite of an increased movement toward recovery orientation, psychiatric staff are still very symptom oriented. Medications and their use is a topic familiar to all psychiatric staff but use of psychosocial interventions and their benefits are not yet that familiar or accessible. Therefore, the preference of focusing more on medications to help patients is understandable. In addition to providing education regarding these aspects of recovery, the availability of some staff that is trained in various aspects of psychosocial rehabilitation and better vocational opportunities for patients are needed.

We did not find a difference in knowledge between the different subsections of the department. This is an important negative finding. The inpatient unit is frequently the first exposure to many patients

for mental health providers. Therefore, recovery-oriented staff on inpatient units are an essential and integral part of a recovery-oriented system.

Factor 4 has a lower reliability than other factors. The Recovery Knowledge Inventory is an important first step toward more empirical research in recovery, but it needs to be developed and tested further to increase its reliability.

These results need to be translated into more training for staff to enhance the department's recovery orientation. Also, further work on assessing recovery-oriented services is needed.

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