



**Caring for Your Clients While Caring for Your Baby: Responsible and Ethical Planning for Parental Leave**

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# Caring for Your Clients While Caring for Your Baby: Responsible and Ethical Planning for Parental Leave

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*Eileen A. Dombo and Ami P. Bass*

## Introduction

Workforce research on licensed social workers across the United States reveals that 85 to 91% of those between the ages of 26 and 44 are women (National Association for Social Workers Center for Workforce Studies, 2006). Providers of mental health services are overwhelmingly female, yet there is little guidance for them as to how take time away from work to care for family obligations, such as having a child. The general guiding principle in clinical practice is to limit self-disclosure to clients, and only reveal personal information when there is a therapeutic benefit (Goldstein, 1997). Clinicians in direct practice settings providing mental health treatment (commonly referred to as therapists) may undergo many life changes, and they have a responsibility to prevent personal situations from impeding their work. Pregnancy is one life change, however, that female therapists cannot keep private for long. While the literature addresses the myriad of ways in which the therapist's pregnancy can influence the transference and countertransference in the therapeutic alliance, there is little published to guide therapists on how to ethically prepare for parental leave, or any type of break from practice (Sarnat, 1991).

The literature on maternity leave is quite dated, reflecting a traditional view of childbearing and rearing that is not relevant to therapists adopting an infant, those who are about to become fathers, or those who are single parents. This article offers a review of the literature on planning for the arrival of a child, and explores some ethical considerations. The term parental leave will be used moving forward to be more inclusive to the need to attend to expectant or adoptive fathers, and those fathers who are the primary caregivers for children. The experiences of four therapists are presented as case vignettes to assist in the formulation of a set of practice guidelines. Finally, implications for practice will be outlined.

## Literature Review

An extensive review of the literature on the subject of the therapist's parental leave reveals a history of minimal attention to this subject. There is ample literature on the impact a therapist's pregnancy can have on clients as well as the therapist. The effects are described largely in psychodynamic terms, emphasizing the transference and countertransference around the pregnancy (Adelson, 1995; Barbanel, 1980; Brouwers, 1989; Clarkson, 1980; Fallon & Brabender, 2003; Gottlieb, 1989; Hjalmarsson, 2005; Pielack, 1989; Rosenthal, 1990; Ulman 2001). Most of the articles on the subject are personal accounts and/or observations of colleagues navigating the personal and professional changes that arose during pregnancy (Barbanel, 1980; Chiaramonte, 1986; Dyson & King, 2008; Haber, 1992; Hjalmarsson, 2005; Korol, 1996; McCarty, Schneider-Braus, & Goodwin, 1986; Stockman & Green-Emrich, 1994). Only two published studies on the topic were found which included qualitative interviews of therapists who had taken maternity leave (Bassen, 1988; Grossman, 1990). Fallon and Brabender (2003) provided the only identified source to address issues unique to adoptive parents and male therapists about to become fathers. Much of this literature is quite dated, displaying a clear lack of attention to the subject in contemporary writing. Core themes from the literature regarding how to handle these scenarios with clients are still relevant however, and are discussed here.

### Notifying clients

Most of the subjective accounts by pregnant therapists detail waiting for the clients to notice the pregnancy on some level before providing confirmation (Barbanel, 1980; Haber, 1992; Hjalmarsson, 2005). If the client acknowledges the pregnancy, either directly or through dreams or associations that signal their awareness, then the therapist can explore any defenses or fantasies associated with it (Uyehara Austrian, Upton,

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Warner, & Williamson, 1995). If clients did not bring it up by the time the therapist's pregnancy was visibly apparent, then she offered the information up and provided an opportunity to process the news in session. While this is the dominant approach in the literature, this model is counterintuitive to social norms, which discourage asking a woman if she is pregnant, and could also be anxiety-inducing for clients who notice the therapist's physical changes but do not receive an explanation. Additionally, clients with a history of having important information withheld from them by their caregivers may feel that their trust has been damaged if the therapist does not offer the news in a timely manner (Fallon & Brabender, 2003; Uyehara et al., 1995). A few sources suggested that some pregnant therapists, especially those with a history of miscarriages, could wait until the pregnancy was secure and announce it to clients during the second trimester or after the amniocentesis (Fallon & Brabender, 2003; Korol, 1996; Uyehara et al., 1995). Uyehara, Austrian, Upton, Warner, and Williamson (1995) provided case vignettes where both announcing the pregnancy and waiting for the client to notice had negative consequences on the therapeutic alliance. They therefore conclude that the client's history, stage of therapy, and presenting problem should all factor into how the therapist ultimately discloses the pregnancy, but that at least two to three months are necessary to process the client's reaction to the pregnancy and explore any transference issues that arise, as well as prepare for the therapist's absence.

The literature exploring the manner of notification and how it compliments client characteristics needs to be updated, but the sources that exist suggest that female clients are more likely than male clients to have intense transference reactions, and clients with greater vulnerability to narcissistic wounds, such as those with Borderline Personality Disorder, will have more difficulty with the news than others (Lax, 1969; McCarty, Schneider-Braus, & Goodwin, 1986; Uyehara et al., 1995). These clients therefore may require more tact in delivering the news and managing the response as well as time to explore the pregnancy's meaning for them. Bassen (1988) added that the pregnancy announcement should include time for the therapist and cli-

ent to explore its meaning and, as such, any discussion of maternity leave should be left for another session. The guidance on notifying child clients is the same as it is for adults, though there is a greater emphasis on the allocation of time to process the meaning of the pregnancy for the client (Fallon & Brabender, 2003). Child therapists must also notify their clients' parents, ideally after the client has learned of the pregnancy, and may have to process their reaction to the news as well.

It is also important to consider whether or not to take on new clients while a therapist is pregnant. Haber (1992) chose not to take new clients once she was in her second trimester in order to prevent an early interruption in treatment but also to allow her to return to a manageable caseload. Women who are not in private practice may not have less control over the size of their caseload and when they are assigned new clients in an agency setting (Grossman, 1990).

#### **Impact on the client**

The pregnancy will factor into the therapy sessions at some point, whether through the initiative of the client noticing and mentioning the pregnancy or the therapist acknowledging it. Many articles address the transference and countertransference issues that arise around the therapist's pregnancy, which can be both disruptive as well as helpful for the client's progress (Barbanel, 1980). Themes that may arise for clients include sibling rivalry, envy, sexuality, anger, loss of control, fear of abandonment, and separation anxiety, all of which may provide impetus for acting out (Barbanel, 1980; Haber, 1992; Hjalmarsson, 2005; Uyehara et al., 1995). Multiple authors cited instances where clients went off their birth control or became pregnant when the therapist's pregnancy had been registered, either in dreams and associations or consciously (Dyson & King, 2008; Hjalmarsson, 2005; Uyehara et al., 1995). Many therapists that wrote about their personal experiences of announcing their pregnancy and managing clients' reactions wound up losing a small number of clients due to the news (Barbanel, 1980; Fallon & Brabender, 2003; Grossman, 1990; Haber, 1992; Hjalmarsson, 2005; Uyehara et al., 1995).

### Impact on the therapist

Pregnant therapists will not only undergo physical changes; they will likely experience emotional and psychological changes that could impact their professional lives. Countertransference issues to be aware of include ignoring the pregnancy's impact on the client or therapeutic alliance, experiencing increased vulnerability and anxiety, ambivalence about priorities to clients and self, and changes in dynamics with colleagues and clients (Dyson & King, 2008; Grossman, 1990; Uyehara et al., 1995). Dyson and King (2008) warned about the risk of denying the pregnancy's influence in therapy and how it can desensitize the therapist to client transference related to her and pregnancy in general, thereby missing important opportunities to work through fantasies and unresolved issues. Grossman (1990) interviewed sixteen pregnant therapists and found a common concern of ensuring that clients were taken care of before directing attention to caring for themselves and their pregnancy. This act of prioritizing care and attention became more challenging after the therapists delivered their babies, and many expressed guilt at not feeling available enough for clients or for their child. Vulnerability showed up as a consistent theme throughout the literature; therapists may feel overly exposed as well as unprepared for and resentful of personal questions they prefer not to share such as the therapist's partner's reaction, the baby's name, sex, birth order, health status, and childrearing techniques (Chiaromonte, 1986; Dyson & King, 2008; Grossman, 1990; Uyehara et al., 1995). Therapists may also feel overwhelmed by clients' transference material, especially anger, malevolent fantasies about the pregnancy, and envy, as well as feel an increase concern about physical violence from clients (Fallon & Brabender, 2003; Grossman, 1990). Some authors expressed shame at having such an intimate part of their personal life exposed, and guilt that they would be seen by colleagues as less committed to their profession (Korol, 1996; Uyehara et al., 1995). In Grossman's study (1990) several pregnant therapists expressed concern of loss of bodily control during a session, either due to nausea, fatigue, dizziness, or the water breaking. De-

spite these concerns, most therapists found that their fears did not manifest.

Just as the client's transference to the therapist's pregnancy is not entirely negative, the same is true for the therapist's countertransference. All of the participants in Grossman's study found that they became more "real" with their clients, which was a benefit to the therapeutic alliance, an experience that was echoed in the literature (1990, p. 73; Hjalmarsson, 2005; Korol, 1996). Therapists will also be challenged to become mindful of the counter-transference that will surface around the pregnancy, which can increase self-awareness while also deepening the therapeutic alliance with the client (Fallon & Brabender, 2003; Korol, 1996). If this is the therapist's first child, she may also become more attuned to issues around parenting and children.

Finally, there are clear professional boundaries that discourage the acceptance of gifts from clients. However, clients may offer baby gifts to expectant therapists and the therapist must determine the therapeutic value of accepting or declining the gift. For example, accepting handmade gifts, but not expensive store bought ones, could be an appropriate boundary. As with all clinical issues, the meaning behind the gift must be processed in session. Gifts that can be received on behalf of the agency may also be appropriate to accept. Receiving baby gifts may require an adjustment to the therapist's protocol on gift acceptance. Offering a baby gift is socially acceptable and therefore is less likely to carry a motive or deeper meaning as a personal gift for the therapist might. Offering a baby gift may also be therapeutic if it reflects growth in clients' pro-social behavior or offers comfort to clients anticipating the temporary loss of their therapist (Fallon & Brabender, 2003).

### Expectant Fathers and Adoptive Parents

Therapists who are expectant fathers, adoptive parents, and/or gay and lesbian parents may have experiences that overlap with pregnant female therapists, but they will undoubtedly have unique issues to address based on their situation. A father-to-be may experience his partner's symptoms of decreased appetite, nausea, weight gain, and anxiety. However, Fallon and Brabender (2003) found

that none of the male therapists they interviewed notified their clients that they were expecting a child. Over the course of their partner's pregnancy, expectant male therapists were more likely to be attuned to themes of babies and parenting among their clients. Some also expressed feeling more vulnerable due to their need to be available to their families. Fathers-to-be are likely to work up until the delivery and may have to cancel appointments at the last minute if anything unexpected occurs.

The most prominent concern among expectant male therapists regarded how and when to explain their leave, especially if it is sudden or extended unexpectedly, and several reported that they would have benefited from supervision from therapists who had personal experience with this issue. In addressing absence from work with clients, some male therapists withheld the details of their leave, whereas some shared the news depending on the pathology of the client and the comfort level of the therapist. The client responses varied similarly to those for pregnant female therapists: some clients hardly noticed the therapist's absence, which was due to "personal reasons;" another client left therapy due to her hurt at not being informed earlier, and another client felt her therapist became "more human" to her, which greatly improved the therapeutic alliance and, subsequently, the client's progress (Fallon & Brabender, 2003, pp. 297, 299). Clients who are at risk of harming themselves or seriously digressing during the hiatus from therapy would likely benefit from advanced notice to develop coping strategies for the therapist's leave. Much like pregnant therapists must choose between waiting for the client to notice and announcing the pregnancy, male therapists "must weigh the risks of betrayal against the complications that personal disclosures create in the treatment" (Fallon & Brabender, 2003, p. 301). Beyond notifying the client of the leave, paternity leave usually falls between one day and one month, and, as such, male therapists who are not primary child caregivers may have fewer concerns for ensuring continuity of care for their clients.

Adopting a child includes unique variables that can influence the experience of becoming a parent: the stress of proving oneself as a desirable parent to adoption agencies, whether the adoption is do-

mestic or international, whether it is done through public or private means, the characteristics of the child, and whether it is an open or closed adoption (Fallon & Brabender, 2003). The wait is often extensive between the assignment of a child and the child's actual arrival, and the parents are likely to be notified that their child is ready at the last minute. This requires therapists who are adopting to prepare their practice for their parental leave at a moment's notice. Fallon and Brabender (2003) recommend making preparations for a substitute therapist far in advance and making clients aware of the tenuousness of the commencement and length of their parental leave. Both fathers and adoptive parents may notice less of a response from clients and colleagues in terms of enthusiasm for the new child. While their pregnant counterparts may receive baby showers, cards, gifts, and attention, fathers and adoptive parents may receive little more than a congratulatory statement (Fallon & Brabender, 2003).

#### **The Ethics of Parental Leave**

There is no one best way to prepare clients for the therapist's parental leave (Barbanel, 1980; Fallon & Brabender, 2003). Each therapist must choose the manner in which she will communicate her pregnancy to clients as well as how long she will work until she takes parental leave (Barbanel, 1980). Mediating factors related to the client include their reaction to the news, emotional stability, and personal and familial history with pregnancy. For therapists working in an agency setting, the policy on parental leave also plays a role in how one should prepare (Barbanel, 1980; Grossman, 1990; Uyehara et al., 1995). Despite the distinctiveness of each therapist's situation, this can be considered an ethical issue that invokes social work's core ethical principles of service, dignity and worth of the person, integrity, and competence as well as the standards of practice (National Association for Social Workers [NASW], 2008). The social work value of *service* ensures that social workers rise above self-interest to cater to those in need. This value is fulfilled by having a specific plan in place that guarantees clients will receive the appropriate care during the clinician's parental leave as well as in the event that the therapist must take leave early or delay

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her return. Notifying clients of the pregnancy and parental leave with ample time for the clients to prepare for and contribute to the development of a plan during the clinician's leave honors the *dignity and worth of the person*. The *integrity* of the profession is dependent upon social workers making responsible professional decisions. Having a plan for notifying clients of the parental leave and referring them to the appropriate resources during the leave is key for consumers of social work services to be able to exercise informed consent and trust the profession. Finally, *competence* calls for all social workers to continually work to enhance their own practice as well as the knowledge base of the profession. Having a plan for parental leave based on the needs of the client and the best practices of the profession is one way in which social workers can practice with competence.

The Standards of Practice (NASW, 2008) offer detailed guidelines for ethical social work practice. When an *interruption of services* to clients is anticipated, Ethical Standard 1.16 encourages social workers to notify clients in a timely manner and plan for the continuation of services with the consideration of the clients' needs and preferences. Ethical Standard 1.07 protects the *privacy and confidentiality of clients*, which is an important consideration when providing referrals to alternate clinicians while on parental leave. The client should give consent through a release of information form before the referral is made. Additionally, the client should be made aware of the type of information about the client that will be shared between his or her primary and alternate clinician. Even if a referral is not included in the parental leave plan, it is prudent to obtain consent for release of information to an alternate clinician in the event that the clinician's parental leave is unexpectedly extended.

Social workers also have an ethical *responsibility to their colleagues, practice setting*, and to *the profession* as a whole. Ethical Standard 2.06 emphasizes the importance of facilitating an orderly *referral and transfer of services*. With the consent of the client, referrals should include client information relevant to his or her continued care. Additionally, the social worker receiving the referral has a responsibility to consider whether

agreeing to cover for the primary clinician during her parental leave is in the best interest of the client in order to determine whether to accept the *client transfer* (Ethical Standard 3.06). When a treatment question arises, social workers also have an ethical responsibility to seek *consultation* with colleagues who have expertise in the area of concern (Ethical Standard 2.05). Social workers who are unsure of how to manage the impact of their pregnancy in session, as well as how to prepare their practice for parental leave in a manner that serves the best interests of the clients, should consult with colleagues who have knowledge, expertise, and competence on these topics. Social workers who provide *supervision and consultation* relating to the supervisee's pregnancy and parental leave must have the necessary knowledge and skills on the topics before providing guidance (Ethical Standard 3.01). Finally, social workers have an ethical duty to the profession to not allow their *private conduct* to interfere with their professional responsibilities (Ethical Standard 4.03) thereby reinforcing the need for a parental leave plan that accommodates the needs of clients as well as any unexpected needs of the clinician.

### Planning Parental Leave

Despite the ample literature addressing the psychodynamic concerns of pregnant therapists and the considerations for notifying clients, there is scant literature addressing how to prepare one's practice for the parental leave. Having considered the ethical implications of preparing for parental leave, a detailed plan is highly important. Ideally such a plan includes the continuity of services for client and accommodates for any complications, such as a premature or late delivery and extended postpartum rest. The following are some issues to consider when planning leave.

While it is up to the individual clinician to choose when is best for her to begin parental leave, Haber (1992) advised against working up until the baby's due date. The final month of pregnancy can be physically uncomfortable, making it challenging to sit upright for long periods and pay full attention to clients. As delivery could take place weeks before or after the due date, basing termination on such a tentative event can be

hard on clients and clinician. One clinician who continued to work within a couple of days of delivering admitted to saying goodbye to clients on multiple occasions as her pregnancy continued long after her due date (Korol, 1996). The Family Medical Leave Act of 1993 (FMLA) has set the standard parental leave time for 12 weeks. The clinician might consider allowing herself time for complications on either end of the delivery; enough time to rest and prepare for the delivery as well as enough time to recover and enjoy the baby, even if the delivery is long after the due date.

In order to ensure continuity of client care, therapists and their clients typically have three options: a trial termination, a temporary therapeutic hiatus, or a temporary transfer to another clinician (Chiaramonte, 1986). The therapist and client can choose the option that best serves the needs of the client. For clients who are simultaneously in treatment with another mental health professional such as couples work, group therapy, or a working with medicating psychiatrist, suggest that these professionals might be natural covering providers who could be asked to expand their services slightly to provide extra care during the therapist's parental leave (Fallon and Brabender, 2003). Grossman (1990) found that several pregnant therapists, while on parental leave, referred their clients for treatments that the clients might not have otherwise pursued, such as biofeedback, relaxation, and anxiety management training. Clients then had the opportunity to learn new techniques to care for themselves while the therapist was away. Haber (1992) referred clients to another therapist during the six weeks she took for parental leave. Towards the end of her leave, she wrote letters to each client to announce the baby's birth, her status, and to confirm the next appointment date. This last step satisfied the need to follow up with clients while preventing the burden of making or receiving telephone calls. McCarty, Schneider-Braus, and Goodwin (1986) used vignettes from their personal experiences to show the effective use of an alternate therapist while the primary therapist is on parental leave. They attributed the success to the fact that the alternate provider was familiar with both the primary therapist and the clients due to their involvement in group treatment.

### Case Vignettes

The experiences of four clinical social workers are presented here to gain insight into the issues that present themselves when planning to take a break to welcome a child into one's life. The stories of Marion, Shoshana, Josefina, and Martin are shared to give readers examples of what works, what does not, and important considerations when planning leave.

#### *Marion*

Marion is a white clinical social worker in her mid-30s, with a full-time private practice. She and her husband had been planning a family for quite some time; due to her experiences with miscarriages, she was hesitant to tell clients about the pregnancy until absolutely sure, but had to weigh this against clients noticing before she told them. As the pregnancy neared the end of the fourth month, Marion began informing clients of her pregnancy and the upcoming plans for a 12-week parental leave. She was nervous at first, as she was uncomfortable focusing on her personal situation, and was unsure how certain clients would react. One client shared that she had recently had a dream in which Marion was pregnant; another stated she was angry with Marion for making a personal choice that would affect her.

Marion sought supervision and consultation with a colleague who had been through this herself. When contacted by new clients looking to begin therapy, she told them about her pregnancy and leave plan prior to the start of treatment. She worked up until a week before her due date, and had linked each client up with a colleague who was covering in her absence. As her leave date neared, Marion received a few gifts from clients, including baby books and blankets. She accepted these gifts and processed the meaning with each client.

Each client received a handwritten letter from Marion about the parental leave plan, and then another letter when the baby was born, communicating that she had her baby, everyone was healthy, and that she would resume seeing clients as planned. When Marion resumed work, she found that a small handful of clients had decided not to continue therapy, but that for the most part, her full practice continued as before.

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### *Shoshana*

Shoshana is a Jewish woman in her early 30s who was working at a private school as a counselor when she became pregnant. Her pregnancy soon became the topic among the 10-13 year old students she worked with, and Shoshana felt able to freely talk about their feelings about her pregnancy, the expected baby, and how her temporary absence from their lives would impact them. Although Shoshana planned her leave well, and arranged for colleagues to work with her clients, there were complications in her pregnancy during her last month, which resulted in an early delivery. Since she had not planned for this outcome, Shoshana and her husband had to deal with the added stressor of contacting colleagues and clients from the hospital to inform them. This resulted in extended stressors during the early part of her leave, as she had to coordinate with colleagues and reassure her clients that she and the baby were doing fine. Upon returning to school after her four month parental leave, Shoshana found many of her clients had formed strong bonds with the covering colleagues, and were hesitant to switch back to working with her so close to the end of the school year. This impacted Shoshana's caseload and ability to meet her productivity goals at work, as well as her self-confidence.

### *Josefina*

Josefina is a biracial woman in her early 30s who had just begun her private psychotherapy practice when she discovered she was pregnant. She informed her clients during her third month of pregnancy, and clearly specified the boundaries of her leave, as well as the process for finding and coordinating with a covering clinician. Josefina was concerned about the unpredictability of pregnancy, so she clearly laid out a contingency plan in the event that her leave started earlier than anticipated. Josefina also had all her clients sign a confidentiality release so a colleague could contact them to inform them of any change in plan. She worked with clients to tailor a plan for managing their clinical needs in her absence. Some clients did group psychotherapy, some did couple work with their partners, a few worked with a different individual therapist, while others used

the hiatus from therapy to do some self-guided work. Josefina set clear boundaries regarding contact during her parental leave, and limited contact with covering clinicians to emergency situations. She had set up appointments with each client prior to her parental leave, and contacted each one by phone to confirm resumption of services two weeks prior to that date. Many clients were naturally curious about the baby, and wanted to know the baby's name, gender, and some asked to see photographs of the child. Josefina was unsure as to how to respond to these questions, and felt she should have thought about these questions ahead of time so she could respond consistently to each client and be clear about information she was not comfortable sharing.

### *Martin*

Martin is an African-American gay man in his late 20s who works at a non-profit organization serving GLBTQ teens and young adults. He and his partner Tom decided to adopt a child and had gone through the process to be approved as adoptive parents. After the approval process was complete, Martin informed his clients that he would need to go on leave at a moment's notice, but due to the nature of adoption, he didn't know when that would occur. Given this uncertainty, he felt he did the best he did to prepare his clients, but was surprised to find that his supervisor and some colleagues had difficulty with this lack of predictability. As time passed, Martin found he had to keep reminding clients of his situation, since there were no obvious physical signs of expecting a child. He found he was able to be open with his clients about his process and their feelings. Martin felt that working in an organization that was supportive of gay rights was a safe forum to talk about becoming a parent as a gay man. He also found most of his clients to be supportive of his decision to become a parent, and Martin was glad to be able to model this prosocial behavior. As Martin was the primary caregiver for the child, he knew he would be out for some time as arrangements were made for childcare. However, he felt he should not take the full 12 weeks leave allowed by FMLA. He returned to work a month after his child arrived. This early return was con-



nected to Martin's fear of losing his job and his clients, as he was the only staff member with a child at the organization. He found the staff to be supportive in concept, but not in practice. Martin was hurt that no one held a baby shower or gave baby gifts, or asked questions about the baby when he returned to work.

### Discussion

The issue of the therapist's parental leave has been left wanting for more research and has been held up for quite some time as an area requiring further research (Stockman & Green-Emrich, 1994). As with other personal life situations, pregnancy and bringing a child into one's family create situations in which therapists must step away from their work in the short term. It is an ethical imperative for professionals to ensure that their clients are cared for when they step away to care for a new baby. There has been a lack of direction and guidance on how to do this in an ethical manner. Based on the limited literature and the case examples presented above, some implications for practice and guidelines are presented here for consideration.

### Implications for Practice

Based on our ethical duties to our clients, our colleagues, and the practice setting (NASW, 2008), preparing for parental leave is an essential part of ensuring continuity of care for clients. Not only should the therapist think carefully about how to share this personal news with clients, he or she should be thinking far in advance about logistical matters in addition to transference and countertransference dynamics. Using Josefina and Martin's examples, the therapist should begin informing clients and colleagues about leave plans around the three-month point of pregnancy, or once one is approved as an adoptive parent. The start date and expected return date should be decided well in advance; however, *contingency plans* for early leave or delayed return should be given careful consideration, so as not to be in the position Shoshana and her clients experienced. Information on covering colleagues and resources for support during the leave period should be *put in writing*, and clearly communicated with clients. Colleagues should be given as much information as possible, and clients should sign confidentiality releases and

other documents well in advance.

Following Marion's example, therapists are encouraged to *seek consultation* and supervision with a colleague who has gone through a similar experience. In addition to helping process and address transference and countertransference, this can help the therapist think through issues of communication about the process and during the leave, handling gifts, and setting boundaries around information about the child. Each client should have a plan in place that is unique to their situation, whether they would benefit most from termination, taking a break, working with another therapist, or doing some other kind of work in group, family treatment, or couples counseling.

Finally, colleagues can learn from Martin's experience. Is the work setting treating pregnant colleagues differently than those adopting children or male therapists who are primary child caregivers? The way families handle childcare is changing, and the workplace must respond to the needs of single parents, gay and lesbian parents, and mothers and fathers who share childcare in a variety of ways. Supports for therapists expecting and raising children should reflect a respect for the *diversity of family compositions*. Many therapists have fears about their absence having a negative impact on colleagues, losing clients to other therapists, and a diminished standing in the professional community. These should be directly addressed by supervisors and within the community of therapists to support expectant parents in our field.

### Conclusion

From the review of the literature and the Social Work Code of Ethics, core issues related to responsibilities to clients, colleagues, practice setting, and the profession are surfaced when a therapist plans to leave clients to welcome a child into their family. The scholarly literature has not given therapists clear guidance on how to handle dynamics around notifying clients of impending leave, addressing care of clients during the leave, and utilizing consultation and supervision to make decisions about how to handle issues that arise. This article has given concrete suggestions for creating a responsible and ethically reflexive leave plan. Therapists who are pregnant, adopting

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children, and/or those who may not be following traditional paths of child rearing and caregiving can utilize these guidelines for developing their own plans.

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