# When two are a family: looking backward and looking forward in a group intervention with single-by-choice mothers

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*Objective*: We describe a preventive short-term group intervention with nine single-by-choice (SBC) mothers to provide maximal support for parental functioning and to minimize possible emotional and/or developmental difficulties in their children.

*Method*: Dynamically oriented group work (fifteen one-and-a-half-hour sessions) focused on: elaboration of painful experiences in the peri-natal period; reducing stress, tension and guilt; helping mothers with problematic aspects of parenting through work on parental self-image and perceptions of the child and the dyadic interaction; and strengthening their acceptance of the chosen family model.

*Results*: Therapeutic gains described by mothers and facilitators include: reduced tension, anxiety and guilt; improved integration of the mother's parental self-image and perception of the child; reduced ambivalence in dyadic relationships; strengthening the mother's fantasized triadic relationships; better acceptance of chosen family pattern; mothers' willingness to tell children their birth story.

*Conclusion*: Dynamically oriented preventive group intervention with SBC mothers can identify potential psychological risk factors and help mothers with sensitive aspects of parenting.

## Introduction

Since the development of fertility techniques such as the use of donated sperm or ovule, IVF and surrogate mothering, new models

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of family and parenthood have sprung up: genetic parenthood, biological parenthood and psycho-social parenthood. Such rapid advances in medical techniques and procedures in the field of fertility and their accompanying social changes have raised significant medical, psychological, social and ethical questions – some of which have not yet been sufficiently addressed (Batzer *et al.*, 2003; the Ethics Committee of the American Society for Reproductive Medicine, 1986; Kovalevsky *et al.*, 2003; Schenker, 2000). Even so, the use of artificial methods of impregnation is steadily increasing (Blickstein, 2003; Insler *et al.*, 2000; Nygren and Andersen, 2002).

Our intervention project, the focus of this article, addressed the needs of single-by-choice (SBC) mothers who became pregnant by artificial insemination; little research is currently available about this population.

In spite of the increase in differing family models (Miller, 1992), many SBC mothers must struggle to establish the legitimacy of their choice (Bock, 2000). In Israel, which is considered a very family-oriented society, there is often pressure from the woman's extended family and social circle to establish a family. Not living according to this social norm may constitute a serious blow to the woman's self-esteem, and create a sense of failure to fulfil herself as a woman and disappointment at being unable to fulfil the expectations of her family, as well as her own (Landau, 2001; Miall, 1986; Remennick, 2000). Ironically, when she tries to fulfil these expectations and join the social norm by becoming pregnant and establishing a family on her own, she often faces the ambivalence of her family and friends, and receives insufficient support (Bar Hava, 1999). The high need of SBC mothers for social, psychological and practical support has been amply demonstrated (Abel, 1996; Mannis, 1997; Pakizegi, 1990).

The condition of SBC motherhood is associated with a number of characteristic risk and protective factors. There is research indicating that women in the typical age group of SBC mothers (35 to 44) tend to experience more stress than younger mothers, as their lifestyle is well established, and pregnancy and parenting are perceived by some as interfering with their chosen way of life, especially in the career domain (Luker, 1996; Reece, 1995). SBC women are often the oldest daughter in their families of origin (Sharp, 2001), and are often expected to take on a larger share of care for ageing parents, creating a double burden: caring simultaneously for parents and a young child.

Exploring the fantasy life of women impregnated by donated sperm, Ehrensaft (2000) points out the possible problematic

consequences of the denial of an internal representation of the biological father as a whole object or of denial of its importance. Being a single mother is often not the mother's preferred choice. Many have had to give up their original wish of founding a family based on an intimate couple relationship (Bar Hava, 2000). Although there have been changes in social norms concerning family models, there are still powerful norms and beliefs with regard to pregnancy and child-bearing as being grounded in intimacy, love and desire (Blankenhorn, 1995; Ehrensaft, 2000; Millett, 1990; Popenoe, 1996). For some, giving up this wish may be painful and involve disappointment, loss, guilt and a sense of failure (Ehrensaft, 2000; Landau, 2001; Miall, 1986).

For SBC mothers the extremely intimate moment of impregnation is taken over by technology and alienation. Often the fertility process necessitates hormone treatment or IVF which entails considerable physical and emotional pain, and these painful experiences are often undergone alone, without any social support (Bar Hava, 1999; Bierman *et al.*, 1991; Leitman, 1996).

All pregnant and child-bearing women face a certain amount of uncertainty intrinsic to these processes, but these levels of uncertainty are far higher for SBC mothers. They know almost nothing about the genetic, biological and psychological identity of the sperm donor, since in Israel he is anonymous under law. The available information is minimal: ethnic background, height, eye and hair colour, occupation, and the doctor's impression, such as nice, spontaneous, sociable, quiet and so on. In Israel sperm donors are only screened to rule out HIV carriers, hepatitis B and C, sexually transmitted diseases, and Tay-Sachs disease (Landau, 1998a, 1998b; Marquis, 2000).

The inevitable anxiety intrinsic in single parenthood is intensified by the SBC mother's sole responsibility for the genetic endowment that she 'chose' for her child – although there was no information on which to base a choice (Breaways *et al.*, 1997; Landau, 1998a). Even when the pregnancy and delivery are healthy and unproblematic, these women may experience higher levels of emotional pain, fear, anxiety, ambivalence, and the loss of fantasies and hopes (Bock, 2000). Such high levels of anxiety during pregnancy are associated with higher rates of behavioural and/or emotional problems in their children (O'Connor *et al.*, 2003). Some elements of the peri-natal experience will be overwhelming enough for some of them to cause difficulty with mentalization (Allen, 1995; Allen and Fonagy, 2002). Thus it is no surprise that both the literature (Cook *et al.*, 1995; Hunter *et al.*, 2000; Lang, 2000) and the women with whom we

worked emphasize the difficulty of telling their children the story of their birth. This telling is necessary to the children for obvious psychological reasons (Bollas, 1987; Verrier, 1996) and due to the necessity of preventing genetic incest when the children marry (in cases where the same sperm donor donated to different sperm banks). Under current Israeli law adults who know how they were conceived, after registering to marry, can ask the sperm bank to cross-check the source of the sperm (Landau, 1998b).

It is important to note the significant protective factors which characterize SBC mothers, such as high level of education, middle to upper socio-economic status, high motivation to parent, and a strong sense of responsibility (Bock, 2000). In the few studies that exist on children of single mothers, no significant difference has been found in the emotional and social development and the development of gender identity of children of single mothers as compared with children raised in heterosexual families (Golombok *et al.*, 1997; Stevens *et al.*, 2002). At the same time, the significance of mothers' fantasized triadic relationships for children's emotional development is well demonstrated by two recent research reports. In their prospective longitudinal study, Von Klitzig and Burgin (2005) found that the ability of parents to envisage triadic relationships during pregnancy correlated positively with the quality and flexibility of their children's object representations, and negatively with the number of behavioural problems in preschool children. Ehrensaft (2000) explores the importance of a fantasized whole-object father in the single mother's mind for the child's internalized objects and interpersonal relating.

At the Infant Mental Health Unit we perceive intervention aimed at supporting and improving parental functioning as an essential part of our focus on preventive treatment for infants and young children. In addition to meeting the therapeutic and preventive needs of individual families, our unit has a major goal of locating and defining groups with special needs within the community and attempting to meet their needs as well. This position underpins the decision to offer a therapeutic group intervention to SBC mothers.

The following report is a descriptive study of the material gathered from the process and supervision notes of the two therapists who facilitated a fifteen-session therapeutic intervention with a group of nine single women who became pregnant by artificial insemination. This is a preliminary, descriptive study of subjective aspects of the SBC experience and of possible directions for therapeutic intervention.

## Conduct of the study

*Preparation for the group intervention*

Due to the scarcity of literature in the field, discussion with professionals dealing with this population (doctors and nurses) was especially important to us. The few mental health professionals dealing with artificial fertility in Israel shared their experience with us. In addition, we collected information from internet sites for SBC mothers in order to learn what issues of parenting concern them, what their problems are, and what kinds of help they are looking for. We also read several children's books written by such mothers, which reveal the mothers' feelings and their perceptions of the child and his or her place in her life.

Mothers were recruited by Well-Baby clinics, welfare services and the Hadassah Unit for Artificial Insemination. The two (female) therapists who facilitated the group (a social worker and a developmental psychologist) interviewed potential participants in the therapy group in order to clarify mutual expectations, to learn about the risk factors and protective factors relevant for each potential participant, and to ensure the woman's suitability for participation in such a group.

Inclusion criteria included being an SBC mother impregnated by donated sperm; having one or more child up to the age of 3; the ability to work within a group; problem areas compatible with group goals; capacity for reflective thinking; and motivation to change. Exclusion criteria included the therapists' impression of the presence of a major psychiatric disorder or markedly inadequate behaviour in the potential participant; history of marked difficulties in group settings; and serious disability/disease/developmental disorder in the child (Yalom, 2005).

The topics that arose in the interviews served as a primary source of guidance as to topics to be addressed. These included: the need for social interaction with other single-by-choice mothers and for a forum for discussing topics of mutual interest; the need for social support; difficulty setting limits for the child; the mothers' sense of guilt for not having provided a father for their children; complaints of stress, tension and exhaustion; the tendency to spend hours of intensive activity with the child to compensate for the lack of a father; concern about the implications for the child of the 'single-by-choice mother' family model; the difficulty of balancing the demands of parenting with their professional lives; and the

question of how and when to tell the children the story of their birth.

Thirty mothers were interviewed and, of these, nineteen were found to be unsuitable because they had not become pregnant by donated sperm. Two of the mothers were ambivalent about the proposed group process, and dropped out before the first meeting. The final group consisted of nine women and two therapists.

### Participants

The nine women who participated in the group were aged 35 to 44. They were all college-educated and belonged to the upper-middle socio-economic range; two were mental health professionals. Each had one child aged 6 months to 3 years, except for one mother who had twins.

As regards their fertility treatments, two had short-term treatment (several months), seven long-term (one and a half to two years). Eight became pregnant with donated sperm, one with donated sperm and ovule. Seven underwent IVF procedures, two, artificial insemination.

## Constructing a therapeutic model

Since we found no reported model of a group intervention with SBC mothers we had to construct our own model. The primary goal of the group intervention was to provide maximal support for these mothers' parental functioning in order to prevent possible emotional or behavioural difficulties in their children. Keeping in mind the issues that arose in the preliminary interviews, we outlined further foci for therapeutic intervention, based on our dynamic approach. These included elaboration of the mothers' stressful experiences in the pre-birth and post-birth period (with the goal of reducing stress, tension and guilt); helping the mothers with aspects of parenting which they found difficult (by increasing awareness of their self-image as parents and their perceptions of the child and of the interaction between them); exploring the possibility of change in the mother–child dyadic relationship; and giving maximal support and promoting the mothers' acceptance of the chosen family model.

In order to further these goals we chose to use a variety of therapeutic techniques. We applied some of the main elements of short-term supportive psychodynamic therapy as developed by Luborsky (1984) – such as the relatively active position of the therapists,

interpretation of transference processes in the group, focusing on the core conflictual theme in dyadic relationships, and the short duration of the intervention – to the format of group psychotherapy (Yalom, 2005). Auxiliary techniques included:

1 Therapeutic playing cards (Voltrod, 1999).
2 Bibliotherapy (Cohen, 1990; Lahat and Ayalon, 1995; Omer, 1997).
3 Guided imagery (Epstein, 2000; Ratter, 1999).
4 Psychodrama (Moreno, 1947; Olsen, 1983; Satir, 1990).

The projective techniques facilitate the expression of feelings, emotions and images which are less accessible to direct verbal expression. In addition, guided imagery aids in reducing stress and tension and enables fantasized experience of desired states. We included psychodrama techniques in order to facilitate the exploration of interpersonal conflicts in dyadic relationships.

There were fifteen one-and-a-half-hour sessions. The therapeutic work was supervised by an experienced supervisor of group work once a week.

**Treatment of the material**

The two therapists kept detailed notes of the events of each session, written down immediately after the session. Where possible, verbatim quotes from the participants were recorded. The therapists also recorded insights and reflections which arose in the supervision. All contents were recorded using initials to designate the participants. Participants' feelings, evaluations and insights presented here are taken from the therapists' notes.

*Description of the process of the intervention and analysis of group processes*

*Phase 1: sessions 1–5*. The first meeting included getting acquainted and establishing the therapeutic contract. The therapists clarified expectations and goals with the group. Therapeutic playing cards (which have been shown to be a relatively non-threatening warm-up technique) were used to help the women express their self-image as mothers and to share their thoughts, feelings and concerns, and to promote processes of acquaintance and acceptance. In addition to the contents described above which came up in the preliminary interviews, in this meeting issues concerning the therapists, the group members and their respective roles in the group also arose. The

participants expressed the need to know the therapists' views about the SBC family model; concern about the therapists' ability to understand them; doubts about the therapists' professional competence; the need for closer acquaintance among the group members before addressing deeper issues; and a need to clarify roles: who is the therapist, who the patient?

In the second meeting the facilitators used an exercise in guided imagination to invite the women to imagine themselves with their children five years hence. Some of the women found this difficult. Some said they were able to envisage the child but not themselves. This led to the expression of the fear of being swallowed up by the dyadic relationship, and the need to learn to separate. Others expressed uncertainty about their own future, especially in relation to their career, due to having the child.

The therapists reflected to the group the main conflictual issues concerning dyadic relationships, and the feelings and attitudes towards the facilitators and other group members that arose.

For the next meeting the therapists prepared slips of paper with the main conflictual issues which had arisen, including quotes from each of the mothers. Each mother was asked to choose two slips with contents, one which aroused a positive reaction, and one a negative. Working in pairs, they were asked to create associations, a story or a picture that expressed these feelings. The aim was to work on conflictual themes in a dyadic setting. While the mothers were surprised and impressed by the facilitators' ability to remember their exact words, most refused to do the task. This led to discussion of parental responsibility and of their sense of being abandoned by the therapists (when asked to work among themselves), and of the feeling that they did not yet know each other well enough. In supervision the therapists understood that the group's difficulty in performing the task reflected the mothers' feeling that there was not yet a sufficiently supportive and accepting atmosphere. As one mother said, 'We jumped into an empty swimming pool.'

In the following meeting one of the participants brought a children's book written by a SBC mother, which expresses her sadness and loneliness before the birth of her child, and the joy, hope and light she felt after her son was born. The boy is a source of strength for her. The group was surprised to learn that the facilitators had brought the same book to the meeting, and asked to read it together. The mothers identified with the feelings of loneliness expressed by the author and went on to explore some of their own painful experiences. They

described their loneliness during the fertility treatments and pregnancy, their bitter disappointment at having failed to establish an 'ideal' family based on a couple relationship, their concern about creating a satisfying dyad with their child and their search for a possible solution, such as having another child, their and their children's sense of lack of the father – which leads to desperate attempts to compensate the child, their fear of being swallowed up by the dyadic relationship and their need for separation. At this stage in the group process the mothers' intense ambivalence and the difficulty of containing both sides of the conflict were obvious. Most of the participants had previously been able to express only one side of the conflict.

At this time the voices within the group were split. Each therapist was identified with a different voice in the group, and the facilitator unit was divided as well. The therapists were in the process of establishing their dyadic relationship, as they had never worked together before. They had to deal with their own anxiety and the emotional burden the group created, each in her own characteristic way.

*Phase 2: sessions 6–12*. At this point in the intervention two significant events occurred that related to the development of group cohesion. The mothers began early, so that the facilitators, arriving on time, found themselves outside the room facing a closed door while the meeting took place inside. One of the women announced that she was leaving the group. Discussing the crisis and work on the conflict which the women described between their natural tendency to function independently and their desire for togetherness enabled the group to continue without losing this member. The women brought up feelings of loneliness alongside the fear of being swallowed up by a close relationship, and were able to explore their feelings about their ties with the therapists in the light of this conflict. These interactions contributed significantly to group cohesion and mutual acceptance.

The women began to be able to give up their positions of strength and allow themselves to be 'cared for' by the facilitators: to ask for and accept help. A (a mother) said, 'I'm asking myself why I worked so hard here to emphasize my stronger parts.' M said, 'I was afraid the group would reflect my own difficulty to me.'

At this point the participants were able to create a sense of 'togetherness' in spite of their basic choice of having and raising a child alone. They talked about their couple relationships, about which they have

mixed feelings. For example, ties with a married man or a man who doesn't commit to parenthood for other reasons created a feeling of loneliness within the relationship. Some of the mothers see themselves as victims in their intimate relationships, and project these feelings on to their relationship with their children. B said, 'When my son was born I said to myself, "Now I have another man I have to give to".'

Psychodrama was used in an attempt to help the women see their dyadic relationships more clearly, and to help create insight into the aspects of their inter-personal relating which seem to arouse negative behaviour and attitudes towards them, leading to a sense of victimization. In the psychodrama B chose two other members of the group. One represented herself as mother, the other her son. B 'sculpted' them into a representation of their relationship. The group members watched and expressed their thoughts, associations and feelings towards the 'sculpture'. The 'sculptures' expressed their feelings about the process too. B was able to see how in her dyadic relations she leaves the other side passive and undefined, and expects him to relate empathically to her. This was painful to her, and B cried and decided to make a new sculpture in which the two parts hug each other. The facilitators and group members felt that the two parts were not looking at each other, which made them uncomfortable. The two women who were the parts of the sculpture said, 'You've put us too close. It's uncomfortable.' B changed the distance between them so that they had more space but could still hug each other.

In the following meetings the mothers talked about their perceptions of their children and their role in the mothers' lives. M told the group that before her son's birth she suffered from depression, which has not returned since the birth.

The group discussed the painful feeling of 'something lacking' in their own lives and most of all in the family, and their need to fill the lack. D expressed an important insight: that the child will suffer if he or she has to 'fill up all of our empty spaces'. This helped the mothers to recognize their feelings of 'something lacking', and to differentiate between their own need for a third partner in the family and those of their children. As a result the mothers stopped talking about their children's sense of a lack and began to look at their own couple relationships. They examined how they choose partners, asked themselves how they establish an intimate dialogue, how it is possible to meet the needs of both sides without neglecting either, and questioned how they can find a balanced couple relationship.

The therapists suggested work with the therapeutic playing cards to help the mothers establish a more integrated perception of their dyadic relationships. D volunteered, and she was asked to choose a card that represents a good couple fantasy, and another that represents a frightening fantasy. She easily chose a card which represents a frightening fantasy. The other women could easily relate to her choice. D found it hard to choose a card representing a good fantasy. She said, 'Actually, I don't know what that would be.'

The participants thought about their past and present ties with men, real and fantasized. On the one hand, the male figure is badly missed; on the other hand, it is castrated and insignificant, or threatening. A said, 'I'm thinking about the not-so-real relationship I have now.' She described it and realized that she wants to both keep her independent life and also to have a working relationship. D agreed with every word, and noted that she is also afraid of intimacy. B joined in: 'I'm also like that, I choose strong men who "erase" me, then I get up and leave.' Other women in the group spoke about how their self-image and their perception of dyadic relationships were affected by the birth of their children. C said: 'I thought I wouldn't be able to truly make a place for anyone. My children taught me that I can. Now I have self-boundaries which enable another to join me, and I'm happy this way.' M added: 'I thought I couldn't really love anyone, now that I have my daughter I know I can.' She told a story which reflects her positive fantasy of a partner and father. Other mothers joined in. A described how pleasant it is that this fantasy has appeared again and again in the group.

We can describe the group process as a pendulum swing: joining and separating, progress and regression. Thanks to these processes B realized that in spite of everything she still denies her need for a positive male figure even in fantasy, her own and her son's. She declared, 'I am in denial!' She described how, when she told her son the biblical story of Jacob and his son Joseph, she skipped over those parts which demonstrate the father's love for his son, fearing that they would arouse her son's longing for the missing father. B's tale led to a group discussion of how to deal with desired but missing elements in the family. The therapists helped the mothers differentiate between their own feelings of need and their denial of the missing parts, and the child's experience. They reminded the participants of the children's need for the fantasy of a loving father with whom to identify and upon which to build an internalized paternal object,

whether there is a real father in their lives or not. As A said, 'After all, your son will be a father some day.'

At this point there was a discussion of the possibility that children can create a whole and integrative internalized paternal object in the absence of an actual father, when they are not denied the right to have their own fantasies. B saw this fantasy as a motivator for the child to search for and find positive ties with real men. This issue was explored several times in the group work. The mothers were concerned with handling and solving the painful conflict: on the one hand, they tried to allow their children father fantasies and allow themselves fantasies of a partner; on the other hand, they had to face the lack of partner and father in reality. How are they to contain both the lacking and the existing elements when they have already paid a painful price in giving up the fantasy of a partner? How can they contain both the child's need for such fantasies and their own need to defend against further disappointments?

Towards the end of the intervention each of the mothers came closer to resolving this conflict in her own way. Some were able to accept fantasies of father and partner. Others learned to differentiate between their pain over the lack of a partner and their children's needs and experiences. D said, 'I know that what hurts me doesn't necessarily hurt my child.' In the final phases of the intervention the mothers were able to speak of their joy in motherhood, and to examine the family model they chose in comparison with the normative, 'ultimate' family model. Examination of the 'ultimate' family helped them to de-idealize it and see it as another alternative, rather than 'the ultimate' choice. In addition, M said, 'When there is an actual father who doesn't help and support the family it's no better than being alone.' Thanks to this discussion the mothers were better able to see their family model as different but not inferior.

*Phase 3: sessions 13–15.* The conclusion of the group work and the parting were hard for the women. They all expressed dissatisfaction with the short time allotted and wished to continue. They all said the group had been very significant for them and described changes (which supported the facilitators' clinical evaluation). They reported a reduction of tension, anxiety and guilt feelings, based on a better integration of their self-perception as mothers. Some mentioned an improved ability to create secure and appropriate dyadic relationships, while others described their new ability to fantasize triadic

relationships or a positive, whole and integrative father image. All the mothers stated that they feel prepared to tell their child his or her birth story at the appropriate time and way. There were positive changes in their actual relationships with their partners. All said they had learned to better differentiate between their own needs, thoughts and feelings and those of their children, and to allow their children to create their own fantasized loving father image. All felt more comfortable with the alternative family pattern they had chosen.

## Discussion

The main issues that arose in the group were quite varied, and included the women's pain and loneliness during the process of fertility treatment, the subjective meaning of the birth experience, expectations of the experience of being a parent, expectations of the child, difficulties in establishing a secure and appropriate couple/dyadic relationship, 'what is' versus 'what is lacking' in the women's lives and in their family life, the totality of the mother–child relationship, fantasy versus reality, dependence versus independence, practicality versus sensitivity, boundaries: practical and psychological, mothers' needs versus children's needs and dealing with social attitudes towards the SBC family model.

The main elements of the therapeutic process may be summarized as follows: building a cohesive dyad of the two therapists, a process which continued throughout the group work; therapeutic work on the mothers' feelings about the therapeutic experience; establishing group cohesion and a sense of bonding which facilitated free and secure interaction and the willingness to request and receive help; examination of conflicting feelings within the group (especially the conflict between the mothers' natural tendency to function independently and their desire for support). Exploration and ventilation of painful and overwhelming experiences in the peri-natal process (such as physical pain, disappointment, loneliness and ambivalence) enabled the women to see that these were experiences that all group members shared. The mutual identification which developed during the group enabled the women to feel understood and supported by others who had similar feelings. This, together with the opportunity for each to learn coping strategies from the others, led in our opinion to a reduction of stress and tension and the perception of these experiences as less overwhelming.

Considerable work was done on helping the mothers to achieve a more integrative self-image as parents, bridging their strengths as well as their difficulties, sensitivities and needs, bridging the experiences of loving and being loved. Another focus of the intervention was helping them to differentiate between their own needs and those of their children, to create a more realistic perception of their children, and to form more appropriate expectations and boundaries. The women's experiences in their dyadic relationships were also explored, which in our opinion enhanced their ability to see their relationships more realistically and to deal with conflicting needs for intimacy and for autonomy within the dyad. Work was done on creating for themselves and enabling for their children a fantasy of the father and partner as a whole, integrative object. We believe that this helped them to better clarify for themselves what is available and what is missing in their own and their families' lives.

All of the above themes contributed to the mothers' ability to integrate the differing elements of their lives based on the understanding that no one element is absolute in itself. They were able to mentalize and come to terms with their peri-natal experiences; and in the end they felt ready to tell their child his or her birth story at the proper time and in an appropriate way. We believe that the mothers' awareness of the importance of allowing their children to create a beloved father image in fantasy will reduce the children's risk factors and strengthen their protective factors regarding emotional and psychosocial development. De-idealization of the traditional, 'ultimate' family model and exploration of the advantages and disadvantages of each model seems to have fostered a more realistic acceptance of their chosen model. Thus, in addition to the mothers' expression of subjective relief and optimism for the future, we can conceptualize the therapeutic gains in terms of strengthening the mothers' coping resources, broadening their understanding of the dynamics of their relationships with their children, and making their perceptions of their children and their relationships with them more realistic and flexible.

## Limitations of the study

This therapeutic intervention is one of the first of its kind (to the best of our knowledge no similar project has yet been reported in the professional literature) and therefore naturally is not free of limitations and errors. Looking back over our work we would like to point

out a number of insights we have gained that can be used effectively in future work of a similar nature.

The emotional intensity of a group experience of this kind makes it essential that the therapeutic dyad have prior experience in working together; this precondition was not realistic for us since the group intervention began not very long after the establishment of our unit. Ideally both therapists should be experienced in short-term group therapy in order to avoid the somewhat overly goal-oriented approach that characterized the early sessions. The early sessions should be devoted to the building of group cohesion and mutual acceptance among the participants, which is often successfully fostered by therapeutic work on shared conflictual subjects. It probably would have been better to suggest experiential work in dyads at a later stage when sufficient group cohesion and acceptance had been built up. Similarly, it seems that the guided imagery exercise asking the women to imagine themselves and their children five years hence was premature; it would have been more appropriate following the exploration of the mothers' perceptions of themselves as parents, of their children, and of the relationships between them.

We are planning to facilitate more groups of SBC mothers within a few months, and to elaborate on the knowledge gained from this experience. Future groups will be accompanied by scientific research aimed at examining the results of the preventive work.

## Conclusion

Preventive group intervention with SBC mothers allows for the identification of potential psychological risk factors. Dynamically oriented preventive therapy helps the mothers to cope with aspects of parenting which they found problematic. In a fifteen-session intervention with nine SBC Israeli mothers, the following gains were reported: reduction of tension, anxiety and guilt feelings; improved integration of the mothers' parental self-image and perception of the child; modulation of ambivalence in dyadic relationships; improved fantasized triadic relationships; acceptance of the chosen family pattern; and willingness to tell the children their birth story.

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