The Maternal Lineage
Identification, Desire and Transgenerational Issues

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Contents

List of contributors xiii
Acknowledgements xvii
General Introduction 1

PAOLA MARIOTTI

Part One
Mothering in body and mind 45

1 Primary maternal preoccupation 59
D. W. WINNICOTT

2 Peaceful islands and dangerous jungles – pregnancy: opportunity or impediment. A psychoanalyst’s view. 67
DANA BIRKSTED-BREEN

3 Shame and maternal ambivalence 85
ROZSIKA PARKER

4 The pregnant mother and the body image of the daughter 113
ROSEMARY H. BALSAM

5 On motherhood 139
ERNA FURMAN

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Contents

Part Two
Subfertility and reproductive technologies  159

6 The ‘Medea fantasy’: an unconscious determinant of psychogenic sterility  169
MARIANNE LEUZINGER-BOHLEBER

7 The baby makers: conscious and unconscious psychological reactions to infertility and ‘baby-making’—an in-depth single case study  205
JOAN RAPHAEL-LEFF

8 Infertility in the age of technology  231
SHARON ZALUSKY BLUM

Part Three
When not all goes well  255

9 Pregnancy, miscarriage and abortion: a psychoanalytic perspective  267
DINORA PINES

10 Postpartum depression and symbiotic illusion  279
HENDRIKA HALBERSTADT-FREUD

11 Keeping envy in mind: the vicissitudes of envy in adolescent motherhood  306
ALESSANDRA LEMMA

12 “What is genuine maternal love?” Clinical considerations and technique in psychoanalytic parent–infant psychotherapy  323
TESSA BARADON

13 Infant–parent psychotherapy on behalf of a child in a critical nutritional state  352
SELMA FRAIBERG AND EDNA ADELSON

14 Bodies across generations and cycles of abuse  381
ESTELE WELLDON

Index  402

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Peaceful islands and dangerous jungles

Pregnancy: opportunity or impediment.
A psychoanalyst’s view

Dana Birksted-Breen

One comes across two diametrically opposed opinions. One asserts categorically that pregnancy is a time when it is not possible to work psychoanalytically with a woman, and the other asserts equally assuredly that pregnancy is a time of particular availability for psychoanalytic work. The proponents of the former view tend not to write papers about the subject but it comes up in informal conversation about psychoanalytic patients. Goldberger (1991) even notes that she has heard the opinion that analysis should be interrupted during a patient’s pregnancy (p. 208). She, herself, however writes that ‘pregnancy is not a contradiction for analysis but, on the contrary, can facilitate analytic progress’ (1991: 207).

It is those who believe that pregnancy is a helpful time for psychoanalytic work, who write papers on the subject (for instance, Kestenberg 1976; Lester and Notman 1986; Pines 1990; Ablon 1994; Raphael-Leff 2000, 2001), usually because they have a special interest in the subject but they do not necessarily focus on transference issues. So, for instance, reviewing the work of Lester and Notman (1986) on pregnancy, Goldberger notes that ‘unfortunately, they did not specifically mention whether they thought the pregnancies interfered with or enhanced the analytic work’. The great paucity of papers on the subject of psychoanalysis during pregnancy is in itself noteworthy, considering that it happens not infrequently
The maternal lineage

and often poses technical problems in terms of practical obstacles after the birth of the baby.

The contradiction between the opinions is intriguing and my attempt to see what this might mean will be the guiding thread of the chapter. I will argue that pregnancy is a time of increased anxiety offering the possibility of a reorganizing of defences and internal object relationships but that whether this takes place will depend on the individual woman and the analytic pair, and that it is the change in cathexes and how it affects the analytic pair which will determine this.

One of the characteristics of pregnancy is its very delimited time span; it has a beginning, if a bit nebulous, but especially a defined end. And this end is spectacular both in the event which marks the finale and also insofar as its end marks the start of a whole new life – a new life in the form of a baby and a new life for the woman, especially if it is a first pregnancy. Pregnancy is a time for reassessment of the past and for thoughts about the future, a time for thinking about one’s place in the natural cycle of life and death.

The very defined time span with its inevitability can feel entrapping to some women. Pregnancy proceeds without respite. There is no going back and no slowing down. The inevitable progression towards childbirth can bring feelings of helplessness, claustrophobia and loss of control. Dreams of wild animals (Faraday 1972) suggest fears that uncontrollable and untamed primitive instincts are taking over. A woman has to accept powerful bodily processes and be able to give in to them. Anxiety about loss of control may contribute to the frequent problems in childbirth itself and preparation classes aim to make her feel more in control of the childbirth.

The inevitable progression towards birth is also a reminder of the inevitable progression towards death, and of time as a ‘fact of life’ (Money-Kyrle 1968) which cannot be avoided. For those women who want the pregnancy state more than they want a baby (Pines 1993), it is also an inevitable progression towards loss, and this will contribute to a difficult postpartum for them. For some women the decision to get pregnant is made in order to gain reassurance that they have an intact and fertile body and there is no idea of a real baby. Changes to the body can be disturbing when the body had been the main seat of preoccupation.

Anxieties become concretized around practical preparations: getting the baby’s room ready, moving to a more suitable home,
Belinda, an artist in her late twenties, had a number of very preoccupying worries when she was pregnant with her first child: she feared a miscarriage, an ectopic pregnancy or a stillbirth; she imagined the baby ‘slipping out’ of her womb. This not only directly connected with her own mother having had a miscarriage when she was two and a stillbirth before her birth but also reflected a feeling that she too had ‘slipped’ from her mother’s mind much of the time and had been ‘ectopic’, not properly implanted there. She often described her mother’s way of dealing with the stillbirth and the miscarriage by throwing herself into her career while leaving Belinda and her sister to their own devices, unsupervised, so that they repeatedly had fairly serious accidents. What the real life mother was like is not so much the issue, what mattered was that in the course of our work, it became apparent that her ‘internal’ mother was one who wanted to abort or kill her children. This unconscious belief generated the other unconscious belief that she herself could murder her children; this was fuelled by the unconscious belief that she was responsible for the death of the stillborn baby whose place she came to occupy (her name was the same as the one given to the stillborn baby). This lead to constant panic and compulsive protective actions. The conscious derivatives of all this were her fear that she could not hold her baby properly in her womb and keep her baby safely there until he or she was ready to be born.

Belinda also panicked about getting the baby out. A dream about cutting open a baby’s head lead to exploring her hatred of babies and the memory of how, as a child, she used to attack her favourite teddy bear with scissors. This in turn lead to an understanding of an unconscious idea that the birth canal would be like scissors which would attack the baby. Becoming conscious of this relieved her anxiety and Belinda was able to have an easy and straightforward childbirth.

Ambivalence around love and hate are central to all relationships and how this is negotiated and the balance between the two will affect the course of pregnancy and the relationship to the child. The fears common to pregnancy and to the upbringing of a child centre around this basic conflict, and as with all feelings, these will be less troublesome and lead to less dangerous consequences when they can be acknowledged. This is where the psychoanalyst can help, but there is also a great reluctance on the part of the psychoanalyst to put the...
negative thoughts about the baby and an image of a murderous mother into words, such is the power of magical thinking at this time. The fear that words and deeds are equivalent can besiege the psychoanalyst as well as the patient, when both get drawn by primitive modes of thinking easily elicited by this situation which evokes early life and fragility, and this can lead to a collusion of silence; the phantasy is that the analyst is the dangerous murderous mother, envious or simply not sufficiently containing. If this predominates over an experience of an analyst as a containing mother, this may lead to withdrawal and the inaccessibility to psychoanalysis at this time referred to earlier. Marianne Leuzinger-Bohleber (in Chapter 6) speaks of the taboo in regard to female destructiveness in which intense wounds and humiliations culminate in boundless despair, rage, hate and revenge – extending even to the killing of one’s own children.

Unconscious projections of such split-off, taboo impulses of female destructiveness in psychoanalyses can give rise to difficult and often almost unbearable countertransference reactions in us analysts, ‘making it hard for us accurately to perceive and recognise this dimension of the “dark continent” of femininity in our female analysands’ (p. 170). In her work with women suffering from psychogenic sterility she refers to the Medea myth as told by Euripides in which Medea murdered her children. She describes how the analysis of these women’s fear of murdering their infant has been a major factor in enabling her patients to get pregnant. The sterility had been a protection from their own unconscious destructive impulses which were aroused in an intimate relationship and were in danger of being directed at the offspring of this relationship in a wish for revenge. Without psychological help, in fact, it can happen that women who have become pregnant following physical infertility treatment request a termination once they fall pregnant (Christie and Pawson 1985).

Leuzinger-Bohleber further suggests that a Medea complex may be an ubiquitous unconscious fantasy of femininity, because it is based on infantile sexual fantasies in which the female body is experienced as a source of uncontrollable libidinal and aggressive impulses, with oral and anal destructive features. She concludes that ‘a reflexive dialogue with the shadow side of one’s maternality appears to be one of the prerequisites for an appropriate capacity for mothering (including the holding function, containing etc.), and for deriving mature narcissistic and libidinal satisfaction from it’ (p. 171, italics mine).
The universal experience of being excluded from one’s own mother’s mind, which is linked in particular to the Oedipal triangular situation of exclusion from the parental relationship, also threatens the relationship of the new mother to herself and to her baby. How a woman is able to deal with the inevitable coexistence of feelings of love and hate aroused at this time, and the balance between these, will determine much of the course of the pregnancy and after. These feelings contribute to the well-known symptoms of pregnancy such as cravings, disgust, vomiting, etc. For the psychoanalyst whose patient is becoming a mother and becomes preoccupied with herself and her body, splitting the transference between the analyst and the unborn baby, it can also be a testing time in which the analyst can feel excluded, with the danger of either enacting some rivalrous feelings or, on the contrary, becoming over-solicitous.

Inner space and pregnancy

Spatial references abound in pregnancy and characterize this time when the balance switches from outside ‘people’ to inside ‘person’, the baby but also herself, and the two are not always distinct. This is relevant to the question of availability or unavailability to the psychoanalyst, that is, how narcissistically turned inwards on herself is the pregnant woman.

In dreams, spatial references concern the woman’s own bodily changes and the fact that what is inside takes on new significance, but also are used to express the configuration of her feelings. Inside and outside take on importance as two delineated spaces each taking on specific meaning. The phobias of certain foods, for instance, which have to be kept outside the body, the craving for other foods which have to be put inside the body, express the geometry of the spaces in which good and bad are carefully delineated and kept apart.

In fact each woman’s experience could be depicted in terms of how she conceives of herself in terms of ‘inside’ and ‘outside’ and the sort of boundary which separates the two. For instance, does she think of herself and the baby as both ‘inside’ and needing to be kept safe from a dangerous outside world? Or is the baby the intruder and invader getting inside her as a dangerous representative of the outside world? Does the baby, from belonging to the outside world become a part of her, or on the contrary from being part of her separates out...
The maternal lineage

as if by parthenogenesis? Is the baby good and herself bad or is she good and the baby bad? Or maybe she and the baby are good and the outside world bad, or vice versa. The question also arises as to the nature of the boundary between what is conceived of as outside and what is conceived of as inside.

Is the boundary like a fortress behind which the woman protects herself – with her baby, or against her baby? Or is the boundary more like a porous surface or like a curtain that is easily opened or shut? The various permutations and the nature of the boundary will obviously depend on a woman’s own history, the meaning she attributes to this particular baby, and her usual way of dealing with conflict, anxiety and her own unconscious thoughts.

One can follow changes in the personal topography in the dreams of pregnancy. I took the title of this chapter from one of Belinda’s dreams. She dreamt of a ‘peaceful island inside the dangerous jungle; the natives had taken the white children and put them safely in underground trenches’. This woman, who had not planned her pregnancy, now wanted to keep her womb, the island of the dream, as a very safe place, and the baby under the protection of the ‘natural’, ‘primitive’ part of herself (represented by the natives), and away from the intellectual, educated part of herself that wanted to have a mind and not a body and a baby, that part of her that could think of having an abortion, and combined with the teeth and poison of the jungle. She believed that her mother, who lived in a country which has a jungle, thought she wasn’t mature enough to have a baby and that she should prioritize her studies. Her mother’s own history of babies who don’t survive added to this picture that the baby was in danger and needed protection.

If I have given this image as the title of my chapter, it is also as a reference to the question I addressed as my starting point, whether women become more or less available for psychoanalytic help during pregnancy. What is the boundary, how rigid is it, what is the degree of ‘paranoia’, the fear of attack and the fear of being envied which restricts contact and makes a woman withdraw, what is the degree of fear of her own unconscious thoughts, of her own feelings? And where is the psychoanalyst placed in this topography? Is the psychoanalyst felt to be the persecutor or on the contrary the ally against internal attack?

The peaceful island in the dangerous jungle I see as the retreat away from the intensity of feelings that threaten to take over, unpredictably, uncontrollably, savagely. The tendency to withdraw which

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is marked in pregnancy is a withdrawal from that jungle into safety, and when the analyst and her interpretations are associated with the teeth and poison of the jungle, her work can seem impossible. In that case, the peaceful island is one where a barrier has been erected for protection, a place away from hatred and envy. Particularly feared by the woman is the envy of others of her pregnant state. Especially so when she feels herself in a state of self-satisfaction, like the cat who has eaten the cream; she is the complete, replete satisfied mother with her precious possession deep inside her. There is also the envy of the baby enveloped and constantly nourished, sometimes her own envy. This will be coloured by how she has dealt with her envy of her own mother and how she dealt with her mother’s subsequent pregnancies. Unconscious envy always causes more trouble than conscious envy, which is how the psychoanalyst can help. Irrespective of what the actual woman’s own mother is like, an envious internal mother can cause anxieties and even risk provoking miscarriage.

The peaceful island may also be a place of narcissistic withdrawal. The woman is faced during pregnancy with an increased neediness due to a regressive identification with the baby inside her. Women will react differently depending on their own habitual psychic make-up. Some women easily welcome help from the psychoanalyst while others are threatened by their increased dependency. The peaceful island as narcissistic withdrawal is a reference to the woman who deals with the threat of neediness by withdrawing into herself and feeling she needs no one, or that the outside world, and the analyst’s interpretations will harm, or at least be useless. In this case the analytic work may seem to stagnate and it is this sort of situation which leads to the view that it is not possible to work psychoanalytically with pregnant women.

This state of mind is different from the often observed self-absorption which accompanies pregnancy when the inside world and the inside of the body become the focus of interest; this is reflected in references in dreams to gardens inside houses, inner courtyards, cloisters. This self-absorption I understand as reflecting the shift of attention which is part of the normal work of pregnancy and often includes rethinking the past, and getting interested in ancestry and lineage, preparing for a new person. This state of self-absorption signals an increased relationship to the internal mother, a sort of internal conversation with her rather than an escape from her, and this can be fruitful to the analysis.
This distinction connects with the distinction I make between two attitudes to pregnancy which I call the ‘hurdle approach’ and the developmental approach (Breen 1975) – attitudes found in women but also attitudes found in the literature on pregnancy. The hurdle approach is the widely held belief that pregnancy is like an illness, that a woman will for a time-limited period act and feel odd and that after the birth of the baby she will get back to her old self again. On the contrary, I would argue in line with a developmental approach that the birth of a baby, as any major life event, offers an opportunity for a woman to work through internal conflicts and relationships, to modify her perception of herself and others and integrate this new experience, so that she will not be the same after the birth of the baby as before. Psychic life proceeds by resignification, and certain key times in a person’s life – adolescence, early adulthood, parenthood, mid-life – are such times which require major reconfigurations. Some moments in the life of a person necessitate change if they are to be lived and not just survived. With a first pregnancy, the internal object relationships need modification, in particular the relationship of identification and differentiation from the woman’s own mother. Some women express this concretely by getting very preoccupied with transforming the spatial organization of their house, which stands for the internal map where rooms, and roles get rearranged. In fact I would say ‘the house’ representing a woman’s inner space and internal world cannot be ‘ready’ until after the birth as the early months after the birth are the time of greatest change.

Some women feel ill during pregnancy and wish for a return to normality along the hurdle model – this illness represents the tremendous upheaval, physical but also psychological, which is taking place. These women want to simply evacuate the uncomfortable, confusing feelings, to vomit it out, mentally or physically. They are unable to integrate the experience and to change with it, but they are in danger of running into serious difficulties in pregnancy and childbirth, and more especially postnatally.

**Idealization and the ‘work of worrying’**

The birth of a baby does require change and the acceptance of time passing. Paradoxically, the very delimited and short time span of pregnancy brings up a new perception of the span of life. It brings a
sense of the generations, of birth and death, of the new mother’s place in the life cycle. Birth and death are closely connected in the unconscious. Sometimes it is the terminal illness of a parent which unconsciously leads to a conception, a birth replacing a death (almost like the idea of reincarnation in some cultures). This new perspective, and I am of course in particular referring to a first pregnancy, reorganizes a woman’s perceptions of herself and her past and her relationship to significant others. This is the work which needs to be done, has to be done. When it can’t be done, trouble lies ahead.

A woman with a fragile sense of her own identity feels very threatened by this because change for her threatens the continuity of self. Such a woman desperately holds on to the notion of pregnancy as illness from which, like flu, she feels she can eventually recover and be the same person as before. These are the women who are more at risk.

Belinda had a fragile sense of her own identity and because of this she erected a strong boundary which often made it difficult to make contact with her. She wanted to be the perfect mother, and only rarely was it possible to discuss the full range of her feelings and fantasies in relation to the pregnancy and the baby. She was angry with her own mother for the inadequate care she felt she had received, the ‘ectopic’ place I described earlier, and wanted to be unlike her, to be perfect. She wanted to be completely ready for the birth of her baby, displaced her anxieties on to the house, and insisted that she and her husband move house to a different part of town during her pregnancy. In fact, studies record moving house as one of the stress factors in pregnancy.

A certain amount of anxiety is appropriate before such a major life event and life change. Worrying is an expression of psychic work, of the work of preparation and those women who show no signs at all of anxiety can also be at risk. In research I carried out with 60 first-time mothers (Breen 1975) an important finding was that the women who later showed a positive adjustment to the birth of their child were able to express more anxieties in late pregnancy. To be more precise, the difficulties occurred at the two extremes, those who expressed no anxiety and those who were overwhelmed with anxiety.

The fact that it is important to be able to experience and express some anxiety gives an indication of the complex processes at work, in particular of the importance of psychological preparation – what
is called ‘working through’ anxiety and conflicts which will enable a woman to cope with the upheaval of childbirth and the relationship with her new infant. In fact this is true of other potentially traumatic events. A research study in America (Janis et al. 1969) with patients who required surgery\(^2\), also found that moderate worry before a surgical operation was linked with a better postoperative adjustment. The patients who did not worry at all beforehand appeared to be much less able to cope with the stresses of surgery than those who had been moderately worried. He found that while the high worry group who also had difficulty adjusting postoperatively had long-term neurotic problems with a chronic sense of vulnerability, the only difference between the patients who did not worry at all and the ones who worried moderately was the amount of information received before the operation. He suggests that if no authoritative warning communications are given and if other circumstances are such that fear is not aroused beforehand, the normal person will lack the motivation to build up effective inner preparation and will thus have relatively low tolerance for stress when the crisis is actually at hand. Janis suggests the concept of the ‘work of worrying’ to emphasize the value of anticipatory fear. He writes:

Sometimes an endangered person remains quite unworried and then finds himself unexpectedly confronted with actual danger stimuli. This is evidently what happens to many surgical patients who are given no explicit warning information that induces them to face up to what is in store for them. They anticipate little or no pain or suffering until the severe stresses of the postoperative period are encountered. Then they are unable to reassure themselves and no longer trust the authorities whose protection they had expected. The patient’s failure to worry about the operation in advance seems to set the stage for intense feelings of helplessness as well as resentment toward the members of staff who, until the moment of crisis, had been counted on to take good care of them, just as good parents would do.

(Janis et al. 1969: 101)

Janis goes on to say that there is failure to carry out the work of worrying when the person is accustomed to suppressing anticipatory fear by means of denial, over-optimism and by avoiding warnings that would stimulate the work of worrying, or when the stressful
event is so sudden that it cannot be prepared for, or if adequate prior warning is not given or false reassurances offered.

I think this is very important in the case of childbirth, which often includes medical and surgical procedures. I have been very struck by how some women (and some men too) seem to remain traumatized for years by a childbirth experience. Usually what they mention is the unexpected side of a procedure. It is the fact that it was unexpected which felt traumatic rather than the procedure itself. The birth, a very complex psychosomatic event deeply influenced by how a woman feels about her body, about her instinctual drives, about her ability to deal with separation, is also significant in that it is a time when the woman needs to rely on parental figures in the shape of doctors and nurses and be able to let herself be helped. The unexpected shock arouses anger in the new mother, and she can feel disappointed in the figures around her who are thought to have let her down, harbouring resentment for years towards the partner, for instance, for not being more helpful or for putting her through the trauma. Or she can blame the baby for this. Alternatively she might blame herself and her body for not conforming to the perfect birth.

Both personality and preparation come into play. The lack of anxiety and of the ‘work of worrying’ in pregnancy is often accompanied by an idealization of the doctors and the hospital who they believe can make everything perfect. The flip side will kick in when there is a problem. These are women who split their views of people into ideal and denigrated, and accordingly expect themselves to be an ideal parent to their newborn child. They do not anticipate any problems and are shocked to be faced with a normal demanding baby and not a picture-book baby, or with a husband who is struggling with his own mixed feelings at this time.

Belinda’s wish to be completely ready for the birth was a sort of ‘once and for all’ idea. Not so much ‘hurdle’ as fairy-tale ‘happy ever after’ notion. This of course does not parallel life and the powerful and often painful and difficult emotions which will be evoked by a newborn baby and for years to come by family life. Belinda felt hugely disappointed in her husband for not coming fast enough when her waters broke and later for not being sufficiently happy about the baby. The wish to be the perfect mother, unlike the mothering she herself received, is a very common experience but one which, if not modified, is a danger signal. The discrepancy between how
a woman thinks she ought to be feeling and how she is feeling, in itself, can lead to guilt and depression. In a case I supervised this issue was central for Annabel who had sought ideal states for mind (through such things as religious ecstasy and drug use) throughout her life to get away from psychic pain. This had diminished during her analysis but she was pulled back in that direction during pregnancy, believing that she needed to reach a state of perfection free of all bad feelings.

Throughout her pregnancy Belinda had spoken with much hatred of both her parents and their failings: her father always on business trips abroad and disinterested in her and her sister, her mother only preoccupied with her career. She struggled with her resentment at the demands she thought her analyst made on her, while at the same time the baby had to be protected from any bad thoughts. As she neared the end of her pregnancy and I started hearing her speak more positively of her mother and of her analyst and to talk about a valued great uncle, but also for the first time to be able to voice some anger with the baby for taking her life away and of the associated fear that the baby would be born damaged, I thought to myself: Thank goodness for the nine months of pregnancy, and that possibility of repair of the internal relationships and the relationship to the analyst in a way which could be less split and allow for ambivalence.

In the research project mentioned above (Breen 1975), I found that the women who experienced most difficulties at some point in the childbearing process had a very idealized picture of what they felt a mother should be like. This picture was often the opposite to the bad mothering they believed they had received. After the birth, they felt themselves to be at odds with this ideal but they found it hard to admit directly to imperfection. They got stuck with this negative experience of motherhood – the need for perfection and the shame at not matching up.

On the contrary the women who were able to deal well with the experience of having a baby, sometimes had during pregnancy an equally idealized picture of what they thought a mother should be like. However, they were able to modify their picture of the good mother to a more realistic one after the birth of the baby so that it became possible for them to live up to this picture and feel positively about themselves. In the group of women who experienced difficulties with having a baby, a good mother tended to be described with words like ‘loving, patient, unselfish, never losing her temper’, whereas in the group of women who coped well, the good mother
was described as needing these qualities: ‘diligence, hard work, reliability, liking to be at home with children’. In other words in this second group they felt a mother needed more ordinary and practical qualities, as opposed to the other group who were making a judgement of themselves as good or bad, loving or hateful people.

An important point is that there was no difference between the groups when I tested them in the third or fourth month of pregnancy and again at the end of their pregnancy (ten weeks before the due date) and the difference between the two groups appeared only at the third test postnatally so it seems that it was probably only once they were faced with the reality of a baby that some of the mothers could readjust their own ideas about motherhood. These mothers may have hoped to make everything perfect, better than in their own life but this was based on a wishful thought rather than an entrenched split and could be easily modified when faced with the reality of a fragile infant whose needs are not always easily understood and met.

In my view if one can work with the pregnant woman with the negative as well as the positive transference (which means picking up on split off bad and dangerous objects projected into the outside world), one can hope to bring greater integration. If one encourages the split and becomes the purely good mother, there is a risk of leaving her with a bad internal mother, and more chance of a melancholic attack on the self postnatally. Depression is of course frequent after the birth, even when it does not take on pathological proportions.

Pregnancy is a time when a woman feels she ought to be happy and in fact she is having to face a number of losses: loss of her previous life, loss of the baby inside, loss of the self as ideal mother, loss of the baby as ideal baby. With the birth of the actual baby, a woman has to give up the fantasy of what kind of mother she will be and now feels she is being put to the test. Those early weeks are a very trying time and often not helped by the level of anxiety which can be generated not just in the mother herself but in the helpers. It seems that the whole system of professionals gets taken over with the mental state of the newborn infant, enacting the multiple splitting of the paranoid-schizoid world of the infant. The anxiety about the very real fragility of the infant and the terror of death often inhibits the capacity to reflect, and busy anxious activity gets set in motion, by health visitors, doctors, friends and family. This can make the new mother more anxious, she feels easily criticized for what she is doing and loses confidence in herself.
Often breastfeeding, which is imagined to be straightforward but in fact needs an un-anxious environment to enable the two partners to get used to each other, becomes the focus of ambivalence and anxiety. The consequence is that it may get undermined by even those helpers who consciously encourage it, because bottle feeding is so much easier to monitor and measure and thus is reassuring. The psychoanalyst’s work at this time involves containing the deep anxieties surrounding these issues of life and death around the real fragility of the infant. If the analyst can contain the anxieties without getting too anxious herself and drawn into knowing what is best, she can help the woman to find her own resources and capacities to mother her baby and gain the confidence to make judgements and find solutions. This is a role some partners are also able to take if they are not trying to be the better mother or else withdraw into hurt exclusion. The latter can be exacerbated by women who think they want help from their husband but are in fact envious of anything he can offer and want to be the only one who can be satisfying to her infant so that in effect the partner is pushed out.3

**Psychoanalysis and pregnancy**

To come back to my original question: why is there a contradiction in how people view the possibility of working psychoanalytically with pregnant women as I described at the beginning of the chapter? The idea that pregnant women are unavailable to psychoanalytic work has to do largely with how women become very preoccupied with themselves and the baby and the transference issues can sometimes seem to them irrelevant or intrusive. They can withdraw into a state of great preoccupation with their body in which anxiety reduces an ability for symbolic thinking. They can become difficult to contact in the way that psychosomatic patients are difficult to contact. This narcissistic withdrawal can be intermittent or quite ingrained. The analyst has to tolerate the feelings this provokes.

The professionals’ attitudes vary according to their own issues. Everybody has experienced childbirth as a baby and everybody has had a mother. The pregnant woman may arouse in the analyst profound feelings connected with separation and exclusion from the primal unity, feelings connected with hatred and jealousy of the mother who can have other babies and other preoccupations, envy
of the mother who can create and feed a baby and of the baby whose needs are met and satisfied. The analyst’s capacity to hold and privately reflect on her own feelings creates a space in the analytic work where the patient can elaborate her fears of those same feelings being present in herself, such as her own envy of the baby who is being cared for, and in other people close to her.

Another aspect of the difficulty is that there is a reluctance by both analyst and patient to tackle the more negative issues at this time, around envy and hatred in the analytic relationship, a reluctance which is there as I suggested earlier in both analyst and patient because of deep-seated primitive magical beliefs that feelings can kill unborn babies. Similar issues are there when it is the psychoanalyst who is pregnant, but this is beyond the scope of this chapter.

Conflicts of love and hate and issues around jealousy in the three-person Oedipal situation are at the fore at the time of pregnancy, but it is in this area that psychoanalytic work can be at its most difficult. In order to help a woman with this, the analyst has to be prepared to explore the more negative feelings in the transference, by which I mean the negative feelings about the analyst who comes to represent the bad mother and the envious mother, alongside the analyst as good mother. The woman wants the bad mother to be located somewhere else, sometimes in her actual mother, or in another female relative or acquaintance, in order to preserve the analyst as wholly good. But in that way she avoids bringing together love and hate.

Interestingly, some of the fears are so deep that it can also be difficult for women analysts not to want to be that good mother who will protect her pregnant patient from danger, and wish to create an idealized situation and new experience for her patient. The magical beliefs that bad thoughts and feelings harm the baby are often shared consciously or unconsciously by analyst and patient. This partly rests on an identification with the mother or with the baby. It may also be a defence against the deeply seated envy of the prenatal state. When the psychoanalyst is a man, the fear of envy may take a meaning in relation to the differences between the sexes, and male psychoanalysts have to work on different sets of feelings of their own.

When this is possible, and when a good birth and healthy baby can reassure a woman of her loving self, that her internal objects are undamaged and that she hasn’t been prey to an envious and retaliating mother, it will be a crucial developmental stage in her
life. The psychological work which takes place during pregnancy is not necessarily conscious, although it is well known that during pregnancy there is a tendency for women to become more introspective as I described above.

Those who point to the increased availability of women during pregnancy are referring to the fact that unconscious phantasies often become conscious or appear with little disguise in dreams (Ablon 1994) and symptoms, and thus offer an opportunity for integration, hence the potential for psychological growth. It is the ready availability of these phantasies, the sense that some repression seems to lift during pregnancy, which brings the view that pregnancy is a good time to work psychoanalytically with women. It also offers the opportunity to work on the fantasies and projections on to the baby of disowned parts of the self and to elaborate mournings so that the child’s otherness can be recognized (Manzano et al. 1999; Scariati 2009).

The difference of opinion is sometimes a question of how ‘working psychoanalytically’ is understood. Those who understand this as being primarily situated in the analysis of the transference can find pregnant women unavailable due to the increase in narcissistic defences and the attempt to create a peaceful ‘treasure’ island from which the analyst is excluded in some cases, while those who are primarily focused on the woman’s feelings about her family, her body, the new baby and the fantasies about them, can find this time fruitful.

The whole of pregnancy is characterized by the conflict between destruction and preservation of the baby, not only in the woman herself but also in people around her. The rituals surrounding childbirth and pregnancy such as the practice of giving birth away from home in straightforward cases (Lomas 1966) or of unnecessary medical and surgical procedures, relates to this unconscious conflict. The baby has to be protected at all costs from danger, while sometimes exposing mother and baby to more danger through the procedures. The danger gets located either in ‘Nature’, one can’t leave it to natural processes, or in the mother herself who is thought to be an obstacle to the birth – she needs to be made unconscious.

The woman’s relationship and feelings about her own mother are central in this. I believe that with women at risk this needs to be worked on in the transference to the analyst as mother in order to try and help the woman be less fearful of her hate and to bring together love and hate. There is a reluctance to tackle this during pregnancy but I believe that the analyst will be helpful if she or he is able to take up
all the feelings and not collude with the splitting off of the hatred into other figures. Otherwise the danger is that the analyst is idealized and that after the birth when the woman herself finds she is not the ideal mother to her baby, she may experience herself as the split-off bad mother and attack herself. This we see in postnatal depression.

During pregnancy the transference becomes more complex because there is also a transference to the unborn baby, and a three-person situation is created in the consulting room, in which the analyst has to tolerate being the excluded party at times or for lengthy periods. Envious and rivalrous feelings in the analyst have to be tolerated. It can become expressed in terms of the woman’s ‘work of pregnancy’ versus the analyst’s ‘work of analysis’. If this opposition is created it can in itself become a fruitful line of work, touching as it does on issues of autonomy, separateness, jealousy, exclusion, and envy. Issues of dependency also come to the fore at this time and may make some women more available and others more cut off, depending on how they deal with their needs. It is those women who are not able to accept their needs and become more rejecting of help when their needs are in fact increased, as well as those who deny any worries, who give a sense that analysis is not possible at this time. For all these reasons, the countertransference can be tested at these times and it would be true to say that a development needs to be possible for the patient and analyst pair.

For women in analysis and sometimes too for their analyst, the pull is to want to retreat to a peaceful island, undisturbed by the wild animals of hatred, jealousy and envy, by feelings of hurt, pride, or neglect, or to decide that analysis is not possible. If this can be tolerated and seen as an opportunity to explore the living of a complex transference and countertransference situation around a three-person situation which is literally brought to life in the room, this work can become an opportunity.

**Notes**

1. In this chapter I am primarily dealing with normal ambivalence and not situations where there is an excess of hatred or cruelty due to early life circumstances or inherited factors.
3 This paper is specifically about working psychoanalytically with pregnant women; working with women in the postnatal period and after would require another paper. The postnatal period brings in the issue of 'primary maternal preoccupation' (Winnicott), and of the place of the psychoanalyst in the new configuration. It also brings in technical issues.

References


