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FROM THE EDITORS

In this Newsletter we are very pleased to be able to bring you the text of a paper given by Norma Tracey on *The Inner World Processes during Pregnancy.* Norma's book **Mothers and Fathers Speak** which describes the work on which this paper is based has previously been reviewed in these pages, but this paper distils the essence of that work. The paper was given in Sydney in January, 1995 at a Workshop on Infant Research which was organised on behalf of the NSW Institute of Psychotherapy as a lead up to the Third Pacific Rim Meeting of the World Association for Infant Mental Health, so it is very fitting that we can publish here as the final arrangements for that Meeting are put into place. Norma's paper is evocative and takes us into the inner worlds of the infant and her parents, an understanding of which are so important to parents, babies and to us as professionals.

The Regional Meeting has all the makings for a very exciting and stimulating time. We hope to be able to report on it in the next Newsletter, but what form this will take isn't clear yet. We will certainly be looking for volunteers who will be willing to write summaries or make comments on the papers presented. If you wish, we will provide complimentary labels saying "Press"!

The Editors look forward to meeting you at the WAIMH Conference, and hope there may be opportunity during that Meeting to get feedback from you about the Newsletter.

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NORMA TRACEY

INTRODUCTION

I will begin with a statement, and then introduce some basic concepts to make sense of this statement: There is for each human being a continuing dynamic process of pregnancy, rebirth and regrowth in every psychic phase of our lives from conception to death. For the woman it never so profoundly affects her real life as when there is a real pregnancy - a physical baby. Here the psychic and physical processes coalesce. Through the psychic processes of pregnancy, a woman "awakens" as a mother in an emotional sense. Becoming a mother means moving towards a surrender of her infantile passions and desires to meet the needs of her infant; she mediates between a backward pull to passive being and a forward push to active becoming; she separates from her inner idealised mother to confront the terror of death from her inner destructive one; hopefully she survives this to become an alive mother to her infant. In her mind she creates a "womb space," where her internal representation of her pregnancy resides. This is a continuing dynamic. She works with the dialectic of life and death, love and hate, from preconception, through pregnancy, birth and every life stage. Parallel processes occur in her partner and her infant.

Before continuing, it may be helpful to define some of the concepts I have used in making this statement. The concepts and processes discussed in this paper, are from Klein and Bion and also belong to the Middle School of Object Relations.

WHAT IS INNER WORLD PHANTASY?

The inner world is the place in our mind where our instincts and our experiences of our parents and others meet in the form of present living imagos (internal representations). Jung (1946) particularly emphasises that some of these are universal; some we are born with, inherited from our parents; all are affected by our life experiences and our capacity to process or think, symbolise and retain models of these life experiences. It is fascinating to understand how an experience is "thought about" and then stored to become part of our internal world. In this internal world, inner world imagos, live a life of their own with laws that are quite different to our conscious mind, but which influence our external world considerably. Some of the different laws are: No distinction between persons; It can be seen how

this forms the basis of all transference. No distinction of time; It can be seen why events of twenty years ago are alive and happening right now. No capacity to discriminate between the outside and the inside world. No boundaries or space; This accounts for one believing one's inner world to be real. Psychotic people particularly seem to inhabit this space. In this unconscious area, opposites are fused, such as life and death, love and hate, without differentiation or discrimination. (Matte-Blanco 1959), (Rayner 1981). In pregnancy the mother leaves the external world and turns towards her inner world- her foetal infant and her inner psychic infant. In this change, emotions from her inner world are exposed producing a degree of chaos, and her normal ego functions are therefore lessened. Such a move binds the mother with her infant at the most primitive level. However, such intensity and exposure of emotions creates problems: old conflicts are reactivated, the pregnant woman is sensitive and vulnerable and in a kind of "madness" as she reaches the birth of herself as mother and the birth of her infant. It is obvious that an area of the mind that cannot, by itself, discriminate between "alive" and "dead", is chaotic. To give it value, "emotional thinking" or processing has to take place. It is out of this processing or emotional thinking that a woman gathers the fragments of herself and finds a new identity that includes motherhood.

How do we process? The mind cannot hold opposites such as life and death or love and hate in the same thought Rather than fragment or go "mad" by trying to hold these opposites, the mind splits and projects. "Good" may go to one person, "bad" to another. (Klein 1946). It is the bringing together of these opposites in a way that is tolerable, rather than fused or split, that gives resolution to an ongoing dynamic. This is where the action of therapy occurs. We process by finding a way in which we can bring the opposites in our inner mind to a meeting place. By doing this we create a neutral territory. Hallucinatory primary passions and emotions are surrendered for an emotional compromise of opposites. In such a neutral territory, symbolisation, models, conceptualising and abstracting of our experiences can take place, and with these tools experiences can be mentally and emotionally stored for future use.(Bion 1962). To take this further and make it more explicit we need to discuss the concept of a dynamic. "What is a dynamic?" This is a very important question, for it is the acknowledging, identifying and interpreting of the dynamic that makes a Psychodynamic psychotherapist. Allowing the movement and free flow of the dynamic is central to our profession. Finding the neutral space where thought can occur, where opposites can be tolerated, where symbols, models and concepts can be born is therapy. The Webster dictionary helps us with the initial thought about dynamism when it quotes Leibniz: " That besides matter, some necessary material force exists which is the prime mover in any physical as well as mental phenomena." (Webster 1976) .The Macquarie Dictionary (1988) says: Dynamic: "pertains to a force that is not in equilibrium. It is opposed to static". The Thesaurus (Macquarie 1988) gives words such as "energetic" and "moving". The Oxford Dictionary (1987) defines dynamic as "energising or motive force opposite to static", but it further defines dynamism as: "A theory that phenomena of matter and mind are caused by action of opposing forces". No dynamic is static. It is a continuously moving psychic energy between opposing forces. Ogden (1985, pp. 130, 131) writes that "a DYNAMIC is a process in which two opposing concepts each creates, informs, preserves and negates the other, each standing in a dynamic ever changing relationship with the other. (Hegel, 1807; Kojever, 1947). The dialectical process moves towards integration, but integration is never complete; each integration creates a new dialectical opposition and a new dynamic tension." Here we have the idea of thesis - antithesis and synthesis. This is only one useful way of conceptualising what occurs in the human personality. From the beginning of humanity, there has been in religion a concept of opposites of good and evil; with philosophers, opposites of rational and irrational, true and false; with Freud (1920), the opposites of life and death; with Klein (1946) the opposites of good and bad; and with Winnicott (1958), the opposites of love and hate. How we process these opposites is very important, particularly in the case of the pregnant woman who has a myriad of opposites to manage. She asks: "Is this the beginning of life or death? Do I love or hate myself as a woman in all this? Am I the mother or the baby?" There is a lot of fusion and confusion!

SOME OF THE DYNAMICS OCCURRING IN THE INNER WORLD OF THE MOTHER DURING PREGNANCY.

The Dynamic Of Fusion And Differentiation.

Pregnancy is a series of ordered, primitive, psychic events, a foundation laid of a repeating dynamic. In pregnancy there is a dynamic of fusion and separation. This dynamic highlights the developmental stages of pregnancy. Raphael-Leff (1976) says the early part of the early stage of pregnancy may be likened to an autistic phase - "a state of alert inactivity during which the woman, like the new born, is involved in minimising her disorientation and achieving a state of well being, without much recognition of its source". Others define a state of fusion so strong that the mother often denies to herself that she is pregnant. The next stage of pregnancy is similar to hatching, involving a gradual individuation, the foetus becoming separate through differentiation, distancing and disengagement. In this stage the pregnant woman feels a movement of something foreign to herself. "My goodness, there actually is a baby in there". This culminates in the final stage with the actual physical separation of birthing.

When a baby is born, and in the first years of life, the dynamic Anna Freud (1946) and later Mahler, Pines and Bergman (1975) recognised is a repeat of the pregnancy stages - autistic, symbiotic, hatching, differentiating, and separating out. In therapy we help these stages to continue in their normal course, like freeing Mercury in a thermometer. We assist movement at different levels and different stages, but always with this pattern.

PRECONCEPTIVE AMBIVALENCE AND THE DYNAMIC OF WANTING AND NOT WANTING A PREGNANCY.

Concepts of pregnancy, birth and parenting, as well as of sexuality, are alive and well throughout childhood. Each child, male and female, write their own individual internal drama of the creation of an infant in their own way. This is made up of their individual childhood experiences, their inner world life, and the phantasies their parents have consciously and unconsciously given them. A child fantasises about having babies. "Can I have one? With whom? How? When?" - will occupy phantasy and play through dolls and cars and other toys or symbols from a very early age. (Kestenberg 1956).

Before an infant is conceived there is a vast array of confusing and conflicting emotions in the infant's parents, resulting from internal world objects born from their attitudes to sexuality which developed during their childhood. Preconceptive ambivalence is the most significant source and model of an ambivalence present in each of us in every stage of development and continuing through the whole of life. Birth is the climax but not the beginning of a continuum that starts at the preconceptive stage. Feder calls the ambivalence of mother and father towards conception "the evidence of procreative joy" as opposed to "procreative panic". The way the pregnancy progresses will affect these feelings. However, "the mutually attracted heterosexual couple awaken and stimulate in each other a series of interpersonal, ambivalent and contrary conflicts, usually unconscious." They have their own respective dilemmas towards pregnancy. There is both a fear and also a wish surrounding a pregnancy. The infant will be the highly vulnerable recipient of these ambivalences to do with sexual and erotic needs. These preconceptive ambivalences from the parent's childhood may be abortive, reparative, phallically or anally sadistic, joyful, or mournful due to object loss. They are different for each person.

The internal representations of their parents, their own childhood experiences and their environment affect these ambivalences. Feder states, "The parent's ambivalence as external objects determine the child's psychological and characterlogical destiny, eventually sensed, incorporated, repeated and perpetuated by the child now turned parent throughout generations. It stems originally from external reality, it is eventually incorporated and its origin unrecognised in the unconscious." (Feder, 1980). He adds, "We feel . . . the importance of preconceptive ambivalences is as determining a psychogenetic force as genes and chromosomes are in genetics." In my study of twenty pregnant couples, I found those most able to tolerate their ambivalences during pregnancy were more positive and less anxious when their baby was born. No infant is wanted totally. The dynamic of wanting and not wanting one's offspring continues throughout the mother's, father's and infant's life, seeking at each stage a psychic resolution. Here then is the paradox of the unborn child. Conceived in ambivalence, surviving or not surviving in the womb in ambivalence and born into ambivalence. The life force is so strong and yet so vulnerable to opposite forces, an expression of the problem of conflict in human life.

THE DYNAMIC OF THE DREAM, THE DREAD AND THE REALITY.

There are three separate paths existing throughout life which are repeated at every phase.

There is a dream of what the parents want their baby to be, there is the opposite which is the terror of what he or she might be, and in pregnancy there is the unknown. Who is this baby? The parental mythology of the "purpose of" this baby's coming formulates itself in their minds during pregnancy. Is he going to be the fulfilment of their love? Is he going to be the declaration of their right to impulsiveness in their sexuality? Is he their sin, their punishment? Is he the embodiment of their evil or their virtue? The children of Holocaust victims were sometimes identified with the role of perpetuating the Jewish race and preserving it from death. The migrant infant often had the role of fulfilling a parent's dream of greatness in a new country. Such mythological expectations affect the parent's perceptions of their child and their expectations. All infants carry some parental myth. The baby's birth can be a disappointment for a mother, as well as a time of exultation. Here is the baby as he is, not the phantasy only, but now in reality. Benedek says that in every stage, past unconscious emotions are awakened, revivified dreams, hopes and fears from the past return, and the parents will have another chance in their own lives to work through the same stage of development their infant is working through. This is no less so during the growth phase of the embryonic and foetal infant.

THE DYNAMIC OF BEING AND REACTING.

Being and reacting are opposite to each other. In reacting, being is lost. Bion (1956) and Winnicott (1949) both speak of a state of being before birth, where no action or response is needed. Everything is provided. With the propulsion of birth the infant is forced to react, and loses being, only to regain it again after birth. Here is another lifetime dynamic, of being one's self, and losing ones self in reacting and regaining ones self. Bion called the centre of self "O". and gave the infant an ego "O" before birth while still in the womb. If there is trauma, the

psychic pain is too severe. Even in utero self can be lost.

THE DYNAMIC OF FULLNESS AND EMPTINESS. THE NORMAL NARCISSISM OF PREGNANCY.

A baby's kick, a baby's movement reassures a pregnant woman that she is full of life. For the pregnant woman there is a sense of superiority and elation, of being full of penis? breast? baby? She feels she has everything. She experiences herself as "full of grace, blessed among women and blessed in the fruit of her womb". After birth is a depression. It is the mourning of the loss of the fullness. If the baby is healthy and feeding, it rivals with the narcissistic loss of the fullness, and hopefully reality wins. The mother settles for a baby outside, and experiences intense pain of loss that goes with being vulnerable and separate. A new stage of symbiosis begins. This is the dynamic of the movement from healthy pregnant narcissism to the actual baby, and acceptance of a depleted and weakened self (Lemoine-Luccioni 1987). (Imagine the tragedy involved if the real baby dies. There is a total narcissistic loss.)

THE DYNAMIC OF PRIMARY MATERNAL PREOCCUPATION - PRIMARY MATERNAL PROTECTION AND PRIMARY MATERNAL PERSECUTION.

In the inner world of archaic objects ever present in our minds are dual opposites. Present and conscious in pregnancy is the phantasy of an evil mother that will rob the womb or kill the baby. The opposite is also present. There is the imago of a mother who will protect from all harm, be omnipotent in shielding the infant and powerful in protecting the mother-infant duo. The lack of control over what is growing inside the woman, be it a Christ child or a monster, heightens her fear of negative and persecutory forces as well as of benign positive ones. Both idealising and negative forces may be projected on to her real mother, mother-in-law or husband. The foetus is not safe from projections either. He may be seen in turn as the saviour of the family, or as a foreign intruder ready to tear the mother's womb apart and endanger her life. These opposites of primary maternal persecution and primary maternal protection are dealt with by the mother in a stage towards the end of pregnancy and immediately after birth known as primary maternal preoccupation.

THE DYNAMIC OF CHAOS AND ORDER

The three main stages in a woman's life where she experiences deep emotional and physical changes are the onset of puberty, pregnancy and menopause. In each of these there is a maturational crisis marked by chaos. This chaos is a result of the surrender of the old order giving place to the new, and the push towards getting things right in the new phase. Pines speaks of the third trimester of pregnancy: "This stage is marked by bodily discomfort and fatigue. There is a need for mothering. Memories of sibling rivalry seem to come to the fore and may be displaced on to in-laws or old friends. There are characteristic mood swings from pleasure at the imminent possibility of her baby's reality to unconscious anxiety that either she or the baby may die at birth. However strongly the outside world reassures her, the anxieties persist and there can be revivals of old guilts whether she can produce anything good or not. There is a beginning of impatience and drive to accomplish the task of birth and have her baby. There is a kind of feeling of exhilaration at being able to play an active role once more, and surrender the passive one." (Pines 1972)).

The preoccupation of this final semester is so great and so intense that Winnicott (1956) says if a baby were not there the mother would be considered mad. There are some mothers who, because of severe deprivation in their own childhood, cannot move into preoccupation. There are others who, having entered it, find great difficulty in moving out. They suffer from post-natal depression.

IN PREGNANCY there is an inward turning that has the quality of a depressive state. This is quite different to post-natal depression because far from crippling, it is creative; far from blinding, it allows insight; far from creating intolerable psychic pain, it allows psychic pain to be processed and suffered.

Professor Brazelton (in a talk he gave in Sydney in 1988) reported: "We started looking at normal parents, prior to the birth of their babies. We chose five families. We interviewed mother once a week for the last four months and father once a month in psychoanalytic interviews. We observed the new born at birth. They exposed themselves in these interviews with dreams and phantasies that were so disturbing and so disturbed looking, that when we made a prediction from these, they all looked like they would be psychotic parents. When they [illegible] their babies all this madness and pathology began to shape up as a normal process. I began to realise this turmoil was serving a purpose by dredging up all the alarm reactions. 'Will I get to be a parent? What kind of parent will I be? Can I separate from my own parenting and be different? Can I become the perfect parent I want to be and not the one I've been rebelling against all this time? If I'm no good as a parent, will I have impaired this baby?'"

This adjustment between the dynamics of hope and despair, of dreams and reality, of joys and fears, continues throughout the parent's and baby's life together. Brazelton's findings were that these same parents interviewed in the months after their infant's birth had found a new order, a new structuring and were considered normal. Out of the chaos the mother and father, initially fragmented, begin a newly defined identity. This is of course massively affected and intruded on by the infant's state of

health. If the infant does not survive they may well go mad.

THE DYNAMIC OF KNOWING AND UNKNOWING.

A woman in pregnancy faces a very long period of unknowing. In the inexorable process of development over which she has no influence, she must tolerate changes that are beyond her control. As the baby is born, she begins to know and not know her baby. That dynamic of knowing and not knowing is one she lives with for the rest of her life. No mother truly knows her baby. She moves between knowing and not knowing as a dynamic from the beginning to the end.

THE IDENTITY OF A WOMAN DURING PREGNANCY. THE DYNAMIC OF REBIRTH.

Several authorities have recognised pregnancy as a normal transitional crisis. Deutsch (1947), Benedek (1970) and Bibring et al. (1959) have stressed the profound emotional disequilibrium of the pregnant woman, and her vulnerability to psychological disturbances. The following have been widespread in normal ante natal clinic populations - anxiety, depression, worry, mood lability, insomnia, impaired cognitive functioning, stress, emotional conflicts, severe disturbances of thought and behaviour, premonitions, magical thinking, paranoid and depressive reactions and regressive shifts. Evidence of the emergence of earlier behaviour patterns, attitudes and conflicts, as well as increased dependency needs have also been noted. Because the transitional crisis of pregnancy and child birth involves widespread psychological changes and emotional upheaval, a reappraisal and redefinition of identity occurs. In pregnancy a woman is born again as a mother.

INNER CONFLICTS CONCERNING THE MOTHER DURING PREGNANCY.

I would like to discuss the inner conflicts a woman may experience during pregnancy. For every woman there is rivalry with her mother or a healthy wish to be like her; there is anger at being a woman, a mother or gratitude for the gift of motherhood; and there is fear of an internal mother taking her baby in revengeful reprisal or an image of a protective mother, who secures her in her role. These are not always either/or - such paradoxes and ambivilances can occur in a short space of time, or even coexist during pregnancy. It is not the absence of, but the mediation of these dialectics that allows a woman to become a mother. (Pines 1978).

Where are the emotional beginnings of these ambivilances? Perhaps from the beginning a little girl is in conflict with her mother and yet identifies with her. She is rivalrous with her mother for her father. She hates her mother's achievement of sexuality with the father. She thinks the mother in return hates her, and wants to destroy her. Simultaneously she loves her mother and wants to be identified with her. There is also guilt. This guilt remains into adolescence, and the extreme effort to relieve and overcome it accounts for anorexia nervosa, a defence against sexually becoming woman and rivalling mother. Other extreme efforts of resolving the rivalry are by sexual acting out, or by enacting the internally feared mother, by aborting her own infant foetus. Some young woman may experience this as a sacrifice to atone to the mother for the rivalry. Hopefully the loving feelings will triumph over the negative ones. A space to think will result and there will be a centre from which to grow. If the negative feelings are stronger than the positive ones, no resolution and no thinking space is born.

A woman may have infantile phantasies about herself as the foetus in her mother's body, reawakening intensely ambivalent feelings at a most primitive level. At a more adult level, one of the most satisfying emotions of pregnancy is the identification with an omnipotent, fertile, life-giving mother. She experiences herself as maturing to become a mother in her own right, a physiologically mature woman, impregnated by her sexual partner, and powerful enough to create life within herself and to hold it. The final separating out from the mother and the resolution of the rivalry in a creative way is only the beginning. The working through of the atonement is by being responsible for her infant. It is the price she pays.

For many pregnant women, some past external crisis may interfere to distort their internal maternal image. A woman's mother may have died during her childhood, or during her pregnancy; a many years old hatred may have been nursed from childhood and never acknowledged or resolved; a vulnerable, depressed woman may feel even more depressed in taking over her mother's role and letting go of her, because pregnancy is the final letting go. If anything goes wrong with the pregnancy she may experience this as a punishment for her sins. I believe that a dynamic for post-natal depression lies in the area I am discussing. In post-natal depression the mediating or negotiating process with the internal mother is impaired or fixated. All the joy that comes from being part of a life-giving mother, the satisfaction of becoming a transformational object, the feeling of being at the centre of creativity, and the privacy of the enclosed circle between mother and infant are intruded on. She feels ever at war in a battle she cannot win or that she has already lost. This has a lasting effect on her internal perception of herself as mother and her inner representation of her infant. This in turn interferes with her intersubjective experience of and with her baby.

SEX AND PREGNANCY.

"For the primigravida pregnancy offers proof of a gender identity and the visible manifestation to the outside world that she had a sexual relationship. Physiologically it is the confirmation that she has a sexually mature body capable of reproduction, but this does not necessarily imply that she has an equally emotionally mature ego capable of

undertaking the responsibilities and demands of parenthood." (Pines 1972)

IDEALISATION OF THE PREGNANT WOMAN

brings its own set of problems. For all of us, pregnancy brings to mind peace, protection, warmth and care. But this denies the terrible power of motherhood to destroy, to abort. Nature also has the terrible power to do likewise, however much the infant may be wanted. Idealisation denies the passion, the sex and all the childhood phantasies about sex. This results in a Madonna-like immaculate conception phantasy, that avoids adult sensuality and the responsibility for its fruit - the infant.

One of the intra psychic tasks the young pregnant woman has to accomplish involves the internal acceptance of what may be termed the representation of her sexual partner, both physically and mentally (Deutsch 1944). The successful achievement of a feminine sexual gender identity can be strengthened by the proof and confirmation of pregnancy.

THE DYNAMIC BETWEEN AUTONOMY AND DEEP DEPENDENCY IN PREGNANCY.

(I use "he" for infant)

I would like to speak of a special autonomous space where the mother and infant reside. I see the mature father as the protector of this space. An embryo is in an amniotic sac which is in a mother's womb. He is not really in the mother, he has his own internal space. At birth the infant is "in the womb of the mother's mind." (Tustin 1981, p. 183). The infant is in her mind because she thinks about and for that infant who cannot think for himself. It is her capacity to reflect on the infant's needs that keeps the infant in a psychic safe holding place. By holding him in her mind, she protects him with her psychic skin until he gets a skin of his own. Intrusion on this is threatening. It destroys his safe place in her mind. There is a line concerning mother/infant autonomy which is particularly precious for the woman, pregnant with herself as a new born mother. Intrusion on this vulnerable womb-mind can cause psychic distress or psychic death, even as intrusion on the foetus can cause distress or death. This can be seen most vividly in a premature infant hospital ward - the place is public, the holder is a humidicrib, the feeder is through tubes. There is medication. The caretaker is not the mother but a ward team. She may well experience them as persecutors and herself as a failure. During pregnancy, anything that goes wrong is viewed by her as a failure on her part to be a good caretaker, a good giver, a full woman. A woman and her partner place themselves in a dangerous position of risking loss during pregnancy, in order to achieve gain.

FATHER

What of the father? For the father pregnancy is also a time of crisis, chaos and change. His identity is also undergoing profound changes. He needs to cope with the responsibility of a changing partner who is preoccupied and emotionally labile. Conflicts to do with his identity with his father are awakened; his rivalry with the woman and his envy of her creativity, her womb, are intensified. He may feel confusion between identifying with his baby and his father at the same time. The resolution of this allows the emergence of his own identity. His relationship with his wife, now becoming a mother, awakens conflicts to do with incest and threats of incest with his mother. His fear of being replaced by his own infant is another conflict he must resolve as he both wants and does not want his baby. He also has the sexual fears of paternal persecution as opposed to paternal protection, as described earlier in his partner. He may well be afraid of being unable to produce good babies. All these, together with the awakening of fears and terrors and excitement to do with pregnancy from his own childhood, place additional burden on him. He is confused about his role in the family now, or even whether he has a role. On the positive side of course is his delight that his potency is proved, his joy in his wife's changes, his looking forward to an infant of his own, and his sublimation of his own needs to become protector of his family unit.

THE FOETUS

The foetus possesses a powerful function towards living and survival. Is there also a fear of life? The dependency is awesome. He needs the mother's body for his survival. Nature helps him assure his survival at any cost to the mother, albeit sometimes unsuccessfully and a miscarriage occurs. The foetal infant is both ruthless and vulnerable. His greed is foetal hunger; his selfishness is the bid for survival, at a cost to the mother's body if necessary. (Paul 1981). He is in no way as fragile or helpless as we imagine him to be. (Lilley 1972). Nevertheless foetal distress means a threat to his existence. Sometimes our phantasies are of baby being safe in the womb as if in the Garden of Eden, having only to exist and to receive, and to use. It is a heaven that can, sadly for all concerned in the pregnancy, turn to hell, chaos and disaster if there is damage or death.

EMOTIONAL PROBLEMS DURING PREGNANCY.

Problems may be caused by:

(1) A past in which the traumas and unresolved conflicts have been so great that the mother-to-be or father-to-be cannot resolve them now. They interfere with relationships in the present.

(2) Social and material hardship.

(3) Marital problems

(4) A previous miscarriage, previous abortion.

(5) A previous baby or infant having died.

(6) A previous infant having an inherited or non-inherited illness.

(7) Something going wrong health-wise for the pregnant woman.

(8) Something going wrong in the pregnancy.

(9) The death of a partner, a parent, brothers, sisters or close friends during the pregnancy.

(10) Migration.

(11) Being single and socially unsupported.

COUNTER TRANSFERENCE DURING PREGNANCY.

I would like to say just a few brief words on the counter transference the therapist may have to deal with in working with a pregnant woman. Rivalry and envy may be aroused. The more unacknowledged by the therapist this is the more it will intrude on the therapeutic process. There may be some forgotten or repressed element of one's own pregnancy or ires to be pregnant that are invoked once more by the presence of a pregnant woman. On the other hand sympathy, empathy and protectiveness may well be present as the therapist becomes pregnant with the expanding patient. She may nourish her with emotional transfusions and interpretations, distilled perhaps from her own pregnancy and her own training. The therapist has two patients - the mother and her foetus, and feelings alternate for one or the other.

There is a fine balance in elucidating the pathological while preserving those elements of idealisation and phantasy that are necessary for the future welfare of the baby and mother. Thus every mother needs to remain under the impression that her baby is the best. It is through this capacity for idealisation and a narcissistic identification with her baby that she will manage to achieve the never er g sacrifices and continuous negotiation of pa ful conflicts and difficulties from infancy to adulthood

Finally, the fact of a birth resulting from a pregnancy - the actual presence of a real and alive infant, no longer a dream, a phantasy, but a real baby - brings pride, pleasure and anticipation. This overwhelming adult achievement gives the push into coping with the realities of parenthood.

BIBLIOGRAPHY

Benedek, T. (1952) Psycho sexual Functions In Women. New York. Ronald Press.

Bibring, G. L., Dwyer, T.F., Huntington, D.S. & Valenstein, A.F. (1961) A Study of The Psychological Processes In Pregnancy and of the Earliest Mother - Child Relationship: I. Some Propositions And Comments. 11. Methodological Considerations. Psychoanalytic Study Of The Child. Vol. 16. pp 9-72.

Bibring, G.L. (1959) Some Considerations of the Psychological Processes in Pregnancy. The Psychoanalytical Study Of The Child. Vol. 14. pp 113 -121.

Bion, Wilfred R. (1962) Learning From Experience. Heinemann.

Bion, Wilfred R. (1963) Elements of Psychoanalysis. Heinemann.

Bion, Wilfred R. (1970) Attention And Interpretation. Tavistock Publications.

Brazelton, T.B. (1989) Unpublished paper delivered at Institute of Psychotherapy. Sydney. (Used with permission.)

Breen, Dana (1989) Talking with Mothers. Free Association Press.

Lisa Miller, Margaret Rustin, Michael Rustin, Judy Shuttleworth. (1989) Closely Observed Infants . Duckworth Publications.

De Monchaux, C. (1962) Realisation. The Psychoanalytic Study Of Thinking (iii) Thinking And Negative Hallucination. International Journal Psycho-Analysis. 43: 4, 311-314.

Deutsch, H. (1945) The Psychology Of Women. Vol 2. pp. 141 - 150. New York. Grune & Stratton.

Feder, Luis (1980) Preconceptive Ambivalence and External Reality. International Journal of Psycho-Analysis Vol.61. pp 161 - 178.

Freud, Anna (1946) The Ego and Mechanisms of Defence. International Universities Press. USA.

Freud, Sigmund, (1920) Beyond the Pleasure Principle, (Trans 1950) S.E. XV111, 7.

Jung, C. G. (1982) On the Nature of the Psyche. (First version 1946) Reprinted 1982 Routledge, Kegan and Paul. London.

Hegel, G.W.F. (1807). Phenomenology of Spirit. A.V.Miller, trans.. London: Oxford University Press 1977.

Klein, Melanie (1975) Envy and Gratitude and Other Works 1946 - 1963. Vol. 3 Hogarth Press and the Institute of Psycho-analysis. London.

Kestenberg, J. S. (1956) On the Development of Maternal Feelings in Early Childhood. Observations and Reflections. Psychoanalytic Study of the Child. vol. 11. pp 257 - 291. New York International Universities Press.

Kojeve, A. (1947). J. H. Nichols Jr. trans. Ithaca: Cornell University Press, 1969

Lemoine-Luccioni, Eugenie (1987) The Dividing of Woman or Woman's Lot. Free Association Books. London.

Leifer, M. (1977) Psychological Changes Accompanying Pregnancy and Motherhood. Genetic Psychological Monogram. 95. pp 55 - 96.

Lester, Eva P., Notman, Malkah T. (1986) Pregnancy, Developmental Crisis and Object Relations, International Journal of Psychoanalysis. 67: 357 - 366.

Liley, A. W. (1972) The Foetus As a Personality. Australian and New Zealand Journal of Psychiatry. Vol.6. pp 99 - 105. London.

Mahler, M.S., Pines, F., Bergman, A. (1975) The Psychological birth of the Human Infant. Hutchinson London.

Matte-Blanco (1959) Expression In Symbolic Logic Of The Characteristics Of The System Unconscious, International Journal of Psycho-Analysis. 40: 1-5.

Menzies, I. E. P. (1976) Thoughts On the Maternal Role in Contemporary Society. pp 5 - 14. Journal of Child Psychotherapy. 12. No 1.

Ogden, Thomas H. (1985) On Potential Space, International Journal Psycho-Analysis.66:130-131.

O'Shaughnessy, E. (1981) A Commemorative Essay on W.R. Bion's Theory of Thinking. Journal Child Psychotherapy, Vol. 7 2: 181-192.

Paul, Michael I. (1981) The Mental Atlas of the Process of Psychological Birth. Dare I Disturb the Universe. Edited by James Grotstein. Caesura Press. Karnac Books Ltd. London. Reprint 1983.

Pines D. (1959) Parenthood As A Developmental Phase. Journal American Psychoanalytic Association Vol. 7. pp 389 - 417.

Pines, D. (1972). Pregnancy and Motherhood. Interaction between Fantasy and Reality. British Journal Medical Psychology 45:333-343

Pines D. (1978). On Becoming a Parent. Journal of Child Psychotherapy. 4,(4): 19-31.

Pines, D. (1982). The Relevance of Early Psychic Development to Pregnancy and Abortion. International Journal of Psychoanalysis, 63:311-319.

Piontelli, Alessandra (1992) From Fetus to Child. An Observational and Psychoanalytic Study. Routledge London.

Rayner, E. (1981) Infinite Experiences, Affects and Characteristics of the Unconscious., International Journal of Psycho-Analysis 62: 403-412.

Raphael-Leff, Joan (1980) Psychotherapy with Pregnant Women. Psychological Aspects of Parenting Birthing and Bonding. Ed. Barbara Blum. Human Sciences Press. New York.

Raphael-Leff, Joan (1982) Psychotherapeutic Needs of Mothers to be. Journal of Child Psychotherapy. Vol. 8. pp 3 - 13.

Raphael-Leff Joan. (1991) Psychological Processes of Childbearing. Chapman and Hall. London.

Raphael-Leff, Joan (1993) Pregnancy. The Inside Story. Sheldon Press. Great Britain.

Stern, D.N. (1977) The First Relationship; Infant and Mother. Cambridge, Mass: Harvard University Press.

Stern, D.N. (1985) The Interpersonal World Of The Infant. Basic Books Inc. New York.

The Australian Oxford Concise Dictionary (1987) Melbourne Oxford University Press.

The Macquarie Concise Thesaurus, (1988) Macquarie Library Publication. Australia.

The Macquarie Concise Dictionary. (1988). Macquarie Library Publication. Australia.

Tracey, N.(1993) Mothers and Fathers Speak. Apollo Books Sydney.

Tracey, N. (1991) The Psychic Space in Trauma. Journal of Child Psychotherapy 17 (2): 29-45.

Tracey, N (1994) Thoughts on some Inner World Processes during Pregnancy. The Child Psychoanalytic Gazette. March 1994 Sydney. (pp. 19 - 34).

Websters New Twentieth Century Dictionary of the English Language (Unabridged) 1986. A World Webster. USA.

Weldon, E. (1990) The Power of the Womb. Mother, Madonna, Whore. Free Associations Publishers. London.

Winnicott, D. W. (1958). The Depressive Position in Normal Emotional Development. (1954) In Through Paediatrics to Psychoanalysis. London: The Hogarth Press and Institute of Psychoanalysis.

Winnicott, D. W. (1958). Primary Maternal Preoccupa( ) (1956). In Through Paediatrics to Psychoanalysis. London:The Hogarth Press and Institute of Psychoanalysis.

Winnicott, D.W. (1965). The Maturational Process and the Facilitating Environment. Hogarth Press.

Winnicott, W. D. (1949) Birth Memories, Birth Trauma And Anxiety. In Through Paediatrics To Psychoanalysis. The Hogarth Press and Institute of Psychoanalysis. London. 2nd Ed. 1977, pp 174 - 194.

Zalk, Sue Rosenberg (1980) Psychosexual Conflicts In The Expectant Father. Psychological Aspects Of Pregnancy, Birthing And Bonding. Ed. Barbara Blum. Human Sciences Press. New York.

KARITANE MOTHERCRAFT SOCIETY

Karitane has been working with Australian families since 1923. In the early days the main reasons for accessing our services were for problems relating to infant nutrition, but today the main reasons for admission are related to infant and maternal behaviours. Our organisation operates several client facilities including a 24 hour residential unit, two day stay 'cottages' at Randwick and Liverpool, and a 24 hour telephone Hotline information and advisory service.

The Residential Unit is a registered public hospital and therefore clients are admitted under Medicare or if they wish they may elect to be private clients. The Residential Unit admits the mother and the index child, and may admit the sibling(s). We recognise the importance of keeping the family intact, so make every effort to include other family members. Karitane has a very high rate of partner participation. The average length of stay is 5-7 days and our discharge planning ensures every family is

connected with local community services for follow on care. Referrals to this service are through other health professionals, the Residential Unit is a tertiary level service so it is important that the client has contacted a primary or secondary service provider before a Karitane referral is made. Our most common referral sources are Family Care Cottages, General Practitioner's, Paediatrician's and Early Childhood Health Nurses. Our clients come from all over NSW with the majority being from the southwest.

In April 1994 the Residential, Education and Administrative Centre was relocated to Fairfield in Sydney's southwest to be closer to families identified as having increased needs. Southwest Sydney also has the highest birth rate in NSW. In addition we are located in an area with a diversity of cultural backgrounds and it is our constant challenge to ensure that our is service sensitive to these needs.

Our new facility has been designed to be user friendly and looks more like a motel than a hospital, there are lots of lights and the decor is very soft to the mood. In addition there is a spa bathroom where mother and baby can relax and have fun together. Our focus is very much on relaxing the mother so that she is able to resolve parenting issues. The parent suites have queen size or single beds, an ensuite and separate baby bedroom. The staff at Karitane are mainly nurses with specialist qualifications in child and family health. They are supported by allied health services and specialist medical services.

Cheryl Richardson

KARITANE MOTHERCRAFT SOCIETY ALLIED HEALTH SERVICE

I have been employed as an Allied Health Worker at Karitane Residential Unit, Fairfield, since August 1994, and previously have practised for many years as an Occupational Therapist in mental health settings. This time has proved fruitful and challenging in many ways. My background as an Occupational Therapist has served me well. Certainly we take a "holistic" look at the mothers, fathers, infants and their "networks". For couples, parenting presents the challenge to adapt to a new life role, especially first time parenthood, and to cope with the gains and losses of this transition. Hopefully parents develop an ability to adjust their home, work and leisure worlds accordingly. A far cry from the days when the infant or toddler was presented as the "issue" or "problem". Indeed, this continues to occur, but our broader understanding now allows us to seek a more comprehensive picture. The mother and infant dyad we know to be inseparable. Difficulties for one party pave the way for difficulties for the other. Partners, too, are affected by postnatal anxiety and depression, not to mention other siblings in the family.

The Allied Health Service at Karitane, Fairfield is based in the new Residential Unit. Physically this is ideal. It makes for good communication with the nursing staff, and efficient time management. There is a part time allocation of 1.6 Allied Health position hours and these are currently filled by Judy Heilpern, Social Worker and Hana Hasselaar, Psychologist and myself. Our roles are complementary, reflecting our individual disciplinary training and areas of personal interest, and although we work alongside each other often with common aims, we retain our professional identity.

Our services at Karitane provide a comprehensive individual interview to those mothers noted to be distressed and in need of psychosocial assessment and support. Referrals to Allied Health are based on Nursing and Allied staff observation of the clients in the Residential Unit together with a score of 13 or more on the Edinburgh Postnatal Depression Scale indicating a need for more comprehensive assessment. If necessary, follow up and referral to community agencies and professional bodies are made.

As a result of the move to Fairfield in April 1994, we are constantly expanding our knowledge of local services as well as potential regional and country resources. The average stay in Karitane Residential Unit is 6 to 8 days. Often the women/families we interview are severely distressed. We see our work as the initial stage of a constructive outcome for the women and their partners, which will enable them to focus on their personal needs and those of their infants and other children.

The three Allied Health workers are involved in running groups. I have been responsible for setting up the first Postnatal Issues Group. I am currently conducting our second Closed Postnatal Issues Group, with a Registered Nurse as coleader. The objectives for establishing such a group were to provide a safe meeting ground for women who are experiencing postnatal anxiety and depression, and for women to realise they are not alone in their distress. They are afforded the experience of working together on common issues. Initially, we aim to develop trust in the group: trust of members for the leader and of members for each other. We are mindful that these women often come from biologically loaded backgrounds for anxiety and depression. Often the group will provide their first experience of worthwhile mothering. While the eventual aim is to challenge and encourage women to take new steps in reorganising and revitalising their lives, they need first to experience unconditional acceptance and support. The Postnatal Issues Group Programme consists of 7 two–hour weekly sessions. Child minding for children under 5 years is provided in Fairfield Community Health centre next door to Karitane. We have been fortunate to gain the assistance of workers from a project funded by the Department of Community Services and the Sisters of Charity Outreach Service, based at Liverpool. The need to provide childcare is considered paramount. If not available, it often prevents depressed mothers from

attending such groups. Although initial separation from infants and toddlers can be anxiety provoking, we maintain that the women need time alone to concentrate on their own issues. Issues covered during the life of the group include women's expectations and goals; personal experiences of PND; building of self esteem and confidence; how to understand our babies' needs, and relationships with one's self, one's mother and the effect these have on wider networks. The basic model I use in my work is Attachment Theory and I find it makes intuitive sense to the women. Fathers are invited to attend on one evening to enable them to have a voice: What has their experience been and what are their needs and concerns? Interaction between partners and the possible need for change in communication patterns is addressed. Appropriate follow up is arranged after the group programme has concluded. For further information please contact her at Karitane Mothercraft Society on (02) 794 1854 or (02) 794 1855.

Mary Morgan

ROTARY FUNDING RESEARCH INTO FAMILY HEALTH

The Australian Rotary Health Research Fund has announced that at least for the next three years they will support research focussed on promoting **Family Health.**

About $500,000 will be available for grants. Advertisements calling for applications will appear in The Weekend Australian, the 1st Saturday in June 1995 and MJA 1st issue in June 1995. Applications will close with the Fund on the 15th August 1995.

Enquiries to Secretary Joy Gillett on (02) 633 4888.

FORTHCOMING MEETINGS

Marcé Society Pacific Rim Conference: Childbearing and Mental Health - Risks and Remedies

Date: April 19 &20, 1995
Venue: Holme Building, Sydney University
Enquiries: Conference Organisers (03 380 1429)

World Association for Infant Mental Health. Third Pacific Rim Meeting. The Baby, Family and Culture - The Challenges of Infancy, Research and Clinical Work.

Date: April 21-23, 1995
Venue: Holme Building, Sydney University
Enquiries: Conference Organisers (03 380 1429)

AAIMHI (Vic). Post Conference Meeting. Infancy and Psychoanalysis.

When: Saturday 29 April 1995
Enquiries: Dr Campbell Paul, Royal Children's Hospital, Melbourne

Western Sydney Area Health Service: The Emotional Aspects of Sleep, Working with Parents and Infants. A presentation by Mrs Dilys Daws (Author of Through the Night)

When: Thursday 20 April 1995 at 1 45 pm (Registration from 1 pm on)
Where: Education Block, Westmead Hospital
Enquiries Margaret Gibbons, phone 689 3804
Cost: Non WSAHS Staff $10-00

Deadline for next AAIMHI Newsletter
15th May, 1995
Please send news, letters, announcements, articles etc, whatever you would like to see in YOUR Newsletter to:
The Editors, AAIMHI,
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BORONIA PARK, NSW 2111