

Taking the psychology of pregnancy seriously:

Implications for intervention.

A review of the psychoanalytic literature.

By

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STATEMENT

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

ABSTRACT

Pregnancy has evolved from being predominantly understood as a medical phenomenon to what psychoanalytic theorists would regard as a holistic experience encompassing both physiological and psychological changes. According to psychoanalytic theorists, pregnancy is a transitional phase and a time of susceptibility and flux for most women. This often results in psychic turmoil where boundaries between conscious and unconscious process become more permeable. The pregnant woman's dreams and fantasies create an inner working model of relationships and this in turn provides a template of how her relationship with her baby will be experienced and conducted. This link to the unconscious increases insight into the process occurring between the woman and her evolving relationship with the fetus and provides the health professional with clues for early intervention. However care should be taken by health-care professionals to communicate the psychological processes during pregnancy within the cultural framework of the pregnancy mother for positive outcomes to be achieved.

OPSOMMING

Die wyse waarop swangerskap verstaan word het ontwikkel vanaf grotendeels mediese verskynsel na wat die psigoanalitiese teoretici sal beskou as 'n holistiese ervaring wat beide die fisiologiese en die sielkundige veranderinge insluit. Die psigoanalitiese teoretici beskou swangerskap as 'n oorgangs fase en 'n periode van vatbaarheid en veranderlikheid vir die meeste vroue. Dit gee dikwels aanleiding tot psigiese wanorde waar die grense tussen bewustelike en onbewustelike prosesse meer deurdringbaar word. Die swanger vrou se drome en fantasië skep 'n innerlike werkende model van verhoudings en op sy beurt voorsien dit templet van hoe haar verhouding met haar baba ervaar en hanteer sal word. Hierdie band met die onbewustelike verleen insig in die proses wat tussen die vrou en haar ontwikkelende verhouding met die fetus voorkom en voorsien die gesondheids werker van leidrade vir vroeë intervensie. Die gesondheids werker moet egter versigtig wees om die sielkundige prosesse gedurende swangerskap binne die kulturele raamwerk van die swanger moeder te interpreteer om sodoende positiewe uitkomst te verkry.

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1.

INTRODUCTION

For most of the last century pregnancy has predominantly been understood as a medical phenomenon with specific interventions at various stages designed to monitor the body of the pregnant woman and developing fetus. Such interventions have primarily focussed on the physiological and have largely ignored the emotional responses that accompany such changes. Pregnancy is, according to psychoanalytic theorists, a time of susceptibility and flux for most women (Raphael-Leff, 1991; Winnicott, 1956). Changes, both physiological and psychological are likely to be experienced differently by different women.

Psychoanalytic theorists believe that the predominant emphasis on the physiology of pregnancy has contributed to a widely held belief that pregnancy, like an illness, is a temporarily lapse of reason and that after the birth the woman will return to her 'normal self' (Birksted-Breen, 1985; Raphael-Leff, 1991; Winnicott, 1956). These authors view pregnancy, like puberty or menopause as a transitional phase within the normal life process of women who choose to become mothers.¹(Bibring, 1959; Helman, 1990). Pregnancy is thus not only about the maturation and development of a fetus but also about the personal, physiological and psychological development of the expectant mother.

The aim of this literature review is to highlight the psychological experiences of pregnant middle-class women during the three trimesters of pregnancy. This will entail weaving in the dynamic issues whose role in determining the nature of the mother-child relationship is pivotal. The pregnant woman's personal attachment history provides her with an inner working model of relationships and thus creates a template in the form of maternal representations of how her relationships with her baby will be experienced and conducted. It is through her fantasy life, reverie, preoccupations and projective identifications with the fetus that prenatal and later postnatal attachment are facilitated. However it is acknowledged that any particular

pregnancy is assigned a variety of meanings which will be influenced not only by individual but also cultural experiences.

Psychoanalytic authors argue that like the fetus the mother goes through corresponding changes (Bibring, 1959, 1961, 1976; Birksted Breen, 1985; Pines, 1993; Raphael Leff, 1993). Apart from physical changes in body-shape, she also experiences hormonal and metabolic changes. This can manifest in nausea and vomiting, sweating, heartburn, constipation and tiredness and is often accompanied by increased emotionality, what Winnicott (1956) calls 'heightened sensitivity' (p.302). Psychoanalytic authors have termed the changes "maturational processes" (Raphael-Leff, 1991, p. 61) since they coincide and run in tandem to the biological and physiological changes of the trimesters. This conception is thus not an attempt to override the value of the trimesters in understanding the processes of pregnancy but is an attempt to integrate the various aspects of experiences into a holistic formulation that can overcome the mind-body dualism inherent in western medical thinking.

Most international research has focused on first pregnancies of middle-class samples in America and the United Kingdom (Raphael-Leff, 1991) and no research has yet been done on the prenatal experience of pregnancy in South Africa. It should be understood that pregnancy unfolds within the context of different emotional, psychosocial and cultural circumstances. While a critical cross-cultural analysis of the literature falls outside the scope of this study, the researcher is mindful of the implications regarding different cultures, especially within the South-African context.

Furthermore, being positioned within a psychoanalytic framework carries certain assumptions about the universality of intrapsychic experience. It cannot be assumed that women from the same culture will experience pregnancy in similar ways, assumptions regarding the experience of women from different cultures need to be circumscribed. Concepts of motherhood are socially and culturally mediated and no claims to the universality of experience can be made. Notions such as pregnancy and motherhood have historical meanings that are not easily accessible to scrutiny

and its effects on particular experiences cannot always be gauged (Helman, 1990). This study will thus also attempt to critically highlight contentious assumptions underlying certain psychoanalytic concepts without necessarily discussing them extensively. It is hoped that by being mindful of these issues will highlight the complexities inherent in applying theories developed elsewhere to a South African context.

The first section of this study attempts to understand how pregnancy developed from its mystical roots as a female controlled system with rituals and taboos, overseen by “wisewomen/healers/midwives” (Raphael-Leff, 1991, p. 228) to a medical condition dependent on the intervention of (often male) physicians. In the section on “The Medicalization of Pregnancy” it will be shown how the medical model has formulated a “plumbing model of a woman’s body” (Helman, 1991, p. 140) which ignores the impact of emotions and the meanings women give to their experiences.

In contrast to the medical model there has been an attempt by psychoanalytic theorists to reposition pregnancy by reformulating it as a holistic experience encompassing both physiological and psychological changes. According to authors working within this paradigm physical symptoms generate psychic interpretations and therefore emotional feelings (Birksted-Breen, 1985; Helman, 1976; Pines, 1993; Raphael-Leff, 1991; 1993). This results in psychic turmoil where boundaries between conscious and unconscious processes become more permeable. This particular approach is discussed in the next section on “The Psychoanalytic View of Pregnancy”. It is here that the permeability of boundaries, dreams and fantasies and the ensuing implications for women’s experience are explored. It is through this approach that the clinician can attempt to realign the mind-body split and provide a framework for support.

Raphael-Leff (1991) believes that the loosening of the boundaries between conscious and unconscious processes and the increased emotionality during pregnancy provides a unique opportunity for intervention. In order to maximize these opportunities, it is imperative that researchers understand how these inner processes

unfold. This can be achieved through understanding the maturational processes that develop during the three trimesters. Each phase provides its own developmental task. The defining features of each maturational phase and its concomitant processes is discussed in the section “Maturational Phases”. The importance of the maturational processes of pregnancy is a central tenet of this paper. It provides a working model for not only understanding the interaction between the different theoretical concepts discussed previously (dreams, fantasies, maternal representations and attachment) but also provides a framework for relevant clinical intervention.

Subsequent research has found that the pregnant woman’s fantasies and her relationship to her own attachment figures not only provides clues to prenatal bonding but also effects the formation of maternal representations. Stern describes how the mother’s (and father’s) history has played a key role in determining the nature of the parent’s relationship with their child (Stern, 1995). Their representational world includes not only their experiences of current interactions but their fantasies, hopes, fears dreams and memories of their own childhood, models of parenthood and prophecies for the infant’s future (Stern, 1995). These maternal representations of the parent’s personal past may be activated and thus enacted in the newest of relationships. This will be discussed under the sections of “Maternal Representation” and “Attachment” respectively.

The importance of psychoanalytic insights will be addressed in the section “Implications for Interventions”. It will examine the role of psychotherapy, the healthcare worker and the healthcare system in terms of the opportunities that pregnancy provides for intervention in this regard as suggested by psychoanalysts (Bibring, 1959,1961, 1976; Martin St- Andre, 1993; Pines, 1993; Raphael –Leff, 1982,1991; Slade, 1996; Sherwen, 1991).

There is a paucity of research concerning the emotional needs of pregnant women within health-care systems. It is for this reason that research into women’s psychological needs, and the opportunities available for intervention becomes

crucial. This is especially true of South Africa where urbanisation has fragmented family patterns and eroded traditional support systems. Poverty, malnutrition and violence may adversely effect many pregnant women's ability to interact with the baby-to-be and prenatal intervention therefore becomes crucial. Research has shown the relationship between poverty, social class and psychopathology (Dawes & Donald, 1994; Richter & Griesel, 1994) and it is thus imperative that preventative strategies should incorporate an understanding of these variables and the subsequent effects on mother-child relationships. Whilst a discussion of this research is needed, the last section of this paper "Class and Cultural Considerations" is merely to set the tone for a more comprehensive debate on this important relationship.

It is hoped that further research will examine how the elements discussed in this study can contribute to understanding the psychological needs of pregnant women in South Africa. This is needed not only to predict and prevent post-birth mother-infant complications, but eventually to contribute to South African women receiving more appropriate and effective prenatal psychological support.

2.

THE MEDICALIZATION OF PREGNANCY

Maternity care has been a task presided over by women in all cultures since the earliest times (Helman, 1990). Raphael-Leff (1991) and Helman (1976) state that reproductive care was a female controlled system whether in the hands of friends, female relatives, or traditional midwife. The fear of “pollution” (Raphael-Leff, 1991, p. 228) associated with female bodies and sex, relegated pregnancy and birth to the realm of these female practitioners. Raphael-Leff (1991) maintains that this was also the case in pre-industrialised western culture where female healers presided over all matters of fertility. According to her the invention of forceps in the seventeenth-century changed this. It led to a process whereby the natural assistance normally provided by “wise-women/healers/midwives” (p. 228) was supplanted by instrumental obstetrics, transforming it into a predominantly male discipline. Stacey (1976) describes how midwifery in the United Kingdom was an exclusively female profession until the seventeenth-century when “men-midwives or accoucheurs” (Stacey, 1976, p. 52) started to appear, and gradually increased their authority over the birth process and how it was managed. Raphael-Leff (1991; 1993) shows how this was possible through “surgical intervention” (p. 238) by restricting female midwifery to ‘normal’ births while male midwives were elevated to dealing with problematic births and those of upper-class women. Important in this conception was the framing of women as fragile and of pregnancy as a potentially harmful event. Despite this, the expertise of midwives was acknowledged and even formalised in legislation in countries such as England (Helman, 1976; Raphael-Leff, 1991; Stacey, 1976). Raphael-Leff describes this as follows about the British Midwife Act of 1902:

In 1902 in Britain, midwives organised and delineated an area of expertise over which they presided until as late as 1973, when the majority of all British babies – 70% of hospital births and 80% of home births – were still delivered by midwives. However, as male obstetricians monopolised ‘pathological’ births, the definition of labour underwent a change, emerging as an abnormal event requiring clinical intervention. (Raphael-Leff, 1991, p. 228)

Many researchers argue that economics were at the heart of this struggle (Fisher, 1988; Janssen-Jurreit, 1982; Rich, 1976). It was in the interest of male obstetricians to convince women, particularly upper-class women that birthing was a high-risk activity in which the pregnant woman needed medical intervention from knowledgeable, male physicians. This reconstructed birth as a medical event, and recommended transferring the birthing process to a hospital setting. Its management thus became an almost exclusively medical matter. Helman (1976) argues that this overemphasis on the biological and technological is a psychosocial phenomenon and is the cornerstone of the mind-body dualism of western thinking. It understands the body as a machine and ignores the meanings women give to their birthing experience. Raphael-Leff (1991) concurs, that with the medicalisation of birth the woman not only lost control over her body and the experience of birth, but the midwife, previously a pivotal figure in the community became deskilled and lost her position as social adviser. The pregnant woman now finds herself isolated and alone, alienated from her body and dependent on medical intervention. According to Helman (1976), the demise of midwifery and the growth of the medical view of the female body as a defective machine forms the philosophical basis of modern obstetrics. A further feature is “the conceptual separation of the mother and infant in the technological model of birth” (Helman, 1976, p.188).

This duality views pregnancy as something different from the rest of a woman’s life, to be treated as an isolated incident, or a temporary act of illness (Birksted-Breen, 1985; Helman, 1976; Raphael-Leff, 1993). The problem with the medical model, says Smith (1993) is that it stresses the pathological at the expense of the normal. The pregnant woman is either disembodied, by focusing on the biological at the expense of the emotional, or pathologised by focusing exclusively on the emotional. What is lost, he argues, is a holistic understanding of how women respond to the experience of being pregnant which integrates both biological and emotional experiences.

According to Helman (1990) all societies experience pregnancy and childbirth as more than a biological event. The meaning of pregnancy is always socially constructed. In most cultures this meaning includes a crossing of boundaries,

whereby, regardless of future events, the woman will be irrevocably transformed. In this sense pregnancy becomes a 'rite of passage' signifying the transition from "the social status of woman to that of a mother" (Helman, 1990, p. 200). This view is echoed by Birksted-Breen (1985) when she describes pregnancy as a phase of psychological and physiological preparation. It is a time for reassessment of the past and for thoughts about the future. It is a phase of deep psychological as well as physiological change.

Pregnancy is thus not a condition – it is a process. Physiological, physical and metabolic changes are experienced differently by each woman and are accompanied by emotional reactions. Each woman's response to her pregnancy is the result of her personal appraisal of what these changes might mean. Physical symptoms generate psychic interpretations that are rooted in somatic experience (Helman, 1990; Raphael-Leff, 1991; 1993). In this way biological, physiological and psychological changes are informed by a woman's world-view and provide a unique window of exploration.

3.

THE PSYCHOANALYTIC VIEW OF PREGNANCY

Like all turning points, the transitional phase of pregnancy reactivates dormant conflicts revitalizing earlier emotional processes which now become reintegrated through current experience (Raphael Leff, 1991). As will be discussed such a turning point has been found to engender an 'emotional disequilibrium' (Raphael Leff, 1991, p. 127) necessitating new solutions to old formulations. Psychoanalytic theorists believe that during the three trimesters of pregnancy thoughts, feelings and fantasies which are usually subliminal suddenly seep into the consciousness and must be attended to or kept effortfully at bay.

3.1 The Permeability of Boundaries: Dreams and Fantasies²

According to Raphael-Leff (1991) regardless of whether the pregnancy is wanted or not, it is potentially a time of confusion. Birksted-Breen (1985) describes pregnancy as a period of profound loss of identity, accompanied by doubts, regrets, anxieties and disbelief.³ Many researchers have recorded similar findings (Bibring, 1959; Oakley, 1980; Pines, 1993; Raphael-Leff, 1991; Robinson & Stewart, 1989; Sherwen, 1981, 1991; Smith, 1993; Stern, 1995). Internal turmoil often precedes great change, states Raphael-Leff (1991). The pregnant woman frequently reacts by either 'tuning in' and listening to her unconscious or may feel her world has been turned upside down, feeling overwhelmed by disturbing, uncontrollable thoughts and feelings in dreams and fantasies.

Elsewhere Burke (1997) has given a comprehensive discussion of the different types of dreams and fantasies during pregnancy. Raphael-Leff (1991) describes the increased emotionality as a sense of emotional confusion where the occurrence of fantasies increases with the pregnancy. She describes it as "an involuntary 'permeability', a loosening of internal barriers between levels of consciousness and within memories" (p. 49). To her it signifies a turning point that necessitates resolution. Each pregnancy therefore calls for a reshuffling of internal resources,

which entails a reinterpretation of the past in the light of the present (Bibring, 1959; Birksted-Breen, 1985; Pines, 1993; Raphael-Leff, 1993; Smith, 1993).

This permeability of boundaries during pregnancy has been illustrated by other psychoanalytic authors (Bibring, 1959; Pines, 1993; Sherwen, 1981; 1991) who believe that there is an increase in accessibility to the unconscious and that expectant women make links and associations more easily, therefore bringing symbolic meaning into consciousness more readily. They argue that this can be witnessed in the prevalence of dreams and fantasies, especially in the last trimester, and in increasingly uncensored nature as the pregnancy progress. The content may also be more distorted than usual and according to Bibring (1959) compares with dreams found in severely disturbed patients. Significantly, it would appear that adjustment to pregnancy is not adversely affected by such unconscious content. Pines (1993) comments that it is as if the foetal kicking “gives added security to the ego” (p. 65).⁴ She believes that previously repressed primitive fantasies will now find it easier to emerge into consciousness without causing overwhelming anxiety. The reality of a kicking baby appears to enable women to tolerate fantasies previously experienced as threatening.

According to Rubin (1972) dreams and fantasies are an essential component of the pregnant woman’s internal reshuffling. They assist in facilitating the reworking of old conflicts and adaptation to the shift that will occur during the acceptance of the mothering role. Furthermore, fantasies serve as a preparation for motherhood: envisioning being a mother, the desired characteristics as well as anticipating future life changes (Lederman, 1984).

According to Rubin (1972) the importance of dreams and fantasies during pregnancy is to communicate the prospective mother’s conflicts, anxieties, hopes and idealisations. Dreams may manifest as representations of past and future relationships and fantasies may serve as mechanisms of “binding” the infant to the mother and family (Rubin, 1972, p.101). This is determined by psychosocial factors,

obstetric history as well as current physical and emotional states (Raphael-Leff, 1991).⁵

Dreams and fantasies therefore serve as the earliest vehicle for attachment, offering a containing environment for mother-infant interaction. Raphael-Leff (1991) argues that fantasies are part of a normal process whereby the mother-to-be, in the absence of real knowledge, uses minimal clues about her infant to construct her imaginary baby.

The pregnant womb acts like a projective test, serving as a symbolic container into which each mother can confide her wishes, hopes, fears and fantasies, and create the baby of her dreams or nightmares (Raphael-Leff, 1991, p. 121)

Every fetus has a meaning for the mother-to-be. Throughout the process of the three trimesters of pregnancy, these clues mixed with her hopes, dreams and fantasies will form an inner representation of what her baby must be like.

3.2 Maturational Phases

According to Raphael-Leff (1991) tracing the development of the three maturational phases is a progression from a belief in the pregnancy, to a belief in the fetus and finally, to a belief in the baby. Deutch (1945) argues that the most powerful experience for the pregnant woman is a “belief in the duality within the still existing unity” (p.159) and with time, to believe in the separateness of this entity within her own body-boundary. It is this growing awareness of the approaching duality that could be described as the main feature of the first trimester of pregnancy.

The First Trimester

The first trimester of pregnancy has been characterised by the growing awareness of change within the body of the pregnant woman. It is a time of heightened self-preoccupation with bodily processes (Bibring, 1961; Deutch, 1945; Raphael-Leff, 1991; Zeanah et al., 1986) and a marked withdrawal from the object world (Pines,

1993). Raphael-Leff (1991) extends this theme to include two emotional processes, “psychological slippage” (p.62) and “freewheeling” (p.63)⁶. The former is characterised by daydreaming, a lack of concentration, forgetfulness and memory-lapses. These, she argues, have symbolic meanings and can reveal “the pregnant woman’s inevitable mixed feelings towards the ‘intruder’ ... and her ambivalence of the changes taking place within her” (p.63). Freewheeling she describes as over-sensitivity, irritation, emotional fluctuation and an acute awareness of others’ reactions towards her. This may cause the mother-to-be to feel out of control and at the mercy of her surroundings and what is happening inside her. This reawakens primitive anxieties and “magical thinking” (Bibring, 1959, p. 115) and other psychoanalytic authors have described similar phenomena (Bibring, 1959; Pines, 1993; Sherwen, 1991; Smith, 1993). These are characterized by an increased frequency of dreams and fantasies (Pines, 1993; Sherwen, 1981, 1991); reactivation of previously repressed memories (Bibring, 1959) and conflicts around the relationship with their own mothers (Bibring, 1959; Smith, 1993). This phase of insecurity and psychological confusion usually culminates with quickening, when the existence of the new life becomes reality. This introduces the second phase of pregnancy.

The Second Trimester

Raphael-Leff (1991) describes the second trimester and the start of foetal kicking as the phase where the pregnant woman feels her attention divided between external demands and the bid for attention from within. This is sometimes coupled with an increased sexuality, whereby her body reveals her sexual relationship to the world (Pines, 1993; Birksted-Breen, 1985). The pregnant woman either feels freedom from previous sexual inhibitions or imprisoned by this revelation (Raphael-Leff, 1991). From this time onwards “the other” is actively interacting with her, and provides that she is no longer alone (Zeanah et al. 1986, p. 195). Raphael-Leff (1991) says that the hallmark of the second phase of pregnancy is the acknowledgement of the baby inside her, and the shift from herself to the fetus.

Deutch (1945) believes that quickening heralds the profound existential experience of two within the same body boundary. The fetus is real, but cannot yet be known and thus becomes an imaginary friend or enemy, the mother-to-be creating elaborate fantasies about the perfect child, ascribing characteristics, features, likes and dislikes (Raphael-Leff, 1991; 1993). Pines (1993) maintains that the most remarkable feature observed at this stage is the emergence of vivid regressive fantasies which would be disturbing in other people, yet are dominant and commonplace in the analytic material of pregnant women. In some cases the fetus can become a destructive devouring creature or something shameful and dirty that needs to be expelled (Sherwen, 1991). These fantasies are interpreted by Birksted-Breen (1985) as embodiments of disowned parts of the self that have re-emerged in consciousness.

It is here that the pregnant woman may find herself re-examining her relationship with her own mother (Birksted-Breen, 1985; Pines, 1993; Raphael-Leff, 1991) and feelings awakened in the previous trimester, increase and demand resolution. Birksted-Breen (1985) maintains that there is a psychic reality, based on the early mother-child relationship as experienced by the mother-to-be, which may be conflictual with her own ideas of mothering, and in turn could determine the future of her abilities to mother. Pines (1993) and Birksted-Breen (1985) argue that under the impact of these fantasies and unresolved conflicts the ego needs additional support from the environment, especially in women where pregnancy is a new and unaccustomed role. Bibring (1959) believes that in the absence of support these conflicts will return with greater force during subsequent pregnancies, resulting in induced negative reactions and may develop into “a chronic malformation of [the mother-infant] relationship” (p. 117)⁷. Raphael-Leff (1991) proposes that an opportunity to grapple with these conflicts around imagined, real and idealised visions of mothering can allow the expectant mother to see her own mother more realistically and as separate from her internalised visions. Sherwen (1991) adds that fantasising about mothering, in both daydreams and nightdreams, marks the beginning of an “internalisation of the mothering role” (p. 57) whereby the expectant mother, through imagery, can project how it will be to mother a child in the future.

Birksted-Breen (1985) summarises this conflict around future mothering as one of the tasks of pregnancy.

Raphael-Leff (1991) concurs and adds that apart from those who are deeply defended, the identity of the mother-to-be develops alongside the steady growth of the fetus. Her worries about her abilities either increase or subside when it becomes evident that the baby could survive if born prematurely. Her preoccupation therefore shifts from an internalised relationship with herself and others to an emotional and physical preparation for birth (Raphael-Leff, 1991). This heralds the start of the third trimester.

The Third Trimester

The third and final phase of pregnancy is marked by bodily discomfort and fatigue as the woman prepares for labour (Raphael-Leff, 1991). It is a time when even the experienced mother has worries about labour and delivery. Contact with health professionals becomes more frequent and the woman experiences herself as a mediator between the outside world and the baby within. Many women search for physical clues and seek explanations from doctors and nurses (Raphael-Leff, 1991) in a bid for reassurance. Suggestibility is rife, and in the absence of real knowledge a woman may be prone to irrational fantasies and premonitions (Birksted-Breen, 1985; Pines, 1993; Raphael-Leff, 1991, 1993; Smith, 1993). Anxiety increases as the inevitability of labour is imminent. During this stage women have reported fantasies about being ripped apart or destroyed (Pines, 1993; Robinson & Stewart, 1989) of giving birth to monsters and animals (Birksted-Breen, 1985; Raphael-Leff, 1991) or fears that their own badness will be revealed; that they will, at last, be found out (Birksted-Breen, 1985; Martin St-Andre, 1993; Raphael-Leff, 1993; Rubin, 1972). The mother-to-be is locked in an eternal race with time, experiencing it as moving both too rapidly and too slowly (Smith, 1993; Birksted-Breen, 1985).

Authors have described the inevitable progression towards birth as akin to the inevitable progression towards death. They argue that fear of death in childbirth is a primeval fear as if the birth of one being is inextricably linked to the death of another

(Birksted-Breen, 1985; Pines, 1993). According to Gillman (1968) fear of death is a common feature of pregnant women's dreams during the third trimester. The pregnant woman must come to terms with enormous bodily changes, and the meaning of these changes. She has to cope with unexpected and overwhelming feelings as well as prepare for her new status as a mother, and the added responsibilities this entails (Birksted-Breen, 1985). Bibring (1959) and Raphael-Leff (1991) argue that if this call for revision is not heeded it could lead to complicated birth, or post-birth experiences. They believe that if psychic change cannot be established, it will result in defensive coping and detrimentally affect the subsequent mother-infant relationship⁸. It is for this reason that the actual experience of pregnancy is important. According to Birksted-Breen (1985) this experience will either confirm the goodness of the expectant mother's body, her loving and creative capacity, her right to have a baby or it will reinforce her sense of failure, resulting in fantasies that she deserves to be punished. Pregnancy, and especially the third trimester, can thus have lasting effects on how women perceive themselves as well as their infants.

Larney et al. (1997) argues for increased understanding of the internal processes during the three maturational phases, and especially the third trimester, and believes that they are as important as any post-birth experiences. Whilst the medical model focuses on birth and post-birth complications, this research has briefly shown the important connection between in utero experiences and the pattern of representation and attachment after birth. Larney et al. (1997) adds that preventative intervention should start during the third trimester of pregnancy, prior to the stabilization of prenatal representations. Dragonas & Christodoulou (1998) have found that life stress and inadequate social support during pregnancy can adversely affect labour and delivery. This, in turn, will affect the subsequent emotional development of the infant. In accordance with Larney et al. (1997), they also believe that preventative strategies should start at the third trimester of pregnancy. Dragonas & Christodoulou (1998), Raphael-Leff (1991) and Sherwen (1991) say that health-professionals should focus on psychological well-being and in so doing may prevent a range of postnatal complications. By incorporating psychological experiences

during pregnancy, prenatal care can become an integrated strategy for preventative health-care. The health-care worker, as primary point of contact to the pregnant woman, can play a vital role in facilitating change before birth, preventing possible long-lasting psychological problems after birth.

3.

THE IMPORTANCE OF THE PSYCHOANALYTIC VIEW.

Pregnant women undergo profound physical and psychological changes and psychoanalysts view this time as a “unique window of exploration” to address hitherto unconscious fantasies (Raphael Leff, 1990 p. ix). Such an understanding is beneficial to comprehend how individual women’s early experiences resurface and shape perceptions of herself and her future child. It is a time of upheaval because projections abound and past anxieties become heightened and need to be worked through to create positive mothering experiences.

Psychotherapeutic treatment during pregnancy can help a disturbed woman achieve better integration of internal resources and self-representations, thereby preventing postnatal maternal distress. Timely intervention can ameliorate negative prenatal bonding.

3.1 Maternal Representation

Representations have played a key role in the history of psychoanalytic psychotherapies (Stern, 1995). Maternal representation, according to Larney, Cousens & Nunn (1997) are “inferred mental constructions of reality based upon verbally expressed perceptions, memories and expectations”. The woman’s personal experiences of relationships which have been internalized are now re-evoked as the pregnancy progresses. This causes past conflicts and anxieties to re-merge and re-enactments which may not be appropriate may occur. The psychoanalytic model therefore offers a useful therapeutic technique through which the pregnant woman’s representational world can be explored.

The work of Winnicott (1956) gave the fantasy life of pregnant women a special, even unique importance. Their reveries, preoccupations, fantasies and projections, were understood as the major building blocks in the construction of an infant’s sense of identity. The work of Fraiburg, Andelson & Shapiro (1975) placed the mother’s

maternal representation at the core of the mother-infant relationship. They showed how the mother's fantasy life and memories could facilitate or impair bonding. Sherwen (1991) describes how fantasies provide clues about impaired representations and the possible future problems in mother-infant bonding experiences. These she believes could easily be traced in the dreams and fantasy life of the pregnant woman. Benedek (1970) argued that fantasy could negatively influence the emotional course of the pregnancy and a mother's subsequent representation of her infant. Caplan (cited in Sherwen 1991) believed that the future mother-infant relationship is a direct continuation of the mother's fantasies about her. These authors therefore placed dreams and fantasies as central to the formation of a pregnant woman's maternal representation, and the consequent quality of mother-infant relationship.

In contrast, Stern (1995) argues that fantasies are just one of the factors that influence a pregnant woman's representation of her infant. He believes that maternal representation develops through "interactive experience" (p.20) and encompasses the totality of the subjective experience of being with another person. This can be real, lived or fantasised experience. Maternal representations, he argues are built up through a parallel process between the real world and the imaginary world.

There is a real baby in the mother's arms and an imagined baby in her mind. There is also the real mother holding the baby, and there is her imagined self-as-mother at that moment. And finally, there is the real action of holding the baby, and there is the imagined action of that particular holding (Stern, 1995, p. 18).

This experience of holding includes not only the mother, and later the father's experiences with the baby, but also their fantasies, hopes, fears and memories of their own childhood. This view is similar to Winnicott's (1956) holding environment. Winnicott (1956) argued that it is through "primary maternal pre-occupation" that the pregnant woman develops a heightened sensitivity that allows for an intense identification with her child-to-be. Stern (1995) has expanded this theme and tries to understand the "matrix of relatedness" (p. 176) that influences, prevents, or enhances prenatal attachment. He examines maternal representation through both the mother and father's life-world.

According to Stern (1995) parental representations are built up from a network of interacting schemas. These schemas he called “schemas-of-being-with” (p.21). They may include schemas about the infant, built up from clues about their temperament; schemas regarding the mother’s new status and her own memories of childhood. The role of the baby in the relationship and the mother’s parents are further common prevalent schemas. Stern includes the father and believes he experiences a similar network of schemas. He believes that maternal representation undergoes a crucial phase when the fetus starts to move at about four months gestation, as research shows that this is the first time that she can imagine her fetus as a real, separate identity. Between the fourth and seventh month the representations intensify and eventually stabilise around eight months gestation (Larney, Cousens & Nunn, 1997; Zeanah, Keener & Andes, 1986).

Larney et al. (1997) agree, and found that prenatal maternal representation becomes stable around the third trimester and remains stable until about four months after birth. This concurs with the findings of Zeanah et al. (1986) who argue that maternal representation only altered antenatally in women where labour was very difficult. It seemed as if a problematic labour challenged the woman’s previous beliefs about herself and her infant. In contrast, Larney et al. (1997) maintain that difficult labour did not significantly change maternal representation in their sample. Both groups agree however that the nature of maternal representation is crucial in the development of prenatal attachment and the type of attachment relationship that will form after birth.

Zeanah et al. (1986) propose that these findings are an important contribution to Bowlby’s (1969) formulation of internal working models. They believe that Bowlby (1969) examined the construction of an infant’s internal working model. Their research on the other hand has examined the other side of the issue, namely the mother’s working model of her infant. They believe that this shows the importance of the mother’s mental representations in attachment relationships as these start prior to birth (and not afterwards as Bowlby

proposed). Larney et al. (1997), Zeanah et al. (1986), Stern (1995), and Raphael-Leff (1993) agree that prenatal attachment can thus influence and affect the infant's inner working model and the consequent attachment relationship.

4.2 Attachment

Bowlby (1969) and Ainsworth (1985) were the first researchers to provide extensive empirical evidence for the attachment relationship between mothers and their infants. They explained attachment as having a biological function in that it enables infants to seek out and maintain maximally close contact with the primary caregiver (Bowlby, 1969).

In so doing a relationship is created which influences the development of the child. Other researchers (Fonagy, Steele & Steele, 1991; Haft & Slade, 1989; Raphael Leff, 1991, 1993; Slade & Cohen, 1996; Zeanah, Keener & Anders, 1986; Zeanah, Keener, Stewart, Ander, 1985) have seen that some form of attachment begins during pregnancy and is influenced not only by the pregnant woman's early experiences of her own her relationships but also her inner psychological processes. The ensuing quality of the attachment will be predictive of the attachment that develops between mother and infant.

Researchers explored the relationship between parents' own inner working models, their prenatal representations and the nature of their attachment relationships with their children (Fonagy, Steele & Steele, 1991; Haft & Slade, 1989; Slade & Cohen, 1996; Zeanah, et al., 1985; Zeanah, et al., 1986). The three patterns of attachment described were secure, dismissive or preoccupied and appear to be present in adults and children alike.⁹ They found that attachment styles seemed to be enduring and stable over time and where shifts did occur it was predictive of change in the mother due to life events (Ainsworth, 1985).

Haft & Slade (1989) found that mothers who were securely attached were able to tune into a range of affects while insecurely attached mothers could only respond to

a much narrower range of cues from their infants. These mothers also had clear signals of what constitutes appropriate and inappropriate behaviour, thereby communicating from a very early age what was shareable and what was not.

Kobak and Sceery (1988) believe that an infant's internal working model develops as a strategy for regulating certain kinds of emotions. This would mean that a securely attached mother could reflect to the child that open communication regarding fear, distress, or anger was acceptable and would not reduce "felt security" (p.138). Both the dismissive and avoidant attachment styles reflect the adult's feeling that negative emotions will disrupt attachment relationships. Thus a parent who cannot tolerate feelings of longing toward her own mother will ignore or distort such feelings in her child as it would mean acknowledging her own unsatisfied longings (Haft & Slade, 1989). A parent's ability to share in and validate the total range of his/her baby's affective experience is therefore central to the healthy developmental of the infant.

It is therefore clear that a pregnant mother's growing relationship with her fetus develops within a matrix of past and present experiences. As stated by Pines (1993), motherhood is a three-generational experience. The emotional disarray experienced during this time plays a fundamental part in the reorientation towards the infant. Most psychoanalytic authors agree that care should be taken not to pathologise this process of change (Deutch, 1948; Benedek, 1970; Bibring, 1959; Pines, 1993; Raphael-Leff, 1991). Turmoil and feelings of confusion are a natural outflow of the biological changes and should be communicated as such. The argument of Bibring (1959), Raphael-Leff (1991) and Smith (1993) is that the negotiation and reconstruction of the expectant mother's internal world is an important developmental task of pregnancy. Birksted-Breen (1985) adds that childbirth and early motherhood should be seen as part of this developmental phase. Brazelton (in Raphael-Leff, 1991) believes that prenatal anxiety is a healthy process which facilitates a woman's adaptation through a period of transition into her role of mothering. This process also helps to make her unusually sensitive to the infant's individual needs and requirements. Raphael-Leff (1991) argues that these changes not only re-orientates the pregnant woman towards her infant, but also assists her in

her own development from woman and daughter to mother. The emotional turmoil common during pregnancy should therefore be regarded as a time for revision.

Raphael-Leff (1991) argues that to be able to utilise the opportunities pregnancy provides, it is imperative that researchers understand how these inner processes unfold including the genesis of attachment. She believes that even though each woman experiences pregnancy differently, the psychological processes develop in parallel with the physiological changes and can be traced through the three trimesters of pregnancy. Each phase provides the pregnant woman with its own developmental task, demanding resolution. These three maturational phases do not attempt to deny the division of pregnancy into trimesters as formulated by traditional medicine. Rather it is an attempt to integrate the totality of women's experience during pregnancy by linking the development of the fetus with her own development - from woman to mother. It also provides a holistic understanding of pregnancy that overcomes the mind-body duality that has largely been ignored and fragmented by the medical model (Raphael-Leff, 1991; Smith, 1993).

As it can be seen from the work of psychoanalytic authors attachment theory is an integral part that holistic understanding. Appropriate intervention aimed at enhancing mother-child relationships will always need to include a thorough understanding of individual attachment styles.

5.

IMPLICATIONS FOR INTERVENTION

In a society like South Africa where resources are scarce a mental health priority should be the early detection of high risk groups and preventative measures to reduced the cost of treating pathology. Pregnancy presents an ideal opportunity to meet both these requirements. Antenatal clinics offer possible screening and where necessary referral for postnatal intervention. The role of psychotherapy as a preventative measure during pregnancy would be to explore deep seated emotions and help women resolve internal conflicts and archaic formulations which may otherwise negatively influence the pregnancy.

Sherwen (1981) believes that understanding the meanings of unconscious processes during the three trimesters, and encouraging women to talk about them, is a vital tool in predicting the development of the mother-infant relationship. By allowing the pregnant woman to express her fears, hopes and fantasies, a dialogue between mother and health-care worker is established. The health-care worker can then utilize an understanding of fantasies during pregnancy to facilitate the ensuing mother-infant relationship.

Sherwen (1991) describes how this can be done: firstly, the health-care worker can support and enhance positive fantasies about the pregnancy, labour and delivery. These fantasies can be used to make the mother-to-be feel positive about herself and her infant. This can facilitate the binding-in of the fetus with her life-world and in turn facilitate positive maternal representations. Secondly, negative fantasies can be used to rehearse the potential problems during upcoming events. A problem-solving attitude to aspects of birth that is fearful can be discussed and missing information supplied. Both Sherwen (1981, 1991) and Raphael-Leff (1991) argue that lack of objective information is one of the main reasons women experience fear and anxiety. By supplying realistic information about the situation or event the woman is given an opportunity to resolve fears in her own manner.

Thirdly, and most importantly they believe that everyday fantasies about the baby provides a valuable measure of the progress of the bonding process. The inability to fantasize about the infant is an important clue to bonding difficulties. Especially during the third trimester, potential impingements to attachment can be revealed in the way the mother thinks and talks about her baby-to-be. Caplan (cited in Sherwen 1991) found that if a mother could fantasize her baby as either sex, or as both a small infant and young child, a positive mother-infant relationship could be expected. When the mother consistently fantasized a specific sex for the child, conflicts could arise due to expectations. Elsewhere, Burke (1997) discusses the full range of fantasies and their relationship to intervention. She shows that crisis intervention regarding particular issues that arise in fantasy can resolve difficulties in attachment and therefore potentially reduce postnatal complications.

Raphael-Leff (1991) and Martin St-Andre (1993) believe that many women are more amenable to psychotherapy during pregnancy due to the accessibility of unconscious material. They are more in touch with pressing issues and are therefore inclined to be more accessible to new insights. The need to become a good mother serves as a catalyst for this as well as the “ ‘built-in’ termination date” (Raphael-Leff, p. 115) which invokes a sense of urgency to achieve growth and stability before the baby is born.

Furthermore, Raphael-Leff (1991) advocates that the health-care worker can play a vital role in facilitating the pregnant woman’s ability to listen to her own inner messages, increasing her availability and ability to bond. She believes health professionals can provide women with more direct access to the fetus. Women tolerate intrusive examinations as a means of getting information because they see health professionals as an intermediary. By creating a trusting relationship with the woman, health professionals can help create an emotional dialogue with the unborn baby and increase subsequent attachment to the infant. This is only possible if the health professional views the antenatal visit as more than just medical screening¹⁰.

Raphael-Leff (1991) believes that this can only be possible when health professionals understand the psychological processes of pregnancy and are able to intervene appropriately during the different maturational stages. Furthermore, they should understand the inner turmoil and distress that accompany the psychological experience of pregnancy as a normal phenomenon. Appropriate intervention at each stage can thus be used as an opportunity for women to develop an intimate relationship with their baby to be.

Dragonas & Christodoulou (1998) have shown that pregnant women have consistently benefited from primary health-care clinics that incorporate social and psychological support. These women are reported to be more positive about pregnancy, labour and delivery. They have been significantly less anxious and afraid of forthcoming events, and more in control as evidenced by asking questions and the ability to communicate fears and anxieties. Most research in this area however has focused on middle-class samples attending clinics in Europe and America (Ballou, 1978; Haft & Slade, 1989; Merbert & Kalinowski, 1986; Shereshefsky & Yarrow, 1973; Slade & Cohen, 1996; Zeanah et al., 1985; Raphael-Leff, 1991) rather than the primary health care clinics of South Africa. Dragonas & Christodoulou (1998) and Raphael-Leff (1991) have shown that socially disadvantaged women have systematically been neglected by health-care services. According to them lack of information and access to health-care has been cited as the major reason for non-attendance antenatally, and this has also been correlated with high infant mortality and post-birth complications.

In South Africa, Dawes & Donald (1994) have argued that “poverty is the single most powerful and multifaceted negative influence on the psychological development (of infants)” (p. 3). It has a circular effect in that “women grow up in this environment, carry a pregnancy to term in it and deliver the new generation into it” (p.114). While there has been a substantial body of literature regarding the effects of the ‘culture of poverty’ on family and caretaking (Richter, 1994), physiological states of pregnancy and nutrition (Richter & Griesel, 1994) and psychological states such as depression (Murray and Cooper, 1996) there is a dearth of information on the effect

of psychological experience of pregnancy. Since every individual is influenced psychologically by their cultural milieu, poor and socially disadvantaged women may experience pregnancy as an increased burden, but very little research has been done to understand these effects on their psychological processes.

6.

CLASS AND CULTURAL CONSIDERATIONS.

The psychoanalytic aspects of pregnancy and attachment have not been extensively researched in South Africa and the cross-cultural aspect has been neglected. Given this paucity Tomlinson (1997) argues it might be more fruitful to research cultural differences or variations in attachment theory rather than trying to find similarities or discarding the theory because no similarities could be found.

Burke (1997) has examined the hopes, fears and fantasies of pregnant women in urban Khayelitsha in Cape Town where women are exposed to high level of violence. According to Malao (1994) killing, the mutilation of children, domestic violence and gangsterism are a common occurrence in this area. However, despite this backdrop of socio-economic instability, Burke (1997) demonstrated that these women's hopes, fears and fantasies did not differ significantly from the middle-class samples discussed in the literature.

The fantasies of economically impoverished women are not entirely unlike those mentioned in the studies on middle-class women, despite the cultural and social differences. The expression of the Khayelitsha women's hopes and fears for their children reflects the conditions under which they live and at the same is a measure of their commitment and involvement with their unborn children.
(Burke, 1997, p. 36)

This concurs with Raphael-Leff (1991) who argues that despite individual variations there appears to be a shared experience by pregnant women across cultures and generations. Pregnancy is understood as a time for re-evaluation of their own experiences of being mothered and a time for fantasies for their child's future. She shows that prenatal care and bonding may be more satisfactory in cultures where the infant is humanised in pregnancy. Assumptions regarding bonding and attachment however cannot be made without understanding the cultural specific beliefs around the status of the infant before and after birth. Regardless of this all societies provide help to childbearing women, and taboos and

rituals serve as preparations of parenthood, affirming parental commitment and responsibility to the baby-to-be. Unfortunately a full discussion of cross-cultural effects falls outside the scope of this study.

Prenatal intervention in South Africa would be useful as it may contribute to a more healthy adjustment postnatally for both mother and child. There can be no doubt that the potential of many pregnant women to establish satisfactory mother-infant relationships is disrupted by escalating poverty and violence. Richter & Griesel (1994) believe that although the nature of mother-infant relationships is culturally mediated the effects of poverty are significant. Donald and Dawes (1994) also show the positive correlation between poverty and social class and psychopathology. It is thus imperative that preventative strategies should incorporate an understanding of how poverty will affect the mother-to-be, and her relationship with her fetus. Whilst more research is need to understand the relationship between culture, poverty and mother-infant bonding, Raphael-Leff (1991) believes that there are far more similarities in psychological experiences of pregnancy than differences. It is only the understanding of these processes that are culturally mediated. It can therefore be argued that prenatal intervention, using the three trimesters of pregnancy as a framework, is a valuable tool in preventative health care providing health care workers are mindful of cultural difference.

7.

CONCLUSION

This paper has explored contemporary psychoanalytic views of pregnancy. Firstly the medicalisation of pregnancy was discussed as a factor that has systematically separated women from their own experiences of pregnancy. Through understanding pregnancy as a medical condition, the mind-body duality inherent in western thinking has prevented women from participating in their own pregnancy as knowledgeable participants. Instead they have become isolated and dependent on medical intervention. In contrast, psychoanalytic researchers have argued that the biological and emotional cannot be separated – physical symptoms generate complex processes of meaning-making. A more holistic understanding that encompasses the totality of the pregnant women's experience has thus been postulated. Psychological features of pregnancy include increased intensity of emotion and turmoil and these result in a loosening of boundaries between the conscious and unconscious. This has been discussed in terms of dreams and fantasies during pregnancy. It was shown how the loosening of boundaries allows researchers and clinicians to have access to the effects of unconscious processes on the development of maternal representation.

The maturational phases that occur alongside the three trimesters of pregnancy was discussed as a schema for understanding the unfolding of these unconscious processes. It was argued that these maturational processes provide a holistic understanding of the psychology of pregnancy that incorporates the totality of a woman's experience. This provided the health-care worker with a framework for intervention. In this way the emotional turmoil of the expectant mother is not ignored or denied, but incorporated as a normal and healthy feature of pregnancy.

It was argued that dreams and fantasies are a key determinant in the formation of maternal representations. By tracing their development, and by following the bonding clues that develop, the possible impediments in the mother-infant attachment relationship can be uncovered. The link between maternal

representation and the ensuing attachment relationship was then discussed. It was also shown that timely intervention before maternal representations stabilised during the third trimester can prevent adverse postnatal bonding.

Lastly, the relationship between culture, poverty and its relationship to pregnancy was discussed. It was argued that whilst cultural differences exist, there are more similarities than differences in the psychological experiences of pregnancy. At various points during the discussion the author also has attempted to highlight the complexity of understanding this research within a cross-cultural framework. It was eventually argued that regardless of the differences in culture this research provides a basis for understanding the needs of pregnant women. In South Africa where resources are scarce, prenatal intervention could contribute to preventing post-birth complications and infant pathology. Whilst more research is needed to understand the relationship between culture, poverty and attachment, prenatal intervention can be a useful preventative strategy as part of primary health-care. Care should be taken by health-care professionals to communicate the psychological processes during pregnancy within the cultural framework of the pregnant mother for positive outcomes to be achieved.

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ADDENDUM

FOOTNOTES

² Phantasy / Fantasy: The terms phantasy and fantasy have been attributed with different meanings by psychoanalytic authors. Initially the term (spelt with an f) referred to conscious fantasies, such as day dreams where the individual is fully aware of imaginary process that s/he is engaged in. Phantasy (ph) implies both the unconscious and psychoanalytic usage of the word (Isaacs, 1948). Phantasies are believed to occur at an unconscious level and are the 'primary content of unconscious mental processes' (Isaacs, 1948). According to Freud (cited in Isaacs, 1948) "the expression of instinctual need via the id also has a mental expression which is represented as the unconscious phantasy". Therefore every impulse, instinctual urge or response is experienced as phantasy. Phantasy besides being an unconscious expression of impulses may be a defence against anxiety, providing the means of controlling instinctual urges and the expression of wishes. The content and function of the phantasy usually dominates the mind at specific developmental stages or in relation to some external stimulation (Isaacs, 1948). Phantasies are not only an expression of an impulse they provide the means to do "worry-work" particularly at life's transitions which necessitate the renegotiation of relationships and identities which may heighten conflict and ambivalence. On the other hand Freud (cited in Isaacs, 1948) used the term fantasy to refer to daydreams, conscious and unconscious, and noted their similarity to night dreams. "Fantasies, like dreams cast configurations of experience into concrete perceptual images ... fantasies can subserve the entire gamut of psychological functions encountered in clinical psychoanalytic work - wish-fulfilling, defensive, self-punishing" (cited in Isaacs, 1948). Since this study is interested in the permeability of the boundary between conscious and unconscious (Bibring, 1959; Bibring, 1961; Raphael-Leff, 1991) the term fantasy will be used to mean both conscious and unconscious representations of psychic work as described by Freud's term of fantasy.