CHAPTER 1

INTRODUCTION

1.1 Aim of the study

The aim of this study is to give an in-depth understanding of the representations of a depressed woman who killed her baby. The representations under study are based on "The motherhood constellation" by Stern (1995) and focus on the woman's representation of her mother as mother-of-herself-as-child, herself-as-mother and her representations of her children. A single case study was done with an extreme case to illustrate the link between depression and these representations. The researcher argues that not enough is done to enhance the relationship between a mother and her foetus, and later her baby.

1.2 Contextualising the research

Pregnancy is an important phase not only in a woman's life, but in the lives of both parents, in their relationship and the relationship with their baby. It is a time to re-think and re-work many issues and to gain new understanding. Perhaps the importance of pregnancy in this sense is often overlooked: "The busyness of modern life provides us with many experiences, but little time to assimilate their meanings – and this is as true for parents (who tend to be the busiest of people) as for anyone else" (Clulow, 1996, p.7).

It seems as if clinicians overlook the importance of pregnancy as well. Parent-infant psychotherapies are a rapidly growing field of infant mental health (Stern, 1995). Early intervention aims to "nip developmental psychopathology in the bud" (Watanabe, 1995, p. 1). What is referred to as early intervention, is mother-infant

psychotherapy. The concept of "ghosts in the nursery" as "...the visitors of the unremembered past of the parents" (Fraiberg, Adelson & Shapiro, 1980, p. 164) is by now well-known. This researcher argues that those ghosts do no wait for the baby to be born: they make their appearance during pregnancy. In her closing remarks at the first Conference of Infant Health in 1995 in Cape Town, Astrid Berg said that we all know about the importance of early life, but that it seems as if we need to start from the very beginning, stressing that enormous potential exists at the beginning of something new. This researcher agrees wholeheartedly.

It is a common experience amongst adults in psychotherapy that the roots of their problems lie in their infancy (Acquarone, 1995). Balbernie (2001) states that if we want to help the next generation, we should be working with their parents now, while they are babies. This researcher is of opinion that the work should start during pregnancy. It is now accepted that a baby's emotional environment, which is his/her mother, will influence the neurobiology that is the basis of the mind. (Balnerbie, 2001; Glover, 2002; Raphael-Leff, 2001a). Neglect, trauma and abuse and prolonged maternal depression cause subsequent neurobiological damage which can cause a child to develop a range of problems such as a learning disability, language delay, lack of empathy, hyperactivity, disruptive behaviour and emotional difficulties (Balbernie, 2001) and as this case study illustrates, even cause death.

Parents tend to project unconscious material of their own past onto their infant, especially during the first months of life. The contents of these parental projections are dependent on the parent's own history. The infant represents an aspect of the parental unconscious. Pathogenic representations exist and consist of unresolved conflicts from

the childhood of the parent. They are activated and enacted in the current interaction with the infant, and are the ghosts in the nursery (Fraiberg et al., 1980; Möhler, Resch, Cierpka & Cierpka, 2001; Raphel-Leff, 2001a; Stern, 1995).

Approximately 30% of all women suffer from a mood disorder, anxiety and stress, and a further 10-15% from major depression in the first six months after the birth of a child (Boyce, 2002). Murray (1995) found in her study that 86% of depressed mothers had stressful events during their pregnancy, compared to 40% of the control group. Longitudinal research shows a link between postpartum depression and the unfavourable emotional and cognitive development of children (Aquarone, 1995; Cooper & Murray, 1995a; Edhborg, Lundh, Seimyr & Wildström, 2001; Emanuel, 1999; Hardie, 1999; Murray, 1995), and an adverse effect on the mother in terms of low self-esteem, mood state and marital breakdown (Milgrom, Martin & Negri, 1999). It is evident that the mother-child relationship suffers profoundly. Maternal depression is also linked with young children's failure to thrive. Research has shown that depressed mood during pregnancy is associated with poor attendance at antenatal clinics, low birth weight and preterm deliveries in poor and wealthy countries (Patel, Rahman, Jacob & Hughes, 2004).

The situation in South Africa is probably worse. Cooper, Tomlinson, Swartz, Woolgar, Murray and Molteno (1999) found in their research that the prevalence of postpartum depression in Khayelitsha is approximately three times that of the expected international levels. They emphasise the need for early intervention.

An existing depression can also worsen with pregnancy and the demands of a baby, as this case study illustrates. In spite of the fact that during pregnancy and the first months after their babies' birth women have more contact with health experts than at any other time in their lives, pre- and postnatal depression are often overlooked.

Mental health problems are the second most significant cause of disability in non-industrialised countries and among the largest causes of lost years of quality life, contributing to approximately 8,1% of such lost years (Seedat, Kruger & Bode, 2003). According to Swartz (2001), major depression ranked fourth in the world as a cause of disease burden in 1990 and is projected to be in the second position for the year 2020. Between 12 to 40% of primary health care presentations are associated with mental health problems. Despite this, psychological services are not integrated into primary health care (Seedat et al., 2003). Although in policy mental health services form a part of South Africa's Primary Health Care, in practice this is not the case. Swartz (2002) states that there is a close relationship between poverty and psychological difficulties, as poverty may have an impact on mental health and mental health problems often lead to problems with earning money.

Although this researcher is very aware of the limitations of a single case study, especially in generalising conclusions, an extreme case does indicate the tip of the iceberg, which should not be ignored. The extreme or instrumental case can give an understanding of what went wrong. If we know that, we can think of ways to prevent it. As was discussed in the preface, people are not educated and informed about the effect of ante- and postnatal depression on the mother-infant relationship. The researcher hopes that this case will illustrate the link between depression and

pathogenic maternal representations and the necessity of early intervention to prevent heartbreaking stories of mothers and children, such as this case is an illustration of.

1.3 An overview of the research method

For the purpose of this study, the representations (of her mother as mother-of-herself-as-child, herself-as-mother and her representations of her children) of a depressed mother who killed her baby, will be researched. Data collection will be done using interviews, documents and participant observations.

Semi-structured interviews will be held, using as a guideline a schedule which will contain questions and themes relevant to the research (Britten, 2000; Merriam, 1998). Documents from the psychiatric hospitals where the woman had been admitted will be obtained and used as data triangulation (Henning, Van Rensburg & Smit, 2004; Merriam, 1998 & Punch, 1998). Data will also be obtained from field notes, before and after the interviews and also while transcribing the audio-tapes, using guidelines by Schurink (1998a).

The specific strategy that will be followed for data analysis is the strategy described by Neuman (2000). Data will be analysed by organising it into categories on the basis of themes or concepts. The relationships between concepts will be examined and linked to each other and interwoven into theoretical statements.

Ethical issues and accountability will receive attention. Multiple triangulation, a thick description, member check and reflexivity will be used to indicate accountability.

1.4 Orientation

This study will be presented in six chapters. The first chapter has covered the aim of the study, contextualisation of the research, an overview of the research methodology and the orientation. Chapter two will contain the theoretical background of the study. A brief overview of object relations theory and the concepts as they pertain to this study will be discussed. Thereafter the focus will be on representations, maternal representations and Stern's motherhood constellation. Finally, the link between maternal representations and depression, as well as the effect of postnatal depression on the infant's representations, will be touched upon. Chapter three will furnish a literature review on pregnancy, early parenthood, ante- and postnatal depression, mainly from a psychoanalytic and psychodynamic framework. Chapter four will contain information regarding the method of investigation. The research design, data collection, data analysis, ethical issues and accountability will be discussed. Chapter five will focus on the results. A brief clinical background will be given. It will be followed by a reflexive analysis to make the research process explicit. Thereafter the analyses of the interviews, participant-observation and documents will follow. The chapter will be concluded by an integration of the discussion. The final chapter will contain the conclusions of the study, a critical evaluation thereof and recommendations for further work in this area.

CHAPTER 2

THEORETICAL BACKGROUND

2.1 Orientation

In this chapter the theoretical background of this study is discussed. The chapter begins with a short introduction, followed by a brief overview of object relations theory and concepts as it pertains to this study. Thereafter the focus is on representations, maternal representations and Stern's motherhood constellation. In closing, the link between maternal representations and depression, as well as the effect of postnatal depression on the infant's representations, are discussed.

2.2 Introduction

The belief that a mother's representations can influence how she acts with her baby is as old as folk psychology and still holds truth (Biringen, Matheny, Bretherton, Renouf & Sherman, 2000; Fonagy, 1999, 2001; Fonagy, Steele, Steele, Moran & Higgitt, 1993; Rosenblum, McDonough, Muzik, Miller & Sameroff, 2002; Stern, 1995). Parents' representations have played a key role in the history of parent-infant psychotherapies in the psychodynamic tradition. The mental world of both parents play an important role in determining the nature of their relationship with their baby (Fonagy, 1999, 2001; Fonagy et al., 1993; Lyons-Ruth & Zeanah, 1993; Raphael-Leff, 2001a; Stern, 1995). This will be illuminated in the discussion on representations. Babies evoke unconscious phantasies in their mothers, which shape the mother-child interaction (Haft & Slade, 1989; Raphael-Leff, 2001a).

Object relations therapists were historically the first to describe some of the ways a mother's inner life might influence her relationship with her infant and the infant's development (Haft & Slade, 1989; Murray, 1991; O'Shaughnessy, 1988a; Scharff &

Birtles, 1997). Seligman (1991) argues that psychoanalytic object relations theory is fundamentally a psychology of internal representations with core concepts such as introjection, projection, identification and transference describing the ways in which such representations can influence the personal experiences of self and others.

Object relations theory highlights two critical components in the relationship between a mother's internal experience and the child's developing sense of him-/herself and others, namely the role of the mother's feelings, phantasies and expectations of the relationship, and her ability to provide a stable organisation which the child can ultimately incorporate as a part of his own psychic structure (Diamond & Blatt, 1994; Haft & Slade, 1989; O'Shaughnessy, 1988a; Waddell, 1998; Winnicott, 1965a, 1965b). Empirical confirmation of these notions has been provided by researchers working in the area of infant-mother attachment (Fonagy, 1999, 2001; Fonagy et al., 1993; Haft & Slade, 1989; Zeanah & Barton, 1991). Blatt and Ford (1994) emphasise the fact that the recent emphasis in psychoanalytic theory on the development of the representational world is consistent and convergent with recent trends in cognitive theory, developmental psychology and attachment theory and research.

This study is based on maternal representations as described by Stern in *The Motherhood Constellation* (Stern, 1995), and also the link between maternal representations and depression. Therefore, this chapter will focus on representations, especially maternal representations as described by Stern. Stern's research and theoretical contributions are described by Haft and Slade (1989) as a bridge between the positions of classical psychoanalysis, object relations and attachment theory. Fonagy (2001) is of the opinion that Stern occupies a unique place in psychoanalysis

and sees his work as a bridge between developmentalists and psychoanalysts. His unique contribution lies in the way he elaborated the representational world concept (Fonagy, 2001). Object relations theory provides a framework for understanding representations and stresses the modifications of the inner representational world (Meissner, 1991). This researcher values the emphasis of object relations theory on the complexity and unconscious processes of mental representations, but identifies more with Stern's (1995) integrative approach. Object relations theory represents a diversity of perspectives (Fonagy, 2001; Gomez, 1998; Ivey, 1990; St. Clair, 2000), thus only the concepts relevant to this study are discussed briefly. The area of representations that has been the most widely researched, namely attachment, is briefly touched on. Finally the chapter is concluded by focusing on representations and postnatal depression.

2.3 Overview of object relations theory

Object relations theory has evolved over the past sixty years. It includes the work of several theorists such as Klein, Fairbairn, Winnicott, Bion, Kernberg, Mahler, Kohut, Bowlby, Balint, Sutherland and Guntrip, representing a diversity of perspectives (Blatt & Ford, 1994; Gomez, 1998; Ivey, 1990; St. Clair, 2000). As Melanie Klein is seen as the founder of object relations theory (Likierman, 2001), her concepts are used as a basic point of departure. Klein's theory is seen as transitional from Freudian thinking to a full object relations theory, which was applied by other Kleinian-inspired thinkers such as Winnicott, Fairbairn and Balint (in Likierman, 2001; St. Clair, 2000). Object relations theory arose primarily from the psychoanalytic study and treatment of young children and psychotics (Bick, 1988; Celani, 1993; Ivey, 1990; Klein, 1997a, 1997d; O'Shaughnessy, 1988a; Scharff & Birtles, 1994; Winnicott, 1958a, 1965a, 1965c).

For Freud the term “object” was external and meant anything the infant directs or drives towards for instinctual gratification (Freud, 1971a). Object relation theorists argue that humans have an innate drive to form and maintain relationships (Gomez, 1998; Ivey, 1990; Klee, 2002; Scharff & Birtles, 1997). The term 'object relations' refers to an internal and external world of relationships, suggesting that an individual’s current interactions with people are shaped by the inner residues of past relationships (St. Clair, 2000). The objects and the relationship with the objects are internalised to form a self-structure. Ivey (1990) gives a useful definition of object relations theory:

> a psychoanalytic developmental account of how primary interpersonal relationships in the infant’s external world become internalized, represented and metabolized at the level of fantasy into a nucleus of personal identity which, whether healthy or deficient, determines subsequent personality development and deformation (Ivey, 1990, p.3).

Freud’s paper on “Little Hans” was one of the first and the most famous accounts of a child’s mental life (Daniel, 1992; Likierman, 2001). Although Freud did not work directly with Hans, his paper provided a working model for Klein’s work with children. Likierman (2001) points to the fact that Klein was revolutionary with her first paper on “The development of a child”, because she disregarded the importance of immediate symptoms, aiming at preventing future pathology. She had a need for a preventive use, and not a purely curative use, of psychoanalysis. Her view was also radical, because it suggested that psychoanalysis could be used routinely with children and that society should begin to think in terms of preventing neurosis from the early years via a different kind of upbringing (Daniel, 1992; Likierman, 2001). Winnicott and Bowlby developed that focus and inspired by them, child therapists began working

in baby clinics and paediatric units in hospitals, to help mothers of distressed infants (Alvarez, 1992).

- **Internal objects**

One of Klein's most important contributions is the concept of internal objects (Hinshelwood, 1989; Roth, 1999). The concept refers to an unconscious experience or phantasy of concrete objects located within the ego. It has its own motives and intentions towards the ego and other objects (Hinshelwood, 1989). According to Likierman (2001), Klein believed the first constructs in the psyche are not representations, ideas, words or symbols, but a less sophisticated form of thinking, namely what she called 'internal objects'. Fairbairn on the other hand, believed that it is not merely objects that the child internalises, but object relationships (St. Clair, 2000). Hinshelwood (1989) notes that internal objects are not 'representations', as they might be in memories or in conscious fantasies (daydreams), but are felt to make up the substance of the body and of the mind. Other object relation theorists do not make this distinction. Framo (1992), in discussing Fairbairn's theory, states that internal objects are retained as introjects, namely as psychological representations of external objects.

Although the experience of an internal object is dependent on the experience of the external object, it also contributes to the way the external object is perceived and experienced. Hinshelwood (1989) notes that our relations with objects comprise what we are. These objects can be people or things with which we form attachments (Klee, 2002). The importance of a good and secure internal object that can be identified with,

is seen as the core of a stable personality, resulting in confidence in oneself (Bion, 1988; Klein, 1997a; St. Clair, 2000; Winnicott, 1965a).

Hinshelwood (1989) postulates that the concrete world of the internal object persists as a bedrock layer of the personality. In later development it is overlaid by the world of object- and self-representations, but it is never actually replaced (Hinshelwood, 1989). It takes on more progressive modes of experiencing, resulting in what is called "representations" in the mind of internal and external objects. For Freud (1971a) the only internal object is the superego, while all other objects are 'represented' in perception or memory. He argues that "...even in the unconscious, moreover, an instinct cannot be represented otherwise than by an idea " (1971b, p. 177). Hinshelwood (1989) notes that representations for Freud had the function of personal symbols, but they were not confused with the actual external object. Hinshelwood (1989) distinguishes between an internal object and a representation by noting that the former is a concrete object experienced in phantasy, as active inside the personality. A representation on the other hand, symbolises an internal object to the ego, but is not confused with it. In the section on representations, the difference between internal objects and representations will be further discussed.

Klein was criticised because she did not always distinguish between theoretical definitions and subjective descriptions (Jacobson, 1965; Likierman, 2001) and overemphasised the importance of the internal world of the infant without attending sufficiently to the influence of the parental objects in the environment (St. Clair, 2000). Klein's concept of internal object was never clearly defined by her. She used the term 'object' without specifying whether she is referring to the actual object or an inner

representation of an object (St Clair, 2000). She emphasised the subjective phantasy, specifically the subject's experiencing of the introjected objects, as an actual being within the self (Likierman, 2001).

> The internal object is thus, confusingly, both a subjective experience of an internal presence, initially based on an introjected breast, and at the same time, the theoretical designation of a process which takes on a relational pattern, treating or maltreating the individual in various ways, and by the same token, being moulded by the individual's internal treatment of it (Likierman, 2001, p.110).

Ivey (1990) shed more light on how the term 'object' has been used by later object relations theorists. He describes an object as "(a) a person or psychological representation of that person, (b) coloured by unconscious fantasy and (c) invested with emotional energy by the subject, who (d) unconsciously experiences this object as an influential presence in his/her psychic life" (Ivey, 1990, p.6).

- **Part objects and whole objects**

Klein (1997a) postulates that the infant's relation with his mother is at first (roughly during the first three or four months) a relation to a part-object, i.e. the mother's breast in particular. In so far the breast is gratifying, it is loved and felt to be good and where it is a source of frustration, it is hated and felt to be bad. She argues further that this antithesis between the good and the bad breast is largely due to a lack of integration of the ego, as well as to splitting processes within the ego and in relation to the object. The infant projects his love impulses on the gratifying, good breast and his destructive impulses on the frustrating bad breast. Simultaneously, through introjection, a good

breast and a bad breast and what they stand for, are established inside. As the infant grows and develops, he gradually realises that the good feeding breast and the frustrating bad breast are one single object. Thus love and hate are experienced towards the same object and his mother becomes a whole object which both satisfies and frustrates. Most of the object relations theorists agree with her conceptualization of part and whole objects. This splitting in part objects and integration that leads to realisation of whole objects, corresponds with the developmental stages described by Klein (1997a) as the paranoid-schizoid and depressive positions.

- **Paranoid-schizoid and depressive positions**

According to Klein (1997a) the infant's first three or four months are pre-dominated by the paranoid-schizoid position. The infant experiences anxiety from internal and external sources. In order to manage this anxiety and to make sense of the chaos (s)he experiences, splitting is used to separate good and bad and as mentioned above, the infant's relation is consequently with part-objects. The splitting serves to preserve the goodness of the needed object (Roth, 1999; St. Clair, 2000).

The depressive position develops between three and six months and is seen by Klein (1997a) as central in early development. It involves psychic integration as the various aspects, love and hate, good and bad, come closer together and objects are now whole persons. The infant slowly realises that the loved object is outside the self and now has more complex, and ambivalent feelings (Gomez, 1998; Roth, 1999; St. Clair, 2000). (S)he experiences love and hate towards the same object, instead of separate part-objects. Guilt, fear and anxiety come into play – the child wants to attack the good object, becomes afraid of the damage he believes (s)he has done and fears losing the

object. Thus the need for reparations develops (Britton, 1992; Klein, 1997b). Although Klein described these two processes developmentally, her use of the term 'position' refers to two different states of mind with its own constellation of anxieties, other feelings, defences and ways of relating to objects (Roth, 1999).

Winnicott (1958a) also notes that around five to six months a change occurs in infants. However, he stresses that the tendency to integrate is not only because of instinctual experiences which gather the personality together from within, but emphasises that maternal care is an important factor in helping the infant to integrate. He notes that Klein makes it clear that the environment is important, but she does not state specifically that the infant exists only because of the maternal care, as he so strongly believes (Winnicott, 1965a). He calls this stage of integration the Stage of Concern (Winnicott, 1958b).

- **The Oedipus complex**

The existence of the Oedipus complex was postulated by Freud, who argued that during the phallic phase of development (3-5 years) children have sexual impulses towards the opposite-sex parent and want to eliminate the same-sex parent. Although Klein's work confirms Freud's findings, she diverged in many respects, claiming that the breast is the starting point of the Oedipus complex in both sexes. She later linked the Oedipus complex to the depressive position, on which mental health depends.

It is precisely this linking to the depressive position that Britton (1992) highlights as one of Klein's significant contributions to our understanding of the Oedipus situation. "As I see it these two situations are inextricably intertwined in such a way that one

cannot be resolved without the other: we resolve the Oedipus complex by working through the depressive position and the depressive position by working through the Oedipus complex" (Britton, 1992, p.35). For Britton, the core issue is that the parents' sexual relationship is at war with the child's exclusive relationship with his mother.

Britton (1992) adds to our understanding in stating that the depressive position and the Oedipus situation need to be re-worked at each stage of development, in each new life situation and with each major addition to our experience or our knowledge. New knowledge and new experiences are at first disrupting. It leaves us with a sense of insecurity, helplessness and even hostility and its integration demands modification of our world view (Britton, 1992). Thus, we are once again in the same state as the infant in the depressive position. O'Shaughnessy (1988b) builds on Klein's views by linking feelings of exclusion, problems of separateness and being single in the presence of an oedipal pair to the Oedipal situation.

Hinshelwood (1989) notes that Klein's contribution to the understanding of the Oedipus complex had far-reaching theoretical implications. Among other things, the internal objects, arising from the oedipal parents, become important psychological figures. He explains that the Oedipus complex in this version gives little account of the actual parents and their actual intercourse, because it is founded on the way in which the infant makes use of the actual objects in his own phantasy world and manipulates them for his own relief.

> This capacity to stand aside and observe a relationship between two objects requires the ability to sustain feeling left out and therefore the full impact of the classical oedipal pain. It is this moment, in which the capacity for love

> and hate is joined by the capacity to observe and know, which is one of the great characteristics of the depressive position (Hinshelwood, 1989, p.64).

Although heterosexual erotic orientation is a primary outcome of the Oedipus complex for both sexes, Chodorow (2000) postulates that the Oedipus complex is more complicated for a girl, because her first love object is a woman. She argues that this creates asymmetry in the feminine and masculine Oedipus complex, and difficulties in the development of female sexuality. According to Chodorow (2000), a girl retains her pre-Oedipal ties to her mother and these attachments to mother and father are characterised by eroticised demands for exclusivity, feelings of competition and jealousy. Feeling excluded in a triangular relationship is often the result.

- **Internal world**

The question of when and how an external object becomes an internal object, is a central concern of object relations theory (Ivey, 1990). Klein (1997b, 1997c) argues that an inner world is built up, which is partly a reflection of the external one. The interaction between internal and external factors happens through the double process of introjection and projection (St. Clair, 2000). Klein believed that children have an interest in their own insides from very early on, because our first experiences of the world are through organ modalities and the bodily functions of eating and excreting (Hinshelwood, 1989; Ivey, 1990; Klein, 1997a, 1997c). Ivey (1990) notes that the bodily functions become the metaphorical modes of interaction with people and things. Gomez (1998) mentions that there is some support for Klein's ideas from developmental psychology, which has established that new-born babies 'recognise' the human face, 'know' how to feed from the breast and are pre-equipped with

considerable knowledge and capacity. In this regard she refers to Stern. However, Stern post-dates Kleinian psychological processes to the period when the child is beginning to use language (Gomez, 1998).

The concept of an internal world refers to the experience of simultaneously being in both a public and a private world (Ivey, 1990). The private or internal world consists of a person's thoughts, perception, phantasies, psychic structures, emotions and forces which make up one's personality. Roth (1999) describes the inner world as consisting of internal objects, relating to each other and various aspects of the self. In a similar vein, Ogden (1992) argues that an internal object relationship consists of a relationship between two unconscious aspects of the patient. One aspect is identified with the self and the other with the object in the original relationship. Both stress the role which unconscious phantasies play in this process.

Winnicott (1958a) acknowledged Klein's contribution of the importance of the inner world. He states that the management of the external world depends on a person's management of his inner world – a life-long task (1958b). He adds:

> …it is this, the patient's fantasy about his inner organization, that is vitally important, so that the analysis of depression and the defences against depression cannot be done on the basis only of consideration of the patient's relations to real people and his fantasies about them (Winnicott, 1958a, p. 146).

In the section on depression, this will be further elaborated.

- **Internalisation process**

Klein believed that infantile mental life is comprised of a continual relationship between the self and the world in which objects of experience are accepted via introjection and rejected through projection (Klein, 1997a, 1997b). She argued that the child projects impulses onto the parent and that he/she introjects parental figures (Hinshelwood, 1989; Klein, 1997a, 1997c). The internalised objects usually belong to the ego and become identified with it. However, some objects may reside in the ego as alien (Hinshelwood, 1989).

Gomez (1998, p.36) states that "each person's external world is in part a reflection of his/her inner world, while at the same time it reaches into his inner experience and changes it". Sandler (Fonagy 2001) describes how complex self-object representations are shaped by everyday affectively laden experiences, fantasies and memories of the individual alone and in interaction with others. He defines identification as the modification of the self-representation to resemble the shape of the object representation. Projection on the other hand, adds unwanted parts of the self-representation to the representation of the other. These representations play a central role in the causation of behaviour and may be more distorted by internal states than by external events (Fonagy, 2001).

- **The mother's capacity for reflection**

Psychodynamic, ego-psychology, self-psychology and attachment theory agree that a mother's capacity to be in tune with her infant is extremely important for the child's psychic survival (Tracey, 2000). This capacity to be in tune with her baby, is in line with what Winnicott calls "primary maternal preoccupation" and the "holding"

function of the mother and what Bion refers to as maternal reverie, the "thinking" breast and the mother's containing function. Winnicott (1965a, 1965b) postulates that in late pregnancy the mother develops "primary maternal preoccupation", which enables her to identify with the experiences of her infant and leads to subtle adjustments in her handling of her baby, anticipating his/her needs and gestures (Murray, 1991; Rees, 1995; Winnicott, 1965a, 1965b). Miller (1999) notes that this refers to the fact that the mother needs to hold the infant in her mind just as much as she needs to hold him/her in her arms.

For Bion (Bion, 1988; O'Shaughnessy, 1988a; Waddell, 1998; Watts, 1999) the mother not only brings her nurturing and loving qualities to the baby, but also her thinking self, her emotional and mental states that contain the chaos of her baby's psychic life, establishing a precondition for more integrated capacities towards a more integrated self. Both Winnicott (1965a) and Bion (1988) are of the opinion that the mother's holding and containing function is conducive to the infant's development of his capacity for object relations, thinking and his continuity of being. Ogden (1992) adds that the infant's relationship with his mother is the matrix within which psychological tension is sufficiently sustained over time, so that meanings can be created. Bion states that the origin of thinking lies in projective identification which is, in addition to being a defence mechanism, the first mode of communication between mother and infant (Bion, 1988; O'Shaughnessy, 1988a). "Thinking is an emotional experience of trying to know oneself or someone else", says O'Shaughnessy (1988a, p. 178), but the infant's capacity for this to develop, depends on the mother's capacity for reverie (Bion, 1988).

The human psyche comes into being within the matrix of the mother-infant relationship. For Winnicott (1965a), the infant's environment, in the person of the mother, facilitates his/her maturational process and emotional development. Good-enough mothering is for him the crucial factor in the infant's environment. Without good-enough mothering the infant is not able to start with ego-development, or such development is distorted in important aspects (Winnicott, 1965b).

Murray (1991) describes the reflective function as the mother's ability to identify with her infant and contain difficult feelings that the baby's behaviour provokes in her, including her ability to respond in an appropriate manner that meets or complements the baby's requirements. In turn the infant will develop the capacity to tolerate and manage his/her own distress. Fonagy, Steele, Steele, Moran and Higgitt (1991) define the reflective self as the internal observer of mental life. Their research has shown that parents who rate high in their capacity for reflective functioning have more secure children.

One can understand why the mother's capacity to reflect is so important when one takes into consideration Klein's views about the infant. Klein (1997a, 1997c) hypothesised that the infant has an innate unconscious awareness of the existence of his mother. The infant not only expects food from his mother, but also love and understanding, which in the earliest stages are expressed through the mother's handling of her baby. Klein (1997a, 1997b) believed that this leads to a certain unconscious oneness that is based on the unconscious of the mother and of the child being in close relation with each other. The mother represents to the child the whole of

the external world, therefore both good and bad come in his/her mind from her (Klein, 1997a, 1997b).

The mother's capacity to reflect depends on her past relationship with key people in her life. As Fonagy (1999) puts it, at the core of ourselves, is the representation of how we were seen. Thus, our reflective capacity is a transgenerational acquisition (Fonagy, 1999). An emotionally absent mother cannot respond to her infant's signals. It leaves the infant feeling meaningless and dead (Tracey, 2000), with "unthinkable anxiety" or "going to pieces" (Murray, 1991; Winnicott, 1965b). Tracey (2000) believes this is what happened with the depressed mother as an infant and she repeats the cycle with her infant, creating an intergenerational problem. This will be further discussed in the section on depression. If a mother is not in tune with her infant, he develops a False Self (Winnicott, 1965c). As this concept of Winnicott has relevance to the effect of depression on the infant, it will be further discussed in the next paragraph.

- **True Self and False Self**

A mother providing good-enough mothering, repeatedly attends to the infant's needs. The infant begins to believe in external reality and this leads to his development of symbol-usage (Winnicott, 1965c). If good-enough mothering is not provided, the infant remains isolated and lives falsely. Winnicott (1965c) argues that the infant gets seduced into compliance with environmental demands. Consequently a False Self develops and the infant builds up a false set of relationships. It must be noted that Winnicott does not refer to social or polite compromising, which he sees as healthy, but rather a lack of spontaneity and creativity. According to Winnicott (1965c) the

True Self starts by existing, while the False Self starts by reacting. The False Self hides the infant's inner reality, the True Self.

2.4 Discussion

Klein was and still is criticised for attributing too much sophistication to infantile mental processes and for her view of human nature being too negative and pessimistic (Fonagy, 2001; Gomez, 1998; Likierman, 2001; Segal, 1993). In this regard, Gomez (1998) is of the opinion that Winnicott's work balances that of Klein's, providing a "split-off optimistic aspect" (p. 105) of Klein. Psychoanalytic critiques about Klein relate to her internal logic, her lack of awareness of the role of language in mental life and a lack of a comprehensive account of cognitive development (Likierman, 2001; Stein, 1990). However, Segal (1993) notes that most analysts today take for granted the early object relationships described by Klein and use her discoveries and concepts without being aware of their origin.

Ivey (1990) believes that object relations theory is an influential and powerful hermeneutic framework for understanding and treating severe psychopathology. Gomez (1998) notes that although there will be differences, few techniques or therapeutic approaches will clash irrevocably with object relations theory. Scharff and Scharff (1991) hold that because it is an intrapsychic psychoanalytic theory that derives from an interpersonal view of development, it has been succesfully extended to couples, groups and families. Object relations theory offers many insights into the human personality, development, human interactions with others and the psychotherapeutic process. As was mentioned before, it provides a framework for understanding representations, which will now be the focus of discussion.

2.5 Representations

Jacobson (1965), also from the school of object relations, is a key figure in introducing the concept of representations. She states that "...the terms introjection and projection refer to psychic processes, as a result of which self images assume characteristics of object images and vice versa" (p. 46). These "images" of self and other are for her key determinants of mental functioning. She postulates that the infant acquires self and object representations with good (loving) or bad (aggressive) valences, depending on experiences of gratification or frustration with the caregiver. With the maturation of perceptive and self-perceptive functions, more realistic object- and self-representations are established. She introduced the term "representation" to stress that this concept refers to the experiential impact of internal and external worlds and that representations are subject to distortion and modification irrespective of physical reality (Fonagy, 2001). Representations can be unconscious, preconscious or conscious (Jacobson, 1965; St. Clair, 2000).

Psychoanalytic, attachment and cognitive theories offer definitions of mental representations (Sperling & Lyons, 1994). They describe the concept in different language, but with remarkable overlap. More recently there has also been interest in the concept of mental representations within systems theory and social-constructionist theories. Diamond and Blatt (1994) argue that in this regard, attachment theory and object relations converge. Traditionally, psychoanalytic theory believes that the infant internalises a static image or representation of the other (e.g. Klein and Fairbairn's internal objects), whereas attachment theory believes that the actual attachment-related transactions are internalised. Attachment theorists criticised the psychoanalytic

models of the representational world as placing too much emphasis on fantasy, drive and defences (Diamond & Blatt, 1994). However, Diamond and Blatt (1994) state that

> …working models of attachment and object representations are overlapping, if not identical, modes of conceptualizing the internalized cognitive-affective schemata that form the bedrock of the intra-psychic world, and that in turn shape interpersonal relationships (p. 77).

Attachment as an aspect of representations is only briefly touched on, as this researcher is of the opinion that attachment theory does not allow for the complexity and unconscious aspects of representations to the same extent as object relations theory does. Fonagy (2001) notes that there is a subtle, but important difference between attachment theory and object relations, namely that for the latter the goal of the child is the object and for attachment theory, it is a state of being or feeling. Although Zeanah and Barton (1991) and Seligman (1991) differ on some aspects, they agree that attachment is a profound and essential aspect of relationships, but only one aspect of an exceedingly rich and complex relationship between infants and parents. This researcher agrees with this notion. In this regard Sperling and Lyons (1994) note that "development of representations need not be attachment relationships – but most are" (p. 334).

Internal representations of attachment are the type of representations that have been the subject of attempts at measurement and are perhaps the most widely researched. The empirical work of Mary Main and her colleagues with the Adult Attachment Interview defined work in this area (Biringen et al., 2000; Fonagy, 2001; Fonagy, Steele & Steele, 1991; Zeanah & Barton, 1989). Fonagy (2001) mentions that 14 studies with

the Adult Attachment Interview have shown that each parent's style of attachment, based on their narrative about their own childhood, collected and coded before the birth of their child, will predict the attachment classification of their infant at 12 and 18 months. He and his co-workers also found that mothers in a relatively high-stress (deprived) group characterised by single-parent families, parental criminality, unemployment, overcrowding, and psychiatric illness would be far more likely to have securely attached infants if their reflective function was high (Fonagy et al., 1993).

Fonagy (2001) postulates that the early relationship environment is crucial not only because it shapes the quality of subsequent relationships, but it also serves to equip the individual with a mental processing system that will subsequently generate mental representations, including relationship representations. The creation of this representational system is arguably the most important evolutionary function of attachment to a caregiver.

Recently there has been the recognition that it is the subjectively experienced relationship that is internally constructed (Diamond & Blatt, 1994). They propose that the cognitive, affective and experiential components of representations of the self and the other, are gradually built up in the course of development as early affect-laden interactions, and are transformed into psychic structures.

In his definition of representations, Stern (1991) includes all the terms that have been mainly inspired by psychoanalysis (such as 'maternal phantasies', 'projections', 'projective identifications' and 'phantasmatic baby'), as well as terms that arose from attribution theory and Bowlby's internal working model. He points out that the term

'representation' is acceptable and usable by most approaches. According to Stern (1995) two worlds exist parallel with each other: the real, objectifiable external world and the imaginary, subjective, mental world of representation.

> There is the real baby in the mother's arms, and there is the 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. This representational world includes not only the parents' experiences of current interactions with the baby but also their fantasies, hopes, fears, dreams, memories of their own childhood, models of parents, and prophecies for the infant's future (Stern, 1995, p.18).

Representation is a necessary and normal part of modelling the world of one's experience with others. What these representations are made of and how they are organised remain largely a mystery, but they are mostly based on the subjective interactive experience of being with another person (Stern, 1995). He postulates that object-related representations are formed from the inside on the basis of what happens to the self, while with others. In this regard Stern (1995) states his position clearly. He stresses that representations are not formed when the outside is taken in, as is suggested by terms like 'introjection', 'internalisation' and 'projective identification'. He also stresses the moment-by-moment interaction as a remembering context in the present that activates different representations as opposed to one or two core conflictual themes, although he does not negate the existence of the latter. He differs from Klein in the emphasis she places on innate phantasies, stating that the infant's

phantasy life is secondary to the innately guided interactive experience. Thus the representations are of interactive experiences with someone. Other authors are in agreement (Blatt & Ford, 1994; Diamond & Blatt, 1994; Zeanah & Barton, 1989, 1991). According to Zeanah and Barton (1991), representations are memory "structures" that re-present a version of lived experience to an individual. "They are the internal aspect of relationship patterns that guide external interactional behaviours" (Zeanah & Barton, 1989, p.137).

There is a growing consensus that internal representations exist as hierarchically arranged networks (Diamond & Blatt, 1994; Zeanah & Barton, 1989). Global, or higher-order representations overlie more specific networks. Diamond and Blatt (1994) stress the fact that such networks are multilayered, with consious aspects that are relatively accurate and unconsious aspects that reflect needs, fantasies and primitive idiosyncratic constructions of self and others. Zeanah and Barton (1989) are of the opinion that Stern provided the most detailed conceptualisation of this hierarchy, in line with recent research on cognition. Stern (1995) proposes that a moment of lived experience of an interaction is immediately transformed into a memory of that experience, called episodic memories. In the same way lived sequences of moments are remembered as episodic memories of sequences. A number of similar episodic memories construct a prototypic memory or representation, forming the lowest level in the representational hierarchy. The next level is called a RIG, i.e. representations of interactions that have been generalised, consisting of a group of similar interactive moments or sequences, for example play, putting to bed, feeding, et cetera (Stern, 1995; Zeanah & Barton, 1989). A represented scenario is the next level in the hierarchy, entailing longer interactive sequences, comparable to what has been

described as a script by cognitive psychologists. The next level comprises of selected RIGs and interactional scripts to form what Bowlby has termed internal working models (Zeanah & Barton, 1989). Behaviour in relationships is guided by these internal working models.

Internal models create a filter through which the parent-child relationship is understood, organised and responded to (Crowell & Feldman, 1989). As each parent interacts with its child in ways which least challenge his or her representational homeostasis, the child's behaviour is subtly shaped to meet the parent's expectations (Lyons-Ruth & Zeanah Jr., 1993). It can be assumed that sensitive, responsive parenting during infancy generates a working model of relationships in which positive expectations regarding intimacy and care from others are encoded. This cognitive affective structure goes on to selectively affect perception, cognition and motivation (Fonagy, 2001).

Raphael-Leff (2001a) adds another dimension in stating that parents' conscious beliefs and expectations about babies and about themselves as parents, draw also on unconscious configurations of themselves as babies. Conflicts regarding the nurturing they imagined they have received, are reactivated. At times these inner conflicts and scripts are played out externally and the infant may be enlisted unconsciously to act in scenes allocated to him/her. The mother's representations are of utmost importance and will be focused on in the following section.

2.6 Maternal representations

The work of Winnicott (1965a) and Bion (1988) present the mother's fantasy life about her infant as one of the major building blocks of the infant's construction of a sense of identity (Stern, 1995). Fraiberg (Fraiberg et al., 1980), with her "ghosts in the nursery", revolutionised this perception by placing the maternal representation at the core of the parent-infant clinical situation (Stern, 1995).

There continues to be an explosion of psychoanalytically inspired therapies and research that focus on the maternal and, less often, the paternal representational world (Bradley, 2000; Biringen et al., 2000; Fonagy, 2001; Raphael-Leff, 2001a, 2001b; Rosenblum et al., 2002; Stern, 1995). Critics have been concerned that this is a new version of "blaming mother", since it is her representations that are seen as causing psychopathology. Stern (1995) stresses that what is at issue here, is the weight given to the parental representations as a contributing cause of psychopathology, not whether they contribute at all. One could reason that awareness of the importance of parental representations need not lead to "blaming mother", but can be seen as an important intervention avenue in preventing the development of pathology or a strained relationship between parent and child.

Although other authors also described maternal representations, Stern (1995) will now be focused on, as he has formulated a useful and comprehensive description of the range of maternal representations that play an important role. He describes these representations in terms of schemas-of-being-with.

- **Schemas about the infant**

The represented baby has a long prenatal history. The represented baby originated in the whole life history of doll play and fantasies of the mother as a girl and an adolescent (Raphael-Leff, 2001a; Stern, 1995). As the foetus grows, the represented "baby" undergoes a parallel development in the mother's mind. The networks of schemas about the foetus develop under the influence of psychic, social and biological factors. At about four months there is a leap in the richness and specificity of the maternal representations of her foetus- as-infant, that can be ascribed to the mother feeling the foetus's movements and seeing a sonar of the foetus. However, studies mentioned by Stern (1995) suggest that between the seventh and ninth months, there is an undoing of the reported representation as a way to intuitively protect the baby and the mother from a potential discordance between the real baby and a too specifically represented baby. "After all, birth is the meeting place for the baby now in her arms and the one in her mind" (Stern, 1995, p.23).

- **Schemas about herself**

With the birth of her first child, a woman's status and identity change. The networks of schemas that undergo reworking are the mother's self as a woman, mother, wife, career-person, friend, daughter, granddaughter, her role in society, her place in her family of origin, her legal status, etc. Although this happens with subsequent babies, it does so with less intensity and less mutation in the representational world.

One of the most important identities of a woman to undergo fundamental change is the shift from daughter-of-her-mother to mother-of her-child, thus part of the fixed representational world has shifted irreversibly. The new mother must give up long-

held fantasies about repairing, redoing or correcting her childhood. It often results in a profound sense of loss, which might contribute to the normal postpartum blues (Stern, 1995).

A second challenge to the new mother's representational world is presented by the realistic need and desire to put the baby's needs before her own (Stern, 1995; Winnicott, 1965a). This shift from narcissism to altruism is difficult (Stern, 1995).

- **Schemas about her partner**

The mother's network of schemas of her husband as father, lover, husband, man, etc. alters. As pregnancy progresses, the representations of her husband become more positive in general. During this phase she is more likely to imagine greater resemblance between the future baby and her husband than between herself and the future baby. After the birth, there is a reversal. Between the birth and the third month after the birth of the baby, she views her husband more negatively. The mother's representation of her husband changes, to centre on his importance as the keystone of the support system that facilitates her primary role as caretaker of the baby (Stern, 1995).

- **Schemas about her own mother**

With the arrival of the new baby, the mother consciously or unconsciously re-evaluates her own mother. This notion is supported by literature (Birksted-Breen, 2001; Lederman, 1996; Raphael-Leff, 2001a; Seglow & Canham, 1999) and group work with mothers and babies (Paul & Thomson-Salo, 1997). Well-established representations change and new or more elaborated networks of schemas of her own

mother emerge. New research in this area, as discussed by Stern (1995), supports the notion of a strong intergenerational influence. In this regard research done by Murray (1991) found that infant outcome of postnatally depressed mothers was especially poor where there had been early childhood vulnerability as regards loss and separation and a poor relationship with the woman's own mother, as it interferes with a mothers capacity to respond to her infant's needs.

The nature of the mother's current representation of her own mother-as-mother is the single best predictor of the pattern of attachment that the mother will establish with her own infant (Fonagy, 2001; Stern, 1995). The aspect of a mother's representation of her own mother that is most predictive of her future maternal behaviour, is the coherence with which she talks about these networks. "Narrative coherence has won out over historical truth as the stronger predictor" (Stern, 1995, p.29).

Stern (1995) poses the question as to why the mother's mother is the central parenting model to be followed or rejected. He points to the fact that research has shown that the experience of remembering happens in the present and not in the past. This means that the present moment, with all its feelings, sensations, perceptions, thoughts and contextual clues, acts as a trigger to activate many different networks that are retrieved. For a mother the moment-by-moment everyday interactions with the baby is the present remembering context, e.g. holding the baby in her arms, unable to console her crying baby, feeding her baby, and so forth. Other experiences belong to the baby, but the mother lives empathically via imitation and primary identification. Thus the mother's stored memories or memorial fragments include both sides of her interaction or relationship with her own mother when she was young: the parts that she

experienced directly as a baby while interacting with her mother, and the parts of her mother's experience of interacting with her that she experienced empathically. Therefore Stern (1995) argues that the interaction with the baby is a very specific remembering context which the new mother may never have had before, because her daily acts with her baby constantly evoke memories of her infancy and, at the same time, of the mothering that she had received. Thus the experiences of both sides of the interaction are evoked – the mother's and the baby's – across a generation.

- **Schemas about her own father**

Representations of the mother's father play a role, especially if he was idealised or devalued and if the infant is a son (Raphael-Leff, 2001a; Stern, 1995). However, Stern (1995) reports that many questions remain in this area. If the father was the most stable "mothering" figure, do the same issues apply as for representations of the mother's mother, is one such example.

- **Schemas about the families of origin**

Family interactions from one generation provide some of the representations that guide interactions of the new nuclear family, thus each parent brings his/her own schemas-of-being-with from their own families of origin (Stern, 1995).

- **Schemas about substitute parental figures**

This group of representations can be of great importance, especially when the substitute figure made up for negative experiences with the primary caregiver (Stern, 1995).

- **Schemas about family or cultural phenomena never actually experienced by the mother**

Although representations are usually based on real experiences, Stern (1995) stresses the fact that powerful representations can be based on cultural or historical events never experienced directly, but represented in terms of narrative or semantic knowledge. He is of the opinion that the media provide more of the representations of who the baby and the mother ideally are than is often realised.

- **The father's networks of schemas-of-being-with**

Although the father's representations are not the aim of this study, it is briefly mentioned in terms of its effect on the mother and their relationship. Stern (1995) postulates that the representational world of the father is less violently shaken by the birth of the baby and reorganisation of the networks of schemas is carried out over a longer time period. This difference often puts new parents out of synch with each other as parents. Raphael-Leff (2001a) is in agreement. Another difference that Stern (1995) points out is the supporting role the father has to play, which involves a special subset of representations with sources in the father's individual and family past.

In the preceding paragraphs maternal representations were discussed. The focus now shifts to maternal representations in pregnancy.

2.7 Maternal representations in pregnancy: Stern's motherhood constellation

Stern (1995) holds that a woman, when pregnant, passes into a new and unique psychic organisation which he calls the 'motherhood constellation'. It concerns three different but related preoccupations and discourses, which require the greatest amount of mental work and re-working. The discourses are:

- the mother's discourse with her own mother, especially with her own mother-as-mother-to-her-as-child;
- with herself, especially herself-as-mother and
- with her baby.

He argues that a woman's interests and concerns change when she falls pregnant.

> Her interests and concerns now are more with her mother and less with her father; more with her mother-as-mother and less with her mother-as-woman or -wife; more with women in general and less with men; more with growth and development and less with career; more with her husband-as-father-and-context-for-her-and-the-baby and less with her husband-as-man-and-sexual-partner; more with her baby and less with almost everything else (Stern, 1995, p.172).

He believes that the following related themes emerge:

- a life-growth theme, which consists of whether she can maintain the life and growth of the baby;
- a primary relatedness theme, which entails an ability to engage with the baby emotionally in her own authentic manner that will assure the baby's psychic development;
- a supporting matrix theme, which means that the mother knows how to create and permit the necessary support systems to fulfil these functions and
- an identity reorganisation theme, which refers to her ability to transform her self-identity to permit and facilitate these functions.

Each theme involves an organised group of ideas, wishes, fears, memories and motives that will determine and influence the mother's feelings, actions, interpretations, interpersonal relations and other adaptive behaviour. These four themes and their related tasks are named the "motherhood constellation" by Stern (1995) and the three discourses she must bring together, the "motherhood trilogy". He argues that the motherhood constellation that emerges, may be permanent, transient or permanently revocable.

Stern is critisized for not paying enough attention to the role of the father's representation on the infant (Barrows, 1997). Research confirms that intergenerational respresentations of the father are also evoked with the birth of an infant and do have an effect (Tracey, Blake, Warren, Hardy, Enfield & Shein, 1996). Although Barrows (1997) agrees with Stern's point about the crucial role of the mother's own mother at this time, he argues that it does not necessarily displace the Oedipus complex. This researcher agrees with Barrows (1997) that the nature of the motherhood constellation will be determined by the way the Oedipus complex has been negotiated. The reason for this is specifically because of the asymmetry of the Oedipus complex for girls, resulting in the retaining of the girl's pre-oedipal ties with her mother, as was discussed in the paragraph on the Oedipus complex. Barrows (1997) is also of the opinion that the role of the father in the present may play an important role in negotiating the distance between both mother and grandmother, as well as mother and infant. This researcher is in agreement.

Stern (1995) further believes that cultural conditions play an important role in shaping the motherhood constellation. He notes the following in this regard:

- babies are valued – their survival, well-being and optimal development is seen as important;
- babies are supposed to be desired;
- the maternal role is important and a mother is evaluated as a person on her success in this role;
- the ultimate responsibility for care is the mother's, even if she delegates the responsibility to others;
- it is expected that the mother will love the baby;
- it is expected that fathers and others will provide a supporting context in which the mother can fulfil her maternal role for an initial period and
- the family, society and culture do not provide the new mother with the experience, training or adequate support to execute her maternal role alone easily.

This seems to be supported by themes discussed in a mother-baby psychotherapy group (Paul & Thomson-Salo, 1997).

2.8 The influence of maternal representations

Stern (1995) postulates that maternal representations are enacted and thus influence the observable maternal behaviour with the baby. The baby is not a passive victim of the mother's representations, but becomes a partner in some manner (Brazelton & Cramer, 1990; Lieberman, Silverman & Pawl, 2000; Stern, 1995). Pathogenic representations exist and consist of unresolved conflicts from the childhood of the parent. They are activated and enacted in the current interaction with their own infant (Fraiberg et al., 1980; Raphael-Leff, 2001a; Stern, 1995).

Raphael-Leff (2001a) points out that a parent's parenting does not follow a linear trajectory by which they follow the practice of their own parents. It may be identifying with or doing the opposite, thus constituting reaction-formations or operating in competition with their current view of internal parents and experiences of being parented. Through projective identification mothers may invest split-off aspects of their self-representations into their unconscious representation of their baby (Barrows, 1997; Raphael-Leff, 2001a). This determines and is determined by the person's present emotional state handed down through the generations (Fraiberg et al., 1980). The specific developmental phase of the infant also plays a role in evoking particular infantile conflicts in each parent.

2.9 Maternal representations and postnatal depression

Literature highlights the importance of caring and responsive parenting and the serious results of an absent or emotionally absent parent on the infant (Bion, 1988; Fonagy, 2001; Murray, 1991; Tracey, 2000; Winnicott, 1965a). Tracey (2000) is of opinion that such events also inform and create the depressed mother.

A depressed mother has lost her central core of identity (Tracey, 2000). She does not value herself as mother to her infant. Tracey (2000) notes further that it seems as if a depressed mother has no sense of being protected by internal "good" objects – her 'good' internal mother has died and is lost to her. This links with Klein's understanding of depression, namely that the adult had failed to cope with the depressive position as an infant (Likierman, 2001).

Tracey (2000) argues that for a depressed mother the baby's constancy as a good object is lost. She suggests that at the core of a depressed mother is either an internally dead mother and an internally dead baby, or an internally destructive mother who kills babies or an internally destructive infant who kills mothers. Her argument is in line with the opinion of Raphael-Leff (2001a) and Klein (1997a, 1997c). Klein suggests that the condition of depression is rooted in interaction with internalised objects that are based on actual objects (Likierman, 2001). The depressed mother believes that her capacity to destroy is greater than her life-giving capacity (Tracey, 2000). From Tracey's (2000) argument, one can postulate that with postnatal depression the mother's representation of herself-as-mother, of her mother as mother-of-herself-as-child and her representation of her baby all suffer.

Depression impinges on the motherhood constellation. The primary relatedness theme is perhaps the theme of the motherhood constellation that is most affected by depression. It concerns the mother's social-emotional engagement with the baby. Central issues, as described by Stern (1995), are: can the mother love the baby, can she feel the baby loves her, can she enter into Winnicott's "primary maternal pre-occupation" and can she relate to her baby in a non-verbal, presymbolic spontaneous manner. It is clear from research in this area that emotional engagement with her infant usually suffers (Cooper & Murray, 1995a; Emanuel, 1999; Murray, 1995, 2002; Rosenblum, et al., 2002).

Another aspect of the motherhood constellation that is affected is the supporting matrix. Several authors mention the relative lack of support from the extended family, which results in an increased pressure on the husband and couple alone for providing a

supporting matrix (Raphael-Leff, 2001a; Spangenberg, 1994; Stern, 1995). Research has shown that a lack of support increases a woman's risk of suffering from postnatal depression (Cooper et al., 1999; Spangenberg, 1994). The mother needs to feel surrounded, supported and instructed – a large part of the supporting matrix is instruction. "After all, learning to parent is at best an apprenticeship" (Stern, 1995, p.177). Although a lack of support contributes to causing postnatal depression, it is also true that people withdraw when they are depressed. Thus one can reason that a mother suffering from postnatal depression may fail to create and permit the necessary support system.

Tracey (2000) suggests that if trauma or accumulated trauma occurred in the sensitive time of the mother's infancy, the physical experience of birth and the vulnerability of this time may awaken memories stored not in the mind, but as bodily sensations similar to terror of death and catastrophe.

Jacobson (1971) was the first to suggest that depression is associated with a gap between self-representation and ego ideal, requiring "…a testing of inner reality" (p. 89). One can expand her argument by postulating that postnatal depression can also occur as a result of a gap between the woman's self-representation as mother and her mother-ego ideal.

2.10 The effect of depression on the infant's representations

A macro-event such as a mother's depression can have no meaning to an infant unless there are depressive interactions present over a period of time (Stern, 1995). Stern (1995) argues that there are different types of depressive interactions. Depression, for the infant, is knowable through many repetitive micro-events, each of which is a different "way-of-being-with-mother" (Stern, 1995, p.63). Being with a depressed mother has been described by Green as "the dead mother complex" (Tracey, 2000; Stern, 1995). The mother is physically present but emotionally absent, because she cannot emotionally invest in her child.

In the past years observers have explored the interactions between infants and depressed mothers. Stern (1995) and Emanuel (1999) provide a good description of what happens with an infant in interaction with a depressed mother. Depression is characterised by psychomotor retardation, sadness, internal preoccupation and follows a progressive process of disengagement. Together they begin to make up the infant's representational world from the onset of the mother's psychic disappearance in the context of her physical presence. The mother's face is flat and expressionless, she breaks eye contact and does not seek to re-establish it, her responsiveness declines and her vitality and tonality disappear. The infant has a desire to be with his/her mother. If he/she fails to get a reaction from his/her mother, to be there emotionally, to play, he/she tries to be with her by way of identification and imitation, thus mirroring her. The result being a drop in positive affect, psychomotor retardation, et cetera – in the words of Stern (1995), a micro-depression. Stern (1995) notes further that if the infant experiences repeated failures at getting a reaction from his/her mother, he/she will turn away and seek a more appropriate level of stimulation and world interest. Depressed

mothers often try very hard, knowing that they are insufficiently there for their child. This often results in over-compensating in bursts, with the effect that there is a false interaction between a false mother and a false self (Emanuel, 1999; Stern, 1995). Thus, the infant develops what Winnicott (1965c) termed a False Self.

Acquarone (1995), Emanuel (2002) and Hardie (1999) agree with Stern (1995). They state that a depressed mother struggles to provide a 'good enough' experience of physical and emotional holding and nurturing. If this is not available from some other close figure, young children may not thrive or develop satisfactorily. Emanuel (2002) adds that the same applies for Bion's concept, that the baby needs to be thought about. The depressed mother is not able to mirror the baby – if the baby smiles, there develops dissinchrony between the baby and its mother. The baby may develop independence as a false defence (Emanuel, 2002).

Murray (1991) notes that is important to establish the impact of maternal depression on the representation of the self and the object. Research has shown that there are longer term consequences for the infant with a postnatally depressed mother (Hay, 1997; Murray, 1991, 1995, 2002; Murray & Cooper, 1997; Papousek & Papousek, 1997; Tronick & Weinberg, 1997). These infants were found to be more insecurely attached, to have more difficulty in emotion regulation, were more likely to have behavioural problems, especially sleep disturbance, and showed poorer outcome on object concept tasks at eighteen months. The object concept tasks give an indication of the infant's capacity to distinguish between self and other (Murray, 1991, 1995, 2000). Despite the fact that the mother had recovered from her depression by three months postpartum, these effects still manifest themselves. The analysis of maternal speech in her

research, has also shown that depressed mothers were more preoccupied with their own experience and less focused on their infant. Although one must keep in mind the variability of the course of depression and its effect on the mother-infant relationship (Campbell & Cohn, 1997), it seems that the bulk of research has indicated that postnatal depression can have a profound effect on the representations of the infant.

2.11 Conclusion

Chapter two has comprised a brief overview of object relations theory and representations as the theoretical background of this study. The focus was especially on maternal representations as described by Stern (1995), as the research is based on his theories. Attention was also given to the link between maternal representations and postpartum depression and the effect of postpartum depression on the developing representations of the infant.

The next chapter will entail a literature review on pregnancy, ante- and postnatal depression.

CHAPTER 3

PREGNANCY AND POSTNATAL DEPRESSION

This chapter furnishes a literature review firstly on pregnancy and early parenthood and then on ante- and postnatal depression, mainly from a psychoanalytic framework.

3.1 Pregnancy and early parenthood

- **Milestones of adulthood**

Pregnancy and parenthood are often regarded as major milestones of adulthood. As Bradley (2001) reminds us, "having a baby is paradoxically the most ordinary thing in the world and the most extraordinary" (p. 28). Dramatic changes in physiology, appearance and body and social status, as well as psychological change, occur simultaneously and provide potential for a new stage of personality change, reorganisation and integration (Birksted-Breen 2001; Lederman, 1996; Leifer, 1980; Raphael-Leff, 2001a, 2001b).

Stern (1995) takes it a bit further by arguing that with the birth of her first child, a mother passes into a new and unique psychic constellation which he named the motherhood constellation. According to him, the primary concern of a mother-to-be becomes the "motherhood trilogy" which consists of her discourse with her own mother (especially as mother-to-her-as-child), herself (especially herself-as-mother) and her expected baby. Stern (1995) argues that themes and related tasks that require psychological work, are the following:

- the life-growth theme, which involves maintaining the life and growth of the baby;

- the primary-relatedness theme which entails engaging emotionally with the baby and ensuring its psychic development;
- the supporting-matrix theme, which requires of the expectant mother to create and permit the necessary support system to fulfil these functions, and
- the identity-reorganisation theme, which refers to the pregnant woman having to expand her identity to include thinking about herself as a mother.

- **Reactions to pregnancy**

A host of past and present circumstances have an effect on a woman's emotional reaction to pregnancy. These include her relationship with her husband and parents, her feelings about her femininity, her desire to take on the role of motherhood, and her assessment of society's evaluation and expectations of her as a pregnant woman (Levitt, Coffman, Guacci & Loveless, 1994; Raphael-Leff, 2001a; Reading, 1983; Siddiqui, Hägglöf & Eisemann, 2000; Stern, 1995; Zajicek 1981a).

According to the literature (Birksted-Breen, 2001; Bradley, 2001; Pines, 1993; Raphael-Leff 2001a, 2001b; Stern, 1995) the most common reactions include increased anxiety, self-preoccupation and a corresponding decline in interest in the external world, increased emotional lability, intensified need for support and, paradoxically, also an intensified sense of well-being. Birksted-Breen (2001) and Leifer (1980) propose that anxieties often reflect attempts to master developmental issues inherent in being pregnant and are related to forming an attachment to the foetus. Furthermore, Leifer (1980) suggests that the introversive tendency is accompanied by a heightened awareness of self and foetus as a special unit undergoing a unique experience, which involves active preparations for the baby. Although

emotional lability is usually seen as a result of radical hormonal changes, she postulates that it may stem from an increased openness to one's inner life and may facilitate the pregnant woman's gradual adaptation to her new role as mother. Research by Breen (Birksted-Breen, 2001) with first time mothers showed that women who coped well once the baby was born, were women who were able to express a certain amount of anxiety in late pregnancy. Seglow and Canham (1999) argue that being anxious is necessarry, helping mothers to be in touch with what it feels like to be a baby so that their more adult parts can respond appropriately.

There is also an increase in fantasy activity, to such an extent that Blum (1980) reports that Rorschach Inkblot Tests of pregnant women are comparable to those of adolescents as far as the incidence of fluid transitional signs relating to emotional lability, psychic upheaval and reactive worries are concerned. Lederman (1996) posits that fantasy and dreaming help a woman to prepare for what lies ahead. Birksted-Breen (2001) is of the opinion that unconscious fantasies disguised in dreams, give the pregnant woman an unique opportunity for integration and hence psychological growth.

According to Raphael-Leff (2001a), dreams during pregnancy tend to be unusually plentiful, vivid and very realistic and often linger on in a waking state. She states that dreams reflect personal fantasies and anxieties about the sufficiency of the woman's internal and external resources. Lederman (1996) found that dreams often expressed a desire to return to the past to avoid the developmental tasks of pregnancy. According to this author's research, categories of dreams occurring during pregnancy include reliving childhood, school events, motherhood-career conflict, the ability to mother,

food and infant intactness. In regard to food, Lederman (1996) argues that it is often viewed as the equivalent of the baby, or the fruit of the womb. Piontelli (2001) has made an interesting observation, namely that women pregnant with twins, often report dreaming they have twins before any knowledge of the fact. Research has shown that dreams described by pregnant women in different societies share common primal themes related to the fertile, shared and changing body, birth and mothering anxieties, maternal unpreparedness, intense love-hate relationships and fear of death (Raphael-Leff , 2001a).

- **Psychological defences**

Several authors (Birksted-Breen, 2001; Blum, 1980; Colman & Colman, 1971; Pines, 1993) refer to the fact that psychological defences are loosened during pregnancy. Unconscious processes are easier to access and more available than at other times in a woman's life cycle. These authors consider it to be an adaptive response, because it represents an effort to resolve primary conflicts with the woman's mother. In view of the above-mentioned facts, one can understand the following statement by Johns (1996):

> It is often said that very early disasters in development are given a second chance during adolescence, that children at this stage of major physical and emotional change re-work many of their very early conflicts with their parents and siblings. I believe that, for many women, there is yet a third chance that is given in their first pregnancy, another stage of enormous physical and emotional change (p. 98).

- **Transition to parenthood**

Pregnancy, particularly first-time pregnancy, is a time of both potential loss and gain - an old identity must be given up, as well as a certain amount of independence and often an active working career (Nicolson, 2001; Reading, 1983; Stern, 1995; Zajicek, 1981b). In this regard, Rossi (1968, in Leifer, 1980) argues that the transition to parenthood is more difficult than adjustment to marital or occupational roles. Although sex-role attitudes and women's involvement in the workforce have impacted on the number of children desired and on the meaning attributed to parenthood, Leifer's study points out that the central issue for most women is not whether to have children, but when to begin with a family (Leifer, 1980). Women seem to regard children as a basic part of the meaning of life.

However, pregnancy is not all roses, as Raphael-Leff (1996) points out: "Inevitably the live foetus poses a threat. Pregnant, the woman is no longer an individual; she is part of a tandem. A pregnant woman is confronted by the bizarre situation of two people living in one body, one inside the other" (p. 76). Our society glorifies pregnancy with the result that pregnant women often have to deny their ambivalent feelings and may feel compelled to hide negative feelings even from herself (Milgrom et al., 1999; Nicolson, 2001; Raphael-Leff, 2001a).

Birksted-Breen (2001) makes an interesting point by saying that too often pregnancy and the postnatal phase are treated as if they were separate. She argues that there is not even a word to describe the total experience. She further notes that expectations change abruptly in the sense that pregnant women are pampered and protected, but mothers are expected to cope. She also points out that even those who help the woman

professionally, consider their job finished when the baby is born. Later professional help is given by a different person.

The first days and weeks after the birth of the baby, is a time when the most primitive anxieties are aroused. Issues of life and death come to the fore, but this time in connection with the baby (Birksted-Breen, 2001). Pregnancy and childbearing are major life events and entails heavy emotional demands. It can be a provoking factor for mental illness and trigger symptoms of varying degrees of severity and social impairment, such as anxiety, depression, perfectionism, eating disorders, substance abuse, delusional moods, panic disorders, feeling depersonalised and dangerous to or persecuted by the foetus. (Raphael-Leff, 2001a). Apart from postpartum depression where a mother withdraws from her baby, Landman (1995) points to the other danger, namely child abuse which also has adverse effects on the child and could even lead to death.

Having briefly mentioned some of the tasks and milestones of pregnancy and early parenthood, the next part of the discussion will focus on psychological tasks of the woman during pregnancy and early parenthood. As her partner is the focal point of her support system, a discussion of how pregnancy impacts on her partner and the relationship will follow. Thereafter the influence of the pregnant woman's family of origin, particularly her relationship with her mother, will be discussed.

3.2 Psychological tasks of pregnancy and early parenthood

With pregnancy and parenthood a woman enters a new developmental stage with certain psychological tasks that need to be mastered. Theorists regard the changing

psychological tasks of pregnancy as a process of incorporation, differentiation and finally separation roughly mirroring the three trimesters of pregnancy (Colman & Colman, 1971). Raphael-Leff (2001a) states that over the three trimesters, the focus shifts from pregnancy, to foetus, to baby.

- **Psychological tasks in the first trimester**

During the first trimester of pregnancy a woman has to adapt to all the physical changes in her body. She is preoccupied with new bodily sensations, symptoms, emotional disequilibrium and adjusting to the practical implications of her pregnancy (Birksted-Breen, 2001; Pines, 1993; Raphael-Leff, 2001a). Raphael-Leff (2001b) states that a continuous reappraisal of self-image and almost daily readjustment of identity, are hallmarks of this stage. A woman may feel energised and emotionally hyped up. However, at other times she may feel physically and emotionally drained.

Ambivalence about the pregnancy, even if it was planned, is common and is usually followed by acceptance at the end of the first trimester (Lederman, 1996; Seglow & Canham, 1999). A question that concerns most pregnant women at this stage, is whom to tell and when (Raphael-Leff, 2001b). Most women feel very vulnerable during the first phase and do not relax until the second trimester, especially those with a history of previous miscarriages (Raphael-Leff, 2001a; Seglow & Canham, 1999).

The realisation that the couple needs to expand to include a third person, comes in the first trimester (Brazelton & Cramer, 1990; Seglow & Canham, 1999). The psychological task to master negotiating a three-person relationship, entails the working through of the Oedipus complex. This task starts in the first trimester and

continues right through the pregnancy and first year of the infant's life. It will be discussed in the section on the influence of pregancy on the relationship.

- **Psychological tasks in the second trimester**

Internal movements of the foetus signify the beginning of the second phase. The focus now shifts to the idea of a separate and unknown being growing inside the woman (Brazelton & Cramer, 1990; Pines, 1993: Raphael-Leff, 2001a; Seglow & Canham, 1999). The baby's movements confirm its reality and separateness and form the basis of speculation about its identity. This speculation marks the beginning of the task of accommodating the infant. The fantasising in the mother's mind allows her to explore the many types of baby she could have and thus prepares her for the infant's arrival (Brazelton & Cramer, 1990; Reading,1983; Scharff & Scharff, 1991; Seglow & Canham, 1999). Reading (1983) notes that the majority of women are very aware of foetal activity, suggesting acceptance of the pregnancy and the evolution of maternal feelings. Ultrasonic feedback of foetal movement has a similar effect. Studies of the psychological effects of ultrasound examination have reported positive reactions (Piontelli, 2001; Reading, 1983).

Raphael-Leff (2001a) postulates that the pregnant woman has to come to terms with having two people under her skin. Seglow and Canham (1999) stress the realisation that the foetus is separate and beyond her control. The pregnant woman has to identify with the fertile, sexual and life-bearing body of the archaic mother. An interesting point that Raphael-Leff (2001a) makes, is that a pregnant woman is most aware of her vulnerable inner-child, while she is becoming a fully fledged adult. As the foetus becomes more vigorous, the woman differentiates herself from the baby inside, as well

as from the internal mother. This usually leads to a change in perspective which affects the external relationship to her mother if she is still alive. "Paradoxically, acknowledgement of herself as joined to, yet different from, the mother in whom she herself grew, can increase a woman's sense of responsibility for her own well-being, and therefore for that of the baby inside her" (Raphael-Leff, 2001a, p. 21).

- **Psychological tasks in the third trimester**

In the third trimester the woman begins to consider whether her baby is able to survive outside her if it was to be born prematurely (Raphael-Leff, 2001a). Fantasies of damage become more pronounced when fears of having a handicapped child threaten even the normal couple or plague the guilty couple for having aggressive thoughts or deeds, expecting punishment (Brazelton & Cramer, 1990; Scharff & Scharff, 1991).

In the final phase the woman usually becomes more aware of the irreversible change that is about to occur, and can be plagued with anxieties about the birth and the baby and all the accompanying uncertainty (Birksted-Breen, 2001; Lederman, 1996; Raphael-Leff, 2001a; Seglow & Canham, 1999). This phase of the pregnancy is characterised by internal conflict, heightened emotions and irrational fears.

- **Adapting to a change in body image**

The pregnant woman's body image has to accommodate rapid physical changes. In the words of Raphael-Leff (2001b): "Her own familiar body becomes strange" (p. 48). Body changes are accompanied by a normal emotional crisis which may facilitate psychic growth or lead to fixation of an earlier phase of development (Pines, 1993). Raphael-Leff (2001a) and Pines (1993) argue that her pregnant body discloses her

secret life to all, proclaiming that she is sexually active and fertile. Strangers may feel entitled to pass remarks, or hand out advice. If a miscarriage occurs, the woman's fertile self-image is disrupted, often leaving her with feelings of shame and a sense of ineffectiveness (Raphael-Leff, 2001a).

Women who accept their pregnancies are less likely to be troubled by their body change. However, Lederman (1996) found in her study that no woman expressed pride in her body size in the third trimester. Such expression was more common in the second trimester.

During pregnancy a woman shares her body with another human being who is always there, who interrupts her thoughts, disturbs her sleep, forces her to change her eating, sleeping, working and toilet habits (Raphael-Leff, 2001a). Sensory hypersensitivity is common, as well as changes in body odour. Temperature control, equilibrium, complexion, hair texture and visual acuity all undergo change.

- **Reorganising self-identity**

Literature highlights the adaptive process of a change in identity that is inherent in pregnancy (Lederman 1996; Pines, 1993; Raphael-Leff, 2001a; Smith, 1999; Stern, 1995). Phillips (1991) states clearly that the self-concept of a mother differs from that of a non-mother. Pines (1993) view a first pregnancy as "...a crisis point in the long search for a feminine identity, and as a point of no return" (p. 118). Stern (1995) lists one of the four themes of the motherhood constellation, as the mother's need to transform and reorganise her self-identity. This implies that the new mother must shift her centre of identity from daughter to mother, from wife to parent, from careerist to

matron, and from her own generation to the next one. In the words of Lederman (1996) the pregnant woman contemplates the question "what kind of a mother should I, can I, will I be?" (p. 87).

Stern (1995) postulates that this theme of identity is both a cause and a product of the reinvolvement with maternal figures of the supporting matrix. Unless the pregnant woman can do this, the other three tasks of the motherhood constellation, namely to maintain the life and growth of the baby, to engage emotionally with the baby and to create and permit the necessary support systems to fulfil these functions, will be compromised. Lederman (1996) proposes that a low self-esteem, excessive narcissism, lack of a good role model and motherhood-career conflict can impinge on motherhood identification.

Apart from identification with her own mother, Pines (1993) argues that the symbiotic state of pregnancy revives infantile fantasies for the pregnant woman of herself as the foetus in her mother's body. Thus there is also an identification with the foetus inside her. Both identifications may reactivate intense feelings of ambivalence. Pines (1993) links this task of adapting to a change in identity to a woman's lifelong task of separation-individuation from her own mother.

According to Tracey, Blake, Warren, Hardy, Enfield and Schein (1995), pregnancy exposes the inner world, and chaos results from changes as a woman struggles towards her new identity as mother. As pregnancy progresses, she leaves the external world and turns towards her inner world. Research has shown that a woman's identification with the motherhood role is related to her acceptance of pregnancy and her relationship

with her own mother (Lederman, 1996). Slower progress in labour was also found to be related to difficulty in identifying with the motherhood role (Lederman, 1996).

- **Psychological tasks of giving birth**

Raphael-Leff (2001b) talks about the birth of the baby as the moment of truth. The woman must now integrate reality with unconscious fantasies, hopes and daydreams (Brazelton & Cramer, 1990; Pines, 1993). Birksted-Breen (2001) says that "the birth of the baby signifies that what was 'inside' will be 'outside' for all to see" (p. 22). She suggests that the experience of childbirth will confirm for the woman the goodness of her body and her right to have a baby, or can reinforce a sense of failure and badness and can colour the woman's feelings about her baby.

Research has shown that psychological factors in pregnancy are predictive of progress in labour (Lederman, 1996). In this regard, acceptance of pregnancy played a significant role in the active phase of labour. Lederman's (1996) research supports the theory that conflict, fear and anxiety in pregnancy are linked with a longer duration of second stage labour and the likelihood of a forceps-assisted delivery.

Birksted-Breen (2001) and Raphael-Leff (2001a) note that the fear of death in childbirth is a primeval fear. Both these authors discuss feelings centring around loss that are evoked with the birth of the baby. The birth of the baby means the loss of the pregnancy, for some women a perfect prenatal symbiotic union. For other women there is the loss of a constant companion. The third loss that is involved with birth, is the loss of the phantasy baby in favour of the real baby and the loss of the phantasy self-as-mother, having to face mistakes and bad feelings (Seglow & Canham, 1999).

Brazelton and Cramer (1990) note that the new mother has formidable tasks to face at the birth of her baby. Fusion with her baby, as well as fantasies of completeness and omnipotence fostered by pregnancy, end. She must now adapt to a new being who might provoke strangeness. The new mother must mourn the imaginary perfect child and create a new bond with the real baby.

Raphael-Leff (2001a) postulates that the baby's arrival arouses evocative memory fragments that revitalise dormant processes related to the parents' own infancies. It seems that these memories are already aroused during pregnancy. She states further that the aroused memories and dormant processes influence the quality of postnatal interaction as much as the parents' caring efforts.

- **Psychological tasks of early parenthood**

Taking responsibility for the full time care of a tiny dependent infant, is a major adjustment for the new mother. Seglow and Canham (1999) state that she needs to be able to feel like a baby without being so overwhelmed by it that she becomes like a baby. For many women pregnancy is a time when they have felt special and they find it difficult that it is now over and they are expected to cope with the demands of a baby (Birksted-Breen, 2001; Seglow & Canham, 1999).

Brazelton and Cramer (1990) posit that the new mother must adapt to a new being who provokes feelings of strangeness and cope with the fears of harming the helpless infant, for example the fear of drowning the baby while bathing him. She must learn to tolerate and enjoy the enormous demands of a helpless and totally dependant baby.

3.3 The impact of pregnancy on the woman's partner and their relationship

- **Partner**

Pregnancy is also a developmental challenge for the woman's partner. The manner in which the pregnant woman's partner copes with this challenge, has a direct effect on her and their relationship. Thus the couple's relationship changes in the transition to parenthood. The marital relationship is a significant factor affecting the course of pregnancy (Durkin, Morse & Buist, 2001; Lederman, 1996). In research conducted by Lederman (1996), a poor marital relationship was associated with earlier admission to the labour unit, more anxiety and consequently administration of sedatives and tranquillisers in early labour and prolonged duration of labour. She mentions that other researchers have found a link between marital dysfunction and lower infant birthweight. Marital problems are also associated with depression during pregnancy and postpartum depression (Barrio & Burt, 2000; Timmermans, 2002).

Scharff and Scharff (1991) postulate that a man may become rejecting of his pregnant wife's body, because of guilt reactions of his sexual desire for her in maternal form. It may also reactivate rage against his own mother for becoming pregnant with a sibling. On the other hand, a man may also utilise feminine identification with his early mother and express nurturing and empathic qualities (Raphael-Leff, 2001a). Recently, there have been more pressure on fathers to participate in birth education classes and to be present at the birth of the baby. This may lead to more protective emotional responses. In this regard, Raphael-Leff (2001a) reports that Rosenblatt's studies with rats have illustrated that males exposed to pups soon after birth, develop maternalistic behaviour instead of eating the pups.

A recurrent theme in expectant fathers, is that of helpless resentment at having so little influence over such an enormous process (Cohen & Slade, 2000; Raphael-Leff, 2001a). Sometimes, the expectant father does the worrying for both, while the expectant mother gets on with forming the baby. He may also be making up for her denial, especially if she endangers the baby's health by smoking, or behaving in a way that is detrimental to the baby's health (Raphael-Leff, 2001a). This may also reflect an identification with the helplessness of the foetus.

The intense difference between the partners is also apparent in the fact that fathers have to engage in parental activities to earn the paternal position, while a woman gets a parental position just by being pregnant (Cohen & Slade, 2000; Raphael-Leff, 2001a). The male partner may feel excluded and rejected. Resentments may surface, but are often unconscious. Raphael-Leff (2001a) postulates that disturbing infantile fantasies and deep-seated envy of his partner's capacities and of the baby inside her, may emerge during pregnancy and the birth of the baby.

> Birth highlights the bedrock difference between the sexes as no other situation can; it is a confrontation with the basic facts of life some men find intolerable. Fear of feeling like a spare part in a female world, of guilt at having put her through this painful experience while unable to share in it in any direct way may colour labour with a sense of personal shame or disturbing helplessness (Raphael-Leff, 2001a, p. 61).

Research suggests that as many as half the population of expectant fathers develop some symptoms relating to pregnancy, i.e. hypochondriacal obsessions. Raphael- Leff

(2001a) posits that this may be a way of unconsciously transferring the focus of attention to the expectant father's own body.

Intense emotions may be experienced. The man is also displacing his own father into the grandparent's generation. Re-evaluation of his own past, as a child to his own parents, especially his father, takes place (Brazelton & Cramer, 1990; Raphael-Leff, 2001a). Internal relationships are reappraised and need to be reintegrated into the sense of self. It is sometimes worked through in dreams, reveries and conscious memories and often played out in reality with his father, or other important male figures and mentors (Raphael-Leff, 2001a). Studies have found that men are encouraged towards reconciliation to their own fathers. Furthermore, Raphael-Leff (2001a) argues that where men fail to sort out their relationships with their own fathers during pregnancy, they become less able to find an internal male mentor to protect them from feminine identification. In some men this leads to a pursuit of males and masculinity through bisexual adventures or extramarital affairs. In a recent study in London, the father's relationship with his own father was confirmed as being the single most significant factor in postnatal male mental illness (Raphael-Leff, 2001a).

Male partners in emotionally dependant relationships might feel threatened by the attention the baby gets (Cohen & Slade, 2000; Raphael-Leff, 2001a). In extreme cases violence is a way to claim back the attention that he feels is his, the woman's belly and the foetus often being the target. It may lead to miscarriages, prematurity and low-birthweight complications. Nicolson (2001) notes that pregnancy and the postnatal period have been shown to coincide with the onset or increase in domestic

violence. Foetal abuse is recognised as a forerunner to neonaticide and child abuse, and this abuse often persists and escalates postnatally (Raphael-Leff, 2001a).

- **The relationship between the pregnant woman and her partner**

Pregnancy alters existing interactional patterns, precipitates change and offers opportunities to renegotiate emotional expectations (Cohen & Slade, 2000; Raphael-Leff, 2001a). Cohen and Slade (2000) add that it will be almost two decades before the couple can make any decision without considering the needs of their child. Raphael-Leff (2001a) proposes that the relationship between the partners is affected, because the gender balance is destabilised. She highlights the fact that pregnancy inevitably emphasises asymmetry, even in a couple who had a more equal relationship. Thus, there is a polarisation of the male-female difference, which may result in sexual problems and may have an effect on power issues in the relationship.

Stern (1995) agrees with this notion in stating that the couple has a difficult equation to balance. Blum (1980) and Stern (1995) argue that pregnancy involves shifts in the level of distribution of narcissistic libido and object libido. Different roles and shifts in roles need to be negotiated and are often not compatible for the partners. The husband may compete with the woman as parent or he may compete with the baby. From the woman's point of view, integrating the roles of mother and wife creates considerable stress. Women feel torn between these roles and consequently experience feelings of guilt and inadequacy in their relationships with their husbands. It is interesting to note that Lopata (in Leifer, 1980) found in her study that a large number of women with young children consider their role as a mother more important than their role as a wife.

Raphael-Leff (2001a) states further that although individual responses may differ, the biological fact and bodily experiences of pregnancy force men and women to re-examine their concept of themselves as 'masculine' or 'feminine'. This leads to gender role stress which has a strong association with anxiety, anger and depression (Durkin, Morse & Buist, 2001). A very independent woman may be surprised at her need to be pampered by her partner during pregnancy, or her need to be mothered by her mother or female friends, or she may feel as if she has found an internal companion. "An empty woman may feel fuller and never alone; a full man may feel emptier and excluded" (Raphael-Leff, 2001a, p. 78).

As was mentioned before, this negotiating of a three-person relationship entails the working-through of the Oedipus complex. In the psychoanalytic framework the Oedipus complex is often seen as lying at the core of relationships. Pregnancy is the beginning of new relationships.

Although the Oedipal relationship is usually viewed from the child's point of view, the residues of unresolved difficulties also exist for parents (Seglow & Canham, 1999). The birth of the first child brings a triangular component into family life and both parents have to make room in their relationship to accommodate a third person (Copley, 2000; Seglow & Canham, 1999). Leach (1996) points out that the transition from couple to parents, twosome to threesome, is almost always difficult: "... stresses of becoming parents do not arise because the child is an outsider and third party to the couple, but specifically because he or she is not" (p. 33). This is supported by an interesting study conducted by Curtis (in Wolkind, 1981), who examined the unconscious phantasies of fathers-to-be. Projective tests revealed that expectant

fathers were more likely to produce material based on an Oedipal situation than a control group, indicating that themes of envy and jealousy may be possible.

Several authors highlight the difficult transition to parenthood for both parents-to-be (Clulow, 1996; Durkin et al., 2001; Johns, 1996; LaRossa, 1977). This transition starts with pregnancy. Issues of boundaries, autonomy, closeness and distance, intrusion and exclusion, sameness and difference surface. LaRossa (1977) states that "what it comes down to is that 'I-ness' and 'we-ness' are both necessary while at the same time incompatible with each other" (p. 118). Johns (1996) stresses that couples under strain tend to return to the mental set of a two-person relationship. It would appear that intense preoccupations with the triangular constellation often indicate unresolved issues of inclusion or exclusion from the childhood parental couple (Raphael-Leff, 2001a).

Sex during pregnancy changes. According to Raphael-Leff (2001a) this becomes another sphere where three interact. To some the baby is a verification of love and signifies a working sexual body. It may be seen as evidence of femininity, virility or potency. On the other hand, pregnancy can also arouse resentment or envy in the man or in the woman, resulting in feelings that males are unfairly spared. Lovemaking may be inhibited, or enhanced. According to Reading (1983) research suggests that sexual activity declines during pregnancy, mainly because of a fear of harming the foetus. However, conception of a wanted baby often heightens tenderness in intercourse (Cohen & Slade, 2000; Raphael-Leff, 2001a).

Marital satisfaction changes with the birth of a baby (Nicolson, 2001; Wolkind, 1981). It seems as if marital satisfaction is initially high, but both partners describe a sharp drop in satisfaction following the birth of their first child. As the children grow to independence, the degree of satisfaction increases, eventually reaching the initial level – that is, if the marriage lasts.

Scharff and Scharff (1991) stress the point that the couple's environment of the marriage and its level of development, affect their relatedness to their baby. They hold that there is the establishment of a prebirth personality potential, based on the projection into the foetus of parts of the parents' personalities. Further variables occur in the physical and emotional environment of the pregnancy, the circumstances of the delivery and the opportunities for parental bonding with the infant, the nursing situation, child-rearing practices and the management of the expansion of the family to include siblings. Pregnancy is the proof of the couple's creative union and confirms them in their view of each other as ideal. This view extends to their perception of their foetus.

3.4 The parents' family of origin

Seglow and Canham (1999) state that becoming a parent puts people in touch with their own childhood and parents. Blum (1980) states that "the experience of pregnancy involves the psychological relationships linking three generations: the unborn child, the prospective parents and their own mothers and fathers" (p. 133). Raphael-Leff (1996) concurs with this notion in stating that carrying a baby within her, as she herself was carried in the womb of her mother, evokes a fluidity of identifications that a woman may welcome or resist. No wonder Colman and Colman

(1971) believe that women are more in touch with their entire life cycles when pregnant than at any other time in their lives.

Pregnancy highlights awareness of the connectedness between the generations and the connections between life and death (Cohen & Slade, 2000). Emotional similarities and differences in the expectant parent's relationship to his or her parents, whether they are dead or alive, come to the fore. Pregnancy reactivates childish anxieties for some couples and for others it consolidates a new adult relationship with their parents (Raphael-Leff, 2001a). She points out that divided loyalties and old conflicts resurface in adopted pregnant women. She further states that it is also possible that there are unconscious connections between a new baby and birth order in the constellation of her own family of origin. It may interfere with the woman's spontaneous investment in her child as person. The new baby may represent an envied, beloved, hated or pitied older or younger sibling.

Sometimes pregnancy is an attempt to compensate for parental loss, or come as a reparatory gift to an unhappy parent, or to fill a gap in their lives. Raphael-Leff (2001a) holds that even with a planned pregnancy old prohibitions on sexuality or unconscious rivalries may resurface. Even as a foetus, a baby may become a pawn in a power struggle between in-laws. Control may be established over the expectant parents and their baby through advice or emotional blackmail.

Pregnancy often has the potential of a second chance and a new beginning for all closely involved (Cohen & Slade, 2000). For instance, women whose fathers were distant and aloof, may welcome pregnancy as a second chance to gain closeness

(Raphael-Leff, 2001a). An interesting study done by Siddiqui et al. (2000) with 161 expectant Swedish women, has shown that women who reported rejection from their fathers, showed more attachment to their unborn babies. These authors offer a stronger need for such women to belong, as a possible explanation. In recognising their own fallibility, parents-to-be often forgive their own parents theirs (Lederman, 1996; Raphael-Leff, 2001a).

- **The mother's mother**

Literature highlights the importance of the pregnant woman's mother (Birksted-Breen, 2001; Lederman, 1996; Pines, 1993; Raphael-Leff, 2001a; Siddiqui et al., 2000; Stern, 1995). In an overview of studies about women's attitudes to their pregnancies, Zajicek (1981a) reports that an expectant mother's relationship with her own mother is important in that it affects her attitude to her pregnancy. The new mother, consciously or unconsciously, re-evaluates her own mother (Lederman, 1996; Pines, 1993; Stern, 1995). Stern (1995) sees it as one of the core issues of the motherhood constellation. Leifer (1980) holds that the visit of the woman's mother after the birth is almost ritualised as the rite of passage into a new life stage and provides concrete testimony to the changes from daughter to mother and mother to grandmother.

Early identifications and unresolved conflicts with the pregnant woman's mother come to the fore. Fantasies relating to envy of her mother when she was a child, as well as jealousy of the parent's special relationship from which she was excluded, surface. Raphael-Leff (2001a) posits that it is unavoidable that parallels are triggered between the pregnant mother holding a baby in her womb, and having been held in the womb of her own mother. Stern (1995) is in agreement. He states that a new mother's

relationship with her own mother undergoes a reactivation and reorganisation with the necessary formation of positive and negative models of parenting. Raphael-Leff (2001a) holds that it often results in anxieties about unresolved issues of love and hate between the pregnant woman and her internal mother, rather than the real one. She notes further that impressions and fragmented memories rise from the unconscious during pregnancy. These memories may unconsciously caution her about outdoing her mother, or she may feel compelled to give up sex, ambition or career, or even hand her child over to her mother or a substitute caregiver. She may feel envious of the love and care her baby receives of which she herself feels deprived (Lederman, 1996; Raphael-Leff, 2001a).

Recent research on the patterns of attachment has shown clearly that the current emotional distance and atmosphere established by a mother to her own mother and her ability to reflect on that relationship and memories, become important factors (Fonagy, 2001; Siddiqui et al., 2000; Stern, 1995). Research has shown that the mother's representations of her own mother undergo major shifts and are the object of active and intense re-working. Particular fears come to the fore. The main source of fears concerns a failure to create and keep a supporting matrix - the matrix can criticise, abandon or devalue her and she might pay a price in terms of self-esteem, autonomy, independence or dignity (Stern, 1995).

Mixed feelings towards her mother are inevitable. If a woman cannot come to terms with these mixed feelings, she may be stuck with an unrealistic image of the mother, trying to live up to the unobtainable model of an over-idealised perfect mother (Raphael-Leff, 2001a). A good mother-daughter relationship is associated with a solid

identification with the motherhood role (Lederman, 1996; Siddiqui et al., 2000) and less fear and anxiety in pregnancy and childbirth (Lederman, 1996). Birksted-Breen (2001) mentions that women frequently expect to have the same sort of childbirth and pregnancy experience as their own mother had. Raphael-Leff (2001a) asserts that the internal mother might also be powerfully controlling or indefinable and the pregnant woman might feel a need to protect herself from real or imagined maternal rivalry or hostility. As a result the pregnant woman struggles with internal conflict, trying to be emotionally independent or to be the 'opposite' to her mother. On the other hand, daughters who have resisted identification with their mothers, may now feel free to do so in a shared female experience. Raphael-Leff (2001b) refers to a study by Ballou who found a pattern of reconciliation with the woman's mother, except in extremely ambivalent women. However, a conflictual mother-daughter relationship may be aggravated by pregnancy (Raphael-Leff, 2001a).

The research done by Lederman and her colleagues, found that the following components are important in the pregnant woman's relationship with her mother: the availability of the grandmother, her acceptance of her grandchild and acknowledgement of her daughter as mother, respect for her daughter's autonomy and a willingness to share with her daughter her own childbearing and child-rearing experiences (Lederman, 1996). Their research has shown that a critical, interfering or controlling grandmother, still sees her daughter as a child. It may also reflect the grandmother's own sense of inadequacy as a mother and she may view the coming grandchild as a second chance at mothering.

Other issues that may play a role emotionally if they are not consciously worked through, are complications that a pregnant woman's mother had, such as miscarriages, a handicapped baby or a still birth. The pregnant woman may find it difficult to have a creative experience without feeling guilty, triumphant or anxious about retaliation (Raphael-Leff, 2001a). In the study conducted by Lederman and her colleagues, they found that the quality of the of relationship between the pregnant woman and her mother is also related to physiological measures of progress in labour (Lederman, 1996). The mother-daughter relationship also plays an important role in a woman's enjoyment of mothering. When a woman has memories of the inadequacies or difficulties of her own mother, she fears that she may also be inadequate as a mother (Phillips, 1991).

Regardless of how many children women had, they tend to think about their own mothers in relation to their pregnancy and their expanded motherhood role (Lederman, 1996). On the whole they are more accepting of their mothers. "Pregnancy, labour and delivery are times of great vulnerability in a woman's life and therefore are times when a woman's thoughts and feelings are likely to turn toward her own mother" (Lederman, 1996, p. 251). This vulnerability that is inherent in pregnancy and early parenthood sometimes leads to mood disorders ante- and postnatally. The mood disorders will be dealt with in the next part of the discussion.

3.5 Ante- and postnatal disorders

3.5.1 Depression

A Major Depressive Disorder is a mood disorder of which the essential feature is a period of at least two weeks during which there is either a depressed mood or a loss of interest in nearly all activities. In some people, especially children and adolescents, there is an irritable rather than a sad mood. Other symptoms are insomnia or hypersomnia, an increase or decrease in appetite which lead to weight gain or loss, psychomotor agitation or retardation, fatigue, feelings of worthlessness or excessive or inappropriate guilt, problems with indecisiveness, concentration and memory and recurrent thoughts of death or suicide ideation (APA, 1994; Kaplan & Sadock, 1991; O'Connor, 1997; Richards & Perri, 2002).

The literature seldom differentiates between an existing depression and ante- and postnatal depression. O'Connor (1997) refers to research done by Weissman which shows that depression peaks during childbearing years. He states that there is a gap in our knowledge, because pregnant women and new mothers are often excluded from research, because of the possible effects of treatment on the foetus or the child.

This is in line with research done by Lederman (1996). She reports that several women in their study were depressed during their pregnancies and the depression was not short-lived. She suggests that these women may have been prone to depression before pregnancy and the conflicts inherent to pregnancy may have triggered a depressed state of mind or deepened an already existing depression.

Antenatal depression can be defined as depression where the onset is during pregnancy and postnatal depression where the onset is after the birth of a child. Cooper and Murray (1995b) add to our understanding of the similarities and differences between depression and postpartum depression by pointing out that the symptom profile, as well as the causative factors of the latter, are the same as those found to be the onset of depression at other times, raising the question whether it warrants specificity of a diagnostic concept. In the research they conducted to test the question, they came to the conclusion that women for whom depression occurred for the first time postnatally, are at a raised risk to develop further episodes of postnatal depression, but not of non-postpartum depression. Women whose depression after delivery was a recurrence of depression, are at a higher risk to develop further non-postpartum depression episodes, but not postpartum episodes.

- **Prevalence of depression**

According to the DSM IV (APA, 1994) the risk of Major depressive Disorder varies from 10% to 25% for women and from 5% to 12% for men. Women are thus twice as likely as men to suffer from depression. McGrath, Keita, Strickland & Russo (1993) state that reproductive-related events, such as menstruation, pregnancy and menopause do not alone explain the overall gender difference in depression rates. Factors such as the fact that women's involvement in social relationships is less protective for women than for men (O'Connor, 1997; McGrath et al., 1993) and victimization and poverty that are more likely to be experienced by women, also play a role (McGrath et al., 1993). However, the most recent studies show that with the blurring of sex-role boundaries, men's risk of depression is rising, while women's risk of substance abuse

is also on the rise (O'Connor, 1997). According to Richards and Perri (2002) 5% of adults are seriously depressed at a given point in time.

Although the DSM IV (APA, 1994) states that the first onset may begin at any age, the average age at onset is the mid-20's, the latest research point to an earlier onset in the teenage years (Richards & Perri, 2002). Major depression ranked fourth in the world in 1990 as a cause of disease burden , but is projected to be second in 2020 (Gibson, Swartz & Sandenbergh, 2002).

- **Cause of depression and contributing factors**

The cause of depression is complicated and no one diagnostic finding has been identified (APA, 1994; Kaplan & Sadock, 1991). The APA National Task Force on Women and Depression highlights the fact that a number of social, economic, biological and emotional factors play a role (McGrath et al., 1993) and stress that women's depression should be studied from a bio-psychosocial perspective. Three general causes that play a role are now briefly touched on, namely biological, genetic and psychosocial, as the other causes will be elaborated on in the section on postnatal depression.

- **Biological factors**

Pathophysiology, such as a dysregulation of norephinephrine, serotonin, acetylcholine and dopamine, is reported in mood disorders, as well as a variety of neuroendocrinal dysregulation (APA, 1994: Kaplan & Sadock, 1991). The symptoms of depression and biological research findings support the hypothesis that mood disorders involve

pathology of the limbic system, basal ganglia and a link with abnormalities of rapid eye movement sleep (REM-sleep) (APA, 1994; Kaplan & Sadock, 1991).

- **Genetic factors**

The fact that depression runs in families is consistent with a biological cause thereof (Kaplan & Sadock, 1991; Richards & Perri, 2002). However, there is often also shared environmental factors that increase family aggregation of depression (Richards & Perri, 2002).

- **Psychosocial factors**

Data suggest that there is a significant relationship between stressful life events and the onset of depression. Richards and Perri (2002) state that dissatisfied spouses are three times more likely to develop depression than satisfied spouses. There is also a strong link between chronic health problems and depression Richards and Perri (2002). McGrath et al. (1993) suggest that sexual and physical abuse as well as poverty, are more likely to affect women than men.

3.5.2 Antenatal depression

Antenatal depression deserves attention as it is often associated with postnatal depression (Barrio & Burt, 2000; Glover & O'Connor, in press; Green, 1998; Spinelli, 1997; Wickberg, 1996) and because there is growing evidence that antenatal maternal mood has an effect on the psychological development of the child (Barrio & Burt, 2000; Glover & O'Connor, in press; Green, 1998; O'Connor, Heron, Golding, Beveridge, Glover & ALSPAC Study Team, in press). Moreover, Barrio and Burt (2000) and Spinelli (1997) warn that pregnant women who are depressed, are at risk of

anorexia, use of nicotine, drugs and alcohol. However, it is often undiagnosed because the symptoms of depression are similar to somatic complaints of pregnancy and these women often fail to obtain adequate prenatal care (Barrio & Burt, 2000; Misri, 2001; Spinelli, 1997).

Authors differ about the prevalence of antenatal depression. According to Wickberg (1996) between half and one-third of women who were depressed after delivery, were also depressed antenatally, while Green (1998) states that antenatal depression is at least as prevalent as postnatal depression. Misri (2001) states that the prevalence ranges from 4% to 16%, depending on the method of reporting.

Research has shown that depression tends to increase in the last trimester of pregnancy (Berthiaume, David, Saucier, & Borgeat, 1998; Lederman, 1996). It seems to be associated with the anticipation of childbirth and the prospect of motherhood and its trials. It seems as if depression is greater when a pregnancy was unwanted (Lederman, 1996). A lack of social support (Odendaal, 2003; Berthiaume et al., 1998), conflicting interactions within the pregnant woman's social network and a low self-esteem (Berthiaume et al., 1998) are also linked with antenatal depression. Glover and O'Connor (in press) postulate that some of the effects on the child attributed to postnatal depression, may derive from antenatal mood, especially anxiety.

- **Maternal influences on the foetus**

Although some authors speculate about the question whether the mother's thoughts and emotions can affect the well-being of the foetus (Raphael-Leff, 2001a), Glover and O'Connor (in press) and O'Conner et al. (in press) report that there are growing

evidence that antenatal maternal mood can have long-lasting effects on the psychological development of the child. Raphael-Leff (2001a) notes that several studies indicate that maternal experience can be transmitted directly to the foetus. Experiments have shown that a pregnant woman thinking about having a cigarette, causes the foetal heart rate to increase to the same level as when she actually smokes (Raphael-Leff, 2001a).

In the Fels longitudinal research, foetuses studied before and after the occurrence of severe emotional trauma to their mothers, showed a four- to tenfold increase in activity and an increase of about twenty-five beats per minute increase in heart rate (Raphael-Leff, 2001a). The increased heart rate persisted for several weeks even after the mother's distress had disappeared. After they have been born, these babies were more hyperactive and irritable compared to other babies and some had severe feeding problems. Clover and O'Connor (in press) note that severe life-events in the first trimester of pregnancy increase the rate of congenital abnormalities with 50%. It is also linked with preterm labour and low birthweight. Barrio and Burt (2000) report that antenatal depression is linked with low-birthweight infants, preterm deliveries and infants who are small for their gestational age. Antenatal depression also has an adverse effect on maternal antenatal attachment, as well as mother-infant attachment. O'Connor et al. (in press) found strong and significant links between antenatal anxiety and children's behavioural and emotional problems at age 4 years. They postulate that maternal mood may affect foetal brain development which affects the behavioural development of the child.

3.5.3 Postpartum mood disorders

There is an increased risk of disorders during the postpartum period. There is a 16-fold increase in the likelihood of being admitted to hospital during the first three months following childbirth, compared with the 3-month periods from one year before and one year after childbirth (Kendell, Rennie, Clark & Dean, in Wickberg, 1996). The three postpartum mood disorders, in ascending level of severity, are postpartum blues, postpartum depression and postpartum psychosis.

3.5.3.1 Postpartum blues

Prevalence rates of postpartum blues are variable. Lucas (2001) states that up to 50 percent of women experience postpartum blues. Raphael-Leff (2001b) asserts that the prevalence is between 50 percent and two-thirds and O'Hara (1995) has found that some researchers report up to 85%. According to Timmermans (2002) and Milgrom et al. (1999) this condition is so common, that it is almost considered a normal reaction to childbirth. It is described as an emotionally labile state on the third to fourth day, which then resolves itself. Some researchers note the duration to be the first week to ten days following birth (Raphael-Leff, 2001b). Its cause is unknown. Raphael-Leff (2001b) believes that the powerful experience of childbirth, the onset of lactation with the corresponding alteration in body image from pregnant to matronly, hormonal changes and the emotional upheaval of becoming the mother of a tiny infant, all contribute to postpartum blues. However, she notes that postpartum blues are also experienced by adoptive mothers.

According to Raphael-Leff (2001a) mild distress is suffered by almost half of all mothers at some time before their child is two. The symptoms are tearfulness, anxiety

and irritability. She suggests that it can be described as the "'necessary depression of motherhood' - recognition of the imperfection of reality compared with fantasy and coming to terms with ambivalence" (Raphael-Leff, 2001b, p. 481).

Birksted-Breen (2001) distinguishes between postpartum blues and postpartum depression by stating that the former refer to fleeting feelings of depression relating to the working through of conflicts and anxieties. These feelings of depression often relate to a woman's struggle with her feelings about good and bad mothering. Timmermans (2002), as well as Barrio and Burt (2000), suggest that women with ante- and postnatal depression have such high levels of anxiety, that they have a disturbed sleep pattern and poor quality of sleep, over and above the ordinary disturbed sleep of pregnancy and care for an infant. They argue that it can be seen as the first sign of depression, distinguishing between the somatic complaints of pregnancy and antenatal depression, as well as postnatal blues and postnatal depression.

3.5.3.2 Postnatal depression

Several authors state that there is not consensus about the diagnosis of postnatal depression (Cooper & Murray, 1995b; Spangenberg, 1994; Wickberg, 1996). The DSM-IV (APA, 1994) classifies postnatal depression as a type of major depression, making provision for a "with postpartum onset specifier" (APA, 1994, p. 386) the criterion being that the onset is within four weeks postpartum. According to Birksted-Breen (2001) the same problems and conflicts, prevalent in postpartum blues, are present in women who suffer from postnatal depression. However, "they get stuck in the experience of bad mothering, in the need to separate rigidly between good and bad,

and the need to attack themselves for being an inadequate mother, and in so doing for the mothering they themselves received" (Birksted-Breen, 2001, p. 24-25).

Raphael-Leff (2001c) distinguishes between postnatal experiences of persecution and depression. According to her both involve unacknowledged ambivalence, denied aggression and/or desire. The former refers to a sense of externalised threats, paranoid ideas often associated with the baby, self-pity, projection or and/or associated phobia like contamination fears, agoraphobia or claustrophobia. Depression, she states, involves internal pressures from unconscious love/hate conflicts. Emanuel (1999) also notes that unrecognised conflict or ambivalence plays a role and adds that women have a tendency to turn anger inside themselves - to be depressed instead of angry. Postnatal depression manifests in self-blame, exaggerated guilt, hopelessness, self-neglect, self-loathing, sleep, libido and appetite disorders, feelings of profound self-depreciation, helplessness, self-loathing, despair and suicidal thoughts (Raphael-Leff, 2001a, Raphael-Leff, 2001c).

Nicolson (2001) and Emanuel (1999) point to the fact that depression, and also postpartum depression, always includes some form of mourning and loss. Nicolson (2001) stresses that becoming a mother means a loss of sleep, time to oneself, a sense of personal independence, self-esteem, belief in one's abilities, the shape and usual feelings from one's body, sexuality, occupation, money, patterns of relationships at home and elsewhere and a loss of identity. Although these losses are not all permanent, a healthy grief reaction involves recognition and acceptance of these losses. Nicolson (2001) states that grief in postnatal women seems to be unacceptable.

The onset of postnatal depression varies. A study in 1985 (reported by Dalton & Holton, 1996) found that 46% started within two weeks of delivery, 14% within six weeks, 22% within three months and 18% within six months. Although some researchers limit the definition of postnatal depression as starting within twelve months after childbirth, the norm is rather six months after childbirth (Dalton & Holton, 1996). Dalton and Holton (1996) note that when postnatal depression starts after three months, it often coincides with the end of breastfeeding, starting of menstruation, starting the on the pill or adopting a rigorous weight-reducing diet.

- **Prevalence of postnatal depression**

Researchers are in agreement that it is difficult to establish the exact incidence, partly because criteria differ, but also because many women are not diagnosed. Boyce (2002) note that at least 50% of postpartum depression goes untreated. Raphael-Leff (2001b) postulates that between 6% and 28% of all new mothers suffer from severe depression. Cooper et al. (1999) found in their study that the rate of post partum depression in Khayelitsha was about three times that found in British postpartum samples, stressing the need for interventions designed to prevent postpartum depression. Recurrence of postnatal depression with a following delivery, is about two-thirds (Dalton & Holton, 1996). Despite the relative high prevalence of postnatal depression, Boath and Henshaw (2001) found in their comprehensive review of the literature that the quantity and quality of research on the treatment of postnatal depression is limited.

- **Cause of postnatal depression and contributing factors**

The causes of postpartum depression are not entirely clear. Hormonal fluctuations, physiological or biochemical effects of high-tech deliveries, ambivalence about the pregnancy, social isolation, lack of marital support, poor housing and unemployment are cited as contributing factors. Some researchers claim that a combination of factors play a role, namely childhood vulnerability aggravated by adult adversity and present life events (Milgrom et al., 1999; Raphael-Leff, 2001c). O'Hara (1995) points out that one should also keep in mind that women with major and minor mental disorders do become mothers.

- **Physiological factors**

Endocrine and metabolic factors may play a role. During pregnancy the metabolism is greatly speeded up along with endocrine exchanges related to the pregnancy, and depression may be the down side of the metabolic curve (Bellak & Faithorn, 1994). Bellak and Faithorn (1994) further hold that some postpartum depressions suggest other organic factors, for example after the birth of a male, androgen levels, which rise significantly in the third trimester, fall after the delivery and may result in depression.

Dalton and Holton (1996) link postnatal depression with a sharp drop in progesterone after childbirth. However, O'Hara (1995) asserts that findings from research supporting hormonal hypotheses have been weak and inconsistent. In a similar vein, Emanuel (1999) refers to Corrigall in stating that hormone treatment has never been found to alleviate postnatal depression, while counselling has.

- **Lack of support**

The relative lack of support from the extended family puts an increased pressure on the husband and couple alone for providing a supporting matrix. Research has shown that a lack of support increases a woman's risk of suffering from postnatal depression (Emanuel, 1999; O'Hara, 1995; Raphael-Leff, 2001a; Spangenberg, 1994; Stern, 1995). This notion was confirmed by research done in South Africa by Cooper et al. (1999) in Khayelitsha and Spangenberg (1994) in Bloemfontein. Spangenberg's research showed a significant link between postnatal depression and a lack of social, professional and partner support. Stern (1995) argues that the mother needs to feel surrounded, supported and instructed - a large part of the supporting matrix is instruction. "After all, learning to parent is at best an apprenticeship" (Stern, 1995, p. 177). Emanuel (1999) and Raphael-Leff (2001a) agree:

> To mother generously, a mother needs to feel mothered. The absence of a loving mother or partner to support her in reality, or to enrich her from within, can make a woman veer from trying to live up to an idealised idea of herself as the perfect mother she never had, to being a deprived daughter who feels a gap instead of maternal resources (Raphael-Leff, 2001a, p. 143).

However, Mauthner (1998) stresses the fact that the whole concept of a lack of support is complex. She argues that depressed women withdraw and are reluctant to ask for practical and emotional support. There are also the underlying beliefs and perceptions about what it means to be a 'good' or a 'bad' mother in our society which may prevent a mother from asking for support. Timmermans (2002) is in agreement. Another aspect that Mauthner's (1998) research points to, is that often relationships with other

mothers who have young children might play a critical role in a woman's perception of feeling supported.

- **Personal and family psychopathology**

O'Hara (1995) reports that research has shown that many women who experience postnatal depression have been depressed in the past. According to him research has shown conflicting findings regarding the question whether depression during pregnancy is a predictor of postnatal depression. Wickberg (1996) and Milgrom et al. (1999) assert that most studies report a strong association. Women suffering from postnatal depression frequently have a family history of depression and anxiety (Dunnewold, 1997; O'Hara, 1995; Milgrom et al., 1999). Women with a previous episode of postpartum depression are at a raised risk of postpartum depression with a subsequent delivery (Cooper & Murray, 1995b; Dunnewold, 1997).

- **Unplanned pregnancy**

An unplanned pregnancy was strongly related to postnatal depression in Khayelitsha (Cooper et al., 1999). Lucas (2001) also states that the child is sometimes unwanted. He adds that these mothers often tolerate the baby's demands poorly.

- **Ambivalence**

An internal mismatch may also cause distress according to Raphael-Leff (2001a). A woman may feel torn by the orientation she anticipated before the birth of her child and the materialisation of her capacities as mother. She talks of bipolar conflicts and postulates that they are sometimes represented by the woman's two parents.

- **Miscarriages and stillbirth**

Miscarriages disrupt a woman's fertile self-image and damages her self-representation (Pines, 1993; Rapahel-Leff, 2001a). Recurrent miscarriages have a profound influence on a woman. Apart from feelings of loss and a need to mourn, a woman may feel like a failure. Questions arise for the woman around her ability to sustain a baby, the goodness of her womb and placenta, and irrational fears of being punished for past misdeeds and guilt feelings about ambivalence or previous sexual encounters (Pines, 1993; Raphael-Leff, 2001a). When a mother becomes aware that her baby has died before the birth, she may feel a mixture of shock, despair, anguish and repugnance for the corpse in her womb (Raphael-Leff, 2001a). It is now realised that parents need time to mourn the death of a foetus or baby. Failure to do the work of mourning may result in postpartum depression with a next baby.

- **Preterm births**

Preterm births are defined as less than thirty seven weeks gestation. It seems to confirm a woman's worst fears of being insufficiently good for the baby. Women often don't feel ready for the baby. Mothers of ill babies feel that they have contributed and might feel ambivalent They may feel resentment and disappointment, often avoiding attachment in case the baby dies (Raphael-Leff, 2001a).

- **The birth experience**

Tracey et al. (1995) refer to Bion's concept that life experience can be "thought about" to become a part of our inner world, via symbols and abstractions. She and her co-workers postulate that in trauma this "thinking about" cannot take place. It leaves a mother with a traumatic birth and perhaps having a premature baby who might die, in a space which is so unthinkable and unbearable, that no processing can take place. They

argue further that the inner emotional meaning of the infant is lost to the mother. The mother looses her confidence in her good internal mother and there is a serious interruption to her idealised image of a full-term baby. The balance of love and hate, protection and murderousness is disrupted, as well as a non-experience of birth to confirm her as a mother. Timmermans (2002) and Dunnewold (1997) also link negative birth-events with postnatal depression.

Raphael-Leff (2001a) notes that an emergency Caesarean leaves a woman feeling cheated out of a natural birth. However some may feel relief. The long term consequences of a C-section, recuperating from a major operation while caring for a baby, can be problematic to some women. A common reaction after a C-section under a general anaesthetic, is the fear of having been given the wrong baby (Raphael-Leff, 2001a). However, in the Khayelitsha study Cooper et al. (1999) found that depression was not associated with the method of delivery.

- **Maternal orientation**

Raphael-Leff (2001a) postulates that precipitating factors of postnatal depression differ according to each woman's maternal orientation. The model that she proposes, suggests broad categories, namely Facilitators, Regulators, Reciprocators and recently also a category for Bipolars. Regulators and Facilitators are in the two extreme positions and Bipolars make room for conflicted people who experience the extreme positions at once. These orientations are not fixed and may change with subsequent pregnancies.

According to her, Facilitators devote themselves to facilitate the baby's well-being pre- and postnatally. Pregnancy is seen as the culmination of feminine identity, feeling merged with her mother who carried her and the baby whom she carries. The Regulator is at the other end of the spectrum and experiences pregnancy as a tedious way of getting a baby. The Reciprocator is more in touch with ambivalence and tries to maintain a balance between inner absorption and an acute awareness of the world outside. She states for instance that a lack of employment can be distressing for a Regulator, but the converse is true for a Facilitator. Marital difficulties arise because of a mismatch of parental orientation, for example, on the basis of his internalised model of parenting a traditional husband may insist that his wife stays home while she is made to feel guilty and reproached for wanting to leave her child.

A Facilitator may suffer depression because of forced separateness, if she has to leave her baby before she is ready, for example a preterm birth or to work because of economical difficulties. She may also feel she has not lived up to her ideal of being a good mother and has become a bad mother to her vulnerable innocent baby. The Regulator might resent the interdependence and might assign the baby a parental role, feeling trapped with a demanding, nagging or neglectful carer who does not fulfil her expectations.

- **The role of the infant**

It is widely recognised that the infant is not passive in the parent-infant interaction, but plays a significant role (Brazelton & Cramer, 1990; Edhborg, Seimyr, Lundh & Widström, 2000; Murray, 1999; Stern, 1995; Waddell, 1998). Recent research suggests that apart from the fact that maternal depression has an effect on the infant,

the infant's temperament also affects maternal mood (Edhborg, et al., 2000; Milgrom et al., 1999; Murray, 1999). The study by Edhborg et al. (2000) has shown that depressed mothers and their partners perceived their children as more temperamentally difficult than couples in families with a non-depressed mother. The result of their study did not indicate whether the depression of the mother was caused by the child's "difficult" temperament, or whether the child was more difficult because of the mother's depression. However, Murray's research (1999) indicates that a difficult temperament and poor motor control of the infant are significant predictors of subsequent maternal depression. She suggests that poor motor behaviour may be linked with an impaired capacity for interpersonal engagement.

- **Other possible causes**

Apart from traumatic background factors contributing to current difficulties such as emotional and/or physical abuse, adoption, being a "replacement" child, deprivation, illegitimacy, etc., Raphael-Leff (2001a) mentions that many people suffering from postnatal depression come from relatively intact homes. However, a high proportion have suffered from previous unmourned abortion, miscarriage or perinatal death in their own childbearing years or family of origin. The loss of a woman's own mother through separation or death, especially if it occurred before the woman was twelve years old, is a significant risk factor (Emanuel, 1999; Timmermans, 2002: Wickberg, 1996). Women suffering from postnatal depression often come from a broken home (Lucas, 2001; Timmermans, 2002). Raphael-Leff (2001a) mentions that some women first recall repressed sexual abuse under the impact of the birth experience or its aftermath.

- **Effect of postnatal depression**

Longitudinal research has linked postpartum depression with adverse effect on the mother in terms of low self-esteem, mood state, marital breakdown (Milgrom et al., 1999) and on the child in terms of emotional, social and cognitive development (Acquarone, 1995; Edhborg et al., 2001; Emanuel, 1999; Hardie, 1999; ; Milgrom, et al., 1999; Murray, 1995; Cooper & Murray, 1995a; O'Hara, 1995). Postnatal depression has its onset at a critical time in the developing relationship between mother and baby, when the baby is very tuned in to the most subtle nuances of feeling and expression between mother and child (Emanuel, 1999; Murray, 1995; Stern, 1995). Infants respond to the sound of their mother's voice in the first 24 hours after birth and are sensitive to the timing and nature of the mother's response. Work done by Maielo (in Emanuel, 1999) found that a depressed mother's voice will be flatter, the rhythm slower, its tone weaker and pitch lower than that of a non-depressed mother. Studies discussed by Chamberlain (1987) show that infants seem to prefer high rather than low-pitched talk. Murray (1995) notes that in a study comparing depressed and non-depressed mothers' interaction with their babies, the former expressed more hostility and criticism.

Emanuel (1999) believes that an easily gratified baby can cheer up a mildly depressed mother. In an extreme form this can lead to an idealisation of the baby where the baby takes care of the mother's emotional needs at the expense of its own. The child is not seen for who he/she is with positive and negative feelings.

Research has shown that mothers mirror the expression on their babies faces and in doing that help the baby to know his/her own feeling (Emanuel, 1999; Murray, 2002).

A depressed mother's ability to focus on and think about her baby, her containment function, is impaired (Emanuel, 1999; Tracey, 2000). Research has shown that a baby shows distress when he/she looks at his mother's expressionless face or when there is mistiming (slower reaction) in her response to him/her, which is frequently the case with depressed mothers (Emanuel, 1999; Murray, 1995). Over a period of time, the baby may withdraw, also becoming "depressed" or very active to elicit a response. Emanuel (1999) is of the opinion that it can be the source of Attention Deficit Disorder.

Several studies have shown that infants of depressed mothers were more insecurely attached than those of non-depressed mothers (Fonagy, 2001; Murray, 1995; Tracey, 2000). Babies of depressed mothers had more behaviour problems , such as sleeping difficulties, eating problems and temper tantrums (Murray, 1995). Research by Ehdborg et al. (2000) has shown that these babies are perceived as more difficult to care for. Their research also shows that postnatally depressed mothers experience stress in parenthood at one year postpartum.

With regard to behaviour problems, a longitudinal study by Murray and her colleagues (Murray, 1995), has shown that boys at the age of five from postnatally depressed mothers, were more likely to show behavioural disturbance on the Preschool Behaviour Checklist, while daughters of postnatally depressed mothers show highly prosocial behaviour, a risk factor for later depression. O'Hara (1995) reports that children from postpartum depressed mothers performed worse on measures of cognitive abilities at age four and a half compared to children of mothers who did not suffer from postnatal depression.

Research done by Edborgh et al. (2001) found that infants of depressed mothers (assessed at 2 months postpartum), had fewer communication skills and were less curious and focused in free play at age 15-18 months than infants of non-depressed mothers. These mothers structured their infants' environment less effectively and perceived their children as more fussy and difficult. Their research also provides evidence that children of depressed mothers develop representations of the mother and the interaction with her as less joyful, beyond the period of the mother's depressed mood.

Apart from the adverse effects on the mother and child, research by Boath, Pryce and Cox (1998) has shown that postnatal depression has a detrimental impact on the marriage relationship, the partner's own mental health and other close family members, for example other siblings. One father in their research describes it as follows: "It's like having two babies" (p. 201). Husbands of depressed mothers are more likely to perceive their infants as more demanding and difficult, perhaps because of greater demands and responsibilities of caring for the infant (Ehdborg, et al., 2000).

3.5.3.3 Postpartum psychoses

Postpartum psychoses is a dramatic mood disorder which is an acute psychotic reaction precipitated by childbirth. It is rare. Most authors (Dunnewold, 1997; O'Hara, 1995; Kaplan & Sadock, 1991) state that between one to two women in 1000 are affected. However, Lucas (2001) argues that the incidence is much higher, more in the order of three in 100 deliveries.

The onset is usually early, within the first three days. Mothers may be severely disturbed, losing touch with reality and can be harmful to their babies or themselves. Symptoms usually occur on the third postpartum day. Early symptoms are insomnia, restlessness, fatigue and lability of mood (Kaplan & Sadock, 1991). Later symptoms include cognitive impairment, depression, delusions and hallucinations, usually related to the infant or mothering, obesessive concerns about the baby's health or welfare (APA, 1994; Kaplan & Sadock, 1991; Lucas, 2001). A family history of bipolar disorder raises a woman's risk to develop postpartum psychosis (APA, 1994; Dunnewold, 1997; Kaplan & Sadock, 1991; Lucas, 2001). The risk of developing bipolar disorder, is 35 times more likely in the first month after childbirth, than at any other time in a woman's life (Timmermans, 2002).

3.6 Conclusion

The importance of pregnancy to re-think and re-work many issues is often overlooked. However, pregnancy can also act as a provoking factor for mental illness such as ante- and postnatal depression with adverse effects on the mother, the infant, the couple's relationship and the family.

CHAPTER 4

METHODOLOGY

4.1 Orientation

This chapter contains information regarding the method of investigation. The research design, data collection, data analysis, ethical issues and accountability will be discussed.

4.2 Method of investigation

4.2.1 Research design

The way the research developed and the nature of the research problem (Strauss & Corbin, 1990) necessitated a pure qualitative mode of enquiry. It was thus a pragmatic choice because of circumstances (Flick, 1999; Silverman, 2000). The researcher decided on an emergent design (Guba & Lincoln, 1989), because of the realisation that there were many unpredictable factors that could play a role, and therefore needed the freedom to be led by the process. As Guba and Lincoln (1989) put it, facing "the prospect of not knowing what it is that they don't know" (p. 175).

A single case study was done (Yin, 2003). A case study design is used when the researcher wants an in-depth understanding of the situation and meaning for those involved (Henning et al., 2004; Merriam, 1998; Punch, 1998). "Case studies are valuable where complex questions have to be addressed in complex circumstances" (Keen & Packwood, 1997, p. 60). Yin (2003) notes that a case study is the strategy to use when the researcher wants to answer "how" and "why" questions about a contemporary phenomenon within some real-life context over which the investigator

has little or no control. However, Punch (1998) states that "we cannot study everything about even one case" (p. 193). Thus the aim was to do an in depth study about the representations (of self-as-mother, mother-as -mother-of-self-as-child- and of the children) in an extreme case of postnatal depression where it led to the murder of a baby, what is referred to in the literature as extreme case sampling (Punch, 1998; Schurink, 1998a; Yin, 2003). It is also called deviant case sampling or an instrumental case study. The assumption is that one can learn from the typical by studying the atypical (Punch, 1998). Another reason why this type of sampling is used, is because it provides particularly information-rich data (Flick, 1999; Schurink, 1998a).

The advantage of qualitative research is that it answers the question of not only "*what* happens but also *how* it happens and, importantly, *why* it happens the way it does" (Henning et al., 2004, p. 3). Qualitative research thus aims for depth of understanding (Babbie, Mouton, Payze, Vorster, Boshoff & Prozesky, 2001; Henning et al., 2004; Punch, 1998; Silverman, 2000). Henning (2004) and Merriam (1998) point out that the danger exists that a researcher can bias the study to mean what he/she wants it to mean.

The fact that case studies are often generalised is one of the most common criticisms of the case study (Yin, 2003). However, Punch (1998) is of opinion that a specific case may be so interesting and unique, that it is worthy of study. Secondly, he states that the in-depth case study can give a fuller understanding of phenomena which can suggest generalisability and can be studied further. Mays and Pope (2000) also state that this factor is irrelevant to the strength of the approach. Silverman (2000) adds that

generalisability is present in the existence of any case, while Yin (2003) argues that case studies are generalisable to theoretical propositions and not to populations. He uses the term analytical generalisation.

4.2.2 Data collection

Any methods of data collection can be used in a case study design (Merriam, 1998; Yin, 2003). The researcher made use of interviews, participant-observation and documents.

4.2.2.1 Semi-structured interviews

Face-to face interviewing is the most common method of data collection in qualitative research (Babbie et al., 2001; Britten, 2000; Flick, 1999; Punch, 1998; Schurink, 1998b). It is a powerful and flexible tool for investigation (Britten, 2000).

As several authors point out, the researcher is the instrument through which research is done (Babbie et al., 2001; Britten, 2000; Henning et al., 2004; Schurink, 1998a). Schurink (1998a) emphasises that the quality of the data depends on the ability of the researcher to establish rapport and develop an open and trustworthy relationship with the participant. Schurink (1998b) is in agreement. He notes that empathy and understanding, warmth and relatedness as well as honesty, sincerity and confidentiality, are qualities that the interviewer should strive for.

The assumption that participants' reality can be known by asking the right questions, is questioned more and more (Henning et al., 2004; Schurink, 1998b). This is even more relevant when there are cultural differences between the researcher and participant as

was the case in this study. English is a second language for both the researcher and participant which further complicates the issue, especially for the participant. Emotionally laden issues should preferably be talked about in one's mother tongue (Brook, Gordon & Meadow, 1998). Thus, although the participant is very fluent in English, talking about emotional issues in her second language, was not the ideal.

Schurink's (1998b) description of an unstructured interview with a schedule is termed semi-structured interviews by other authors such as Britten (2000) and Merriam (1998). The researcher had a schedule as a guideline which contained questions and themes relevant to the research. In this study questions and themes for the interviews were about the experience of the participant around the mothering she received, her perception of herself as a mother, her experiences of mothering her two children and of murdering her baby. Henning et al. (2004) talk about a phenomenological interview when describing the interview about someone's articulation of their lived experience or deeply felt emotions and state that the data are regarded as credible and believable.

One of the critiques of interviewing, is that the process of interviewing cannot be completely neutral because the process of interviewing in itself gives rise to a specific type of interaction (Henning et al., 2004; Punch, 1998). Merriam (1998) stresses the fact that the researcher as human instrument is limited by being human – mistakes are made and opportunities are missed. Another limitation in this study is that because of a time limit, only seven interviews with the participant could be arranged. (An eighth interview was arranged later on in the research process). Thus, the researcher did not have the luxury of saturation point, that is when no further light can be shed on the topics (Schurink, 1998b).

Advantages of conducting interviews as means of data collection are that it allows for subjective meanings and permits exploration of issues (Burman, 1994). Stringer (1996) asserts that interviews not only provides information regarding the participants' views and perspectives, but also symbolically recognises the legitimacy of their viewpoints. A specific advantage of the extended in-depth interview is that the conversation and rapport develop more naturally as the process continues (Henning et al., 2004).

The interviews were audio-taped and transcribed. Silverman (2000) notes that audio taping interviews allows the researcher to focus on actual details of a conversation, whereas relying on memory or notes alone makes it virtually impossible. Flick (1999) warns that one cannot forget the fact that recording may have an influence on the participant's statements. Audio taping the interviews highlighted the difference in voice quality of the participant. It was very clear that there was still a lot of anger towards her mother as she spoke in an angry voice whereas she spoke very softly in the sixth interview, talking about the baby she suffocated.

4.2.2.2 Documents

Henning et al. (2004) note that documents are a valuable source of information, but are often neglected in qualitative research. Merriam (1998) and Punch (1998) posit that documents in conjunction with other data, can be important in triangulation. More will be said about triangulation in the paragraph about accountability.

One of the disadvantages of documents are that they may not contain information or insights relevant to the research question (Merriam, 1998). Merriam (1998) further

points out that even records that are supposed to be objective and accurate, may contain built-in biases that a researcher is not aware of. One of greatest advantages of documents is their stability and the fact that they exist independent of the research process (Merriam, 1998).

4.2.2.3 Participant observation

The researcher made use of field notes, before and after the interviews and also while transcribing the audio-tapes, using guidelines by Schurink (1998a). Observation was more unstructured without using predetermined categories and classification as is usually the case in a qualitative approach (Punch, 1998).

Henning et al. (2004) posit that the principles relating to data acquired by means of interviewing, also apply to observation. What is observed, is also the researcher's version and can thus not be neutral. Merriam (1998) agrees, stressing the fact that human perception is very selective. However, there is consensus that observations in conjunction with interviewing and document analysis substantiate the findings (Babbie et al., 2001; Merriam, 1998).

4.2.3 Data analysis

Several authors note that there is no right or wrong approach to data analysis in qualitative research (Henning et al., 2004; Poggenpoel, 1998; Punch, 1998). However, Henning et al. (2004) emphasise that the process of analysis is the heartbeat of the research. Pope, Ziebland and Mays (2000) mention that data generated by qualitative studies are cumbersome and difficult to analyse. Yin (2003) adds that analysis of case study data is one of the least developed and most difficult aspects of

doing case studies. Merriam (1998) notes that the paramount consideration in analysing the data in a case study, is to convey an understanding of the case. As Smith (1995) states, the assumption that one can learn something about the participant's psychological world, necessitates that the transcript is read many times to produce new insights. Thus the following steps in analysing the data, were followed:

- The transcript was read a number of times;
- Themes were determined by using key words to capture the essential quality of what was found in the text and
- Connections between the themes were determined to integrate initial categories into clusters.

Yin (2003) suggests that a researcher has a general analytic strategy apart from specific techniques for analysing case study data. This researcher followed his suggestion by using two general strategies described by him, namely relying on theoretical propositions and thinking about rival explanations. As this study was based on Stern's (1995) motherhood constellation, the theoretical propositions that were followed, are the following:

- the participant's representation of her mother as mother-of herself-as-child;
- the participant's representation of herself-as-mother;
- the participant's representation of her first child and
- the participant's representation of the baby she murdered.

The other general strategy that was followed, was thinking about rival explanations. This strategy involves the definition and testing of alternative explanations for theoretical propositions.

The specific strategy that was followed for data analysis is that described by Neuman (2000). Data is analysed by organising it into categories on the basis of themes or concepts. The relationships between concepts are examined and linked to each other and interwoven into theoretical statements.

The procedures for the analysis are called coding and analytic memo-writing (Neuman, 2000). There are similarities between this approach and that described by Strauss and Corbin (1990), especially the procedure of coding. Coding involves two simultaneous activities, namely data reduction and categorizing data into themes (Neuman, 2000).

Coding is defined by Punch (1998) as putting labels on pieces of data. It is the analytic process by which concepts are identified and developed in terms of their properties and dimensions (Strauss & Corbin, 1990). It brings themes to the surface from deep inside the data (Neuman, 2000). This is accomplished by asking questions about the data and making comparisons for similarities and differences between each incident, event and other instances of phenomena (Flick, 1999; Punch, 1998; Strauss & Corbin, 1990). It leads to the identification of concepts that can be grouped together to form categories, which is more abstract.

Neuman (2000) notes that a theoretical framework can be helpful if it is used in a flexible manner. He states that a researcher can start with a list of themes, or generate the coding themes while reading the data notes, but regardless of which process is used, the researcher makes a list of themes after coding which extends to analytic notes or memos. Coding was applied in various degrees of detail, namely line by line, sentence by sentence and paragraph by paragraph (Flick, 1999; Strauss & Corbin,

1990). The researcher followed Flick's (1999) basic questions of *what, who, how, when, how long, where, how much, how strong, why, what for and by which* to disclose the text.

The next step refers to the process of refining and differentiating the categories resulting from the first process through inductive thinking (developing concepts, categories and relations from the text) and deductive thinking (testing the concepts, categories and relations against the text) (Flick, 1999; Strauss & Corbin, 1990). In this second phase the researcher focuses more on the initial coded themes than on the data (Neuman, 2000). Strauss and Corbin (1990) state that initially all concepts, categories and hypotheses are to be considered provisional.

The second procedure, analytic memo-writing, runs parallel with the first procedure, coding. It contains the researcher's reflections on and thinking about the data and coding (Neuman, 2000).

4.3 Ethical issues

Ethics indicate what is right and correct (Strydom, 1998). The importance of moral principles to guide correct conduct in research is increasingly realised (Strydom, 1998). The following was done to meet the requirements of the ethical conduct of research. Written permission was obtained from the interviewee's legal representative and from the authorities from Correctional Services, to have interviews with her, as she was awaiting trial. The fact that permission from Correctional Services was granted only ten days before her trial date, was a dilemma for the researcher. As described in the previous section, it was difficult to know beforehand how talking about the murder

of her baby would influence the interviewee emotionally so shortly before her trial date. As Strydom (1998) postulates, emotional harm is difficult to predict and to determine, but can have far-reaching consequences.

In line with ethical guidelines (Henning et al., 2004; Schurink, 1998b; Strydom, 1998) the researcher discussed what the research would entail in the first meeting. She was informed that the interviews will be audio-taped and transcribed afterwards, that confidentiality will be maintained and that the interviewee was at liberty to withdraw from the research at any time, because of the emotional nature of some of the issues. The interviewee was given the option to think about participation overnight. However, she stated that she was ready to start immediately and signed the letter of informed consent.

The interviewee was also asked to give written permission to the researcher for obtaining information concerning her case as regards her treatment and observation in psychiatric hospitals (Denmar Clinic, Sterkfontein and Weskoppies hospitals), the psychologist who testified at her trial and her legal representatives concerning her case. A very challenging ethical issue arose when the researcher phoned the psychologist who witnessed at her trial to obtain his report. He mentioned that he learned after the trial that she is HIV positive – information that she has not given in the interviews. It could have been a contributing factor to her depression. He had no written report, but was willing to answer questions via e-mail.

Power and status were other ethical issues that the researcher was aware of. Strydom (1998) points out that prisoners might feel compelled to participate, because they

might feel that they have less power or status than the researcher or it might be a way of handling boredom. The researcher also had to make sure that the interviewee had a clear understanding of the fact that participation in the research would not at all benefit her case (Schurink, 1998b). Even after ten years of democracy, it was also possible that the interviewee being black and the researcher being white, might have power implications. The researcher is also at least 20 years older than the interviewee, who mentioned in her interviews that she found it hard to question older people. The researcher tried to convey respect to the interviewee and tried as much as possible to equalise the relationship (Burman, 1994; De Vos, 1998; Parker, 1994; Schurink, 1998a). In the last part of the last session the interviewee was given the opportunity to debrief and to talk about her experience of the research (Strydom, 1998). It seemed as if she found it helpful to talk about her experience.

4.4 Accountability

"The problem of how to assess qualitative research has not yet been solved" (Flick, 1999, p. 221). The question of trustworthiness or legitimacy is an attempt to answer the question whether the research is scientific (Stringer, 1996), or in the words of Bradbury and Reason (2001, p. 447) "'Am *I* doing good work' and 'are *we* doing good work?'". *Scientific* usually refers to objectivity, generalisability, reliability and validity (Stringer, 1996). Silverman (2000) notes that validity is another word for truth. "The search for both validity and reliability rests on the assumption that it is possible to *replicate* good research" (Parker, 1994, p.11). He notes that this is just not possible for qualitative research – repetition will bring about a different piece of work. Flick (1999) agrees and states that this understanding of reliability should be rejected. Stringer (1996) argues that we now recognise that scientific knowledge is less stable,

objective and generalisable than previously assumed. He also states that there is an increasing acceptance of the difference between the physical world and the social world.

There seems to be consensus in the literature that new concepts of validity in qualitative research are needed (Gaventa & Cornwall, 2001; Levin & Greenwood, 2001; Poggenpoel, 1998; Tindall, 1994). Gaventa and Cornwall (2001) argue for instance, that one needs to measure the quality of participation and the quality of knowledge, while Levin and Greenwood (2001) posit that it should be measured according to whether actions arise to solve problems. For Tindall (1994) the essential notion is consistency, the extent to which the same approximate results will be attained repeatedly under similar conditions. Silverman (2000) uses the word reliability in this regard.

Guba's model of trustworthiness is well developed and often used by qualitative researchers, also in South Africa (Poggenpoel, 1998). She identifies truth value, applicability, consistency and neutrality as criteria for assessing the trustworthiness of research. Truth value refers to confidence in the truth of the findings for the participants and the context in which the study was undertaken.

Yin (2003) states that research should be conducted "as if someone were always looking over your shoulder" (p. 38). In the light of this, this researcher uses the term accountability to include all the concepts described above in order to be as trustworthy as possible. This researcher realises as Tindall (1994) points out, that accountability is

not an all or nothing issue, but a matter of degree. In this study, multiple triangulation, a thick description, member check and reflexivity is used to show accountability.

Triangulation is often used in case studies to ensure validity of findings (Keen & Packwood, 1997). This method is used to confirm findings by showing that independent measures of it agree with, or at least, do not contradict it (Cook & Fonow, 1986; Huberman & Miles, 1994; Keen & Packwood, 1997). Smaling (1992) notes that the aim of triangulation is to study the object of research in at least two ways.

Different types of triangulation can be distinguished. In data triangulation two or more kinds of data resources are used. Method triangulation involves two or more research methods, for example, two or more data-collection methods. In researcher triangulation, more than one researcher works on the research project. Theoretical triangulation means research material is illustrated from different assumptions and mental triangulation involves different ways of thinking about the object of research (Flick, 1999; Smaling, 1992). Investigator triangulation involves that a second investigator audit the data analysis and interpretations to determine if the conclusions arrived at, correspond with that of the researcher (Miles & Huberman, 1994). This is also called an audit trial (Babbie et al., 2001). In multiple triangulation more than one type of triangulation is used (Flick, 1999; Smaling, 1992). In qualitative research triangulation also involves that "researcher uncertainty and not knowing are actively engaged with" (Tindall, 1994, p. 143).

This researcher used method triangulation by using interviews, documents and participant observation for data collection. Investigator triangulation was also used.

The data about the interviewee's relationship with her mother was given to two independent investigators to look for themes. Investigator one is a clinical psychologist and works mainly from a psychodynamic frame. Investigator two is a clinical social worker who has worked for years in the psychodynamic tradition. The last couple of years she has been working mainly from a narrative framework. The reason for doing this was to audit the researcher's work and to look for themes that could be used as rival explanations.

To further enhance accountability, this researcher attempted to give a thick description. "A *thick description* gives an account of the phenomenon (a) that is coherent and that (b) gives more than facts and empirical content, but that also (c) interprets the information in the light of other empirical information in the same study, as well as from the basis of a theoretical framework that locates the study" (Henning et al., 2004, p.6). Punch (1998) adds that a thick description must specify everything the reader must know in order to understand the findings, as well as providing sufficient information about the context so that the reader can judge the transferability and generalisability of its findings.

A third method that the researcher used to enhance accountability, is a member check. This entails taking the transcripts and analysed texts back to the interviewee to check whether what the researcher constructed from the data is what the interviewee actually said (Babbie et al., 2001). After transcribing and analysing the data, the researcher had another interview with the interviewee to check data and interpretations that the researcher were unsure of.

The researcher also attempted to be accountable by giving a reflexive analysis. The term "reflexivity" is used to describe the researcher's reflection on his/her own experience and role within the conduct of the research (Burman, 1994; Flick, 1999; Mays & Pope, 2000; Tindall, 1994, Wilkinson, 1988). Tindall (1994) notes that reflexivity is perhaps the most distinctive feature of qualitative research. It is an attempt to make every aspect of the research process explicit and to critically evaluate it throughout. Three types of reflexivity is identified, namely personal, functional and disciplinary reflexivity (Tindall, 1994; Wilkinson, 1988).

Personal reflexivity refers to the acknowledgement of who the researcher is and how personal interests and values influence the process of research from the initial idea to the outcome. "This centralizes, rather that marginalizes or denies, the influence of the researcher's life experience on the research and the construction of knowledge" (Tindall, 1994, p. 150). The danger with personal reflexivity, is that it is difficult to be critically subjective, gaining a balance between engagement in the participants material and the researcher's understandings, thus to balance subjectivity and objectivity. Parker (1994) sees the subjectivity of qualitative research as a source, not a problem. He argues, for example, that when researchers believe they are most objective by distancing themselves from their objects of study, they are actually producing a subjective account, because a position of distance is still a position, and is even more powerful if it is not acknowledged.

In functional reflexivity, the focus is on how the course of research is shaped and directed by who the researcher is (Tindall, 1994). It is the continuous critical examination of the process of research to reveal its assumptions, values and biases.

Wilkinson (1988) notes that functional and personal reflexivity is so closely intertwined as to be inseparable. She proposes that personal reflexivity focuses on the researcher and functional reflexivity on the research itself. This researcher agrees with her that the two are inseparable. She notes further that a full reflexive analysis would entail not only asking how life experience influences research, but also how research feeds back into life experience. The third type that can be distinguished, is disciplinary reflexivity. This refers to an analysis of the nature of a discipline to explain its own form and influence (Wilkinson, 1988). This researcher focused on personal and functional reflexivity in the reflexive analysis.

4.5 Conclusion

In this chapter the method of investigation was described. Attention was given to the research design, methods of data collection and analysis, as well as ethical issues that were taken into consideration. Finally accountability was discussed. The next chapter will be a discussion of the results of the study.

CHAPTER 5

DISCUSSION OF RESULTS

5.1 Introduction

In this chapter the results will be discussed. The chapter starts with a brief clinical background. Then follows a reflexive analysis, endeavouring to make the research process explicit in order to enhance accountability. It is written in the first person because of its personal nature. Thereafter follows the analyses of the interviews, participant-observation and documents. The chapter is concluded by an integration of the different discussions.

5.2 Clinical background

Lerato (a pseudonym) aged 27, is Tswana-speaking. Her story follows, in a nutshell, as details will be given in the analysis of the interviews. She was the eldest of six children. When she was a baby, her mother worked and her aunts, who were still at school, and her great grandmother looked after her. Her parents moved around quite a lot. Her father often abused alcohol and there were many fights (verbal and physical) between her parents. She had a poor relationship with both her parents, but especially with her mother. It seemed as if her mother was very depressed during Lerato's teenage years. School was very important to her and she spent a lot of time in the library, reading up on careers. In standard nine she became depressed, mainly because of the stress at home. She could not go to university after matric, as there was no money for further studies and her applications for bursaries were not successful.

She spent a year at home and then got work as a diesel mechanic apprentice. Later on she worked as a train driver assistant and then as a clerk in an office. She had an affair

with a married man, became pregnant and aborted this baby. She spent a month in a psychiatric hospital for depression, where she had a relationship with one of the workers there and fell pregnant again. She again considered having an abortion, but was advised by a doctor not to go ahead. She then decided to keep the baby, and a girl was born by Caesarean section.

Three months after the birth of her daughter, she was pregnant again. The father of this baby was a colleague at work, married and much older than her. She went to have an abortion, but on arrival at the hospital, learned that they do not carry out abortions there and she had to go to another hospital. Because of transport problems, she decided to keep this baby. When she was five months pregnant, she was admitted for depression at another psychiatric hospital for two weeks. Another girl was born by Caesarean section.

At this stage Lerato was living with her parents again. She had a lot of problems with the baby's father, who had other girlfriends, and with colleagues at work. When her second baby was three months old, she tried to suffocate her. When her parents went to town, she wrapped the baby in a blanket in order to suffocate her, left both children alone at home and went to work. When she came back, her mother had taken the baby to the doctor, as she could not breathe or suck a bottle. Because of all her problems at work, she resigned. When this baby was seven months old, she suffocated her with a plastic bag.

5.3 Reflexive analysis

Eight months after my own daughter's death, a friend who is a community psychologist, visited me. She told me about a colleague's niece, who suffered from postpartum depression after her first and second child. She murdered her second baby and was in jail, awaiting sentence. I was immediately interested. I was intensely aware of the fact that depression could kill – my daughter took her own life because of it, and this woman killed her own daughter. Even though our circumstances were so different, I felt a bond with this woman – she was, after all, also a mother who had lost a child.

It took several weeks to get permission from the woman's lawyer and correctional services to conduct interviews with her in prison. When permission eventually was granted, there were ten days left before her trial date, compelling me to conduct all the interviews in very limited time, which is not the ideal situation. I was worried that even if she gave permission to participate in the research, it might not be ethical to have interviews with her so shortly before her trial date. I was anxious that she would be so upset by talking about her experience, that she would not be able to stand trial. I was also concerned that she might be so depressed or aggressive that it would be difficult to get her to cooperate. I had never been in a prison before and was scared that it would be upsetting for me too.

For the initial interview, I planned to get acquainted with her, explain what the research would entail and to get her informed consent to participate. I was very emotional the first day, driving to the town where she was in prison. My daughter was born in that town and we spent the happiest ten years of our family's life there. I

realised that in years to come, the woman that I was about to meet, would have very different memories of this town. It was a beautiful morning in late summer and I was aware of the fact that I could enjoy the scenery while she was confined to a prison cell.

The prison was very different from what I had expected. Although there was the typical government furniture, attempts were made to make it look homely. I could hear people talking and laughing. I later realised that it was the section for people awaiting trial and that it might be very different in the other sections. I was taken to a lounge where I met Lerato. She was small and looked intelligent. She was dressed in a t-shirt, denim shorts and tackies, had a "What Would Jesus Do"-band around her arm and looked like a teenager to me. I found it difficult to imagine her as a mother.

She was neither depressed (she was on an antidepressant) nor aggressive and was quite keen to participate. She was eager to tell me her life story and after an hour and a half, I had to stop her, reminding her that we would continue in the next interview. I had seven semi-structured interviews with her in the course of five days. I was interested to learn about her representations of herself-as-mother, her mother as mother-of-herself-as-a-child and her representations of both her children. I shall discuss the interviews in detail in the next section. At the stage when I had the interviews with her, she had been in prison for almost eleven months, awaiting trial.

My own feelings during the interviews vacillated. Most of the time, I had empathy for her, but I was very upset when she told me how she tried to suffocate her baby and how she left both children all on their own at home and went to work. I wondered how disturbed she had been at that time. I realised that at times she had psychotic traits to a

certain extent, and that I was not dealing with pure postpartum depression as I had been told. Up to the sixth interview, I could not feel any connection with her as a mother, especially not as a mother who had lost a child. In the fifth session she verbalised this and said that she did not feel like a mother who had lost a child. She did not feel any pain and she was not sorry. She said that it felt as if doors had closed in her mind. Something shifted overnight. In the next session she spoke about the time after her second child's birth. She spoke very softly and there were long silences. After the interview, when I had already switched the tape recorder off, she said that she wished it was a nightmare, that it had never happened, and that she missed her child. This resonated very strongly with me. I was on the verge of telling her that I really understand, telling her that I had lost a child through suicide. On my way back, I struggled with what the boundaries should be. In the quantative paradigm, it is crystal clear – I would be the researcher and she the subject. In the qualitative paradigm, one strives for a more equal relationship. I was not sure whether it was the right thing to keep quiet.

I was also very touched when we said goodbye after the last session. She said I was like a mother to her, I listened and I understood. She had no one to talk to. The jail was a bad place with very bad people. We hugged and she said "I love you". I did not know what to say. I felt I could not in all honesty say the same to her, and yet I felt she needed to hear these words from me.

Transcribing the interviews was a laborious task. Although the noise in the corridors was not disturbing while we were busy with the interviews, it influenced the sound quality of the tapes to a large extent. Where it usually takes about six to seven hours to

transcribe a sixty minute interview (Pope et al., 2000), it took me six to seven hours to transcribe ten minutes of an interview. Luckily, I also took notes during the interviews and it helped considerately to pick up some of the words that were inaudible. However, I had to take two tapes to a sound engineer. The sixth interview, during which Lerato talked about the time after her second child was born, she spoke very softly. Her speech was almost completely inaudible and I only had my notes to revert to. I tried to arrange to have another interview with her. By now she had been sentenced to eight months in prison. I learned from the prison authorities that she was very aggressive and they asked me whether I could make a recommendation regarding other more suitable placement for her. I was quite nervous about seeing her again.

However, before I could see her, she was transferred to another prison. Again it took me weeks to arrange to have another interview with her. By then I had done the analysis of the interviews. I used this interview to get clarity on certain aspects, for instance cultural issues, questions that arose from doing the analysis and also to validate some of the facts that I had. It seemed as if her depression was worse again and she admitted that the "troubling thoughts" were back. She was being treated by a psychiatrist.

5.4 Analysis of interviews

The researcher stayed as close to the data as possible and attempted to let the data speak for itself. Reflections after each relationship are given in order for the reader to follow the thinking behind the subsequent discussion. Inaudible words from the transcript are indicated by an empty bracket. The interviewee's words are in quotation marks and no language corrections were made. The data was grouped chronologically

for each important relationship of the interviewee. Names and places have been altered to protect her identity.

5.4.1 Lerato's relationship with her mother

Lerato, the eldest of six children, was an unplanned baby. The second child, a boy, died as a baby. Lerato did not know any details about his age or the cause of his death. Her mother was 19 years old when she was born. Her parents were not married at the time, which, according to Lerato, could be customary in their culture at that time. She felt that her mother did not want her:

> "You know the things that she used to say, she said I wouldn't be here because of you, you know. She said to me that she thought that I would work for her when I grow up. She didn't expect me, it was like she felt bitter about it. It was like she didn't want me. Or my grandmother said you know this child didn't want her daughter. She almost killed her, something like that. So I grabbed it from there, but my mother also said something. I can't remember what."

Lerato remembers very little of her pre-school years. They lived with her great grandparents. Her mother was not there as she was working, probably in another town. She said her three aunts looked well after her. They were like sisters to her. She remembers once crying for her aunt while she was at the house of a relative whom she did not know.

When Lerato was 5 years old, they moved to another town. They moved a lot, usually living with her father in a shack in the backyards of family. During her early primary

school years (when she was between 5 and 8 years old) her mother taught her how to keep house and would do anything for her. She started being scared of her mother when she lost R2 and her mother chased her with an umbrella and beat her. She described several incidents when she had been punished severely.

When Lerato was nine years old, her sister was born. Her mother changed, according to Lerato, because of fighting between her parents. Lerato described her as becoming sick because of stress, complaining a lot, still sleeping when she came home from school, being tired all the time and fighting a lot. Lerato was now responsible for the housekeeping and cooking and helped her mother to take care of her baby sister. Looking back, she understands that her mother had been depressed.

Their relationship deteriorated. Her mother complained that she did not listen and compared her negatively with other girls, in spite of the fact that Lerato thought she did a lot for her mother**.** They never talked about anything, apart from commands about chores Lerato had to do. She said her mother was unreasonable, harsh, rude and called her names. Lerato started to stress because of her parents' relationship, the responsibilities she had and her mother's fighting with her. She believed that the fights between her parents had done some damage to her mother. When asked to elaborate she said:

> "Mentally. She is not herself. She can't be a mother. She can't look after her children. She's tired all the time. She's just not herself. She, she can't think for herself. She can't clean the house. I was not really proud of her, you know. She could not stand up for me, she could not fight for me, she could not help me in any way. I am not trusting her."

They never had a relationship. Being scared of her mother, in addition to her mother's harshness and rudeness, drove her away from her. She remembered her mother saying: "If I can just grab you in my arms I would kill you, you know". Lerato said the following:

> "Because I remember when we were kids, my mother would do things not exactly like a mother. I mean I can't trust her to be loving and caring as a mother does and understanding."

During Lerato's high school years, they lived in a big house. Her parents' relationship was very disturbing to her. Her father had a drinking problem and often came home late. Her mother would wake the children to go and look for him. There was verbal abuse between her parents. Her father also physically abused her mother. She felt very responsible to help her parents, but did not know how. She started hating them. "I didn't want to have a family like that. I wanted to have a better family."

Her relationship with her mother deteriorated further. Her mother blamed her for things that were not true, was often angry, fought with her and yelled at her to do the housework:

> "I didn't have any understanding. I was just seeing my mother as lazy and she cannot be in control of her life, she cannot fight for herself, she can't do things for herself. She is always asking me to do things for her. She just wants me to do things for her, she just wants people to do things for her, but she can't do it for herself. So she was, I did not like her. She was not the kind of mother that I would want to be. One day I even told her that I don't want to be like her."

Lerato's mother did not want her to have friends over, because she believed they would have a negative influence on her. Lerato thought her mother underestimated her and thought lowly of her. "She couldn't see the good in me. She would only see the bad." Her mother was unreasonable, bossy and bullying her around. They never talked about anything, Lerato was only given instructions about work she had to do. She did not feel known by her parents or that they were interested in her. Lerato mostly locked herself in her room. Once she ran to her aunt because of a fight she and her mother had.

When Lerato was in standard nine, she complained at the doctor's "that something is wrong", she was "shaking on her bed", she could not sleep, could not concentrate, was tired, stressing a lot, worried about everything, especially her parents' relationship and she started thinking too much. She was put on antidepressants.

When asked about thoughts that she had during that time, she replied:

> "That she would leave me, she would leave us (silence). She would poison us, you know (silence). But I didn't care about her anymore. I didn't care anymore. I didn't felt sorry for her. She can't stay with a husband beating her. Why doesn't she fight back. She () it happen to herself."

Lerato tried to get bursaries to go to university, but was not successful. She wanted to get away from home, as she could not handle the situation at home any longer. A year after matric she ran away from home. More details about her adult life will be given in the section on her relationship with herself. Her relationship with her mother was difficult. She believed that her mother loved her, because once she asked her not to

leave. Her mother said she could not live without her. Lerato felt "very, very, very," responsible for her mother. She felt sorry for her that she was treated the way she was by her father, as she believed a woman does not deserve to be treated like that. She wanted to fight for her mother, but didn't know how to confront her father. Her description of the relationship at this stage, is as follows:

> "But our relationship, with my mother, was not good, because we was just there () you know, a child, a mother. But it doesn't mean anything, you know. I don't like it. She bored me, you know. But I don't show her that I don't like her, she affects me. I don't show anything. I was keeping it all inside. So I didn't show it. So I didn't have a relationship with my mother. I was there, she was there."

Lerato's mother didn't say anything about the fact that she was pregnant. There was still no communication. At this stage her mother sometimes did the cooking. Lerato was depressed and did not appreciate what her mother did.

Her mother helped her the first day after her eldest child was born. Lerato's aunt looked after her baby for the first three months as she went back to work. She did not trust her mother to look after two children - her mother also had a small child at that stage. It seems as if her mother did sometimes help her look after her child, as she later on said that is how she fell pregnant with her second child. Lerato's mother was there after the birth of her second child, but didn't help her. She felt that her mother did not help her with her children, although she was there. Lerato expected a lot from her mother and was often angry if things were not the way she expected it to be, for example like looking for the baby's socks. After Lerato tried to suffocate her second

child the first time, and left her two children alone at home to go to work, her mother took her child to the doctor when she came home. However, her mother never asked her anything or made any comment about it.

Their relationship deteriorated further after the birth of Lerato's second child:

> "Because my mother, you know, my mother, my mother took me like a fool, treated me like a stupid child. More like a stupid child. Just because I was afraid I didn't say anything about it. () I was just a child. She took me for a fool, my mother, she treated me like I don't have brains. I also treated myself like that in front of her, because she treats me like I don't have brains. I would also act like that, like I don't have brains. Because they don't want to hear a word from me. It felt like she was taking advantage of me
>
> Interviewer: In what sense?
>
> Interviewee: Like I'm stupid, she can, she, she can make a fool of me. She can tell me to do this and do that, you know the way my mother wants me to do, to do, to do. She can control my life, you know. You sit down and I'll just jump and sit down, stand up. She was more like that, she wanted to have control over me. But she didn't have control over my life."

When her mother visited her in prison, she did not want anything to do with her. However, since she has been in jail, she understands her mother's behaviour in the light of all the stress her mother had as a result of her relationship with her husband:

> "She was stressing because of the fights. If you are involved in a world of violence, there is a lot that is affecting you. For an example, me, you

know, I was very affected by what was happening in the house and I was worrying too much, I was thinking too much, you know. So my mother was also going through the same thing. She was thinking too much. Maybe she was not having money so that she could leave the house and she would think what to do. She doesn't have any move. She's trapped. (Silence). (Sigh)."

"So, she was, she was not in control of her life anymore. You see, all the beating had made her stress a lot. When you are stressed you are not in control. The stress is the one that is in control. So you are listening to it most of the time."

- **Reflection on Lerato's relationship with her mother**

A theme of an unwanted and unplanned baby started with Lerato's mother being pregnant with her. Another theme that emerges, is that of a destructive mother – a mother who could kill, who poses a real danger for her child. Lerato was not protected from this knowledge, it was openly said by her grandmother in front of her. Lerato's representation of her mother is thus that of strong negative feelings about having her.

It is not certain whether Lerato's grandmother was a part of Lerato's mother's support system, although the great grandparents were there. The grandparents were divorced. One wonders how well Lerato's aunts could look after her as they were at school.

The family had little stability and suffered the additional stress of poverty. Her mother's anger got out of control, contributing to the destructive mothering that Lerato received. Her mother even verbalised the real danger that she could kill her child. The

realisation grew further that her mother could not be trusted. She was not loving, caring and understanding as a mother should be and Lerato realised this. This is an indication of Lerato's representation of an ideal mother and of her representation of her own mother not only of lacking in these qualities, but also of being dangerous.

Lerato's mother became depressed not only because of the relationship between her and her husband, but possibly also suffered from postnatal depression after her sister was born. Lerato was a parentified child who had to fulfil her mother's needs. Her representation of her mother is of someone who did not fulfil her responsibilities, who expected a lot of help from her and who was always fighting.

Her mother was very dependent. Lerato knew what she missed – a mother who could be there for her. Her representation of herself is affected negatively by the criticism from her mother, but she could still hold onto a sense of knowing that she was doing a lot for her mother. She started to realise that she could not trust her mother. The theme of a depressed mother who could not look after her children emerges and influences Lerato's representation of her mother.

She felt responsible to help her parents, but was helpless and powerless as she did not know how. The responsibility was also passed onto the children to look for their father. Physical and verbal abuse was the norm in this family, as well as uncontrolled anger, all eventually becoming a part of Lerato's representation of a parent.

Her mother remained very dependent. The marital abuse was passed onto Lerato. The fact that she did not want to be this kind of mother showed that she already had insight

into how a mother should be. It underlines what was said in a previous paragraph regarding a negative representation of her mother in her role as mother and the forming of an ideal representation of herself-as-mother.

Acts of self-protection (locking herself in her room, running to her aunt) might have been the start of a pattern of running away from problems. She recognised the good and bad in herself, but her mother only saw the bad. Thus, at this stage Lerato's self-representation was still balanced, but her experience informed her representation of her mother as of someone seeing only the negative in her. It is possible that her mother used splitting as a defence mechanism and projected her own badness onto her child.

Her description of shaking on her bed could possibly be an indication of panic attacks. Her own depression became so deep that she did not feel anything and seemingly did not care anymore. She also realised that her mother need not put up with all the marital abuse.

There was a relationship of no connection between mother and child, a repetitive theme “I was there, she was there”. As an adult she believed her mother loved her, but one wonders whether her mother did not only need her. She carried a heavy responsibility. She started showing compassion for her mother when she became an adult. Her representation of her mother now included someone who loved her, but also someone who was very dependant and needy. Her feelings of helplessness became intense – she wanted to fight for her mother, but could not.

Another theme of not talking but bottling up feelings became repetitive. The theme of not talking about important matters is very evident when nothing is said about Lerato's pregnancy. Depression during pregnancy impacts on a mother's readiness to have a child and will be discussed further on.

As a part of the cultural tradition the grandmother is there for the young mother, especially with the first child, but Lerato's mother was there only on the first day. Thus Lerato had very little support, the effect of which will be discussed later. She took her child to her aunt – perhaps evident of the fact that her mother could not be trusted with a baby. It is possible that her mother was almost like a sister, as she herself had a small child at that stage.

The fact that Lerato's mother could take her child to the doctor after Lerato's first attempt to suffocate her, showed that she did know what a baby needs, although she often did not respond to the children's needs. Again, something very important happened, but it was not talked about. One wonders why her mother did not ask or say anything – perhaps an indication that for her mother it was "normal", or that she just did not care.

It seems as if Lerato's depression after the birth of her second child became worse and contributed to the fact that all her relationships deteriorated. The fact that her mother did not have a balanced picture of her by seeing only bad in her, or possibly projecting her own badness on her, resulted in Lerato acting that way. As an adult, Lerato's representation of her mother is that of someone who thinks she is stupid, but now her self-representation echoes this. This will be elaborated on in the discussion. "She

didn't have control over my life" – one wonders whether killing her child could mean that it is one thing her mother could not stop her from doing.

Lerato shows insight in her mother's behaviour in stating that stress was in control. She also knows how living in a world of violence impacts on a person. She knew her mother also felt trapped as she did. Her mother was not in control of her life in the same way as Lerato was not in control of hers.

- **Reflection of investigators**

The data about Lerato's relationship with her mother (not the reflections), was given to two independent investigators to look for themes. As was explained in the methodology chapter, the reason for doing this was to audit the researcher's work and to look for themes that could be used as rival explanations.

The themes from both these investigators were mostly the same as that of the researcher. There were no discrepancies. Investigator 1 commented on the fact that both Lerato and her mother had high expectations of each other, was critical of each other and compared each other with peers. Investigator 2 added that Lerato's story was "heartbreaking" and that she showed remarkable wisdom and resilience as a child to still thrive at school under those circumstances.

5.4.2 Lerato's relationship with other mother figures

Lerato's three aunts looked after her as a baby and in her pre-school years. Two of them were still at school and one was a teacher. She believed they looked well after her. It is possible that her great grandparents looked after her while they were at

school. She felt close to her teacher: "I felt like I could love her like a mother because she was more understanding than my mother".

- **Reflection on Lerato's relationships with other mother figures**

Very little is known about Lerato's substitute mother figures. Her representation of substitute mother figures is positive. Lerato's need for love and understanding is very evident.

5.4.3 Lerato's relationship with her father

During her pre-school years, Lerato did not see her father often, as her parents were not married and she stayed with her mother at her great grandparents. She remembers once sleeping with her father when her mother was not there. She loved her father. They had a good relationship. According to her, he did everything for the kids.

During her primary school years, her father drank a lot and their relationship deteriorated:

> "So I wasn't having any problem with my father (silence). So the problems started when they started fighting. I didn't see any reason why he should be fighting with my mother or hit her the way that he used to hit her. I started hating him. And all these things, they started pushing me away from them."

Once in her early teens, when her father was drunk, he asked her who her boyfriend was. She felt embarrassed by his question and felt that he did not really know her. At that stage her school work was very important to her and boyfriends were not on her

mind. When she was about fourteen he asked her whether she was accusing him of molesting her. He was drunk again and again she felt embarrassed. At that stage she did not know what the word 'molesting' meant. She never felt that her father looked at her in a sexual way.

When he was at home, the children were not allowed to watch TV. He wanted to listen to his own music. She did not want to see him and went to her room when he came home, without confronting him: "You're not suppose to question adults". They did not talk, except when they went shopping, they would talk about groceries or money. She pretended to be happy to see her parents. She described her feelings about her father when she was in high school, as follows:

> "Still I didn't feel like () or thanking him for what he had done, so I didn't appreciate anything that he was doing for me (silence). So since then we just stayed in the house like strangers. I felt like I wanted to fight with him. I wanted him to hear what I have to say to him but I couldn't, I was too scared to say (). I wanted to (), to scold him and tell him what he's doing is not right. I just kept quiet. I was scared, I was, I hated my father. I didn't want to, I didn't even want to talk to him. I didn't even want him near me. I don't even want to listen to what he has so say."

Her father physically abused her mother, but not the children. However, there was one incident when Lerato dropped a candle:

> "My father just came in there and he kicked me and he asked me what was I doing with the candle, you understand () always the things that are pushing me away, but he was doing things for me, and he would buy, buy

things for me and I would be happy, you know. He used to do everything for me."

Although her father wrote a letter to her work when she had problems there to explain the situation, she did not trust him to help her with anything. She could not start a conversation with him. According to her, they did not have a relationship, they were like strangers. She was scared to confront him about the way he treated her mother, as she feared that he would beat her.

When she fell pregnant with her first child, her father did not say anything or treat her badly. After the birth of her second child, their relationship deteriorated further. Once he said to her he was leaving and not coming back home and she had no say in the matter. She could not discuss anything with her father. She saw her father as a coward who could not face his problems.

- **Reflection on Lerato's relationship with her father**

There is too little information to theorise about their relationship during her pre-school years. One can see elements of the Oedipus complex in her sleeping with her father when her mother was not there and the fact that she loved her father.

Problems with her father arose because of the way he treated her mother. As she said, she lived in a world of violence. The theme of uncontrolled anger is also evident in her father's behaviour. In this family children needed to be scared of their parents – parents could be dangerous. As a result, feeling scared is also a theme. Even as an

adult she was scared of her father. Lerato's own feelings of anger were suppressed and became a pattern in her life.

There was very little communication. A relationship of no connection is also evident here – they were like strangers living in the same house. She did not feel known by her father. Parents could not be trusted to help.

Ambivalence is evident. Her dad would buy things for her and then she would be happy. The parenting style is very authoritative – children are not supposed to question parents. There is no space for children's needs. She started hating her father.

Her father's questions when he was drunk embarrassed her. His question about molesting is very strange. One wonders whether he had such thoughts and could only verbalise it under the influence of alcohol. Her father had a drinking problem. Alcoholism is often seen as self-medication for depression.

He also said nothing about her pregnancy – it was ignored. As was said before, all Lerato's relationships deteriorated after the birth of her second child, possibly an indication that her depression got worse. Her feeling of helplessness is also a theme from childhood that carries on into adulthood. Her father was leaving and not coming back and she was not allowed to question it.

5.4.4 Lerato's relationship with herself

Lerato's description of herself revolved more around her high school and adult years. Even as a young child, she never spoke about her problems to anyone. This tendency

continued in her high school and adult years. She saw herself as a pleaser, especially in relation to her parents, and pushed herself to do things. She enjoyed school. She was good at reading and studying and spent a lot of time in libraries reading about a career. Although her appearance was important to her, she was not interested in boys. "I was not ready. The only thing that was on my mind was my career, you know. My future was on my mind." She often thought that she did not want to lead a life like her parents. She saw herself as sensitive, independent and the only one she could trust.

When Lerato was in standard nine, she began to think there was something wrong with her. "I started thinking too much. Questions without answers." She thought her problems came because of her parents' fights, what she saw they were doing wrong, the fact that she was dealing with it on her own and didn't know what to do. She experienced a lot of pressure – she did not know what kind of person her parents wanted her to be. She did not feel accepted by them. She went to a doctor who prescribed antidepressants. She could not remember for how long she took the antidepressants. Her depression got worse – she felt out of control and realised that she was not doing things the way she should or wanted to.

A year after she left school, she ran away with a friend. After three months she left her friend to go to her aunt, without telling him. She wanted any job to get away from the problems at home, thinking she would feel better if she was away from her problems. She started drinking something to give her energy and smoking to relieve stress.

She described her depression as having difficulty concentrating, making decisions and plans and losing her ambition.

> "I left my first job because I can't use my mind, I can't think of anything different I could do. I was not ambitious, you understand. I say, no, I can't stay, I'll go there, maybe something different will show up. I'll be positive, maybe I'll become a different person (). Things was not happening the way I want them to."

At the age of twenty one, she had an affair with a colleague at work. She fell pregnant and aborted the baby. Three or four months after the abortion, she left her job. She was on antidepressants again and was abusing sleeping tablets. She could not do the housekeeping anymore. Her mother also did not do it and Lerato blamed her mother. Once she ran away and stayed with a boyfriend. Her mother came to take her home and she went with her, although she did not want to.

Her relationship with her parents was very bad:

> "No, I didn't want to be in that kind of a situation, because I don't have to say anything about it (). Even if I see that there is something wrong, I shouldn't say anything, you understand. I know I am not a part of the family, you understand. If I see something is wrong, then I should just keep quiet, because most of the time I would sit there, you know something is wrong, you understand, or it will go wrong. I will tell myself I will just let it go wrong. I'll just tell myself I don't care. My father doesn't care, my mother doesn't care. (Long silence)."

Lerato was scared of how her depression impacted on her. She could not do the things she wanted to do, she felt as if she could not use her brain and it lead to her doing

things without thinking. She felt that she had lost her feeling of control. She felt her mother controlled her life. She was uncertain, tired, and could not function at work. Although she earned a substantial amount of money, she was disorganised and careless with her money. She described herself as unstable in the sense of moving here and there and leaving jobs.

She saw herself as good, wise and understanding, and a hard worker. She believed that her school friend, with whom she had little contact as an adult, would also describe her as wise and understanding, and added that she would think that Lerato was a good person . She had always expected a lot of herself. She saw herself as a perfectionist and didn't want anything to go wrong.

She became very angry and frustrated with herself and her mother after her first child was born, because she felt she was not living up to her own standards. It became worse after the birth of her second child. Her self-esteem was very low. In response to a question about her feelings at that stage, she said: "Really bad. Really bad. I didn't appreciate the person I was (silence). But I couldn't help myself (silence)". She believed all the "stupidity" of her actions was caused by the fact that she could not talk to her mother.

After the birth of her second child, she had very disturbing thoughts. She thought that the planets would collide, or the world would fall, or the moon would fall on their house. When a song played on the radio, she would think the song was about her. There were also thoughts about herself – who she was, the situation and change in our country, her work and why her colleagues wanted to kill her. She felt as if she was

losing her mind. She heard voices which told her she was a useless mother and voices that asked her if she knew Jesus. She would do something and the voices would tell her not to do it. She then would not know what to do.

- **Reflection on Lerato's relationship with herself**

She could only rely on herself as her parents could not be trusted. She could not trust her parents enough to talk to them. The theme of not talking about problems is strong throughout. She was almost cast in the role of being a pleaser – she had to be there for her parents. Perhaps it was a way of hoping that she could earn their love. It was also what her parents expected from her. She excelled in school, possibly because it was the only place where she received some recognition. In primary school and her early high school years she had a positive representation of herself, especially, herself-at-school. Her representation of herself-as-child-of-her-parents was more negative, but still hopeful – if she worked hard enough, she believed she could please them.

Her feeling of helplessness intensified as she got older: she did not know what to do about her parents' problems and how to be to be acceptable to them. Perhaps she unconsciously thought of herself as being the reason for their problems, as she was the product of their union and her mother did not want her. Her depression resulted in a feeling of being out of control and not doing what she wanted to or should do – a recurrent theme in her life. Her representation of herself changed as result of depression and this will be explained in the discussion.

Her desperation is evident after she left school. The fact that her dreams to study further could not materialise and she was unemployed for more than a year on top of

her depression, made matters worse. She hoped to get away from her problems by running away. Drinking something to give her energy and smoking to relieve stress are perhaps also indications of her desperation.

Even after she got a job, the desperation continued. She hoped finding another job would make her feel better, it would change her and she would become a different person. This suggests a self-representation that is getting more negative. The theme of unrealistic expectations is a thread throughout her adult life.

The question arises whether leaving her job had something to do with her affair. One wonders whether the fact that her mother came after her was because she really cared or whether she needed her to do the housework. There were two depressed women in the house, possibly resulting in chaos. Lerato described her depression as thinking too much, especially at night. Perhaps her abuse of sleeping tablets was a way of trying to escape all these thoughts.

The theme of feeling isolated became stronger. As an adult she did not feel part of the family. Her helplessness and powerlessness to do anything about the problems suggest that at that stage she was giving up. Giving up is also evident in the theme of not talking about anything – it would not help. She was also giving up in the sense of joining the club – (at home,) no one cared. The theme of giving up suggests a deepening of her depression.

Impulsiveness – acting without thinking, is seen by her as a result of her depression. There is also a loss of a feeling of control – like her mother. Her mother controlling

her might have been a part of the family pattern – father controls mother, who then controls Lerato. Her carelessness with money, lack of stability and wanting to have sex made the researcher wonder whether Lerato might have been suffering from a bipolar mood disorder. However, there is not enough evidence to confirm this.

The fact that she saw herself as good, wise and understanding reflects perhaps not only her ideal-self-representation, but also how she wished her mother would be. Interestingly, this is also how she saw her children, as will later be seen. Despite negative messages from her parents, she could hold onto some good in herself. This is even more remarkable if one takes into account that she is a perfectionist and had high expectations of herself. As was seen in the reflection on her relationship with her mother, she did internalise her mother's criticisms. Perfectionism and depression are often a fatal combination, because the gap between the ideal self and real self becomes very large. This will be elaborated on in the discussion.

After the birth of her first child she felt he was not living up to her own standards. The theme of perfectionism is carried further. It lead to anger, criticism of herself and her mother. Frustration and anger were building up. She was letting herself down. She was becoming more helpless. Her depression was getting worse and her representation of herself suffered.

After the birth of her second child, there are signs of a loss of contact with reality. It is not clear how severe it was or how long it lasted. However, more light will be shed on this in the analysis of the documents and the further discussion.

5.4.5 Lerato's relationship with the father of her first child

Lerato felt she did not really know him. She didn't enjoy being with him. Although she said she did not like him, she was not sure whether she loved him and was scared of showing love to him. She could not sleep with him in her parents' house. She described herself as shy and disorganised with him. Although she said he was good to her, she fought with him and "tortured" him, verbally and physically. Eventually she chased him away and did not regret it, because she did not really love him. She denied being angry with him. According to her, she fought with him because she did not want him and did not know how to tell him that.

- **Reflection on her relationship with the father of her first child**

She is very ambivalent. She is not sure if she loves him. Their relationship echoes that of her parents', apart from the fact that she was the "persecutor". It is possible that the fact that she could vent her anger on him, spared the life of her eldest child. This is the first time that she is not suppressing her anger. It is interesting that she denies being angry. This could possibly be one explanation why she eventually murdered her child – she denied it, suppressed it, and eventually it erupted.

5.4.6 Lerato's relationship with her first child

A friend persuaded her to talk to a psychologist to get help for her depression. She was sent to Weskoppies for a month. She still did not talk about her feelings or problems. She met one of the workers there and they started a relationship. As a result she fell pregnant, at the age of twenty three.

> "I slept with a man knowing I will fall pregnant, you know, without using a condom. And I don't even know the man (silence). I don't even know if

> he is sick or not sick. I don't even know where he's staying, I don't know his home."

When she was eight weeks pregnant, she went for an abortion. She contradicted herself, because she first said that the doctor persuaded her not to have an abortion and then later that she did not have money for an abortion. She also said she changed her mind and decided to have the baby, because the baby would make her happy and if the baby's father was there, she would have nothing to worry about. She was scared of how her parents would react if they found out she was pregnant. However, it does not seem if that fear was one of the reasons for thinking about an abortion. She did not really think about the baby, although she did wonder about the sex of the baby. She had no feelings when she found out she was expecting a girl after going for a sonar.

She had intense feelings: she worried about her life, her mind, her way of doing things – she could not stand the fact that she was acting without thinking. She was getting tired of that kind of life. She became angry. She was also angry about the house that was not clean and she was too tired to clean it herself. She had no energy and felt other people took control of her life. "It was upsetting. I was getting angry and angry and angry, without showing it or talking about it." She felt life was not what she wanted. She could not sleep and was anxious about going back to work as she had problems with colleagues. She felt alone and hurt and regretful. She also felt out of control.

> "So I was not trying to make any sense at all (). I was seeing myself as something else, like I was not ready to be a mother. I was not ready to be a mother… But I didn't realise that I was pregnant. It didn't mean anything

to me that now I'm a mother, I'm a grown up woman. This will be a change of my life, I better change my mind. Because I think that I was doing something wrong… I want to make my life right, but I don't know how, where to start. I was hoping that if I have this baby that I will start acting like a mother, or that my mind will change, you know (). It will record something like that now you are a mother. Then you have changed. You know, something like that. I was hoping it will change. It will happen automatically… and I was not feeling safe that I will be able to act like a mother. I was not thinking that I will be able to act, to act like a mother. You know, the way that I think that I want to treat my child….The feeling that I had, I was, I was feeling scared and insecure, all by myself (silence) (cracks her fingers). I wasn't feeling safe. It's just like when you are being left alone then you are scared to be left alone (). Scared of it. It's just you and your thoughts that are coming to you. But it was, it was the fear that I had for all these years. So, it, it never went away. That I'll be able to stand on my own, that was it, you know, it was that kind of fear. I was very insecure.

Interviewer: Would you say you were angry because you fell pregnant?

Interviewee: (Silence). Well, I wasn't angry. I wasn't angry. I wasn't angry (silence). But something I remember I said () how can somebody have a baby without saying I want to have a baby, you know. But at the time I was, my mind was, was rolling in another direction (). Now I can see that I was wrong (silence)."

When asked if she ever thought about how it would be for her to be a mother, she said that she thought she would be a good mother. She also had these thoughts while being pregnant. She responded:

> "I have. I thought of me, of me as being a very good mother, and very understanding and loving, you know. I, and, I will even think of the things that I would buy for my, for my children, the things I will do for her. I would make her very happy, you know, I would look well after her, you know. So, but my mind was, was full of things. The baby was not one of it, was not one of those things on my mind (silence)."

The baby was born by Caesarean delivery and she did not see the baby directly after birth. She knew that she was going to have a C-section and preferred it, because she was scared of a normal birth, as she reasoned a vagina is too small for a baby to pass through.

Her child was small and sweet. She said she loved her child and was happy to have her. However:

> "…my thoughts about my mother and my father, you know, the way I feel, they're still there. That they were not going to be happy about the child you know. Even though when they came to see me in the hospital, I was just pretending as if I am happy to see them, but I felt like I don't want to see them, I don't want to be with them. So the other thing that upset me was that you know, I was expecting myself to be a good mother or you know, I would do anything, anything for my child. I would see to it that she eats, she, she, the way she sleeps, you know, the way I prepared things

for her, but I wasn't, I wasn't preparing things for her, I was always tired, I was always angry, you know, I was filled up with anger. So, that anger was broking my ways. You know I couldn't see the way forward or the way I could do things, the way I want, I want them to be done. (Long silence). (Sigh)."

She did not spend a lot of time with her baby. She worked night shift and slept during the day. The first three months Lerato's aunt looked after her baby. She did not want her mother to look after the baby. One of the reasons was that her mother also still had a small child. However, at times, she did.

"So when the child was born, I, (silence) I was still working but I didn't want to stay with my parents. Like sometimes I would leave her with my mother, you know, I was, it was not making any sense, you know. The way I was acting. I was not acting like a mother.

Interviewer: Can you be more specific?

Interviewee: OK, I got used to the life that I was used to. It was in me, in me, you know and I was still in that mode of the way I like to do things. I wasn't settled, I was not, my mind didn't register I was pregnant and I am a mother, you know, that I have that understanding and I should be acting like a mother, I have a child and the things that I should do for the child I wasn't doing them. I wasn't thinking about now I have to wash the napkins or now I have to feed the baby, or. These things were not there (silence). And () sometimes I would leave the child with my mother and go to the place to meet my, the other boyfriend…I didn't see the baby, you know. I am having a baby now, now what to do, you know, the things that

> I should be thinking about, you know, what to do next. It was just the baby there and there's nothing that I could do about it."

Lerato had an affair with an older married man while she was pregnant with her first child. At first she did not know he was married, she "wanted to try sex, was being naughty". Three months after her first child's birth, she was pregnant again. She also had financial problems by then.

She believed that she had her child before God made her ready to have children. She believed God wanted her to help her family to have a family life before having her own family. She needed to make peace at home. "I was wrong to have that kid." She was still angry with both her parents, but with her mother in particular. "So, (sigh) that anger, it was there all the time. It was, it was there from my childhood. I, I grew up with it." She was also angry with herself, because she was doing the wrong things.

Sometimes she would try to make her baby laugh by acting funny or once by dancing for her. But mostly there was no interaction between her and her child: "She was just there. It was just like maybe, my, my, my aunt's child, something like that, you know."

Her description of herself as mother, is as follows:

> "I, (sigh) I don't see a mother there. (Long silence). () while the baby was there so I was just acting as I am having a baby. You know, not like a mother, loving and understanding you know, the baby's just there, so I have to be around. I'm going to work but I have to go and see the child,

> but sometimes I'll leave her with my, with my mother. That's how it got possible that I, I fell pregnant, with the second child**.** She never taught me how to raise my child or how to handle her, you know, things to do with her, you know, because I think I know better, you know. I have experienced a lot in life, so I know better about babies and how I should take care of them, but with my child I was not practising that. I was very careless. It was not like I am careless. My mind was just functioning in that way that I was careless."

When she compared the way she acted towards her baby sister with how she was with her first child, she said that she was calm and natural with her sister. She was able to handle a crises and she was accepting. With her own child she was not accepting, she was tired and depressed and "I couldn't do the things the way I thought that I could do them.". It disturbed her that:

> "I was becoming more like my mother (silence). Lazy and not in control, you know, always worrying and not doing the right things that I, which I would see myself doing. (Long silence). …Yes, I always thought of myself as that (good, wise and understanding) and I could be like that in the future. So, I was amazed that, it was a surprise to me that I was becoming, you know, like I'm not making any sense, acting very foolishly, you know, in front of other people. Or even in front of God. But, it was the anger that was taking over and the pain that I was feeling. So it was making me do the wrong things all the time (silence)."

She saw her eldest child as someone who could help her. When she tried to suffocate her second child the first time, she experienced her child as wanting to stop her, intelligent and wise, she could help her think, could see what was going on and could come up with suggestions as what to do:

> "She took a, (silence) a book of songs, (a Bible songbook) because one day I was, I took it and I was singing for them. So she took that book and gave it to me that () stop doing that, you know. So I didn't listen to her. So I see her like she, she, she understands what is going wrong, she can see what's going on and it is wrong."

She believed her eldest child saw her:

> "As a good person, the one that would not hurt her. Like my first child, one day that I was, I was leaving her to cry, she was, she was crying and I, I didn't pick her up or make her to be quiet, or she wanted me to hold her or what was happening and she was, she said no, you know, she, she said like, you know it is not possible for you to do this, you're not that kind of a person that would do this to me, you know, you are a good person. (Long silence)."

- **Reflection on her relationship with her first child**

The fact that she wanted an abortion suggests not wanting the child. Her first child was thus an unwanted and unplanned baby as she herself was. Her baby was not thought about. There is a strong realisation that she was not ready to have a child. An inner sense of mothering, maternal preoccupation and a primary relatedness were missing. She did not receive what a mother should give to a child. She knew how a

mother should be and she wanted something else for her child than what she received. However, she felt helpless to provide it, according to her, as a result of depression. Her representation of herself-as-mother is very negative and echoes that of her representation of her mother-as-mother-of-herself-as-child. Her mind was occupied with worries and troubles and not with her future baby, in spite of the will to give her child the good mothering that she did not receive. Thus, the gap between her representation of the ideal mother and herself-as-mother was huge. The motherhood constellation suffered and this will be elaborated on in the discussion.

She protected her child by not leaving her with her own mother – she took her to her aunt, who was a mother figure to her. The fact that her mother was still busy with her own small child, possibly added to her feeling that her mother was not there in a maternal role for her.

The theme of being scared of her parents is still there – she could not stand on her own in spite of the fact that as a child, she saw herself as independent. She did not expect support from her parents: they had never helped her then and would not now. She also had unrealistic expectations again and hope was projected on her child – her baby would make life better, would make her happy. Again huge responsibility was placed on a child. – her needs needed to be fulfilled by her child, as she tried to fulfil her mother's needs. Thus, even though she did not think about her baby, these thoughts and feelings about her future baby indicate what kind of a representation of her child was beginning to form.

Her fear of a normal birth and lack of belief in her body's ability to do this, is a wish to retain maximum control. One wonders if it could also be an indication of a negative representation of herself-as-mother in the sense that she did not trust her body to be a mother.

She was still pretending to be happy, which meant that a lot of her emotional energy was going into hiding her real feelings – again an ongoing theme. The theme of anger that is not talked about is running right through. Anger was building up. The effect of her depression in being too tired to do what she wanted to do or knew needed to be done was frustrating and difficult, especially for a perfectionist. She felt like a failure. Her helplessness and anger that she was not the kind of mother she wanted to be, is strongly emphasised. There was an acute awareness of the gap between her representation of an ideal mother and herself-as-mother.

Why she was so sure that her parents would not be happy about the baby, is not certain. It might be because she could not trust that they were honest about their feelings, but it is also possible that she projected her own feelings onto her parents. Even as an adult, she still carried the responsibility to rectify what was wrong in her own family, to such an extent that it felt not right for her to begin with a new family. It is interesting to note that she projects this feeling on God.

There is no connectedness between her and her child, as with her and her parents. The theme of a parent and a child "just there" features strongly throughout. Sometimes she tried hard to compensate, resulting in a false interaction. There is the realisation that she was acting out of character, which is what depression often lead people to do. She

could not act on what she knew babies need, namely love and understanding, what she herself needed as a child, again an indication of the large gap between her representation of an ideal mother and her representation of herself-as-mother.

She projected her own wise understanding part of herself, or perhaps her ideal self, on her child. The similarities between Lerato as a child who saw what was wrong but was not able to stop it, and her own child, is evident. As a result of splitting she lost the good part of herself, she could not hold on to that, but she believed her child saw it. Her representation of her child at that young age is very similar to her representation of herself when she was a child. Thus her representation of an ideal mother is projected on her child, and her representation of-herself-as-mother is that of a bad mother, like her own mother, who did not respond to her child's needs.

5.4.7 Lerato's relationship with the father of her second child

Lerato's relationship with the father of her second child became very bad. He was much older, in his late thirties or early forties. At first she saw him as very responsible, he would respect her and she hoped he would make life better for her. He said he loved her. Later, she found out that he was married and had relationships with a few women. She felt humiliated – he talked to their colleagues about their relationship and about the other women in front of her. He gossiped about her and said that she was "mad" when she was admitted to a psychiatric hospital.

> "So I thought he was a very responsible man and very loving and caring man. So, he wouldn't do anything bad to me. He would help me. He wouldn't say ugly things about me, like the things that he used to say in the office in front of me, like the time when I, when I was leaving for the hospital, you know, he

was so happy. He was talking to the other colleagues, that by now I should be mad, now, I'm leaving for ever."

He did not react at all and said nothing when she told him she was pregnant. He never asked about her pregnancy or how she was. He took her to hospital when she wanted to have an abortion, but abortions were not carried out at that specific hospital. She felt angry and hurt. She felt betrayed, as she did not expect he would be doing these things to her, because he said he loved her and wanted her. "I hated him (silence). I would kill him (silence) (sigh). Because he had done me wrong. He treated me really bad. (Long silence)." And then she adds: "So, (silence) but sometimes I don't blame him, you know, people are having problems all around this world."

- **Reflection on her relationship with the father of her second child**

Again she had unrealistic expectations. She was desperate for someone to make life better for her. She was looking for someone to help her, as there was no help from her parents and she could not help herself.

She had unrealistic hopes, as was pointed out before. She hoped he would make a change in her life. Her unrealistic hopes are followed by disappointment. Again the theme of not talking is apparent – there was no talking about the pregnancy. She was so angry she could kill him. She killed his child, perhaps a projection of that anger. This man treated her badly, like her father her mother. She allowed this, even though she said with reference to her father, that she did not believe a woman should be treated that way. In spite of all of this, at times she had compassion and understanding in stating that everyone has problems.

5.4.8 Lerato's relationship with her second child

Lerato was very depressed while she was pregnant with her second child. She had a lot of problems with colleagues at work and the relationship with her second child's father turned very sour. She was scared of the reaction of her parents and the father of her child if they should learn that she was pregnant again. She was also worried that people at work would think that she was very stupid and careless and that it was easy for people to take advantage of her. She felt she was losing her self-esteem and dignity. She made an appointment to have the baby aborted when she was between three and four months pregnant. The hospital that she went to did not carry out abortions and she did not have transport to the other hospital where it could be done.

Thus she said she was not "fully accepting" of her baby. "In a way I resented the pregnancy. I hadn't accepted it." She was absorbed with thoughts and feelings about the child's father and his behaviour towards her. She did not think about the baby:

> "No, I'm just telling you that (laughs), it's like you are disturbed and you are just far away from, from, from things which are happening to you. You are not yourself at all and those things, it's like you don't know something. So even if you tell me that, for an example I was pregnant, but I, I didn't, I didn't notice (silence) or it didn't come to my mind that I was pregnant and you know, I would change the way I am or the way I do things or that I would start acting positively, or, in a way that, that would, (silence) (sigh), would make me to be more of a mother. So, (silence) so, sometimes I think that I was in a world where I had to prove myself. I had to stop things to happen to me. So, I was in that world (silence). But, I myself, I was living in my own world, (silence) that I created, or which was created by the way I was treated.

> I went to that world to live there all by myself. I was not living according to the standards of other people or of the world. I was far away from the world or from reality. (Long silence)."

She also had a Caesarean delivery with her second child. Her feelings at the birth of her second child were the same as with her first child: "It was just the same. Uh, and I felt like I don't want her, you know, I can't do anything for her, because she was looking more like her father and it was really disturbing me if I look at her. Oh, I, she was there. There was nothing I could do about it (silence)." She did not show the way she felt about the baby to her mother. "I would just act like I'm happy, everything is fine, where as inside I felt like you know, nothing is right." It felt to her as if her baby wanted to be close to her. She considered leaving her child in the hospital with the nurses, but was scared about how her mother would react. As with her first child, she hoped that having the baby would change her or change her life. "I'll became more positive, I'll become a mother to my children."

Her feelings were very disturbing to her. Again she did not feel ready for a baby, she felt her mind did not register that she was a mother, she felt frustrated and felt that the child's father used her sexually:

> "I took it very bad. I but I still don't (). I didn't feel like I'm ready for a baby. I don't feel like a mother. () but the thing is that I didn't feel like that my mind had registered that I'm a mother. It keeps worrying me, keeps worrying me, what is happening. I was still not feeling like a mother. I have, still, not feel any changes in me…Because you know, some of the things were just small things but the thing is, the thing is that I

didn't have anyone to, to share my feelings with, the way I feel. I couldn't tell my mother afterwards, you know, something happened to me at work and I'm feeling like this or I want to cry. I wouldn't cry, but I felt like crying. Because it was hurting. And I, I, everything was locked up inside (silence). So, I didn't cry. I didn't say anything. I didn't say anything to anyone. There was no one there. So there were all those things. If I could just say to anyone, you know what happened today at work or I could just tell them, but there was no one."

It seemed to her as if her baby liked to be held. She slept better while sleeping in Lerato's arms. Her second baby was bigger than the first one. She found her more difficult to bath and carry around because she was heavier (Lerato is very small). She said that she did not take proper care of her children:

"Sometimes the children would cry. (Long silence). I would just, just feel bored. I don't want to pick up the children because I was not breastfeeding. (Long silence). Like one day I left them in the house. My mother was, my mother went to town and my father. I was going to work. I, in the morning before I went to work, I put the small child, the second child, inside the blanket, cover it all over like trying to suffocate it. Then again I tried to suffocate it with a plastic. So and again when I left for work I left the small one, (silence) the small baby, she was looking more like she was struggling from breathing. I left her there with her sister (silence). There was no one in the house. So, I just locked the burglar () and the key inside () and left them, both of them. (Long silence). Then I went to work."

That day she felt let down by her family. They had gone to town and she had to go to work. "I felt like nothing is in order. My family knew I was going to work. How can they all leave to go to town. Nothing in this family is in order." She could not remember what else she was feeling that day, she thought she might be angry with the baby's father about something. She could not remember thinking anything. She said that there were no voices in her mind that day telling her to do it. She could not remember what she told herself. When she came home from work the baby was alive, but sick, she could not suck or eat. Her mother had taken her baby to the doctor. Lerato bought food for her baby. She was not concerned or scared. She just took the baby and went to sleep. Although it seems from this extract that she also used a plastic bag on the same day to suffocate her baby, she explained later on that it was on a second occasion when the baby was seven months old, three weeks before she killed her, again suffocating her with a plastic bag.

She was stressing a lot and felt hurt. She was feeling down, lazy, tired and troubled all the time. Her self-esteem was low. She felt scared of being in the world, she was scared somebody or the devil would kill her. She was also angry: "I was angry that I was becoming more like my mother and father. (Long silence). So, I didn't feel safe at all. You know even before, before that () in my parent's house I didn't feel safe. It felt like, like I was a prisoner in my own home, you know (silence). So, I was very angry."

She once left her children with her mother and went to her aunt for a week without telling her mother that she was leaving because of something that happened at work. She said that she could not and did not want to talk about it (meaning in the interview).

She felt her colleagues were attacking her and saw them as murderers, but saw her boyfriend (the second child's father) as behind that – "It was part of his attack to me". She had thoughts about people at work wanting to kill her. She said it was not voices in her head, but she was scared because of what her colleagues said and how they treated her. She felt that she could not trust anyone, not even her manager or the psychologist at work. She felt if she was becoming mute, "disabled to talk". She became scared and decided to leave.

Once when she visited a relative and the woman took her child and gave her something to eat, she was very angry. "What was she doing to my child?" Although she was very angry, again, she didn't say anything or showed any anger. There were also tenants in the house, which was disturbing to her. She felt helpless.

She always thought that she would be a good mother as she loved children and were used to looking after them.

> "You know, a lot of kids grew up in front of me, like my young sister, my aunts' children. They grew up in front of me, when they were babies. So I loved children. The way I was acting was something new, but it is the results of the way things were happening to me. (Long silence). But I was, for an example, like animals, you know, they, their babies are there, they, they feed them and they take care of them, they don't leave them. Like even when () they feed them, they don't leave their babies, you know. So, I, I was not having that. I am having a child now, I have to do things for the child, you know. It was like I have to be programmed first, you know, to be in that mode before I could do anything. So like I say it was before the Creator

> determined for me to have a child, to have a family, you know. It wasn't that time (silence). So, you mustn't expect a lot when you are pregnant (silence). You'll struggle. It depends on, on what's, what's in your head, what is going on in your head. (Long silence)."

She felt she was a bad mother. She treated her children badly by not attending to them when they cried or by beating them at times. She did not want her children:

> "The other thing was that I, (long silence) was feeling like, (long silence) I don't want the child. I was feeling angry towards them. I didn't want them**.** I don't have love. I didn't feel connected to them like a mother should be to her children. (Long silence). It was just like, I felt like I hated it, because I was hating the father. So, (long silence) I was feeling tense. (Long silence). So, (silence) everything was more like a tension to me. (Touched her head, shook her head). (Long silence). (Sigh)."

Lerato felt that her mind was not working well. She describes her mind at that time with expressions like "it was like corrupted", "it was not in order", "I couldn't think straight", "it's like a scrap car, something doesn't work anymore" "like a computer that does not process information" "mentally and physically out of order" "like a radio playing on two stations at the same time".

She saw her second baby as someone would help her a lot and who would help her to make decisions. She described her baby as follows:

"And she looked very strict, like a very strict child. (Laughs). You know, that she could tell you what to do. That you should do this, you should do that, you know. My first child was a very loving and caring somebody.

Interviewer: I'm interested to know, what did this baby do or what made that you perceived her as, that she is strict, or that she could be strict and that she could control you?

Interviewee: The way she looked. You know, she looked very serious most of the time.

Interviewer: Mm. And how did that make you feel?

Interviewee: No, good, that I'll have somebody like that in my home. (Laughs). Somehow good, but it didn't really show that I felt good. (Sigh). Well, she's not there anymore. (Long silence)."

Apart from the fact that her child looked like her (the baby's) father, she reminded Lerato of herself in the sense that she saw herself also as serious and quiet. In another interview her description of her baby was as follows:

"Mmm, She doesn't cry easily, or now and then. She, the way she looks at me (silence) mm, like she could really see me (silence). She, (silence) uh, I don't know how to describe about her. I can't put it into words. (Long silence). I would say she was, she was like God. (Laughs). Yes, if I can imagine God the way He is (silence)." When asked to elaborate, she said:

"Like God is, He want to give you rules. (Laughs). So, that, He is very serious. He doesn't joke with you. If He tells you to do something, you must do that thing. You mustn't go like you don't want to do that thing, you must just do it."

When asked about her hopes and wishes for her second child, she replied that she never thought about it, her mind was too troubled about the issues at work. She did think her youngest child saw her as a good and very loving mother, one who would do anything for her child.

At another time, not long before she suffocated her baby, she took her kids and left, because of problems at home with and between her father and her mother. She only packed nappies for her baby, not even clothes for anyone of them. She felt that she would look after them, she just wanted to get away from her mother. She did not care about being in an accident and wished it would happen.

The day she suffocated her baby she was thinking about her life and how miserable it was. She was angry because she didn't have money to buy the children food. "I saw her like a stumbling block in front of me and that was her I had to get rid of her. So I killed the baby and that was it."

After the tape was switched off, she said that she could not understand that she did not feel any pain, that she was not sorry that she did not want them. In the last interview she said her child only wanted her to hold her in her arms, she was full of love, she wanted to be loved, to be taken good care of. When asked about it, she said that was what she was feeling then, thinking about her child then (meaning in prison) – when she murdered her child, she did not feel anything, she didn't think of her child, her mind was too busy thinking of all her troubles.

- **Reflection on her relationship with her second child**

Abortion and an unwanted baby is an ongoing theme. Her description of the very lonely world of depression is an indication that her depression was getting worse. She was isolated from everyone, even from herself and from what was happening in her body. She could not even cry, all her feelings were locked up inside. At first her house was a prison to her, now she herself became the prison.

Her mind was so busy with her worries and troubles that her baby was not thought about. She could not prepare for motherhood, even though she was already a mother. Again she had the insight that she was not mothering the way she should or wanted to. Even though she knew how to mother, what to do for a baby, she was not able to put it into practice. The gap between her representation of her ideal-self-as-mother and herself-as-mother, is apparent. It is ironic that she warns against unrealistic expectations when one is pregnant. The irony lies also in the fact that one does expect a lot when one is pregnant – one's life is going to change irrevocably. Thus again, her representation of herself-as-mother is very negative and even though she is not thinking about her baby, her negative feelings about the pregnancy suggest that a negative representation of her baby might be forming. Her fear of what other people would think about her is a representation of herself.

Immense turmoil is apparent with the birth of her second child. She acted happy, while everything just felt so wrong. There was no space for her real feelings when she was with her mother. She developed a false self with her mother. One wonders whether her mother was depressed when she was a baby. Again unrealistic hopes were linked with a baby. What was expected from her child was to save her from misery.

Again, a child had to rectify what was wrong. She considered leaving her child at hospital, which is another indication of rejecting her child. Her representation of her baby was negative, especially because she looked like her father. On the other hand, as with her first child and herself-as-child, the representation of her baby also included being someone who could rescue her. She must have felt that her baby was failing her, seeing that she hoped that her baby would change her into a mother, possibly influencing her representation of her baby negatively.

A feeling of boredom is often associated with depression. Her child wanted connectedness and she was aware of that. However, she was not able or willing to give it. She did not communicate with her baby, echoing the lack of communication between her and her parents. It is interesting that she found a bigger baby more difficult to handle – it is usually the other way around. At this stage this baby was only two months old. It might be an indication that the responsibility for caring for her child was too big, or that her depression was too deep and that she literally had no energy.

The theme of not feeling safe and that she could be killed continued. She could not trust anyone, perhaps because she could not trust herself. The theme of anger is there, but now it was directed at her from people outside of the family. It is difficult to know what exactly was going on at work and if there was any reason for her persecutory thoughts. Although she could never talk, because there was no one who would listen, she now felt unable to talk even if she wanted to. The theme of running away is there again. She ran to her aunt, who was a substitute mother figure for her.

The day she tried to suffocate her baby the first time, she again felt not supported by anyone. It is possible that anger at her baby's father and/or her anger at her family, was projected onto her baby. The theme of anger runs through, at this stage it was about becoming like her parents – the last thing that she believed would happen or wanted to happen. Her beating such small children was a repetition of severe punishment and uncontrolled anger, like her dad beating her mother and her mother beating her. She talked mostly of her second baby as "it". Her representation of herself, especially as a parent, was becoming more negative. The theme of feeling scared and not feeling safe is there, suggesting that she could not provide safety for her child. One wonders about the meaning of suffocating. Could it be: "Do not talk to me, do not cry, do not make any connection with me"?

Her description of feeling lazy and tired all the time is a description of depression – she used almost the exact words to describe her mother when she was a child. Her description of how she struggled to make sense of what was going on in her mind, suggests that her depression was getting worse and some psychotic traits were present. Her persecutory feelings of being killed might have been a projection of her own murderous feelings, or it might have been linked to psychotic traits.

A baby who could tell her what to do, reminds one of her mother. However, she denied that her child resembled her mother in any way. It could have been on an unconscious level that murdering her child could also mean murdering her mother. It is interesting though, that she said a baby like that could help her make decisions – again the theme of a parent needing a child to help with adult responsibilities, features. Her representation of her second child is in this aspect the same as that of her first

child and of herself-as-child. The fact that her child looked serious might be an indication of a depressed baby, which is often the case when the mother is depressed. One also wonders about the possibility of brain damage after the first suffocation, as the baby had found it difficult to breathe. However, there is no information as to how long her baby suffered before she was taken to the doctor by Lerato's mother.

Her child reminds her of God, in her framework the ultimate One to obey, who could "really see". In this description of her child, her projections on her child are even stronger. In a way her child becomes her Superego. People often project the traits of their own father onto God. One also wonders what was it that this baby saw that she felt uncomfortable with. Perhaps because she lost her own sense of the good in her, she felt all her baby could see, was her badness.

Her description of how she thought her child saw her, echoes her ideal-self-representation – how she wished to be and also how she wished her mother would mother her. Again it is quite clear that she was too preoccupied with her worries and troubles to think about her baby.

It is clear that her depression deepened just before she finally suffocated her child. There was now suicidal ideation – a wish to be dead. When she suffocated her child it could have been her own wish to be dead that she acted out in killing her child. The theme of running away of problems is present again. However, what was also present at that stage is a willingness to look after her children and a belief that she could. Unfortunately, the ability to think clearly about their needs was lacking.

At some level there was a thought that her baby made her life miserable. She was angry about the lack of money and she projected that anger onto her child. Before she tried to suffocate her child the second time and when she finally did, she again felt that she had no support. One wonders whether her words "and that was it" suggest that the topic is closed for further discussion or whether they underline the fact of the irreversibility of her child's death.

At the time the interviews took place she had the insight to realise what her children needed. Previously, her mind was too preoccupied with her own troubles to think about her children, her depression too overwhelming.

5.5 Analysis of participant-observation

This researcher found it difficult to draw a line between data from participant-observation and that which forms a part of reflexive analysis, as they are so closely linked. It was decided to include global. impressions and the personal reflections in the reflexive analysis and to focus on the more specific details in the various interviews in the analysis of participant-observation.

As was mentioned in the reflexive analysis, Lerato did not look her age. The second day she wore a dress. Even in a dress, she looked like a teenager. The researcher found it very difficult to think of her as a mother. Although she was not shy or timid at all, she acted with much more self-confidence from the third interview onwards. She also made more eye contact. Perhaps she just felt more at ease.

In the second interview she talked mostly about her two children. She yawned a lot, her voice was very soft and there were long silences. The researcher wondered whether the silences could mean that there was more resistance to talk about her children, especially the second child, or whether it was more an indication of how difficult it was for her to talk about her two children. The researcher was aware of very different feelings through this interview. At times the researcher felt empathy for her, at times upset (when she talked about suffocating her baby), at times worried about her eldest child and about her. Towards the end of the second interview when she described her thoughts, more or less the last month before she killed her child, the researcher was aware of feeling uneasy. She sounded confused and the researcher wondered about Lerato being psychotic at that time.

The researcher was struck by the intensity of the anger in Lerato's voice when she talked about her parents, especially her mother. She also talked at a faster pace when talking about her parents. Her voice was soft and at times very soft when she spoke about her children. There were much more sighs and more and longer silences when she talked about her own feelings and about her children.

It was also noticeable that she often replied that she could not remember details of her pregnancies and the time after her children were born. The researcher was not always sure how to interpret it. It could be that she was too depressed at that stage and that she really did not remember everything because she was too worried about her problems, or it could have been resistance to talk about it. Another possibility is that she was denying very painful memories.

It was interesting to see how she touched her head, making a circular movement as people sometimes do to indicate that someone is a little bit mad, when she talked about her mother's stress. She made the same movement when she discussed how the stress of her parents' fights disturbed her and in one of the other interviews where she talked about troubling thoughts that she had.

She laughed twice when she talked about her father being drunk and asking her about boyfriends and then again when he asked her if is she was accusing him of molesting her. It could have been a way to disguise her embarrassment. In the fifth interview she laughed when she described her feeling of being far away from what was happening. The researcher was not sure whether being of a different culture made it more difficult to understand the meaning of the laughs at these particular stages.

She cracked her fingers a few times during the various interviews. It occurred while talking about her mother criticising her, talking about her visits to the psychologist and psychiatrist and about feeling scared and insecure.

In the first interview the researcher became aware of a feeling of sadness when Lerato spoke about her regrets and she repeated twice that her behaviour had cost her a lot. She also said: "So, (silence () look at what happened." Later on in the same interview she said: "Because your actions () determines your life, you know, but () something that you don't know". Again the researcher was aware of feeling sad. The researcher also thought about her own child and how her action of suicide impacted on so many people's lives. In the fifth and sixth interviews where Lerato talked about her second child, the researcher also felt sad at times. In the fifth interview she remarked upon her

second child, saying “Well, she’s not there anymore”. Again the researcher thought about her own child and felt very sad. There was a heavy feeling in the room during the sixth interview and she spoke very softly, sometimes almost in a whisper, when she talked about the time just before and when she suffocated her baby.

She emphasised important feelings by repeating them, for example, “I was really getting angry, and angry, and angry”, or ”I was feeling very down, very down.”. Lerato often used the words “I don’t know” in telling her story, or saying that her mother did not know.

Lerato used the phrases “you know” and “you understand” constantly throughout the interviews, but not in a questioning way as if to make sure that one understands. The researcher interprets it as a wish to be understood.

Listening to the tapes, the researcher realised again that she is a good listener. Although she was sometimes very silent during the interviews, she made a lot of encouraging and empathetic utterances.

5.6 Analysis of documents

5.6.1 Documents from the first psychiatric hospital

A short one page report was obtained from the first psychiatric hospital Lerato attended. Lerato was referred to this hospital for evaluation by a private psychiatrist. She was on Cipramil 20 mg daily and Normison 20 mg nocte. She presented with depressed mood and suicidal thoughts. Her DSM IV Diagnosis at the time was Major Depressive Disorder.

According to this report, she had a history of alcohol abuse and multiple suicide attempts by drinking drain-cleaner, paraffin and sleep medication. A week before her admission, she had taken Rattex. The report confirmed that her depression had started in standard 9. She was treated with 20 mg Fluoxetine and discharged after a month, for follow up at her local hospital.

5.6.2 Documents from the second psychiatric hospital

When Lerato was five months pregnant with her second child, she was admitted to another psychiatric hospital for two weeks. She was diagnosed with recurrent Major Depressive Disorder of a severe degree without psychotic traits. She was treated with Cipramil 20 mg and Stillnox and received individual and group therapy.

In an assessment report, she wrote that her eldest child was always happy to see her and laughed a lot when she talked to her. About her mother, she said that she was always tired and sick, adding "I know why", without writing anything further. She stated that her father drank, but was changing. On a question about her family's feelings about her admission, she replied that they felt nothing, because they did not know what was happening to her and they were very ignorant. She said that she felt as if she had no future and would never have it. She reported having no friends and turning to cigarette smoking for support.

She verbalised that her life was in a mess and that she did not know where to start to solve her problems. Stressors were stated as work stress, domestic problems and personal stress, having an eight month old baby and being pregnant with the second one. During her stay there she had vaginal bleeding and was seen by a gynaecologist.

According to the report she was relieved to know that her baby was OK. She also discussed the fact that care for her new baby would be a problem to her. Adoption was discussed with her.

5.6.3 Documents from the third psychiatric hospital

Three months after she had murdered her baby, she was admitted to a psychiatric hospital for a month for observation. She was diagnosed by a psychiatrist with depression with psychotic features, capable of standing trial, "managing her own affairs" and able to appreciate the wrongfulness of her actions and to act in accordance with such appreciation.

Handwritten notes from the state psychiatrist revealed the following: Apparently there were times when she "virtually didn't answer a single question". A set response was "I don't know". She apparently also sighed often, averted her gaze and covered her face with her left hand. According to the psychiatrist she was at times dismissive and even disdainful.

His notes confirmed a very difficult relationship with her mother. Her mother once called her a "straatmeid" (whore). Her parents' abusive relationship, her mother's abuse and fear for her mother also featured strongly in the interviews he had with her. She added that apart from sleeping excessively, her mother also ate excessively.

Her depression since standard 9 was also confirmed in his notes. What was added is that she often had headaches, was worried that she would gain weight and would binge eat and vomit, and that she generally felt bored. Her eating disorder was better when

she started working. Apparently she also once had a suicide attempt – she tried to cut her wrists. She had shopping sprees when she would spend her month's salary in three days.

She felt that the she was a threat to her colleagues at work, as she would get their positions. She was frustrated at work in 2002 as she was not promoted nor transferred. She felt betrayed. A month later, she "argued" with voices that she was hearing. She believed the people at work were poisoning her with muti.

In an interview that the state psychiatrist held with her aunt and uncle (one of the aunts that was a substitute mother for her), they reported she had frequent headaches between the ages ten and twelve. They confirmed that family relations were very difficult in her teenager years, because of her parents' fights and her father's drinking. According to them, she "cannot get through to her parents". They became her confidants. She sought advice from them concerning relationships and her work. They tried to talk to her parents. In her twenties they could hear "anger in her talk", she started to smoke excessively and started drinking.

They also stated that there were bouts of verbal aggression, she was easily frustrated, slept excessively, had an erratic appetite with binging and vomiting and she misused money. According to them they saw her at the end of 2002 at a funeral. She then stayed with them for a week. She looked unstable, read the Bible incessantly, talked about "this is now war", had a decreased appetite, but was not suicidal. They reported that she had discovered that she was HIV-positive. When they saw her a few days

after the offence, she appeared to be in a daze, but was coherent. She said that she could not remember what had happened.

According to the intern psychologist's report, she heard voices which told her to kill her child. This report stated that she was previously admitted to two psychiatric hospitals, not only for depression, but also for behavioural problems.

According to an interview that the intern psychologist had with Lerato's brother, she was a "good" child and always quiet. When she started working she said to her mother that she was scared of the night. She broke all the windows in her parent's house in 2003. She often treated her children badly. His explanation was "I think it was because of the father", meaning the father of her second child. The last two months before the offence, she was suddenly always fighting. The day before she suffocated her baby she had an argument with the tenants in the house. Her brother reported that she had been very calm the day of the offence.

According to the police record, Lerato's brother reported seeing Lerato being aggressive with her children during the last three months before the murder took place. He saw her hitting her child through the face with a cloth and hitting her with a fist on her chest. It is not clear whether he referred to the eldest or youngest child when mentioning these two incidents.

According to the report cards of the psychiatric nurses, Lerato denied hearing voices, seeing visions and having suicidal thoughts. She admitted that she had suicidal thoughts in the prison. She was well orientated, answered questions relevantly, had no

delusions or hallucinations. There was no history of mental illness or epilepsy in the family. She was mostly quiet and well behaved, but mixed minimally with fellow patients. Her behaviour in the ward was described as manipulative and attention-seeking. After two weeks in the psychiatric hospital, they reported that she was paranoid and that there was underlying aggression. A week later she had a fight with a fellow patient, swore at her and hit her with a chair on her arm. Four days later she was again involved in an argument with another patient.

5.6.4 Information from her psychologist at work

As the psychologist from work was in a town 400 km away from her, they never had face-to-face interviews, but had regular telephonic contact since 2001. He was instrumental in helping her to get hospitalised at the first psychiatric hospital in 2001. There was little contact in the beginning, but at times she phoned three to four times a week and conversations were often an hour or longer. She made very frequent contact during her pregnancy with her second child and after the birth.

She was anxious and depressed. There were no phobias, although she feared life in general. Since her childhood she felt that she did not fit in. She had underlying aggression towards her parents and the world in general. He confirmed the difficult relationship with her parents, especially her mother. There were sometimes signs of depersonalisation. He confirmed that she had a suicide attempt before they started having contact, but he did not have any details.

He confirmed that she tried to escape from problems. She voiced her feelings as "always sad, angry, tired and bored. I cannot face my problems, I am useless and

stupid. I am pretending all the time". According to him, she isolated herself from her colleagues. Before she left her job, there were signs of a delusion of persecution and he urged her to get medication. She asked for partitions in the office. His assumption was that it had to do with the father of her second child.

She admitted that she sometimes had impulses of killing her second child. He linked these impulses with feelings of persecution at work. He reported that she had more compassion for her elder child than for the younger. He mentioned that her depression was complicated by her feelings for the father of her second child, the possibility that she and her child was HIV-positive and caring for her two children while battling to take care of herself emotionally. The day he testified at her trail, she said to him that she could not understand why she was not getting ill from being HIV-positive.

5.7 Discussion and triangulation with the literature

Lerato was surprised that she was not the good mother that she wanted to be and had thought she would be. Two factors played a role, namely her depression in and of itself, and problems in the motherhood constellation. The interplay between these two made it worse. Because of the interaction between these two factors, it is difficult to draw a line between them. However, the focus will first be more on depression and then on the motherhood constellation.

- **Depression**

A strong theme is that of depression. There is not enough information to know whether Lerato's mother suffered from depression when Lerato was a baby. Her mother definitely became depressed more or less at the time her third child was born, according to Lerato, because of the fights between her parents. Although the abuse certainly played a major role as a cause of the stress and depression, other factors might have contributed, for example poverty and instability (moving a lot), but possibly also postnatal depression after the birth of her third child. However, this researcher argues that the precise cause of the depression is of less importance than its impact on the mothering role.

Lerato's mother was very dependant. It could have been a part of her personality, but it is also possible that it was as a result of her depression. However, her dependency and depression and perhaps her parenting style, contributed to a huge responsibility that was placed on Lerato's shoulders which in the end became too much for her and she too became depressed. Apart from the responsibility she had to carry, her mother was not available for her, especially not emotionally. The effect of her mother's depression on Lerato was severe.

It seems as if Lerato's depression never lifted since she was seventeen years old. In fact, her depression became progressively worse, to such an extent that she became apathetic. With the depression came feelings of helplessness, powerlessness and a loss of control. It also resulted in feelings of isolation that grew, so that she later on said "I am not a part of the family". She even became isolated from what was happening in her body while being pregnant, which impacted on the motherhood constellation.

When someone is depressed, they are preoccupied with their own feelings and thoughts, as Lerato described. Thus maternal preoccupation suffers – during pregnancy and afterwards, the baby and child is not thought about. Depression also results in feelings of failure. It is clear that Lerato did not feel like a good mother. Her perfectionism made it worse. As was said in the reflections, perfectionism and depression are a fatal combination. Perfectionism is about having control, whereas depression is about losing control. For a perfectionist that is the worst thing that could happen. This links with Jacobson's (1971) suggestion that depression is associated with a gap between self-representation and ego ideal. Perfectionism results in an ego-ideal that is unreachable, even more so when one is depressed. As was discussed in the reflections, there was a huge gap between Lerato's representation of herself-as-mother and her representation of an ideal mother. She felt, therefore, that she was acting out of character. This is evident in the lack of maternal care that her children received. She was able to help her mother with her younger sister and she wanted to give her children the mothering that she had not received. She shows insight into what a baby needs from a mother. However, as a result of depression, nothing of this knowledge is put into practice with her own children.

When one has depression, emotional energy runs low as it is. Lerato spent some emotional energy to hide her real feelings from her parents by pretending to be happy in front of them, which in the end aggravated her depression. Lerato's depression impacted on all her relationships, especially with herself and her children, which deteriorated drastically.

Depression during pregnancy impacts on a mother's readiness to have a child. The motherhood constellation suffers. Even without the depression impacting on the motherhood constellation, there were enough factors that indicated that Lerato would have a problematic motherhood constellation.

- **The motherhood constellation**

The motherhood constellation consists of the three discourses that come into play with pregnancy and the four related themes that emerge (Stern, 1995). The discourses are with the pregnant woman's mother, herself and her baby. The themes are life-growth, primary relatedness, supporting matrix and identity reorganisation (chapter 2).

- **Representation of mother as mother-of-self-as-child**

The first discourse is with the woman's own mother, especially as mother-to-her-as-child. Lerato's representation of her mother-as-mother-of-herself is very negative. Her mother did not want her, was destructive, could not be trusted, physically and verbally abusive and emotionally absent. Lerato was aware of the fact that her mother "almost killed" her according to her grandmother. The severe punishment from her mother is evident of her mother's anger which was often out of control. Her mother's words "If I can just grab you in my arms I would kill you" and Lerato's fear that her mother would poison them, are evident of the destructive mothering that she received and that she could be in real danger.

The theme of an unwanted and unplanned baby runs throughout. Lerato was unplanned and unwanted by her mother. All three of her own pregnancies were unplanned and unwanted. Her first pregnancy ended in an abortion. Although women

often are rejecting of a pregnancy in the beginning, they usually accept the pregnancy in the later phases, and if not, there is acceptance once the baby is born. With Lerato and her mother, it is clear that the negative attitude towards their baby carried on into childhood. Lerato never felt accepted by her both her parents, even as an adult.

- **Representation of herself-as-mother**

The second discourse is with herself, especially herself-as-mother. It is clear how pathogenic Lerato's representation of herself-as-mother was when she described herself as mother. She was aware that she was not ready to be a mother, she did not register that she was pregnant, even though she knew she was. There was no integration of what was happening in her body with what was happening in her mind. She said she did not feel safe that she would be able to act like a mother, and she did not. Even after her second child was born, she still did not feel like a mother and knew she was not mothering the way she wanted to or thought she would.

There might be two reasons for Lerato's pathogenic representation of herself-as-mother. In object relations theory it is argued that the child internalises parental figures (Hinshelwood, 1989; Klein, 1980a, 1980c). Pregnancy leads to a reorganising of self-identity (Lederman, 1996; Pines, 1993: Raphael-Leff, 2001a; Smith, 1999; Stern, 1995). The shift from daughter-of-her-mother to mother-of-her-child entails that a part of the fixed representational world of the new mother shifts irreversibly (Stern, 1995). Identification is defined as the modification of the self-representation to resemble the shape of the object representation. In Lerato's case, the object representation is of her mother as mother-of-herself-as-child. In the reflections it was

pointed out how her representation of herself-as-mother echoed that of her representation of her mother-as-mother.

This links with Tracey's (2000) notion that a depressed mother has lost her central core of identity. She has no sense of being protected by a good internal mother. It is evident that Lerato did not in the first place have a good mother to internalise. Tracey (2000) argues that at the core of a depressed mother is an internally dead mother, or an internally dead baby, or a destructive mother who kills babies or a destructive infant who kills mothers. It is evident that both Lerato and her mother had a destructive internal mother. However, Lerato had a sense of what a good mother should be and thought she would be that for her child. In spite of that, she could not hold onto that representation, which brings us to the other reason for Lerato's pathogenic representation of herself-as-mother.

In Klein's understanding of depression, the adult failed to cope with the depressive position as an infant (Likierman, 2001). This might have been the case with Lerato, although as was shown in the reflections, there is evidence that as a child, in spite of her mother's criticisms, she had a more balanced representation of herself. Roth (1999) states that Klein's use of the term 'position' in describing the paranoid-schizoid and depressive positions, refers to two different states of mind with its own constellation of anxieties, other feelings, defences and ways of relating to objects, in spite of the fact that Klein described these two processes developmentally. This researcher argues that when a person becomes depressed, that person moves to a paranoid-schizoid state of mind where splitting is used as a defence mechanism, and the ability to integrate is lost. Through the process of projection unwanted parts of the

self-representation are added to the representation of the other (Fonagy, 2001). This researcher believes that it is not necessarily unwanted aspects that are projected on another, but aspects that a person with depression cannot identify with. As was shown in the reflections, Lerato projected the good, wise, understanding part of her self-representation on her children, especially on her eldest child.

- **Representations of her first and second child**

The third part of the motherhood constellation consists of her discourse with her baby. As was shown in the reflections, Lerato stated openly that she did not want to have her children, apart from the fact that with both her first and her second child she seriously considered aborting the baby. The fact that Lerato's second baby resembled the baby's father, added to her negativity towards this baby. She wanted to leave this baby at the hospital with the nurses.

She hated the father of her second child and said "I would kill him". Her anger towards her children was evident in the severe punishment she gave them, the abuse that her brother described, the three attempts to suffocate her baby and the fact that she verbalised her hate towards her second baby. She vaguely remembered that the first time she tried to suffocate this baby, she was angry at the baby's father. It is quite possible that she projected that anger on her child. She mostly referred to her second child as "it". She expected from both her children to change her and to make life better for her, placing unrealistic expectations and hope on them. They were set up to fail her. Her second child was almost her last hope to change everything and the child was failing her. It is possible that she projected the split-off aspects of her own self-

representation on her child in the sense that her child became the symbol of her own failures. Thus killing her was also a way of trying to get rid of her own failures.

Primary relatedness refers to a mother's ability to engage with her baby in an emotional authentic manner (Stern, 1995). It is closely linked with her reflective function, which entails her ability to identify with her infant and contain difficult feelings that the baby provokes in her, as well as her ability to respond appropriately to her baby's needs (Murray, 1991). In chapter 2 the effect of depression on primary relatedness and the mother's reflective function was discussed. It is clear that Lerato's depression impinged seriously on her ability to be in tune with her children. She said she was bored and on more than one occasion that the baby was "just there". She did not respond to her children's emotional needs. As in her relationship with both her parents, but especially her mother, there was no connectedness.

Research has shown that a lack of support is one of the causes of postnatal depression. It goes without saying that a lack of support for a woman who is depressed when she falls pregnant and then has a baby, is detrimental. Her mother was not there for her in a maternal role and only helped her the first day after her first pregnancy. This lack of support is evident throughout her whole life, but seems to be worse after having her second child. When someone is depressed, they feel isolated from everyone else and it often plays a role in distancing themselves from other people. Thus Lerato failed in creating and permitting the necessary support system. The fact that Lerato's relationships deteriorated after the birth of her second child, points in this direction. This could have contributed to her turning to other people to meet her needs, to make

her life better, resulting in having unrealistic expectations of the fathers of her two children and the children themselves.

Both Lerato's mother and Lerato did not respond to their children's needs, especially not their emotional needs. On the contrary, the reverse was true. In this family a child was there to fulfil a mother's needs. Lerato was a parentified child who became a pleaser. She helped her mother with housekeeping tasks and caring for her baby sister. She felt responsible to help her parents with their marital problems and to rectify what was wrong in her family. The children were also expected to look for their father when he was drunk and did not come home. As was discussed in the reflections, Lerato felt she could not have a family of her own before she could help her family. Stern (1995) states that a new mother must give up these fantasies about repairing, redoing or correcting her childhood. In a family where so much responsibility was placed on a child, this is very difficult to do. Lerato on the other hand, expected from both her children to make her life better, to save her from misery, to make her happy, to help her make decisions and also to rectify what was wrong.

Living in a world of violence and growing up with anger impacted on her. Frustration and anger also built up in Lerato. She hated her parents. Lerato's way of dealing with her anger was to deny and suppress it. Only later on did she vent it. Even though she denied being angry with him, her anger erupted for the first time with the father of her first child. She openly stated that she "tortured" him and was verbally and physically abusive to him.

Her anger also turned against herself. She was angry that she was not the kind of mother she hoped to be and that she became more like her own parents. She saw her anger (and her pain) as the reason for making the wrong decisions all the time.

Thus, Lerato constantly was the recipient of her mother's anger, at times of the anger of her father, of the father of her second child and of that of her colleagues. Her anger on the other hand, was directed at her mother, her father, the fathers of her two children, her two children and herself. Apart from venting her anger towards her first child's father, she vented her anger towards both her children, but particularly her youngest baby. She admitted beating both the children and her brother reported her at the police for slapping her youngest baby through the face. The first time she tried to suffocate her baby, the baby was three months old and her eldest twelve months. She left them both alone at home and left for work. In the end, when her youngest was seven months, she died after Lerato suffocated her. Lerato failed in the most basic task of the life-growth theme, namely to maintain the life and growth of her baby.

5.8 Conclusion

Chapter five contained the research results and interpretations. To enhance accountability, a reflexive analysis was given where the influence of researcher's life experience on the research was acknowledged. Thereafter information gathered during the semi-structured interviews, participant observation and documents were analysed and discussed. Finally the chapter concluded with a discussion which attempted to integrate the results and interpretations.

In chapter 6 conclusions will be drawn from the literature and research results. The limitations and strengths of the study will be discussed. Recommendations regarding future work and research will also be made.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

In this chapter conclusions concerning depression and maternal depression will be drawn from the case study presented in the previous chapter, as well as from the literature reviewed for the purposes of this study. The aim of the study was to give an in-depth understanding of the representations of a depressed woman who killed her baby. The representations were based on "The motherhood constellation" by Stern (1995) and focused on the woman's representation of her mother as mother-of-herself-as-child, herself-as-mother and her representations of her children. A critical evaluation of the study will be given and finally recommendations will be made for further work and research in this area.

6.2 Conclusions

The conclusions which this study brings to the fore are not all new. However, they underline the importance that should be attached to such known factors in pregnancy and parenthood. From this study the following conclusions can be made:

6.2.1 Conclusions regarding the impact of depression on the motherhood constellation

Depression impacts seriously and negatively on the woman's representation of herself-as-mother. However, not enough attention is paid to this issue. As was pointed out, the symptoms of depression, pregnancy and the postpartum period (such as fatigue, sleep disturbances and changes in appetite) show similarities. Therefore depression can easily be overlooked by women and health practitioners.

The impact of depression on the woman's representation of herself is greater when the pregnancy is unplanned or unwanted. The themes of unplanned and unwanted pregnancies which run so strongly through this study, raise a red flag about the attention that any woman in the situation of an unplanned and/or unwanted pregnancy should receive. If a baby is unplanned or unwanted, a pathogenic representation of herself-as-mother or/and her baby might form. This does not imply that the representations of wanted babies are in all cases healthy, but the risks in case of unwanted and unplanned babies are greater.

A woman's discourse with her own mother, especially as mother-to-her-as-child, is another important factor in determining the impact of depression on the mother's representation of herself. In this extreme case where Lerato herself received destructive mothering, it influenced her own representation of herself as mother. This need not be the case if the woman's reflective capacity is competent to re-work it sufficiently, so that it does not impact on her representation of herself. What is not clear is the impact of depression on a person's capacity to reflect. The researcher is of the opinion that depression can impinge on this capacity to reflect. On the other hand, it is also possible that depression is a warning signal that maternal representations are not healthy. The interplay between these two aspects makes it impossible to say what comes first. Further research could cast light on this interplay.

If the woman's representation of her mother as mother-of-herself-as-child is pathogenic, it might influence her representation of herself-as-mother negatively. As the literature shows, pregnancy leads to a reorganizing of the self-identity, which means a modification of the self-representation to resemble the shape of the object

representation. Thus, in pregnancy the representation of self-as-a-mother might echo the representation of a woman's mother as mother-of-herself-as-child. Therefore, it can be concluded that if the woman experienced destructive mothering when she was a child, the impact is likely to be that her child will receive destructive mothering, as is borne out by this study.

Depression during pregnancy could be a warning signal that unrealistic expectations are being placed upon the pregnancy and/or the baby to better the life of the mother, or that pathogenic representations are present or developing. Further research is necessary to investigate this issue.

Perhaps the literature concentrates so much on the concept of postnatal depression that very little attention is paid to people who are already depressed before they fall pregnant. It seems as if the depression gets deeper during pregnancy. It stands to reason, since a depressed woman can already not cope with what is on her plate. The baby is then seen as an additional burden, as was demonstrated in this study.

As was reasoned in the discussion (chapter 5), depression can lead to a paranoid-schizoid state of mind where splitting is used as a defence mechanism and the ability to integrate is lost. Through the process of projection, parts which a person with depression cannot identify with are projected onto another. This can lead to a mother losing her positive self-representations. It is also possible, as Fonagy (2001) pointed out, that unwanted parts of the self-representation are added to their representations of the other, and that the parent can project the negative parts onto a baby, as had happened in this study.

Perfectionism and depression together have been shown in this study to be a fatal combination – to both mother and baby. The risk of feeling a failure as a mother is greater when depression decreases the quality of maternal care. Perfectionism and depression in combination lead to an even greater gap between the ego ideal of mothering and the representations of the self-as-mother, and possibly also a greater gap between the phantasized baby and the real baby.

6.2.2 General conclusions

The past history of the mother profoundly affects her mothering of her new baby. "The ghosts, we know, represent the repetition of the past in the present" (Fraiberg et al., 1980, p. 166). This was clearly illustrated in this study. Fortunately the literature stresses that history is not destiny. Parenthood can also become a time of renewal. The ghosts can be chased out of the nursery by helping the mother to see the repetition of the past in the present. The affective link, recognising and remembering the feelings, helps a parent not to repeat the past in the present - "…it is the parent who cannot remember his childhood feelings of pain and anxiety who will need to inflict his pain upon his child" (Fraiberg, Adelson & Shapiro, 1980, p. 182).

All the literature agrees that primary relatedness is a basic necessity for effective mothering. This study has shown how depression impinges seriously on the ability to be in tune with a baby and how it can lead to no connectedness and even to infanticide.

A lack of support is one of the causes of postnatal depression. When a woman is depressed, she does not permit and/or create the much needed support system, which in turn makes the depression worse.

This study also shows that where good-enough mothering has not been experienced, especially in a context of deprivation, the perception can be formed that care should be given by young children to their parents and that parental responsibility is to be carried by the child. In this particular study, high and even unrealistic expectations were placed on children – both on the interviewee as a child and subsequently by her on her children. This lead to the interviewee not having had the freedom to be a child, having had too much responsibility, inevitably failing her mother, and later on her own children failing her.

The demanding needs of a baby can cause many frustrations and possible anger. When pregnancy and depression occur in a context of cultural and personal violence and anger, the new baby is particularly at risk.

6.3 Critical evaluation of the study

Yin (2003) suggests that a case study can be evaluated by applying five criteria, namely that such a study has to be significant, complete, consider alternative perspectives, display sufficient evidence and has to be composed in an engaging manner. This researcher uses the criteria proposed by Yin (2003) for a critical evaluation of this study.

- The criterium that the case study has to be significant refers to the fact that it must be unusual and of general public interest. Underlying issues must be of international interest either in theoretical or practical terms, or it must be revelatory in the sense that it reflects some real-life situation that had not been studied in the past. This case is unusual in the sense that it is an extreme case involving the death

of a child by the hand of its own mother. To the researcher's knowledge, no study concerning the maternal representations of a mother in a case of infanticide has been published. The impact of depression on the maternal role is of public interest.

- The case study has to be complete. Yin (2003) states that it is extremely difficult to describe this criterium operationally. In a complete case, the boundaries of the case are given explicit attention. A weakness of this study is that the boundaries of this case were partly determined by time. As was pointed out in the chapter on methodology, saturation point was not reached because of time limits set by the judicial system and thus only seven interviews could initially be arranged (an eighth interview was later arranged and used as a member check). Another limitation was the fact that the effect of the participant's HIV-status on her depression could not be checked with her.

  A second way of defining completeness involves the collection of evidence. This researcher is satisfied that the relevant evidence was collected in the interviews, and supporting material was collected from other sources.

- The third criterium regards the considering of alternative perspectives. The purpose of the study included putting this specific theoretical framework to the test to see if it is a useful way to understand the raw material. The study does not imply that there are no other possibilities of ordering the facts, only that this specific framework is useful and clarifying. The fact that two independent investigators confirmed the themes in the interviewee's relationships to her mother, supports the confidence in the view held by the researcher.

- The case study has to display sufficient evidence. The researcher attempted to give the most relevant evidence so that the reader can reach an independent judgement regarding the merits of the analyses. However, the researcher realizes that other judgements are possible. Strict adherence to qualitative research methodology is the best safeguard in preventing prejudiced selection of material.

- The fifth criterion refers to the fact that the case study has to be composed in an engaging manner. This case study is in itself engaging, as it is a true story with extreme situations that are quite intriguing.

6.4 Recommendations and future research

From the literature review and this particular study, South Africans will benefit from the following recommendations:

- This study illustrates the tragedy of the lack of prevention. In our country we have limited resources. Apart from the fact that prevention is better than cure, it also is more cost effective. The integration of psychological services into primary health care at all levels of our health care systems is necessary. Although it is set as a norm for government policy (The Primary Health Care Package for South Africa, 2004), not much of this has been happening in practice.

- Training for mothers, especially in disadvantaged communities, to provide support and help to mothers of new infants, as in the Thula Sana Project in Khayelitsha, can provide a supporting matrix that is both economic and practically viable. Consideration could be given to start training during pregnancy.

- A concerted effort to increase psycho-education, aiming at the prevention of mental health problems and development of human potential (Roos, Taljaard & Lombard, 2001), is needed on all levels of society. Especially pregnant women and their health care workers should be involved. Programmes on television to educate young mothers (as in Canada) could be very useful in this regard.

- Much greater vigilance regarding the early detection, diagnosis and treatment of depression during pregnancy is necessary. Particular attention should be paid to the symptoms which mimic those of depression at other times and which are similar to difficulties experienced during pregnancy and early parenthood, like disturbance of sleep, appetite change and fatigue. The short form of the Edinburgh Postnatal Depression Scale (EPDS) is a very useful tool that can be used in this regard. It should be routinely applied. Health practitioners should specifically enquire about a history of depression or an existing depression**.**

- In cases where a baby is unplanned and the woman decided against terminating the pregnancy, such women should receive special attention. The method of representations as used in this study could be very useful in structuring such special attention intervention.

- Special attention should be paid to screen for risk factors as regards ante- and postnatal depression, such as previous termination of pregnancy, bereavement during pregnancy or other current loss, and a personal and family history of depression.

- Perfectionism in combination with depression during or after pregnancy should be recognised as another red flag signifying a risk, indicating that special care should be given.

- Positive ways of handling anger should be part of every person's education and abilities. In a country like South Africa, where so many people live in a cultural or personal milieu of violence and anger, this issue should be addressed in school programmes.

- Greater provision of support and counselling services should be given in the antenatal period in order to improve maternal and child health outcomes.

- Intervention programmes should be given *during* pregnancy, as the mother's defence meganisms are then less rigid than at any other time of her life cycle.

- Programmes that promote the *emotional well being* of pregnant women and that would enhance the *relationship* between mother and child are necessary, as both mother and baby will benefit. At present ante-natal classes focus on preparation for birth and practical issues such as physical care of the baby (which the researcher fully supports), but not enough attention is given to what the emotional care of a baby entails or to the prevention of relationship problems between mother and child.

- Mental health programmes and/or psychotherapy for mother-infant couples are necessary to reduce the impact of depression on the parent-infant relationship.

- Stern (1995) mentions the possibility of a three or four-year training course, specialising in infant mental health. One could perhaps think of a BPsych. course, with infant mental health as specialisation. The researcher would like to see interventions starting during pregnancy.

- The area of battered babies can be studied by making use of the theoretical approach of parental representations.

- The interviewee was hospitalised for two weeks in a psychiatric clinic during the fifth month of her pregnancy. Yet, she murdered that baby less than a year after her hospitalisation. It confronts us, as psychologists and mental health workers, with the question where our responsibility ends. With pregnant women not only the mother is involved, but also her child. Perhaps we should consider doing some kind of follow-up in such cases.

6.5 Concluding remarks

The aim of this study was to give an in-depth understanding of the maternal representations of a depressed woman who killed her baby. The researcher used an extreme case to illustrate the link between depression and pathogenic maternal representations and the necessity of early intervention to prevent heartbreaking stories of mothers and children, such as this case was an illustration of. The concept of maternal representations is the only approach that opens the possibility to start working at the earliest point of prevention, because intervention can start even during pregnancy. Other approaches can only start after the birth of the baby. Intervention during pregnancy is the ideal, because defence mechanisms are less rigid during pregnancy and women are more in touch with their entire life cycle, as was discussed in chapter 3. Brazelton (in Stern, 1995) stresses that it is ideal to intervene at "touch points", his term for the start of a new developmental phase, because the individual and the whole system is more open to change. If there is a "relationship problem" between a mother and her unborn baby, intervention during pregnancy could be beneficial to both.