Healthy Maternal Ambivalence

Joan Raphael-Leff

I

Psychoanalysis has long neglected maternal subjectivity. Within psychoanalytic theorising, a mother is usually treated as '*object'* of the baby's desires, or depicted through the 'containing' or 'transformative' *function* that she performs. The mother as a person in her own right has been largely absent, as are the subjective meanings a woman gives to moment to moment lived experience of mothering a young child.

Psychoanalytic omission of maternal subjectivity is not merely a theoretical lapse, but has several dire consequences as will be mentioned here:

- Maternal de-subjectivisation negates the personal experience of mothers.
- By demanding that mothering extend intrauterine 'merger' postnatally, psychoanalysis unquestioningly privileged the *biological mother* of pregnancy as carer.
- The neonate's assumed '*monotrophic'* connection to the gestating mother relegated all other relationships as secondary (including paternal and siblings) and ruled out shared-care.
- This exclusivity conflated autonomic *'placental'* provision with the conscious postnatal carer, demanding she provide continuous nurturing: '365 days a year 24 hours a day' as Bowlby advised (WHO Monograph, 1951).
- Idealisation of maternal function (coupled with denigration of mothers) is linked to inevitable failure to deliver.
- The consequential maternal guilt, anxiety and self-blame were labelled as natural *female masochism* (Deutsch, 1944).
- Extrapolation from research into homeless children, '*maternal deprivation',* was held responsible for long-term mental health and behavioural problems (Bowlby, 1951) – causing ordinary mothers to feel self-conscious about work outside the home, and wary of limit-setting.
- Pathologising of maternal ambivalence led to demonisation of mothers – not only of Frieda Fromm-Reichman's 'schizophrenogenic' variety but of all mothers for all ills in the child.

Furthermore, by ignoring the complex interpersonal dynamics that denial of maternal subjectivity triggered, not only were psychoanalytic scenarios of 'normal' family engagements distorted, but this had *implications for treatment*.

- When mother-infant interaction is regarded as a paradigm for analytic work (Ferenczi, 1932; Mitchell, 1991) it fosters isomorphic expectations of the *psychoanalytic carer* – in this case his/her 'neutrality' and de-subjectivisation.
- The ideal analyst was promoted as a 'blank screen', an impassive reflecting 'mirror' (Freud, 1912) lacking 'memory or desire' (Bion, 1970).
- Counter-transferential feelings were deemed pathological residues of an incomplete training-analysis.
- By negating the bidirectional arousal of emotions inherent in the psychoanalytic relationship, treatment was seen as a solipsistic process.

Thus, when in 1949 the pioneering paediatrician-psychoanalyst Winnicott wrote about 'Hate in the Countertransference', his paper was regarded outrageous by classical analysts. Moreover, in likening the subjective experience of the analyst to that of the ambivalent maternal-provider, Winnicott not only referred to the analyst's reactions of 'objective hatred' towards psychotic patients, but cited 18 reasons *why an ordinary mother might hate her baby.*

Hitherto, idealisation of the early mother-baby bond had excluded negative feelings, upholding Freud's view that a mother's feelings, and in particular towards her son fosters the 'most perfect, the most free from ambivalence of all human relationships' (1933, p. 133) - this despite Freud's contrary belief that mixed feelings are an inevitable part of all intimate and durable human relations.

So powerful was the psychoanalytic need to glorify motherhood that the Madonna myth prevailed, seeing her need to mother as symmetrical to the infant's need to be mothered (Balint, 1939). Even Winnicott succumbed, resorting to the ordinary mother's devotion to her infant primed by 'Primary Maternal Preoccupation' (1956) as the pathway to normal mothering.

Over the past 40 years, mothers such as Adrienne Rich (1976) have exposed their own subjective experience more roundedly, raising awareness of the mother as a flesh-and-blood subject with her own feelings and independent locus of need and desire. Feminist theorists queried the romanticised version of self-effacing

motherhood (Dinnerstein, 1976; Chodorow, 1989; Chodorow & Contratto, 1979; Raphael-Leff, 1980, 1985a; Benjamin, 1988; Bassin, Honey & Kaplan, 1994). Nonetheless, painful maternal experiences of ambivalence, persecution and hatred remain under-explored. This bias continues to assert its influence over ordinary mothers, compelling us to hide our conflictual and shameful negative feelings from professionals – and from ourselves.

Noting the very high incidence of perinatal emotional disturbance in Westernised societies today, I would like to bring a model depicting a wide spectrum of maternal experiences, featuring different manifestations of maternal ambivalence.

II
Heterogeneity

Before doing so, I must note that much psychoanalytic theorising has suffered from a further fundamental problem. Addressing '*The'* Mother universalises the particular, neglecting each mother's unique attributes and personal psycho-history, including the specific circumstances of this particular conception; her own current internal representations of mothers and mothering; the number of other children in her household and the age-gaps between them; the degree of emotional and practical support available to her as well as the surrounding matrices of socio-cultural expectations, economic resources and restrictions, provisions of maternity care, grants and leave, and normative considerations of age, sex, education, peers, class, race, ethnicity and so on.

Furthermore, psychoanalytic theorising which has conflated the maternal and the feminine must extend to encompass our new age. Some 12-20 per cent of European women now choose to remain childless. Efficient, female-based contraception has enabled sex without pregnancy. Reproductive technologies now enable pregnancy without sex! The broadened range of possibilities means that 'natural' conception may occur following conscious choice, unbridled desire, chance contraceptive failure or brute force without a woman's consent. An embryo may result from *in vitro* combination of gametes – of her own egg or another woman's, inseminated with a sperm derived from her mate, or donated by a stranger or someone

known to her. Furthermore, the advent of asexual procreation lets us to tease out hitherto conflated subdivisions of maternity into components: genetic, incubatory, social (Raphael-Leff, 2010).

Not surprisingly, each pregnant woman's feelings will reflect representations of the unique primal scene of this conception, – whether as a loving, casual or abusive act between a man and woman or a union of gametes; privately behind a bedroom door or following fertility treatment in a laboratory's petrie dish. The baby may be designated to a single mother, a nuclear or composite family, a heterosexual couple or same-sexed partners, whose intention of parenting may tend towards a range of child rearing practices, including exclusive or shared care...

Each mother's emotions are coloured by a wider social network and their attitudes towards the acceptable or unwanted gestation. The permutations are myriad – fertilised embryos may also be frozen and stored for future use or destroyed in the lab. One or more may be implanted in the womb of one of its originators or in a surrogate. The gestating woman may miscarry or, for complex psycho-social reasons, decide to terminate or keep the pregnancy. If not aborted, a baby may be gestated to term or born prematurely, be welcomed or rejected, mothered or given up for fostering or adoption at birth or later. But importantly, whatever the trajectory, the meanings of pregnancy, baby and motherhood are generated as much by personal imagery of hope, promise, uncertainty and risk of loss as by factual circumstances.

Needless to say, this quintessentially female activity of gestation and birth is shared with all adult female mammals. However, unlike other mammals, a gestating woman is beset by imagery fleshing out the unknown cherished darling or the threatening 'invader' kicking within her, dwelling on the futurity of child rearing, and the inexorable expulsion of the baby from her body, at birth or before. Such subtle mental configurations are uniquely human.

Gestation involves commensuality. As with all female primates, during pregnancy, a woman contains at least two beings within her body. However, women are absorbed by the double alterity of the maternal body itself. Whether interpreted as mystical 'communion' or nightmarish exploitation, humans worldwide are aware of the reciprocal exchange via the placenta which transmits nutrients in one direction and waste-products in the other. To some expectant mothers, this process may feel bizarre,

even 'mad'. Given the western focus on autonomous individuality and the tacit message of impossible bodily connectedness and/or psychic fusion, pregnancy and providing sustenance from the juices of her own body in utero and breastfeeding, may seem equally strange to the new mother.

III
Placental Paradigm

During the second trimester of pregnancy, the uncontrollable nature of the other occupying the maternal body becomes increasingly evident. Unless she is in a coma or an extreme state of denial, each expectant mother's experience is continuously reshaped -– modulated by her reactions to their placental union, to fetal movement and in response to mutual hormonal influences. These are variously interpreted, draped with preconscious fantasies, desires and projections drawn from her own inner assemblage. Mental construction of the unknown baby partakes of internalised relations and interactive patterns since the woman's own infancy. Thus, the baby is drawn out of multi-layered imagery and pluralistic temporalities of her psychic world – coloured by her own imagined baby-self in the eyes of archaic carers, coupled with childhood registrations of her mother's procreative body, and anticipatory imagery of her adult-self as caregiver to a future baby (Raphael-Leff, 1993).

These representations may be fluid and flexible, with mixed feelings about herself and the baby which vary many times within an hour *["I love feeling so lush but when the baby kicks me between the ribs I wish it was over"* says a woman in her 7th month of pregnancy]. Or, as depicted in the chart below, feelings may be *fixed* in women whose representations of tethered baby-and-self are inflexible, forming an emotional 'set' towards pregnancy and motherhood. [Plus and minus signs signify predominantly positive or negative representations].

Mother	*feelings*	Baby	*representation*
±	*mixed* ±	healthy ambivalence	
+	*fixed*	+	idealisation
-		+	depression
+		-	persecution
-		-	anxiety
+-		+-	obsession
+/-		0	dissociation

Raphael-Leff, 1991/2005 p.U-56.

Antenatal representations are not a hypothetical issue. In their extreme form, the 'fixed' representations reflect ways of splitting ambivalence linked to maternal emotional distress, which has implications for the unborn child. For instance, depression is associated with poor antenatal clinic attendance, low birth weight and preterm delivery. Some 20 to 40 per cent of depressed mothers also report obsessional thoughts of harming baby before or after the birth. In persecutory states, phobia or paranoia prevail. If the fetus is regarded as a destructive internal abuser, or competitor over limited resources, persecutory feelings may lead to fetal deprivation or abuse. Partners, have fantasies, too. Domestic violence which increases during pregnancy heralds postnatal violence. Depression, persecution, anxiety and post-traumatic stress disorder (PTSD) are often linked to childhood abuse, and associated with smoking, unhealthy eating, alcohol, drugs, self-harm and risk-taking during pregnancy. Nor is the effect short term. A longitudinal study of 14,000 women found that chronic antenatal anxiety provoked high cortisol levels which were linked to behavioural problems in the offspring when measured ten years later (O'Connor et al, 2002).

My own local and cross-cultural research has confirmed that a variety of approaches to pregnancy and early motherhood exist even within the same society. Trying to capture these variations, I formulated them as 'orientations', stipulating that they are *not* personality traits, as in keeping with her feelings and circumstances, the same woman may hold a different orientation in subsequent gestations.

I want to stress that all primary carers of whatever sex and age find parenting difficult, especially in societies-in-transition such as our own, where extended families are dispersed and child rearing traditions eroded. Being constantly attentive and attuned to the needs of someone else for whom one has total responsibility at all times is a daunting task. In addition to broken nights, dream deprivation and exhaustion, a biological mother also contends with hormonal fluctuations, recovery from labour exertions and possible birth damage, painful engorgement or mastitis and the frightening orgasmic feelings that accompany breastfeeding. Not surprisingly, perinatal breakdown is common. Postnatal distress is experienced by almost half of all new mothers and a quarter of fathers (Paulson & Bazemore, 2010) in the West. Furthermore, a comparative study of 15 centres in 11 countries showed that morbid unhappiness after childbirth comparable to postnatal depression is widely recognised. This distress is associated with crying babies, difficulties with feeding and concerns about the health of the baby in the context of loneliness, lack of emotional and practical social support, poor relationships with partners, family conflict and tiredness (Oates et al, 2004). However, these researchers note that 'surprisingly' no mention was made of 'negative feelings, of irritation or frustration' - feelings which we know must often remain secret and hidden

Ideation and fantasies vary, yet in many societies identifiable perinatal disturbances will include:

- Manic elation
- Depression
- Persecution
- Anxiety
- Obsessive Compulsive disorders
- Schizoid withdrawal
- Psychosomatic/behavioural manifestations
- PTSD
- Puerperal psychosis

Depending on the capacity for tolerating ambivalence, these range in intensity from mildly disturbing to incapacitating (see Raphael-Leff, 2000).

IV
Orientations

Like my own clinical and empirical studies (Raphael-Leff, 1985b,c,1986), independent research on my model (Scher & Blumberg, 1992 Scher, 2001; Sharp & Bramwell, 2004; van Bussel et al 2009 a,b, 2010) found that maternal experiences cluster, with each orientation holding a distinct mothering philosophy. Some women do experience 'primary maternal preoccupation' as Winnicott (1956) called it during pregnancy and the early weeks or months of mothering. In-depth exploration reveals that a woman of this orientation, whom I termed 'Facilitator', sees conception as the culmination of her feminine experience. She regards women as uniquely privileged in pregnancy, Russian-doll-like, each carrying the baby as she herself was carried. Thus identified with both her mother and the baby with whom she 'communes' in introspective thought, she resolves to minimise the transition with as natural a birth as possible.

Mothering is seen as a cherished vocation. Suspending her own subjectivity in adaptation to the baby, her identity is primarily that of a Mother, believing she is the only one who is primed (by pregnancy) to fathom her baby's needs. She therefore aims to be the exclusive carer, devoting herself to facilitating, holding and gratifying the infant's every wish, thereby gaining vicarious satisfaction through unconscious identification with both maternal ideal and idealised baby-self.

To sustain this idyll, any negative feelings and resentment must be suppressed. Yet many facilitating mothers feel devastated by complications in pregnancy or birth interventions which 'spoil' the inimitable experience. Similarly, they feel deep remorse if unable to breastfeed. Despair over minor lapses of maternal perfection can lead mothers in this group to anxious over-involvement and guilt-ridden depression. Sometimes, the baby's crying may be experienced as an excruciating reprimand, telling a Facilitator that she is a bad mother who is let down letting her perfect baby. In extreme cases, the deep sense of irreparable culpability at failing to provide the flawless mothering she intended, or shock at her own involuntary irritation, may result in her wishing to end it all.

Many other women have a different experience that I have termed ‘primary maternal persecution’. While each mother's subjective experience varies, the negative arm of ambivalence prevails and thematic exploration of maternal experience in this group of mothers boils down to a feeling of being exploited. Far from an idyllic 'communion', pregnancy is often accompanied by a sense of invasion from a parasite sapping her resources. Anxieties abound that the baby occupying her can tap into her hidden thoughts and weaknesses, which s/he might reveal after birth. Dreading the pain of childbirth, she plans as 'civilised' a delivery as possible, making use of medical innovations to decrease the damage. Corresponding to the sense of being drained and mauled from within throughout the long months of pregnancy is the postnatal experience of being at the beck and call of an inexplicably demanding and critical infant. To minimise these persecutory aspects of early mothering, many 'Regulator' mothers choose to socialise their babies through a routine to help the baby adapt to the household and to regulate their 'uncontrolled' passions. This can work well, as the regime also reduces uncertainty and introduces consistency across carers. Co-caring enables Regulator mothers to replenish themselves by working part-time and leading enriching adult lives. However, circumstances such as unemployment may prevent a harassed mother from returning to a fulfilling use of her adult competence. If she is unable to protect herself by sharing childcare, she may feel mounting resentment about unmitigated mothering of an infant, who drains her emotional resources and threatens her adult stability. At this time, mothers who have themselves experienced deprivation or trauma are vulnerable to an unwanted reawakening of early feelings of their own neediness or rage with involuntary thoughts of harming the infant. Obsessional defences are intensified, but if bitterness intensifies and defences fail, mothers may experience unconscious pressures to externalise internal scenarios.

Other mothers, who I have called ‘Reciprocators’, are better able to tolerate uncertainty and mixed emotions – their own and those of the baby. This is not necessarily due to an easier childhood. They too may have experienced interpersonal privations, excessive frustrations or inadequate response to their needs. However, having repeatedly accessed and reworked developmentally earlier versions of their own internal conflicts, they are better able to understand not only the baby, but their

own parents and the difficulties of parenting. Ambivalence is accepted as part of the complex experience of mothering a sentient infant, who is similar in having human emotions and needs, yet different in being little, dependent and needy. This orientation involves a great deal of emotional effort, as rather than adapting or expecting the baby to adapt, each moment must be consciously negotiated, taking into account the often conflicting needs of all members of the family. For Reciprocators, the primary unit is neither mother-baby as with Facilitators, or the sexual-couple as with Regulators – but a fluctuating set of relationships within the family. And, rather than identification or dis-identification as in the first two orientations, the mechanism here is one of empathy – a compassionate experience of the baby's needs as separate and different from her own.

A final group of mothers are themselves 'Conflicted' between maintaining an ideal of maternal perfection and rebellion against it. Alternating between idealisation and persecution, they are preoccupied by envy of their baby's care in the face of their own unresolved live resentments from the past.

These different orientations towards parenting are already measurable during pregnancy and hence cannot be seen as responses to the baby's personality. Furthermore, independent researchers have found this clustering in very large community samples and also in different societies. Mothering in the first three groups usually falls within the normal range. It is only at the extremes that pathology occurs. Postnatal distress is especially intense if the experience of mothering a young baby retriggers a Facilitator mother's own early anxiety of catastrophic separation and fear of annihilation, a Regulator's anxiety of unstructured disintegration and potential fragmentation, or a Conflicted mother's version of both sets of anxieties.

The innovation here is to note the variety and different intensities of both antenatal and postnatal distress – ranging from depression and guilt, through anxiety, persecutory experience, obsessional disorders and combinations of these. It is not a unified occurrence, but is precipitated differentially across these orientations by psycho-social, economic and cultural factors that conspire to prevent a woman from fulfilling *her own intrapsychic maternal expectations.*

V

Contagious arousal

Having to open oneself up to the baby's non-verbal raw communications revitalises an area of implicit emotions, coming seemingly 'out of the blue'. Most western mothers are deeply shocked by the fierce strength of their emotions and surprised by the unexpected inner turmoil. Writing about the early period, Adrienne Rich (1976) described arousal of:

> The excitement of long buried feelings about one's own mother, a confused sense of power and powerlessness, of being taken over on the one hand and reaching new potentialities on the other, and a heightened sensibility which can be bewildering, exhilarating and exhausting… (p. 17).

I have termed this reactivation of previous experience and confusing identifications with both mother and baby *contagious arousal,* ascribing its sources to right hemisphere activation to the baby's highly evocative 'primitive' emotions, but also exposure to *primal substances*: amniotic fluid, blood, breast milk, urine, baby feces – all reminiscent of the infantile period and retriggering sensual non-declarative memories and procedural emotions (Raphael-Leff, 2003). To some mothers, this intense experience can be healing – a chance to rework and integrate emotions previously foreclosed to articulation.

The focus and timing of a mother's disturbances reflect the weakest links of her own infancy and childhood. Identification or failed dis-identification resonate with a profound sense of the infant's helplessness, rage, fusion and confusion. Drawing on multiple identifications, the child as tormentor may unconsciously represent the woman's withholding or intrusive mother; or her own vulnerable baby-self in relation to being thus controlled. If, due to a woman's own psychohistory or the prevalent assumptions in her social milieu, becoming a mother feels like a forbidden challenge, motherhood itself may be experienced as usurpation – necessitating giving up her own agency to *become* her mother -– emulating or even surpassing her idealised excellence. Conversely, a prohibited triumph may necessitate negation of her archaic mother – by doing/being the opposite of her.

In addition, intrapsychic representations are subject to many *psycho-social precipitants of maternal distress*, not least obstructions to each woman being unable to fulfil her own personal standards and model of mothering. The anticipated maternal ideal weighs heavily, and its discrepancy is exacerbated by unrealistic expectations due to little previous contact with babies. Lack of preparation for the emotional impact of motherhood is especially rife in the context of scattered extended families, unfamiliar communities and insufficient emotional and practical support and developmental guidance. Finally, I argue that most importantly, in stratified societies such as our own, today's small and isolated nuclear family units offer less chance to emotionally work-through one's own infantile loss, grievances and traumatic experiences in the presence of a baby before becoming a parent.

In conclusion, professionals as well as mothers are still reluctant to acknowledge the prevalence of persecutory experiences. Maternal resentment and hatred have been raised as evidence of emotional pathology or perversions. Estella Welldon (1988) was one of the first British psychiatrists to draw attention to the deep-seated 'almost universal' social split between mother as 'Madonna' and 'whore', denigrating maternal sexuality as perverse (a view shared by some breastfeeding mothers). She noted that conversely, idealisation of motherhood delayed recognition of the reality of violent 'baby battering' and maternal incestuous abuse. Welldon also pointed out a different, unconscious use of the body between the sexes, in expression of hatred. If in men perverse violence is localised in the penis and aimed at others (in rape, or their symbolic equivalents of gun and knife crime), then in women self-hatred is expressed through reproductive organs and/or whole body, and aimed not only at herself but at her baby as an extension of herself. Syndromes of self-injury, anorexia nervosa and bulimia, self-mutilation and prostitution, Munchausen by proxy and infanticide are examples of female pathological behaviour, seen to reflect a means of retaliating against their own mothers.

Contemporary psychoanalysis is now demonstrating an increased recognition of the complexities of maternal subjectivity in primary dynamics. Infant researchers (Beebe & Lachman, 1988; Stern, 1985; Trevarthen & Aitken, 2001) reveal the bidirectional patterns of interaction between carers and their babies. Most importantly, the myth of perfect synchrony between mothers and their babies has been dispelled.

Microanalysis demonstrates that about 50 per cent of communications are mismatched in ordinary exchanges. The crucial element for infant mental health is not perfection but the capacity of the carer and the baby to *repair* miscommunications and impingements (Tronick, 1989).

Psychoanalysts now accept that co-created dyadic states of consciousness are influenced by interactional pressures. Evidence of the mutual influence of emotional processes in recurrent intimate interactions is leading to a richer view of therapist-patient interaction too (Raphael-Leff, 1997/2008; Lyons-Ruth, 1999). Conversely, recognition of the unavoidable enactments, failures and difficulties inherent in psychoanalytic transference/countertransference configurations validate equivalent maternal reactions.

In sum, I suggest that due to educational parity and new occupational opportunities, a high discordance exists between the dramatically changed women's expectations over the past 40 years and the needs of babies, unchanged over the millennia. Healthy ambivalence is an inevitable feature of such intersubjective experience – how it manifests in mothering is a function of both maternal orientations and contagious arousal by the child's affective communications.

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