

**Title: An investigation into perinatal psychotherapy as
a treatment for first-time mothers with anxiety
disorders**

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Abstract

It is widely recognised that the perinatal period brings an increased risk of mental health problems for women, with more than one in ten women in the UK developing a mental disorder during pregnancy or within the first year of having a baby. Perinatal mental disorders are potentially far-reaching in terms of the negative impact they can have on the lives of childbearing women and the foetus or infant. For example a mother's disturbed mood can have an adverse influence her child's emotional development and psychosocial outcomes, and can affect the parent-infant relationship.

In the UK, perinatal treatment usually takes place on an outpatient basis although in extreme cases, for example where psychosis is diagnosed, a woman may be admitted to a psychiatric unit. In either case, sometimes the use of psychotropic medication may be needed. However, women's fears about harm to their babies as a result of using psychotropic medication, plus concerns about their own possible dependency, mean that many women prefer psychological intervention to treat their perinatal mental disorder.

Psychoanalytic psychotherapy is one type of psychological intervention used in the UK NHS in the treatment of perinatal disorders. However there tends to be little attention from research and literature on the role and effectiveness of psychoanalytic psychotherapy in working with mothers, and on the sorts of things that can lead to mental disorders in the perinatal period. Hence it is the aim of this study to explore these issues through a qualitative case study of three patients attending one outpatient perinatal service for psychotherapy treatment with a male therapist, specifically for anxiety disorders.

Drawing on the material from the three individual case studies, the fear of being judged a bad mother is illuminated as each patient tries to adjust to the transition to motherhood when suffering from complex psychological conflicts. Observations are made of their conscious and unconscious identifications with the vulnerability and dependency of their babies and the interrelated anxiety arising when faced with the primary responsibility of care. A range of factors which have serious implications for the mothers feeling emotionally capable of being the primary caretaker come to light as the case studies unfold. Attention is paid to the transference in the patient-therapist relationship and the technical

challenges for psychotherapeutic technique in relation to the gender dynamic. The case examples show a working through of psychological dilemmas in the setting of a perinatal service focussed on strengthening mother-baby relationships at risk of being damaged.

Contents

Acknowledgements	5
1 Introduction	
1.1 My journey	6
1.2 Shaping of my practice and research in perinatal	7
1.3 Treatment and recovery	9
1.4 Historical perspective: the perinatal service	11
1.5 The perinatal service present day	12
1.6 Mental health care for pregnant women and new mothers	13
2 Literature review	
2.1 The scope and significance of perinatal mental illness	17
2.2 Psychoanalytic thinking around perinatal psychological problems	21
2.3 NHS interventions for perinatal illness	24
2.4 The place of psychoanalytic psychotherapy	26
3 Methodology	
3.1 Study design	30
3.2 Setting	33
3.3 Sample	33
3.4 Data collection	34
3.4.1 Observations	35
3.4.2 The place of semiotics	37
3.5 Data analysis	38
3.6 Ethical issues	40
3.6.1 Consent	40
3.6.2 Confidentiality and anonymity	40
3.6.3 Data management	40
4 Case Studies	
4.1 Emma	42
4.2 Lucy	78
4.3 Kate	102
5 Commentaries	
5.1 Emma	115
5.2 Lucy	126
5.3 Kate	134
6 The Three Cases	
6.1 The Family Environment as a Pathway of Transmission	143
6.2 Paternal Absence	145
6.3 The Paternal Function	146
6.4 Working with the Mother-Baby Configuration	149
7 Conclusion	153
8 References	165
Appendix 1: Coding	174
Appendix 2: Glossary	183

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1. Introduction

1.1 My journey to practicing perinatal psychotherapy and carrying out this doctoral research.

I left school aged 16 to commence a carpentry apprenticeship. In 1992, aged 32 I thought about changing career and found an opportunity to work as a volunteer in a local NCH Home to help support a very troubled young boy aged 3½ years. This boy was prone to violent outbursts and acts of brutal aggression against other children. He had an early history of emotional disturbance within a context of neglect and abuse. For over 12 months I witnessed some of his violent and brutal reactions to situations that displeased him which were often sudden and unexpected. From this point onwards I wanted to learn about and try to understand more about the troubled mind and primitive reactions. As a result I returned to education as a mature student in my mid-thirties, initially undertaking an access course during which time I was introduced to the Social Sciences. In particular I quickly became interested in Sociology and how it looked deeply into aspects of human behaviour in social and cultural groups. I applied to undertake a bachelor's degree in Sociology and thoroughly enjoyed discovering the sociological perspectives of Marx, Durkheim, Mead, Husserl, Foucault and many others within the tradition. I was fortunate to have a personal tutor who could see that I was keen to explore further the emotional responses of individuals within social contexts and he introduced me to the work of Freud, Winnicott, Fairbairn and Bowlby.

The detailed descriptions and explanations of their psychoanalytic theories and their versions of the workings of the internal world inspired me towards a professional training within the mental health field. After completing two post-graduate psychoanalytic study courses at The Tavistock Centre with infant observation as a key component, I took two years out from studies, and was employed as a family support worker in Slough, where I focussed on making positive links between the child, parents and school for excluded children and adolescents. During that time I made up my mind to apply for the 4 year clinical training in child and adolescent psychoanalytic psychotherapy. I was lucky enough to have a joint clinical placement between the Child and Family Department and a CAMHS/Perinatal Department at a London Hospital. Already having a keen interest in the work Donald Winnicott and his particular way of

thinking and working with the mother and infant from an emotional perspective, I began to develop my clinical speciality around the clinical work in the perinatal department. This was under the expert supervision of Dr Marguerite Reid, Consultant Child Psychotherapist. Following completion of the clinical training I was fortunate enough to be offered a post in the perinatal team and shortly afterwards really began the process of developing this doctoral study.

1.2 Shaping of my practice and research in perinatal

Through having caseloads of female patients experiencing psychological dysfunction in the perinatal period I have learnt to appreciate that they often had resources and strengths which could be therapeutically drawn upon to help facilitate better outcomes with their babies. I have realised that within the dynamic of the patient-therapist relationship it has been possible to help my patients draw on their own resources and strengths.

In 2009 following qualification in the clinical training I began the task of developing a psychotherapeutic outreach service for women in the perinatal period in a West London borough. This was a project that was supported at that time by the Maternity Commissioner and agreed that satellite clinics would be set-up within a Children's Centre and GP Practice, which are currently still up and running. In 2009 over 40% of all women booked to have their babies at the hospital I worked in lived in that West London borough. The commissioner saw a need for perinatal psychotherapy to be reaching into the community as well as maintaining the clinical work with the hospital.

There are services which focus upon adult mental health and some which focus upon infant mental health, however, there is little joined up working between the two. The perinatal service has been committed over the years to integrating the mental health needs of the mother and baby. There is vision and focus evident in promoting the well-being of parent-infant relations, including 1001 Critical Days, National CAMHS Support Service Parent-Infant Mental Health Network (NCSS PIMH Network), Parent-Infant Mental Health Project (PIMH Project), National Institute for Clinical Excellence (NICE) guidance on Post Natal Depression – but very little with a direct focus upon infant mental health.

Between 10% and 20% of women (Public Health England 2015), are affected by mental health problems at some point during pregnancy or the first year after childbirth. This covers a range of mental health problems including Depression, Anxiety Disorder, Post-Traumatic Stress Disorder (PTSD), Postpartum Psychosis and Adjustment Disorders and distress.

Patients referred to the service present with a range of perinatal mental health disorders including women with histories and a diagnosis of Borderline Personality Disorder, Eating Disorder, Obsessive Compulsive Disorder (OCD) and Depression. During my time working with patients in the perinatal service as a psychotherapist I have noticed that characteristically many of the patients seen either during pregnancy or post-birth have been severely troubled by self-critical and self-attacking thoughts which have come to light during the course of their treatments. This has been almost regardless of whether the patient was suffering from general symptoms of anxiety, stress, and depression or of the personality disordered group. Of particular note is that I have become very aware through my face-to-face contact with a large pool of patients, that those suffering from anxiety disorders have been the most vociferously self-critical and self-attacking in their feelings, thoughts and behaviours. Featuring heavily alongside their self-devaluation have been acute and chronic states of vulnerability, emotional isolation and lack of hope.

I have felt especially inclined to explore the anxiety disordered patients in relation to their self-criticism and devaluing of self, as a common denominator which has arisen across many patient sessions as patients often refer to themselves as 'pathetic'. This self-appraisal of being pathetic has proved a major hurdle to cross when working therapeutically with these patients. They often feel that they should be able to care for their babies without any complex thoughts or feelings towards them. When patients have described themselves as pathetic during sessions, typically they have been self-critical about their own behaviour, for instance, having had a tantrum or something simple as they see it, for example, avoiding travelling on public transport due to panicky feelings. This type of perinatal patient also tends to be very unforgiving towards herself, finding it difficult to make any allowances for herself, and often trying to extract affirmation from the therapist of their pathetic status, and at the same time conversely not wanting to feel judged by the therapist. This has been

symptomatic of many of the perinatal patients I have met with in the therapy room.

The negative self-criticisms expressed, and especially by those patients who have described themselves as pathetic can drastically impede their capacity to view themselves as the kind of mother they would like to be and feel that they should be. Patients such as these often appear to have destructive mechanisms operating within them.

1.3 Treatment and recovery

The patients featuring in this study all suffered from anxieties and insecurities but had not broken down emotionally. Accordingly their psychotherapy treatments were put in place to help avert possible breakdowns. Like many other perinatal patients they perceived themselves liable to fail in their maternal roles which cast a destructive shadow over mother-baby bonding in the early postpartum period. The three case studies highlight the kind of problematic maternal anxieties they experienced, some anxieties relatively normal for a first-time mother to encounter and some which had more profound impact. Much of what these patients feared during the perinatal period is depicted by Maldonado-Duran et al (2000):

At times, besides the normal concerns associated with pregnancy, a woman has a specific concern about becoming a mother and uncertainty about how she will be as a mother. This is more commonly seen toward the third trimester, as the reality of the delivery is imminent. The future mother may experience a pervasive fear that she will not be able to feel like a mother, that she may not love her baby and bond with him or her, or that she will actually neglect or mistreat the child. Such experiences can cast a negative shadow over the current condition and the future birth. In particular, women with a history of major family conflicts in their life, significant losses, or disruptions in attachments may experience marked fear of being mothers themselves. (2000:326)

This study will illustrate a number of problematic preoccupations that repeatedly surface within perinatal psychotherapy with anxiety disordered patients. Having spent much of my time from the outset of constructing this research proposal reviewing relevant literature and research I have found that a large proportion is focused on a range of relevant areas such as early detection of, management of and diagnosis of perinatal disorders. However, in the main the research literature available does not focus on the psychological dynamics involved in the

relationship between patient and clinician during the course of treatment. To a far greater extent the repetition of focus of the relevant literature is that of the management of perinatal disorders in terms of screening, assessment of symptoms, diagnosis and treatment, often in relation to psychotropic medication.

The approach of psychoanalytic psychotherapy is towards in-depth processes, where interchanges between conscious and unconscious archetypes of the patient's psychological world become reflected in the patient's relationship with the therapist (transference). A major objective within this form of psychological treatment is for the therapist to help his/her patient develop more insight into and self-awareness of detrimental patterns of functioning.

A key aspect of why patients come to see a psychotherapist during the perinatal period typically involves the patients' need for "relatedness" in a time of crisis. I have first-hand experience of the patient-therapist engagement and the potential for the transference aspect of the engagement to positively impact upon the mental health of the patient. Through the development of a therapeutic relationship and transference that forms within it, there is the potential to focus on often key psychological conflicts existing within the patient that come to light during the sessions. For example, historical conflicts of disorders such as Anorexia Nervosa and OCD, habitual tendencies towards self-criticism, fear of abandonment, feelings of loss, and lack of hope. The emphasis that psychoanalytic psychotherapy places upon the relational aspects and mechanisms of the practice, such as transference, is a key technical difference from other therapeutic techniques and psychological treatments such as cognitive-behavioural therapies.

Using the three case examples this study primarily aims to explore factors that can be activated in the psychotherapeutic process, which can result in effectiveness in terms of helping the patient's emotional functioning. This is in the context of the three women when beginning their treatments appeared trapped in a morass of self-doubts about having the capacity to be good-enough mothers. This study also aims to explore whether the gender dynamic in the patient-therapist relationship might play a role in affecting the treatment outcome.

The perinatal period is a remarkable developmental time for both mother and baby. It provides an extraordinary window of opportunity to address longstanding psychological distress and disorder, often originating in early life experiences of abuse or neglect, trans-generational issues, as well as later trauma and loss. This study aims to throw light on the psychotherapy relationship as a subtle mechanism for mobilising emotional repair and growth in the perinatal period, using the accounts of three patients whose emotional processing during sessions illustrate the pivotal role of past parenting experiences and this emotional functioning in how they define themselves as new mothers.

Qualitative methods have been used to analyse psychotherapy sessions in order to identify themes that emerged within the patient–therapist discourse that teased out central aspects of what had contributed towards three women to feel so bad about themselves in the context of becoming mothers.

1.4 Historical perspective: The Perinatal Service

The Perinatal Service was developed in 1994. Traditionally work within the area of perinatal mental health fell within the remit of Adult Mental Health Services. A service based within the Directorate of Child and Adolescent Mental Health (CAMHS) was unusual. In fact, this was the first perinatal service based in child and adolescent services in England and probably within Europe.

In a report to commissioners during the early years of the service Reid (1998) outlined the developmental ethos behind this. Reid described a child-based service that would not only ensure a specific focus on the needs of the mother, but that the relationship between mother and baby and the relationship between the parental couple and their infant would be central to the clinical work within the department.

Research showed that emotional difficulties during both the antenatal and postnatal period had a negative impact on the mother baby relationship e.g. antenatal and postnatal depression, previous perinatal loss, and attachment and bonding difficulties. The work with parents of children referred to child and adolescent mental health services clearly indicated that often disturbances within the family stemmed from these early difficulties.

Under the Directorate of CAMHS, with strong links with primary health care, originally it was anticipated that the majority of referrals to the perinatal service would be made during the postnatal period. From the inception of the service however, the majority of referrals were made during the antenatal period. The National Service Framework - Maternity Guidelines' October 2004 and 'Recommendations of the Confidential Enquiries into Maternal Deaths in The United Kingdom Why Mothers Die 1997-1999' highlighted the need for early intervention. Liaison with obstetric and midwifery services following the formation of the perinatal service, drew attention to their experience of inadequate provision for women with mental health needs during the antenatal period.

1.5 The Perinatal Service present day

Currently NHS commissioning arrangements are evolving, however, the service essentially accepts referrals across four local London boroughs. In September 2009, the Perinatal Service was commissioned to establish a community-based outreach service by one of the commissioning groups. This now long established, specialist multi-disciplinary outpatient service has continued to offer consultation, assessment and treatment, both psychiatric and psychological, to women with moderate to severe psychological disturbance during pregnancy and post-birth. It is not commissioned to provide an acute crisis service. At the same time each week there is a team meeting where referrals and ongoing cases are discussed. In terms of new referrals they go through a triage assessment. The team is multi-disciplinary with a Consultant perinatal psychiatrist in the clinical lead role. Based on the referral information the team make a decision either to:

- Log the referral and if assessed as not meeting the referral criteria returned to the referrer with advice offered.
- Signpost to the most relevant other service/s
- Directly allocated to a perinatal team member to offer an initial assessment appointment and manage it on their caseload within the perinatal mental health service. The outcome of an initial assessment will determine what level of treatment is needed.

A number of cases are regularly co-worked within the service between perinatal psychiatry, psychotherapy and midwifery. For instance, patients with severe depression in pregnancy will be assessed by the consultant perinatal psychiatrist and if the assessment yields that the patient would benefit from a course of psychotherapy the two clinicians will devise and carry out a treatment plan, with the involvement of the patient. This might include the team psychiatrist prescribing psychotropic medication.

Particularly through patient feedback the service has learnt about the benefits of focussed work with women and their partners where there is an attachment disorder or bonding difficulties particularly between mother and baby as a result of the mother's mental state. The service has maintained and developed working collaboratively with midwifery, obstetrics, general practitioners, social services, health visitors, Family Nurse Partnership and early years services such as Children's Centres. There are often problems with historical origins that patients bring with them; hence clinicians working in the service are aware of the potential for transgenerational transmission of disadvantage as an influential factor in mental health problems and disturbed attachments between parent and baby.

1.6 Mental Health Care for Pregnant Women and New Mothers

In October 2013 a report was published into maternal mental health funded by the Boots Family Trust in association with Netmums, Institute of Health Visiting, Royal College of Midwives and the national charity Tommy's. The report described the key findings from two surveys of around 1,500 women and of more than 2,000 health professionals. In the survey the women reported some form of mental health problem during the perinatal period. Almost half said they had suffered with either depression or anxiety while they were pregnant, and two thirds said they had suffered with postnatal depression. Two per cent had suffered with puerperal psychosis.

Developing a mental health problem during pregnancy or post-birth can invoke a feeling of stigma for the first-time mother, and may have a detrimental effect upon the development of the mother forming a bond with her baby and damage other significant relationships. A woman who feels severely anxious about being suitable and capable of nurturing her baby due to her own state of mind may

lead to the development of unhealthy coping strategies, for instance self-harm, and avoidance in seeking the support of professionals, fearing being judged as an unsuitable parent.

There is a need to understand the personal experiences of this specific female patient group in order to improve the effectiveness of mental health treatments. This is an important aspect for mental health professionals to keep in mind given that pregnant women and women with new babies can feel reluctant to admit to experiencing psychological difficulties. Women can fear that if they reveal feeling depressed, overwhelmed or disengaged, the result could be that they will have their baby taken away by social services; consequently women can be inclined to disguise their illness as far as they can. The more this area of mental health can be understood and de-stigmatised, the better possibility of the mental health condition being treated and any risk issues such as harm to the baby and/or mother decreased.

Babies develop in an environment of relationships that begins within their family, extends into their social world, and is affected by widespread social and cultural factors. Throughout the early stages of development post-birth, they automatically seek contact through such behaviours as babbling, making facial expressions, and they develop best when the primary caretaker responds with love, and is consistently attuned. A secure bond between parent and baby encourages the development of wellbeing in the baby and in the relationship. In contrast, Teicher (2000) notes that when the environment is disadvantaged, neglectful, or abusive, the child can often lack empathy and not understand what others feel like when they do something hurtful. This can lead to an increased risk of mental health problems, aggression, anti-social behaviour and delinquency, as highlighted by Tremblay (2010).

Relationships are dynamic, and the relationship between the primary caretaker and the baby is a foundation stone in the developmental process. The personality of the baby or the parent can affect how they relate to each other. The parents approach to parenting, their health, their baby's health and their wider social context all impact on their developing relationship. Pregnancy is a crucial time for beginning healthy infant development and it is essential that the mother is healthy, both physically and mentally, with easy access to support and care if needed. Health providers have a responsibility to ensure that

patients who have complex mental health needs receive the most appropriate support and service committed to continuity of care, collaborative and integrated care, and accessible care, for instance, establishing a clear referral and treatment pathway.

The following section in this paper provides a review of literature pertinent to mental illness during the perinatal period and new motherhood which can entail a range of physiological and psychosocial changes with an increased risk of mental illness. I will refer to psychotherapeutic outpatient treatment adapted and refined over many years to the particular needs of women suffering from complex perinatal mental health disorders as a treatment option within an NHS setting. The latter part of this section acknowledges the emotional and psychological interchanges occurring clinically between patient and therapist as it develops into a significant relationship.

Section 3 provides an overview of the methodological approach taken in gathering data relevant to this dovetail between a qualitative model of research and a psychotherapeutic process with three perinatal patients. Reflexivity was a central device in the research-psychotherapeutic process, including drawing on the psychoanalytic concepts of transference and countertransference and reflecting on processes of projection and projective identification as they occurred within each of the case studies. This section describes the use of integrating different modes of close observation, listening to, and examining data, with a psychoanalytically trained observer/psychotherapist developing findings and conceptualizations from psychotherapy sessions grounded in the patients' experiences.

The main focus in section 4 is devoted to sessional material from each of the case studies which is intended to function as the bedrock of this thesis, to present a picture of each patient's feeling of internal damage using the therapist's first-hand experience of them. The therapist's work with patients Emma, Lucy and Kate and their babies puts a spotlight on different dimensions involved in the process of perinatal psychotherapy.

The section following the case studies is formed into structured commentaries and analysis of the clinical material from each of the three cases, organised by sub-headed themes. The thematic contexts and analysis is

supported by psychoanalytic concepts. I use the term material in relation to a whole range of verbal and nonverbal communications between patient and therapist as manifested during the treatment.

In the section of the thesis titled 'The Three Cases' themes that emerged from each case are drawn together and discussed with the help of psychoanalytic concepts, with some cross referencing between the cases where appropriate.

2. Literature Review

2.1 The scope and significance of perinatal mental illness

This literature review covers a range of aspects relevant to perinatal illness and the potential for psychotherapy with a psychoanalytic approach to be offered as a treatment option. This is set out with the premise that the perinatal period is a critical period where future mental health prevention efforts should be focused and prevention models developed. There is an emerging body of evidence that mental illness during pregnancy and postpartum is associated with a woman's experiences of mental health disorders within the perinatal period and the adverse impacts. If successful, psychological interventions during the perinatal period have the potential to have lifelong effects on mental health of family relationships. The literature review in this section is used to identify some of the significant features and interventions in the area of perinatal mental health. I have included literature in the review pertinent to the identification and treatment of mental health during pregnancy and in the postpartum period and relevant psychoanalytic theory that can be applied to working with perinatal patients has been reviewed.

Perinatal mental illness refers to psychiatric disorders that are prevalent during pregnancy through to one year post-birth (O'Hara et al, 2014). It is widely recognised that the perinatal period brings an increased risk of mental illness for women. Mental disorders in perinatal women bring about an increased risk of suicide, especially in expectant mothers with a previous history of mental illness and when the disorder is untreated (World Health Organisation (WHO), 2008). Perinatal mental illness encompasses a wide range of disorders including depression, anxiety disorders, affective/mood disorders and psychotic disorders. Anxiety disorders are often experienced alongside depressive disorders and include panic disorder; generalised anxiety disorder; obsessive compulsive disorder; social anxiety disorder; separation anxiety disorder; post-traumatic stress disorder and specific phobia (Buck et al, 2009; SANE, Australia). Anxiety disorders have been found to be 'common' during the perinatal period, 'with reported rates of obsessive-compulsive disorder and

generalised anxiety disorder being higher in postpartum women than in the general population' (Ross et al, 2006:1).

More than one in ten women in the UK develops a mental illness during pregnancy or within the first year of having a baby (London Perinatal Mental Health Network, 2015). This figure is consistent with other high income countries where approximately 10% of pregnant women - and 13% who have just given birth - experience some type of mental health disorder (Fisher et al, 2012; WHO, 2013). The incidence of postnatal depression, for example, ranges from between 13% of women in the first few weeks to 20% in the first year after giving birth (Buck et al, 2009). Perinatal mental illness has not only been found to affect women in developed countries; the disorder affects a similar proportion of women in developing countries (O'Hara et al, 2014).

Many factors are seen to contribute towards poor mental health in women during the perinatal period. Factors that can trigger perinatal mental health disorders are complex and often multiple. Winston & Chicot (2016) for example draw attention to the hard-hitting shock of becoming a new parent which has its roots firmly set in an historical context. Historically, new parents would have learnt the skills of parenthood over many years from living with, or close to, extended family members and through having responsibilities for younger siblings. In UK society today, living in such close proximity to family is less commonplace. A first time mother may have little or no previous experience to prepare for motherhood and is therefore greatly affected by the shock of becoming a new parent, and consequently lack confidence about how to bond with and care for her baby.

Other causes of the onset of perinatal mental health disorders include genetic, biochemical and endocrine, psychological and social factors (Buck, 2009). Changes in hormone levels, emotional stress, personal and social changes for the expectant mother, and the interrelationship between psychological status and biological changes can have a powerful influence on maternal mental health (Adams et al, 2006; Dinan & Kohen, 2003). Links have also been reported between greater levels of depression in the perinatal period and difficulty sleeping and sleep deprivation (Ross et al, 2005). Moreover, research shows that children of alcoholic parents are more likely than children of non-alcoholic parents to experience internalising disorders such as depression and

anxiety, and externalising disorders such as substance abuse and problems (Bygholm et al, 2000; Chassin et al, 1999; Dinwiddie & Reich, 1993).

Social determinants are seen as a significant cause of mental health problems, especially - although not exclusively - in pregnant women and mothers in developing countries. These include poor socioeconomic status, less valued social roles and status, poor marital relationship, poor social support, stressful life events, unintended pregnancy and domestic violence (WHO 2008; O'Hara et al, 2014). Whilst some problems come to the attention of professional health workers for the first time during pregnancy, other problems may be masked by the pregnancy and therefore do not receive the attention needed (Kohen, 2003). In developing countries, perinatal mental health problems often compete with other mental health problems and therefore may not receive the attention warranted.

The perinatal period can bring about a range of emotional upheavals for the mother which are often prone to fluctuations in terms of intensity.

Psychoanalyst Raphael-Leff (1991; 1993) highlights pregnancy and childbirth as profound and complex psychological and emotional events, with a lasting impact on lives, including that of 'our daughters, and grand-daughters'. She describes conception as 'the beginning of a bizarre story' and whilst some women embrace the changes to their body during pregnancy, for other women there is a distressing psychological impact.

The distress that some women experience in the perinatal period is triggered by the 'mysteriousness' of what is going on inside their bodies during pregnancy, the fear of physical damage to their bodies being integrated with psychological fears, for example uncertainty or fear about survival from childbirth (Bernstein, 1993). A further angst for some women is whether they are going to project onto their baby their own emotional complications or anxieties. Negative feelings with regard to how a woman has experienced her own close relationships and interpersonal relations can determine in part her perceptions of and fantasies about her baby. Negative attitudes and fantasies, consciously or unconsciously, can in turn powerfully affect how a mother responds to her baby (Berlin, 2002).

A healthy mental state for women/women's mental health during the perinatal period is extremely important for the wellbeing of the mother and the foetus or baby; there are many negative outcomes associated with perinatal mental illness.

Perinatal depression, anxiety, bipolar disorder, and postpartum psychosis represent mental health problems that, in the case of depression and anxiety, are relatively common and serious, and in the case of bipolar disorder and psychosis, while relatively less common, can have devastating consequences for the mother and her family (O'Hara et al 2014:9).

Perinatal mental disorders are potentially far-reaching in terms of the negative impact they can have. Not only can the lives of childbearing women be disrupted, but anxiety or mental disorders can also generate adverse effects for the foetus or infant (Ross et al, 2006). There is an increased risk of suicide in women with a mental disorder if the disorder is not treated. Additionally, growing evidence suggests that severe depression during the perinatal period, for example, is linked to increased rates of schizophrenia and bipolar disorder which in turn are linked to infant mortality.

Furthermore, perinatal mental disorders that are not treated can have a serious negative impact on childhood development: 'untreated mental disorder may lead to poorer long-term outcomes for children, such as cognitive delay and a range of behavioural and emotional difficulties' (Buck et al, 2009, p.28). A mother's disturbed mood may negatively determine her child's own emotional development and psychosocial outcomes, especially when there is a lack of appropriate attentiveness to her child's needs. Maternal mental health problems are not only detrimental to a woman's health; they have also been linked to reduced sensitivity and responsiveness in caregiving and to higher rates of behavioural problems in young children" (WHO, 2013).

There is a developing evidence base that effective intervention in the perinatal period requires not only a focus on parents' mental health, but also a specific focus on the parent-infant relationship. This is because of the negative impact that untreated mood and anxiety disorders in the post-birth period can have on the mother-baby relationship and/or negative feelings the mother may possess towards her baby (National Institute of Clinical Excellence (NICE), 2014).

Maternal anxiety has long been documented as a potential influencing factor in mother-baby relationship difficulties (e.g. Gaudet et al, 2010; O'Connor et al, 2002; Parcells, 2010). An insecure mother-baby attachment can significantly impair a child's ability to form and maintain healthy relationships throughout life (Winston & Chicot, 2016). Reid (2012) cites research into the area of postnatal depression which highlights depression affecting the developing mother-baby relationship and the infant's cognitive development. Reid refers to a growing body of research evidence that suggests anxiety during pregnancy may impact on the foetus and potentially contribute to problems in early childhood.

2.2 Psychoanalytic thinking around perinatal psychological problems

The mothers featured in this study were all suffering from anxieties and mood disturbance after having their first baby. This study acknowledges the significant personal and social changes during the transition to motherhood. It can be a key marker for potential modifications and transformations to the women's sense of identity. Reilly (2010) identifies pregnancy and the perinatal period as an experience, marking the creation of new life and the transformation of adult roles, responsibilities, and states of mind. The onset of motherhood can motivate a new mother to work through feelings of ambivalence about their own parents and encourage a desire to parent differently in order to give her baby an experience different to her own. Reid (2003) carried out research that considered the mother's state of mind when she gives birth to another baby following a perinatal loss. The research captured the emotional experience for the mother and acknowledged how the next baby can become eclipsed by the image of the dead infant until the mother can fall in love with her new baby.

There can be multifaceted reasons why many women become impaired in being able to remove themselves from negative emotions in the perinatal period which often are glued into their internal state of mind. Perinatal patients have referred to always feeling in 'repeat mode' and on a 'ferris wheel', denoting the way they often feel stuck and repeating destructive patterns of behaviour. The repetitive and self-destructive aspects of the way many patients function fits with the compulsive and relentless inclinations of the death drive. Perhaps because of the life and death nature of childbirth and/or the weight of responsibility involved in caring for a baby, many women are terrified by a deep lying sense of destruction that can feel unbearable. Bell (2015) points to Freud having an

understanding that an 'awareness of all beauty must bring thoughts of death and the passing of all things'. Segal (1993a) referred to Freud's concept of the death drive as a death instinct and viewed it as a protest against the pain of life. Klein (1958) linked the death instinct and envy within a destructive narcissistic constellation, in this context there is a compulsion towards directing something destructive toward the living self, which paradoxically wants life, but also towards the life-giving object.

Often the social, cultural, political, familial and psychological context that engulfs the mother instils an expectation that she will automatically fall in love with her baby and have beautiful associations with the whole process of having a baby. Working consistently in the consulting rooms of the perinatal department it becomes apparent this is not necessarily the case. In many cases the therapist witnesses the loss of the illusion of the perfect baby and perfect process. It is important to recognise that some women who are not diagnosed with anxiety disorder might share some of the same characteristics as those who are diagnosed: crying, feeling lonely, hopelessness, isolation, and feeling inadequate in their mothering abilities.

Studies have shown that stigma has led to many people refusing to seek help for themselves or their relatives seeking to find them help (Parle 2011). Goffman (1963) distinguished stigmatized groups as discredited (with relatively obvious marks such as people of colour or gender) or discreditable (without obvious marks, causing stigma to be largely hidden). Conceivably the concept of alienation articulated by Marx (1844) in terms of factors external to the individual such as work and organizational systems and processes can also be applied to the realm of factors internal to the individual's "state of mind". Women suffering with perinatal disorders at a time when they anticipate being intrinsically connected to the process and activity of motherhood can feel detached and depersonalised. Overwhelming feelings such as a loss of identity, a loss of control and powerlessness can bring about a basis for self-estrangement. As a critic of the industrial revolution, at a time of enormous transition Marx pointed to how the transformational changes from a premodern to a modern industrial society resulted in the inevitable detachment of most workers from the sense of coherence and meaning that results from doing significant work (Jeannot, 2010). "Humans as they work invest a certain

amount of self into what they are doing and on completion there is a satisfaction or reward in what has been produced and a replenishment and enrichment of self in seeing the labour complete". (Ollman,1976:142).

The stability of self is difficult to maintain when faced with moments of unsettling transition and can contribute to a sense of not feeling intact. Klein's (1940, 1957) theory of two developmental phases the paranoid-schizoid and depressive positions is relevant to feelings of instability and the internal situations patients find themselves in when suffering from an emotional breakdown in pregnancy and postpartum. It is reasonable to consider the paranoid-schizoid position a hopeless and uncertain internal experience when there is an overwhelming sense of primitive schizoid anxieties. The depressive position is more characterized by finding a way to mourn loss, manage sadness and longing as a normal, developmental process of integration.

When these patients are caught in the grip of internal conflicts there is much potential for the arousal of destructive thought processes and actual self-harming behaviour. As a result, emotional expression can become discharged through actions as opposed to words. Expression through the channel of language may be an adequate and normal medium for communication for some (with conflicts in their emotional development) to convey the way they are feeling but for others actions speak louder than words. For some self-loathing can play a significant role in deliberate self-harm. In her work as a forensic psychotherapist, Adshead (2010) found there to be a significant association between deliberate self-harm as a form of communication and feelings of rage. She refers to the body as the default setting for people who self-harm to communicate anger and hostility towards themselves and others.

In relation to hostile feelings toward the self and resulting self-destructive processes, Fairbairn (1952) recognised - through his encounters with patients - the part the 'internal saboteur' played in the barrier to mental growth, hindered by their pathological tie to a rejecting internal object. Fairbairn emphasised the 'satisfactory transference situation' as a mechanism for therapeutic change. The therapist and the therapeutic situation are internalized as a new object. This kind of object usage by the patient correlates with Winnicott's (1965) emphasis on the pivotal relationship between mother and baby in which the infant is hard-wired for relationship but primarily moulded by the maternal environment. The

therapist can create a holding environment in which an emotional atmosphere can facilitate emotional growth. The impact of gender on the psychotherapeutic relationship can be considered a variable in some transference reactions.

Underlining the psychotherapeutic relationship and the therapist's role in sensitising himself/herself to the emotional disposition and personality of the patient, Pines (1993) described how 'sensitive listening to language, the choice of words and their meaning, is as important to psychoanalysis as in literature'. Before practicing psychoanalysis, Pines had qualified in general practice and dermatology which supported her understanding of the interrelationship between psyche and soma. Pines developed an awareness of her patients somatically expressing through their skin the emotions they could not consciously handle. She came to understand that what many patients needed was a doctor who could think about each patient's psychological irritation as if she were a mother trying to soothe the discomfort (Hatch,2010).

2.3 NHS interventions for perinatal mental illness

Perinatal mental health problems can have significant implications for the wellbeing of the mother, her partner and their baby, and therefore the perinatal period is a critical time to identify psychological disorders. Treatment of perinatal mental health problems is crucial because of negative outcomes for the mother and child that can result (Howard et al, 2014).

Henshaw et al (2011) refer to pregnancy and the early postpartum period as times of high 'surveillance' by healthcare providers, providing great opportunity for early intervention for women with diagnosed psychiatric conditions as well as identification of women at risk, to facilitate preventative strategies. A critical analysis of factors associated with postnatal depression in particular is provided by Wylie et al (2011) who note the importance of facilitating appropriate healthcare provisions in order to improve standards of care. The authors conducted a critical literature review and synthesis of research papers on post-natal depression. They determined that interventions were often ineffective and that more research was needed on how best to engage people suffering from perinatal depression. The authors also identified a need to improve how women are identified initially and then 'managed' within a programme of

treatment. However, perinatal disorders can present 'unique issues' for detection and management for clinicians (Ross et al, 2006).

The Edinburgh Postnatal Depression Scale, a screening tool for measuring perinatal depression, is widely used amongst mental health clinicians globally to identify the incidence and extent of the condition in women. In the UK, in cases where depression or anxiety disorder is identified, women are usually referred for perinatal treatment. Treatment usually takes place on an outpatient basis although in extreme cases, for example where psychosis is diagnosed, a woman may be admitted to a psychiatric unit (O'Hara et al, 2014).

Psychological intervention is one form of perinatal treatment. Psychiatry is another model of treatment and in some cases women may be required to take psychotropic medications (anti-depressants, mood stabilisers, and antipsychotics) as part of their treatment process. However, although untreated perinatal mental illness can have negative outcomes for the foetus and/or baby, taking psychotropic medications during pregnancy or whilst breastfeeding can also carry risk. Whilst psychotropic medications may be an effective form of treatment for mental disorders, a significant downside to the use of this treatment during the perinatal period is the risk associated with harm to the baby (NICE, 2014; Taylor, 2016). Another important aspect to be considered relates to the 'co-morbid problems that women with mental disorders are more likely to have as these may also impact on the neonate' (Hind et al, 2015). The risks to mother and baby must be carefully considered by the perinatal team and psychiatrist.

Battle et al (2006) discuss the implications of treatment for women who actively seek psychiatric treatment, including those with a prior psychiatric history. The authors' research found that while most women were willing to take psychotropic medications, a significant proportion were not, especially those who were breast-feeding. Their study highlighted that although breastfeeding may seem an optimal choice, the decision to breastfeed is considerably more complicated for women who suffer from depression during the perinatal period.

The NICE guidelines (2014) further note that many women who take medication for disorders such as anxiety and depression in the pre-perinatal period, will stop taking it when they are pregnant, and also post-birth if they are breastfeeding their babies. Women's fears about harm to their babies resulting

from using psychotropic medication, together with the potential for their own dependency, mean that many women prefer psychological intervention in the treatment of their perinatal mental illness (NICE, 2014). Knowledge in the area of appropriate intervention around perinatal mental illness is continually developing, and rigorous and scientifically sound research into the effectiveness of psychological interventions for moderate to severe anxiety disorders is recommended within the NICE Guidelines (2014).

Given the developing evidence base that effective intervention in the perinatal period requires not only a focus on parents' mental health, but also a specific focus on the parent-infant relationship, NICE guidelines also recommend psychological interventions that focus specifically on the latter when the mother is diagnosed with having mental health problems. This is because of the negative impact that untreated mood and anxiety disorders in the post-birth period can have on the mother-baby relationship and/or negative feelings the mother may possess towards her baby (NICE, 2014).

2.4 The place of psychoanalytic psychotherapy

Findings from research suggest that psychotherapeutic intervention with mothers can lead to positive outcomes for the baby's emotional development (e.g., Barnes et al, 2009; Smith et al, 2010; Emanuel, 2006). Psychoanalytic psychotherapy is a specialist psychological intervention used in the NHS in England in the treatment of perinatal disorders, albeit to a lesser extent than mental health interventions such as perinatal psychiatry. However, psychiatry and psychotherapy sometimes work together in NHS perinatal services.

A major objective of psychotherapeutic treatment is for the psychotherapist to help his/her patient develop more insight into and self-awareness of detrimental patterns of functioning. A psychoanalytic psychotherapeutic approach examines in-depth, interpersonal processes, characteristically through the transference process. This process has been defined as 'a tendency in which representational aspects of important and formative relationships (such as with parents and siblings) can be both consciously experienced and/or unconsciously ascribed to other relationships' (Levy & Scala, 2012, p.392). Transference is typically a central component in the patient's relationship with the therapist. Through the recognition of transference in the therapeutic

relationship, the therapist is aware of evocative feelings that can stir in the therapeutic dynamic. Celenza (2010) notes some challenges when dealing with emotional issues inherent in the erotic transference.

...there are two persons committed to working together and withstanding whatever emerges....this commitment holds out the hope for and promise of continued acceptance and understanding for the patient of even the most loathsome aspects of the self. Because the analysed is invited and encouraged to reveal areas of self-contempt and self-hatred, the promise of continued engagement in the face of these aspects of the self is simultaneously dangerous and seductive. The danger is inherent in the risk of rejection or withdrawal, despite the (sometimes overt) promise of sustained commitment. The seductive aspect coincides with the universal wish to be loved totally, without judgement or merit. (2010, p.289)

The relevance of the relational focus of the psychotherapy process in treatment and what the therapist offers the patient through the relationship is noted by Ruzczynski (2010):

Through the work of John Steiner (1993) and others we have learned to respect the difference between a patient being understood by their therapist and the patient understanding themselves. Understanding oneself requires a capacity to take in experiences that by definition for these patients feel to be unbearable, which is why they are projected externally. As a result, a necessary aspect of our clinical role is to allow patients to use our minds and bodies to deposit that which they fear, whilst they watch and observe how we process and manage that.....however crucial the content of interpretations may be, these patients do, in addition, need this experience of borrowing our minds, sometimes into which to deposit some pretty unpleasant things! (2010:23).

Ruzczynski's point about patients developing self-understanding within the psychotherapeutic process is extremely important and significant when working with patients who often have lacked opportunities during their development to engage in emotional dialogues and relationships with others able to contain their emotional conflicts and impulses.

From a psychotherapist's perspective, the psychological and emotional development of the patient is central and this can be nurtured through the therapist-patient relationship, with contributions from both sides through

interactions and exchanges, and on the psychotherapist's part with the support of theoretical and clinical tools, underpinned by an extensive training. Through the development of a patient-therapist relationship, and transference that forms within it, there is potential to focus on often key psychological conflicts existing within the patient that come to light during therapy sessions. For example, psychological conflicts and disorders such as anorexia and obsessive compulsive disorder, habitual tendencies towards self-criticism, feelings of abandonment, isolation, perfectionism and lack of hope can emerge from therapy sessions. This is an important aspect to the treatment of women in the perinatal period in terms of the mother-baby relationship. The emphasis that psychoanalytic psychotherapy places upon the relational aspects and mechanisms of the practice, such as transference, is a key technical difference from other therapy techniques and psychological treatments such as cognitive-behavioural therapy and interpersonal psychotherapy (Cutler et al, 2004).

The philosophical premise of the training of the various clinicians and authors, for example mental health nursing, midwifery and psychiatry that practice in and research perinatal mental health, is pivotal in the way research and patient care is approached. There appears to be much research and literature around perinatal disorders from these disciplines. Likewise, there tends to be much focus on areas such as early detection, management, diagnosis and treatment, especially in relation to the use of psychotropic medication. Conversely, the psychoanalytic psychotherapy model of treatment for perinatal disorders - with its emphasis on the psychodynamics of the patient-therapist relationship - has received little attention from research and literature. There is less understanding of the role and efficacy of psychoanalytic psychotherapy in working with mothers experiencing maternal anxiety, and outcomes of that work.

As mentioned previously, research into the effectiveness of psychological interventions for moderate to severe anxiety disorders during the perinatal period is recommended within the NICE Guidelines (2014). Psychoanalytic psychotherapy is one specialist psychological intervention used in the NHS in England in the treatment of perinatal disorders. It is important, therefore, to understand the ways and extent to which this model of treatment may relieve symptoms of maternal anxiety. Furthermore there is a need to understand the

personal experiences of this specific female patient group in order to develop the effectiveness of psychological treatments.

Pregnancy and childbirth are a time of physical, social and psychological upheaval for most women. While symptom presentation is typically critical to diagnosis and subsequent decisions about appropriate treatment, for women who prefer not to take medication, other options such as psychotherapy require consideration as a non-pharmacologic treatment alternative for women suffering from perinatal mental health disorders. The review of literature considered a number of psychosocial variables related to poor mental health in the perinatal period, the destructive thoughts and feelings that can stir in the mind of the patient and the transference dynamic during the psychotherapeutic process. The literature reviewed indicates the importance for making available the most appropriate assessment and treatment model possible for the perinatal patient, taking the severity into account. It noted the potential for perinatal psychotherapy and perinatal psychiatry to work collaboratively in delivering a positive outcome.

It is anticipated that the findings of this study will contribute to an existing body of knowledge - on which mental healthcare workers and funders may draw - of (a) factors that contribute to maternal anxiety, (b) the impact of maternal anxiety on mothers' self-perceptions and the mother-baby relationship, and (c) how and the extent to which psychoanalytic psychotherapy can work effectively with mothers to alleviate maternal anxiety.

3. Methodology

This chapter sets out the research methods used in this study. It describes the design of the research and the reasons for the design which are informed by existing literature in this field of research. A description is given of the setting in which the research is conducted. The chapter goes on to describe the sampling technique used for recruiting participants to the research, the inclusion criteria and participants' characteristics. The approach to data collection and the methods of data analysis are discussed. Finally, details are provided of ethical issues and the ethics guidelines that are followed.

3.1 Study Design

This is a qualitative study which draws on ethnographic, interpretivist and psychoanalytic approaches to investigate the role of psychoanalytic psychotherapy as a model of treatment for mental health problems in women during the perinatal period. These methods are widely viewed as traditional psychotherapy methods of research which involve the use of observation and case study narratives, and are described below. Rustin (2009) draws attention to an extensive history of psychotherapy research that contributes to its knowledge base. Rustin notes that research derived from clinical practice is instrumental in our understanding of many developmental issues and clinical disorders. In this sense, psychotherapy research may be viewed as applied research which refers to a method of investigation that seeks to find a solution to a specific problem.

Mason (2002) points out that many qualitative researchers do not identify with any one particular approach to investigative study. This is true in the case of this study. As mentioned above, the psychotherapist-researcher associates the psychotherapy model of investigation with three main approaches. First, in the ethnographic approach, observation and participation are the characteristic features (Atkinson et al, 2001 in Mason). Observation is a fundamental method of the psychotherapy model of treatment, a point revisited below in *Method of data collection*. In perinatal psychotherapy treatment, therapist observation occurs in a number of ways, for example, observation of the interaction between mother and baby; observation of the patient's response to the therapist; observation of the patient's behaviour and actions. The participation aspect of

the ethnographic approach in psychotherapy treatment concerns, for example, the therapist responding and posing questions to the patient. Thus, in a research context, the psychotherapist is an active participant in generating 'data' from their patient. Hocoy (2005) identifies associations between ethnographic research and psychotherapeutic research:

The term "participation-observer" (Agar, 1996) is typically used to describe the role of a researcher engaged in the primary research technique of cultural anthropology, namely, ethnography. Interestingly, the work of the ethnographer has many parallels to that of a psychotherapist. The role of the ethnographer is to understand another person's way of life from the point of view of the other (Malinowski, 1922, 1944) through immersion in the other's culture and "encounter(ing) it firsthand" (Packer, 1995). Similarly, for the psychotherapist, it is only through experiencing the client's reality (i.e., transferences, dynamics) first hand in the therapeutic relationship that she or he understands the other. The observations of the ethnographer are drawn from the unique, co-created field of researcher and cultural subject(s), while the observations of the psychotherapist are similarly drawn from the unique interpsychic space of the therapeutic dyad. Both ethnographer and psychotherapist are required to have an awareness of their own perceptual filter or transference lens to be able to distinguish the dynamics of the other from their own projections" (2005:101-102).

Second, the interpretivist approach sees people and their meanings and interpretations, of theirs and others' actions and social situations, as a primary source of data. It is people's perceptions - or the 'insider view' - that interpretivists seek, rather than to impose an 'outsider view' (Blaikie, 2000). In perinatal psychotherapy treatment, the therapist seeks to understand the patient's way of being and how they react to situations; the meanings that patients attribute to internal representations; their emotional and social contexts in terms of relations and how they relate to themselves, to others (for example their baby; their partner) and to the world around them. All have an impact on how the patient feels about how they function.

Third, the psychoanalytic approach also sees people as data sources, but 'the methods used have to provide access to the inner or unconscious subject' (Mason, 2002). The emphasis is on eliciting from patients their free associations rather than a narrative that is structured according to conscious logic. This method enables the therapist access to the patient's anxieties which

may otherwise not be visible. 'Free associations [...] enable the analyst to pick up on incoherences (for example contradictions, elisions, avoidances) and accord them due significance' (Hollway & Jefferson, 2008, p.310). Historically, psychoanalytic psychotherapy is influenced by the free association approach of psychoanalysis and the transference aspect of the patient-therapist relationship through which the therapist gains understanding of the patient's internal reality. In the work presented here, the psychoanalytic psychotherapy approach that the psychotherapist-researcher uses in the treatment of perinatal patients does take a non-structured approach to eliciting patients' narratives, placing importance on conscious and unconscious processes. Transference in the patient-therapist relationship is a fundamental aspect of perinatal psychotherapy.

However, the context of this study's data source bears much relevance on the extent to which the traditional or pure methods of psychoanalytic psychotherapy may be utilised and the subsequent way in which psychoanalytic psychotherapy is practiced. The perinatal service operates from within a NHS hospital. The service provides psychotherapy treatment (between conception and the first year of birth) to patients who present with serious vulnerabilities, often with the potential risk of the mother harming herself and/or her baby. Flexibility is an important and valuable component in terms of the way of working with perinatal patients. For example, flexibility in adjusting to each patient's turmoil or to the trauma they are experiencing, and in the psychotherapist-researcher sensitising themselves to each patient's emotional needs and their emotional whereabouts. Given these circumstances, classic psychoanalytic psychotherapy is not the approach practiced by the psychotherapist-researcher in the treatment of perinatal patients.

The study used multiple (as opposed to single) case study methodology in that three 'cases' - or individuals - were participants in the study. Multiple case study methodology is appropriate where replication across the cases is anticipated (Yin, 1993). Qualitative research in the form of a *single* case study is sometimes criticised for lacking scientific rigour and being non-generalisable. The strength of multiple case study, however, is that if replication is found across several cases, this allows greater confidence in the findings (Noor, 2008). While a multiple case study on this scale cannot provide a

representative sample with statistical validity, nevertheless, where replication is found across several cases, there are greater grounds for having confidence in the findings. Where differences are found, these may also contribute to knowledge.

3.2 Setting

This study took place in a single, London, NHS hospital-based perinatal service which provides treatment to psychologically disturbed women during pregnancy and post-birth. This is an outpatient service which operates out of a child and adolescent mental health (CAMHS) department. Patients are referred to the perinatal service by general practitioners (GPs), health visitors, obstetricians or midwives.

The usual way of preparing for psychotherapy sessions with perinatal patients was followed for each of the three study participants. For each patient who comes to the service, the same consulting room is used for all their therapy sessions; it is important for the patient in terms of consistency and reliability. The psychotherapist-researcher prepares the room before patients arrive for their therapy sessions. This involves laying out play-mats, rugs, and toys for the baby.

3.3 Sample

Purposive sampling technique was used to identify and select participants. Purposive sampling for the psychotherapist-researcher is a procedure useful for selecting specific target groups containing particular features (Abrams et al, 2009; Mason, 2002). During the referral stage to the perinatal service, patients already highlighted by the referrer with anxiety symptoms were identified as potential participants for the study.

The research sample comprised three female participants aged between 20 and 30 years, who had been referred to the perinatal service and undergone initial assessment by the perinatal team. Their therapy sessions with the psychotherapist-researcher took place on a weekly or fortnightly basis for a period of between 8 and 15 months. It is standard practice in the perinatal service to encourage mothers to bring their new baby to therapy sessions. This is applied psychotherapy, and the work enables the new mother to think about

her emotional experience and relationship with her new baby. The three participants each brought their baby to the vast majority of their therapy sessions.

Each psychotherapy session lasted between 50 and 60 minutes. The number of psychotherapy sessions carried out with participants varied, mainly depending on the length of time for which they were undergoing psychotherapy treatment. The first participant underwent 55 sessions over a 15 month period, the second participant 54 sessions over a 15 month period, and the third participant 27 sessions over an 8 month period. For this reason more data were generated for the first two participants. All three participants were white and British. Two were of middle socio-economic status (SES) and one of low SES.

The principal inclusion criterion for this study was that anxiety disorder was evident in the referral made by the health professional and in the referral information about the patient. Patients referred to the perinatal service were identified as potential participants based on having recently given birth as a first time mother. Patients were also identified for the study as possessing particular characteristics of anxiety disorders (for example panic attacks, obsessive compulsive disorder, phobias) during the perinatal period. Finally, patients were not undergoing any other type of psychological intervention for the treatment of maternal anxiety disorders. Patients referred to the perinatal service with a history of severe mental illness, such as schizophrenia, were excluded from the study. The focus of the study was patients who were experiencing maternal anxiety issues, but not maternal psychosis.

3.4 Data collection

The data collected for this study comprises the psychotherapist-researcher's observations of participants' narratives, and verbal communication with participants during their psychotherapy sessions.

Notes of observations and participants' verbal accounts were made at the end of each psychotherapy session with participants, which were subsequently written up in full within a few days post-psychotherapy session.

Psychotherapy treatment took place with the selected participants during the psychotherapist-researcher's child and adolescent psychotherapy training. Therefore the investigation may be classified as retrospective in that the therapy sessions and observation notes from those sessions had been written up at the time but underwent research scrutiny subsequently, during the current investigation. Nonetheless, the psychotherapist-researcher's notes from sessions with participants had been presented at the time during trainee supervision sessions with a senior clinician (the perinatal team's consultant child psychotherapist) who later also became supervisor to the psychotherapist-researcher. This undoubtedly bore influence on the way in which therapy sessions were interpreted, and more recently analysed, by the psychotherapist-researcher. The supervisor was a joint lead clinician in the perinatal service who had studied in-depth and written extensively on perinatal mental health.

There were various reasons why therapy session data from the psychotherapist-researcher's training (as opposed to therapy data generated from more recent psychotherapy sessions with patients) were used for this research study. Firstly, the three participants fitted the study criteria in terms of diagnosis and attributes as outlined above. Secondly, the psychotherapist was in training, therefore his patient case-load was less than that post-qualification and he was writing up in-depth psychotherapy sessions to present during supervision. This meant that participants' post-therapy written notes were more detailed during his training than those for current patient cases, post-qualification. These factors, together with the supervision received for each of these participants during training, facilitated a more in-depth analysis of participant therapy sessions.

3.4.1 Observations

The observation method of data collection in this study has its roots firmly embedded in infant observation methodology undertaken during the psychotherapist-researcher's child and adolescent psychotherapy training. The contributions of infant observation methodology include 'the development of observational skills; familiarization with transference and counter-transference phenomena; noticing non-verbal communications and experiencing the value of maintaining an interested presence [...] [and] the valuable experience of

observing change without actively intervening to contribute to it, based on the exercise of restraint' (Covington, 1991:248; Harris, 1987).

There is some contentious debate around psychotherapy being considered as both a research method and a treatment, often relating to the methods used to gain understanding of the worlds of patients or research participants. It is not the intention here to discuss this issue in-depth. However, building on Hocoy's (2005) passage above, it is relevant to acknowledge that some similarities between psychotherapeutic work and social research can be drawn. Bott Spillius (2005) recognises likenesses between psychotherapy treatment and anthropological research:

I think of the two disciplines as not reducible to each other but as using the same basic methods of thinking. And without quite realising it, I began to think that the study of an individual through psychoanalytic sessions was much like the study of a small society by the structural-functional method. An individual's behaviour and his conscious and unconscious beliefs form a system somewhat analogous to the organisation of a small society, with mutual though sometimes conflicting interactions maintaining the whole, after a fashion, and often resistant to change' (2005:663)

Whether conducting research or psychotherapy treatment, the observer must keep in mind the significance of their own participation in the context of the possible impact of their presence on people's interactions or behaviour and their subjective responses to what they observe (Miller et al, 1987). Furthermore, the observer's subjective interpretations of what is being observed could be influenced by their own background, history and feeling state. Mindfulness and consideration of the impact of the observer's own involvement in the research (albeit unintentional) or therapeutic practice, characterises a reflexive process which is a 'significant feature of social research' (Hammersley & Atkinson, 2007). Hammersley & Atkinson point out that social researchers are part of the social world they study and therefore research cannot be carried out 'in such a way that its findings can be unaffected by social processes and personal characteristics' (2007:15). Questions have been raised about the credibility of research which uses ethnographic observation method, on the basis of the researcher's mere presence influencing the observed's behaviour (Judd, 1991). According to Denzin (2001) we all see situations and structures in terms of prior understandings and prior interpretations and therefore can never become the 'all-knowing subject'.

However, through the process of systematic observations, reflexivity and immersing oneself as an investigative practitioner in patients' psychological nuances and reactions, complex unconscious messages could be regarded as credible evidence about the patient.

Grebow (2010) has described the therapist's transference responses (feelings, images, sensations, and associations) as informing the therapist's understanding of the patient. This process is greatly informed by the verbal and non-verbal communications that evolve in the psychotherapeutic dyad. Grebow acknowledges how the therapist has the ability to grasp and translate the patient's embodied and enacted experience within the intricate 'moments of meeting'.

The method of psychoanalytic investigation can yield much information about the subject but there are limits to what can be discovered about the uniqueness, history, internal and social context of the patient. In many cases the search for psychological truths in the psychotherapeutic work with patients and the often intense involvement that comes about, invokes powerful inward responses in psychotherapists on a daily basis. The patient-therapist dialectic in the transference relationship can arouse strong feelings and sensations in both and is required in order to detect subtle enactments which can guide patient and therapist towards promoting change in the patient's core disturbance. Transference and countertransference dynamics are key facilitating instruments.

3.4.2 The place of semiotics

It is pertinent to consider less concrete methods of gathering data in therapeutic work with patients, in particular with reference to semiotics, the study and interpretation of signs and symbols which, among others, include the study of metaphor and communication. Aragno (2009) refers to a bridge between the unarticulated and the graspable image, a composition of sensory data transformed by and transferred into the 'currency of mind'. (Modell, 2009). The range of verbal and non-verbal communications that naturally emanate from the patient in psychotherapy sessions requires the therapist to be open and sensitive to the signs and symbols denoting the patient's internal state of mind.

Subjective and very personal self-perspectives are communicated continually during the course of a psychotherapy session, sometimes in conspicuous ways and sometimes in more non-transparent ways. As a method of making the difficult-to-understand clearer, the semiotic dimension of the communication system between psychotherapist-researcher and the patient-participant is particularly relevant as a tool. This is sometimes in the form of metaphor. The concept of metaphor according to Borbely (1998) is not only a phenomenon of language but of mentation; its units are not only words but psychodynamics. Metaphor is thus defined as seeing something in terms of something else. This is a part of the linguistic and symbolic tool kit that the psychotherapist or researcher is able to utilise when engaged in the process of emitting and receiving messages. The very nature of psychotherapeutic practice involves interpreting the hidden meaning of the patient's communications, both purposive (conscious) and impulsive (unconscious), and thus requires staying attuned and receptive to the signifiers that emanate from the patient's words and actions. Bion's alpha process noted by Muller (2005) can be understood semiotically as 'the capacity to take things as signs', which provides the basis of all conscious and unconscious thinking.

As psychoanalysts engaged in clinical work with patients, we are always researching the operation of the unconscious. This is what we do. We listen to the symbolic communications of our analysands as they consciously report their experiences, thoughts, and wishes. We pay attention to the gaps between what is consciously expressed and desired and what is implied by actions and by contradictory communications and what is absent in the communications. We pay special attention to the feelings generated in us as we listen and sit with the patient, and we observe the nexus and sequence of associations of all sorts in the session, verbalized and un verbalized (Snyder, 2011:44-45).

3.5 Data analysis

Analysis of the data was an iterative process which the psychotherapist-researcher carried out at different stages, starting from the collection of data during psychotherapy sessions through to writing up the current study. Each stage involved analytic and reflective processes.

The first stage of analysis took place during each of the psychotherapy sessions. This constituted the ways in which the psychotherapist experienced

the patient in terms of, for example, what the patient was saying, their narrative, how and what they were presenting, and how they responded and reacted to their baby and to the psychotherapist. Analysis of descriptive verbal accounts is a standard practice in qualitative research (e.g., Avdi & Georgaca, 2007; Ayres et al, 2003; Burck, 2005; Lincoln, 2000). It is particularly useful for understanding the subjective experiences of patients (Danielsson & Rosberg, 2015).

Second, the psychotherapist-researcher made hand-written or process notes of his observations of patients, their narratives and verbal communication with them immediately after each session had ended.

The third stage involved building on the components noted in the hand-written process notes to develop a fuller picture of the content of each therapy session. These more detailed notes were written up within a few days post-therapy session and presented during the psychotherapist-researcher's supervision sessions with a consultant psychotherapist. Through the processes of writing, presenting and discussing therapy sessions during supervision, analysis and reflections were expanded upon. Written notes were made during supervision accordingly. Some, but not all, therapy sessions for each of the participants were presented during supervision.

The final stage of analytic thought and reflection took place during the current process of writing up this study, during which all data in the form of written detailed notes were collated and coded.

Coding was carried out manually, grouping data into similar themes and generating interpretations from them (appendix 1). A thematic analysis method was used, involving an inductive approach. The psychotherapist-researcher identified emergent themes within the data, looked for patterns and key concepts, and developed analytical categories to understand the phenomena of interest (Braun & Clarke, 2006; Pope et al, 2000). Psychoanalytic literature and theory were drawn on to assist the analysis process. Resulting themes from the data were compared between participants' narratives across the sample.

3.6 Ethical issues

The research was conducted in accordance with the National Research Ethics Service guidelines.

3.6.1 Consent

Permission for psychotherapy sessions to be used as data for the study was gained from patients identified as potential study participants. Following their first assessment appointment with the perinatal service, patients who fitted the research criteria were asked by a designated senior clinical colleague if they would be willing to take part in the study. The designated colleague explained to potential participants what the study was about, the purpose of the study, how findings would be disseminated, how data would be stored and who would have access to it, participants' right to withdraw at any time, and the extent and conditions of anonymity and confidentiality guaranteed. Potential participants were informed that their clinical treatment plan would not be affected by their decision to a) take part in the study, b) decline to take part in the study, or c) withdraw from the study. Potential participants were provided with a participant information sheet to this effect. Patients who were willing to participate in the study were asked for their informed consent by signing a written consent form.

3.6.2 Confidentiality & anonymity

The psychotherapist-researcher was guided the Caldicott Review, 2013 and Caldicott Principles, 2014, in terms of patient confidentiality and handling of patient information. All data were fully anonymised so that participants would not be identifiable. Each participant was assigned a unique identification code. Pseudonyms were allocated to participants and no names or personal information are used in reports of study findings. Signed consent forms were stored separately from personal data in order to further protect identity.

3.6.3 Data management

Data were stored on a secure, encrypted computer in the perinatal service department at the hospital where the study took place. Access to electronic data was password protected; passwords were known only by the psychotherapist-researcher and changed at regular intervals.

Paper records were kept in a secure lockable filing cabinet under controlled access. Research data will be stored within the psychotherapist-researcher's institution for 5 years in accordance with the NHS Trust's data management protocols. Memory sticks used were encrypted and password protected, and stored in a secure filing cabinet.

Any requests by patients to access their clinical notes are managed by the Trust's Data Protection Office, in accordance with the Data Protection (Subject Access Modification) (Health) Order 2000. Participants in the study had the same rights with regards access to the psychotherapist-researcher's detailed notes of their sessions for the study in accordance with the Trust's protocols. No requests were made by any of the participants to access the psychotherapist-researcher's notes from their psychotherapy sessions.

To summarise, this study takes place in a single, London, NHS hospital-based perinatal service which provides treatment to psychologically disturbed women during pregnancy and up to one year post-birth. The researcher is a psychotherapist in the perinatal service. Research participants are three women (patients) who have been referred to the perinatal service to receive psychotherapy treatment for maternal anxiety disorder. Their therapy sessions last between 50 and 60 minutes on a weekly or fortnightly basis, over a period of between eight and fifteen months.

The study uses traditional psychotherapy methods of research: observation of patients, and patients' narratives. This involves three main approaches: ethnographic, interpretivist and psychoanalytic. The data collected for this study, therefore, comprise the psychotherapist's observations of participants' narratives and verbal communication with participants during their psychotherapy sessions. The psychotherapist's observation notes of the participants' verbal narratives, along with post-therapy session detailed notes, are analysed using a thematic, inductive approach. Themes that emerged from these data are compared between the three participants.

The research was conducted in accordance with the National Research Ethics Service guidelines.

4. Case study chapter

I have decided to present the three case studies using detailed session notes as I wanted them to be at foundation of this study, to be the driving force behind the evolvment of it. The data findings and conceptualisations to emerge from the sessions essentially result from the evolution and progression of the psychotherapeutic process as it unfolded. I recognise that even the most well reported narrative is still a scaled down and edited version of an interactive experience, observations, many hours of analysis and reflection over process notes, however, it felt to me the best way of presenting to the reader the process of discovery for patient and therapist within each case. There is a rationale for trying to present in this way, to illustrate the development of often subtle mechanisms played out within the patient-therapist relationship, not least transference and countertransference.

4.1 Case study Emma

Antenatal Referral

Emma was referred by her Antenatal Clinic midwife when 6 months pregnant. The referrer reported that Emma was diagnosed with depression at the age of 18 and prescribed Paroxetine which she remained on for 3-4 years. It was reported that Emma suffered from panic attacks and was increasingly feeling that something bad was going to happen. Emma was said to be extremely worried about not being able to cope with the labour and delivery of her baby. The referrer noted that Emma and her husband were living with her mother. It was also noted that Emma had previously terminated a pregnancy.

Initial assessment appointment (34 weeks pregnant)

I was not involved in the initial psychological assessment appointment with Emma, as an appointment had been made with the Consultant Psychiatrist in the perinatal service. Following that appointment it was reported that Emma had scored 21 on the Edinburgh Postnatal Depression Scale (EPDS) which is high.

The Consultant Psychiatrist reported that during the assessment Emma spoke of feeling anxious about something bad happening, but the patient was unable to pinpoint what she thought might happen, but something disastrous. She

spoke of this feeling being characteristic of the anxiety she had experienced for much of her life, and that it had intensified during pregnancy. Emma had referred to having “panic attacks”, especially when travelling on the tube. When asked by the Consultant Psychiatrist what the panic attacks felt like she described her heart pounding and how it felt like she was not going to get out of the tube train and was going to die. She had recently left her job (events organising) because she had found it to be too stressful. It was stated in the assessment report that she and her husband had recently moved into her mother’s home, also occupied by her siblings, Emma’s two sisters and her brother. She confirmed that she had attended a local Mental Health Service when aged 18, and had been diagnosed with depression. At that time she was prescribed anti-depressants, which she took for 3-4 years. She spoke of having had two CBT sessions and five counselling sessions after she was diagnosed with depression. Emma reported finding the CBT and counselling sessions being of limited help because they were short-term interventions, and she felt that she was unable to form an engagement with the therapists on that basis.

During the initial assessment Emma described herself as feeling happy about being pregnant but felt very worried that she might not have a healthy baby. She also worried about her past depression and that it might be linked to her father’s depression, and that it might get passed on to her baby. Emma had no history of suicidal attempts, no suicidal thoughts and no other services were involved apart from maternity services and Emma’s GP.

Emma told the Psychiatrist that her parents had separated when she was aged eleven and they divorced subsequently. She spoke of being the eldest of four children and that her own birth had been described to her as traumatic by her mother and had resulted in her mother having an emergency C-Section. Emma described her husband Steven as supportive, but worried that he would leave her because he would become fed up with her tendency to feel depressed and anxious, and her tendency to be disproportionate about situations and events.

At the end of her assessment appointment Emma said she was very concerned that the birth process and a needy baby might trigger more depressive feelings within her and prevent her bonding with her baby. Emma was in agreement with the assessing Psychiatrist who thought psychotherapeutic support would

be a helpful way forward, and a perinatal care plan was put in place which included regular perinatal psychotherapy. Emma was placed on the waiting list and seen by the Psychiatrist for one further appointment prior to giving birth, to help Emma prepare psychologically.

Post-birth: March

Fortunately Emma experienced a relatively uncomplicated delivery. However, post birth, baby Lily was diagnosed as suffering from gastroesophageal reflux problems which heightened Emma's worry over her child's capacity to be healthy and survive. I was able to offer Emma one session per week, and the first appointment was arranged via telephone contact, six weeks post-birth.

The commencement of the treatment.

Session 1

When I first met with Emma and baby Lily, Emma worried that Lily would wake from her sleep needing a feed and asked whether it would be okay to breastfeed her in the therapy room. I assured her that it was okay to do so, especially as she was in a mother-baby friendly environment. Emma appeared to be feeling nervous initially, and gave me the impression that she was very concerned about her mothering skills being judged by me, as though she felt very much under a spotlight. However, as the session progressed she appeared to become a little less tense. She told me that the reflux problems Lily was having had not helped her feel any sense of confidence as a new mother, in particular, adding anxiety to the "something bad is going to happen" feeling she often had. Emma told me that feeling anxious and having a sense of trepidation was historically commonplace for her, and she remembered feeling anxious during her childhood. She recalled being awake much of the night as a child, not being able to feel relaxed. When I asked Emma about whether she had any thoughts about what hindered her from sleeping as a child, she recalled feeling worried a lot but was not sure why. She told me that her parents managed her not sleeping by giving her things to do, such as Jigsaw puzzles.

She recognised that having to be responsible for Lily's well-being had increased her level of anxiety, and that this was something she wanted help with, hence she was prepared to attend regular psychotherapy sessions. Emma stressed to me that what she was very concerned about was passing on her anxieties to Lily. She appeared very committed to trying to stop this from happening, and hoped I could help her. I felt clear that we would need to think about any possible underlying issues that may have prevented her developing more secure feelings. I had a strong sense that Emma was desperate to find a way to feel more emotionally secure and result in feeling more confident about parenting Lily. I felt the past and present contexts of Emma's intense anxiety needed to be better understood, but with a view to the future improving. When I suggested this to Emma, she told me "nobody's ever really tried before".

She talked about Steven being very supportive, but that he was also concerned about Emma's level of anxiety, which had negatively affected their relationship over the time they had been together. They had met in their teens and married in recent years. From Emma's descriptions, her poor self-image and chronic worries had hampered their relationship, and Steven sometimes found it difficult to make sense of Emma's anxious behaviour. Before the session ended it became clear that Emma was keen to attend some sessions with Steven, but she stressed that she also needed a therapeutic space for herself along with Lily; a need to say things that may not be so possible were Steven sitting beside her. We agreed a plan for weekly sessions, on a designated day and designated time, and they would be on-going for a period of four months and then reviewed. Lily hardly stirred throughout the session, and did not require a feed. She had remained asleep, snuggled in her pushchair. She looked very content and peaceful, and I thought that she had a very pretty face.

Easter approaching and first break

We were able to arrange two further sessions before a short Easter therapy break. Problems with Lily's reflux were at the fore and also the anxieties linked to Emma's past, which we jointly felt were impinging upon her functioning in the present. Emma was evidently low in confidence and spoke about never really having a sense of confidence in herself. From her account it appeared that she had developed an uneasy relationship with alcohol, not that she had developed

an alcohol dependency, more that when she had a few drinks in a social setting, her behaviour troubled her. She spoke about feeling that she had sometimes let herself and Steven down by becoming “loud and flirtatious”. She described to me how following such occasions she would feel very low and “worthless”, and felt convinced that she was such a dreadful person, that it was only a matter of time before Steven would leave her.

An opportunity arrived for Steven to join his wife and baby daughter for a session, as he was on annual leave. He made an immediate impression of being caring and loving towards his wife and baby daughter, but also perplexed by his wife’s anxious pre-occupations, and self-condemnations. He appeared to be committed to supporting Emma and expressed a hope that Emma attending the psychotherapy sessions would improve matters at home, in terms of Emma’s chronic self-negativity and anxiety. Emma expressed severe self-doubt about whether she had personal resources that she could draw upon, a lack of conviction about having any initiative, an inability to recognise any accomplishments and capabilities, all amplifying a feeling that she was not competent enough to be a mother. These feelings of personal failures and having flaws in her character appeared to engender an abiding anxiety within Emma that she may well prove unworthy of the love of her husband and baby.

Over the following weeks Lily’s reflux continued to cause Emma great distress, and during this time she was rushed to hospital with a severe episode, which resulted in Lily being prescribed medication to help regulate the reflux. With Emma’s anxiety levels rising in relation to the worries over Lily’s reflux condition, she was concerned about her capacity to manage such difficult episodes well-enough. This was a very difficult time for Emma when trying to do the best for her baby as a breastfeeding mother, when Lily would often choke and splutter. Emma seemed to be left feeling even more uncomfortable with herself in relation to the difficulties Lily was experiencing. We touched upon the possibility that Emma was harbouring thoughts about her milk being indigestible; however, the therapy was still in its infancy, and Emma’s vulnerable state suggested that this was not an especially helpful aspect to focus upon for Emma at that stage. It did appear to me that she did fear that what Lily digested from her could be harmful.

According to Emma her father had been a promising young footballer, on the books of a premier London club, but sustained an injury in his late teens, which ended his promising career. It seemed from Emma's description that her father's mental health deteriorated further following the end of his marriage, which took him into destructively misusing alcohol. There was a profound sense of sadness and misery when Emma described the feelings of disappointment that her father has subsequently experienced after the demise of his promising football career and later breakdown in his marriage with Emma's mother. According to Emma he had descended into a steep depression as a result.

Emma told me that she felt "something was missing" in her relationship with her mother. She said that she had not felt a sense of closeness between them. Her mother had told Emma that she was delivered through emergency caesarean-section. Emma reported that her mother had described the event as life threatening and deemed it to have been highly distressing. Emma wondered about what kind of factors had impeded her relationship with her mother.

Lily was approaching 5 months when the early summer arrived. Exclusive breastfeeding had become difficult with Lily's chronic condition. Feelings of disappointment emanated in relation to this and other matters. This appeared not to help Emma's anxiety but she was able to see that Lily was developing overall. In the therapy room Lily showed signs of being interested in and curious about her surroundings, the therapist's voice, etc. There were large elements of regret and upset expressed by Emma about the mental health of her father. She said that he had been sectioned under the Mental Health Act for a short time, approximately 5 years ago. According to Emma, he felt vulnerable to feeling the family might have him sectioned again, should he suffer a similar emotional break-down. Also it became evident that Emma was feeling vulnerable regarding Steven's close relationship with his mother, and had provocative, nagging thoughts in her mind, that Lily might view them as some form of ideal parenting couple to gravitate towards, excluding Emma from the picture.

This uncomfortable feeling was highlighted when Emma spoke of a recent weekend visit to her in-laws. She relayed to me a difficult experience when

having dinner while there. Steven's mother offered to hold Lily in order for Emma to finish her meal, but Emma found this a distressing event, feeling an unbearable separation had occurred. She described a vivid image of seeing her mother-in-law being in a through-room holding Lily, and feeling like she would "never get her back". The feeling of despairing separation that Emma reported also triggered a link in my mind to another vivid account she provided about the separation that occurred between mother and baby when Emma herself was born. Via her mother's recollections Emma told me how her mother awoke from the emergency C-Section to see Emma in her father's arms, and felt deeply separated from her baby. I alerted Emma to the association my mind was making, and she took a great interest in the fact that I was associating two events that on the surface might not bear any relevance. Emma began to probe me about my thinking and whether I really believed an experience involving her as a baby could have any relevance to the way she had felt separated from her baby. This seemed to prompt Emma into making her own associations between events that spanned her life.

Session 13 (Lily 5 months)

Emma had arrived 15 minutes late having "misjudged" the time it would take to walk from home to the hospital. When I arrived at the waiting area I noticed that Emma looked and sounded flustered, whereas Lily looked wide-eyed and curious about entering the therapy room. Emma was anxiously apologetic for being late. I remained quiet initially, allowing mother and baby to settle into the room again, as Emma went through the process of getting Lily out of the pushchair and finding a selection of items for her, such as a prepared bottle and some toys.

When that was done, Emma vocally and physically pointed out to Lily the toys that I had already placed on the play-mat and, untypically for Emma she went to sit with Lily on the play-mat. Emma took the cushions off the couch and used them to prop up Lily who looked a little unsteady sitting up facing towards me (in the centre of the mat). Emma sat close to Lily at the end of the mat nearest my chair; this brought Emma quite close to me. She pulled her dress down as she settled on the mat.

Emma picked up a small rattle from the mat and waved it close to Lily who looked mesmerised by it. Emma then looked up at me and said “right I’ve been thinking about last week’s session and my mum not really wanting to talk about what happened (the emergency c-section), and I don’t know why but something reminded me of when I was at school and being bullied. I had not been used to Emma engaging in dialogue so quickly and making links to the previous session. She turned towards Lily again and shook the rattle again. This time Lily made an effort to hold the rattle, and put it in her mouth. Emma looked back towards me and appeared to be nervously awaiting what I might say. I spoke of Emma seeming to be more hurried today, and that perhaps this was influenced by the late arrival. She took a swig of water from a bottle and said with an air of desperation “I just hate being late”. I then remarked on her linking two historical aspects of her life together and wondered what it was that was resonating with her. Emma swallowed but not water this time, more as though she was gulping with anxiety. At the same time Lily began to cough/choke. Emma quickly tended to Lily, gently rubbing her back and mopping a milky trickle from the corner of her mouth. Emma looked at me again with a tense expression on her face and in her voice as she told me “I don’t know, it was just something about mum thinking one of us was going to die and then with the bullying, how at school people were so unpredictable”.

I commented “so perhaps for you there is some common ground in the unpredictability of the two different situations?” Emma looked and sounded perturbed as she said “I think it’s something to do with mum saying she felt she had been treated like a piece of meat {giving birth to Emma}.....and when I was at school I can remember never knowing how the other kids were going to be towards me”. Emma had a sad facial expression. I told her that I recalled her saying last week that she had experienced a feeling after giving birth to Lily similar to the feeling her mother had spoken of. Emma immediately said “yes, abandoned”. Lily appeared to be watching and listening to her mother’s emotional responses. As she did, Emma spoke with an air of dejection, saying “and that’s what I felt when I was bullied – abandoned”. Sensitivities to feelings of abandonment had spun out of Emma’s familial past, in which she had experienced her mother as emotionally unresponsive, her father’s absence and his descent into alcoholism and mental illness.

Old Habits

During this period of the therapy Emma often seemed terrified she would be perceived by others, including me as having an unpleasant, immoral side to her, and hence rejection from others was inevitable. These feelings converged to trigger significant episodes of depression and anxiety in Emma. It was as though the anticipated rejecting attitudes of others towards her, sparked feelings of being unworthy of other peoples love. Paradoxically, for Emma there was a profound sense longing for connection and yet feeling unworthy to be connected. As a result I felt that Emma was emotionally challenged to fully share in the psychotherapy closely held thoughts, feelings and behaviours which she viewed as shameful and reprehensible.

Approaching the summer break (Lily 6.5 months)

Session 19

In Emma's session nearing a four week summer therapy break there were a number of relationship based topics that Emma raised in the session, in particular she spoke of her propensity to doubt whether she could really ask me something personal, and became uncomfortable when thinking that she may have misinterpreted the nature of a patient-therapist relationship, and it's boundaries. This was illustrated when Emma asked where I might be going on holiday. Emma said that she was not sure whether she could ask me where I might be going, but then thought "oh why not", because the "relationship" with me had spanned a number of months and she was feeling more "able" to ask.

I decided to explore Emma's interest in my summer holiday destination before answering the direct question. When I asked her what was in her mind about my holiday destination, she chuckled and said that she "pictured me holidaying in the South of France". We spoke about Emma's concept about her therapist heading off to the South of France. I tried to explore the imminent summer holiday break and how Emma's mental 'picture' might have represented feelings of uncertainty about the break in sessions. Emma said "what kind of person must you think I am being so nosey?" I spoke of It being completely understandable that she might want to know more about me and be imagining

things about me, wondering about my life outside of the therapy and whether I could really identify with her life, or whether I led such a different life to her that I would not be really be able to understanding hers, whether we might two people poles apart.

I discussed with Emma the possibility that her fantasies about me being away in the South of France may have had elements of her wondering about me being away in a family situation and what I might be like away from the therapy setting. I also raised that she was trying to manage the idea of my absence and an absence of the sessions. Emma reacted by saying “but I like to think we do have a good relationship, and I’m interested in you”. She continued “Oh, no,” she exclaimed, and made an instant correction to what she had just said, by saying “oh, of course this isn’t a relationship”, as though she felt she had said something ridiculous, and made a fool of herself. I felt other complexities were coming into play, too. For instance, Emma’s fears around attachment which could leave her vulnerable to painful rejection or disappointment, fears of dependency, and profound feelings of being unworthy of her therapist's care and concern or potentially feeling embarrassed by it.

The relational aspects of the therapy were rising to the surface for Emma as she doubted whether she could classify this as a relationship. Emma told me that she was surprised to hear herself question whether the relationship with me was genuinely a relationship, but at the same time found it “strange” to think of it as such. I told Emma that it crossed my mind that she could be feeling somewhat afraid of it feeling like a relationship for fear of disappointment, being let down, and thus it could feel safer to avoid any feeling of attachment. I felt that there would be negative implications for Emma’s treatment if I did not pick-up on Emma’s moment of doubting the existence of a relationship between us as it could leave her feeling that I was treating what she had said as trivial, in a disregarding way. I told her that I thought a relationship had developed in the context of the therapy, and she reacted by smiling and telling me that she felt “almost relieved” to hear that. She went on to tell me that she felt a sense of relief when she felt that her concerns were being listened to and taken seriously, as she had often felt that her family were “bored by my same old problems”.

Emma also seemed to have a persistent air of uncertainty about how much longer her sessions would continue for, and continued to express concern that I would decide to bring her treatment to an end at any point, telling me “you’re bound to throw me out because I’m such a pain”. This encouraged me to be clear with Emma about her treatment plan prior to the summer break, and I agreed with her that the therapy would continue until the end of the year, at which time we would re-assess the effectiveness of the therapy in relation to Emma’s problems and whether it should end there or not. She spoke of feeling pleased that she definitely had more time “to get better”, but had another more negative feeling that she thought she “must be bad” to remain a patient until the end of the year and perhaps beyond. I was unsure how possible it really was for Emma to feel a sense of security about the continuation of her sessions.

During the session directly prior to the therapy break Emma had arrived with Lily a few minutes late and when I went to collect them from the waiting area I thought Emma looked and sounded tense as she worriedly apologised for being late. Inside the therapy room I took my seat and waited for Emma and Lily to settle.

Session 21

As Emma leant over the pushchair getting Lily out, she looked over at me and said “I’m feeling really nervous today, there’s something I’ve been thinking about telling you for a couple of weeks”. Emma sat down on the couch with Lily and she carried on in a nervous way. She said “I’ve been thinking ‘should I tell him or not’”. She added “anyway here it goes”. She looked tearful as she continued “when I was about ten...” I was listening carefully to Emma and very interested in what she was about to say but at the same time I was noticing that Lily (on her mum’s lap) was regularly looking towards her pushchair, as though she was hankering for something. Emma did not seem aware, until I alerted her to Lily’s apparent hankering. Emma then determined that Lily was looking for the soft book lying on the top of the pushchair and she got up, still holding Lily, and picked up the book. As she did so, she said in a despondent way “see, I’m a useless mum”.

Sitting down again Lily immediately started touching the raised shapes/figures in the book and Emma spoke excitedly to Lily momentarily. Then Emma returned to what she had started saying before. She spoke as though she was revealing something really devastating. She said “when I was at primary school I told two friends that my dad had abused me but it wasn’t true – why would I do such a thing?” I was reflecting on what she had told me and Emma added “actually that’s just one thing but there are two other things I want to tell you”. She started to cry and I offered her the box of tissues. She said “I’ll just take one”. I said “so you’re saying it didn’t actually happen and you are struggling to understand why you had spoken of your dad abusing you”. She blew her nose as Lily continued to grab the shapes. Emma said “no, he really didn’t abuse me, but what sort of wicked person would say that, I must be so disgusting to you”. She continued “I love my dad so much and he could have got in to so much trouble”. I said “so the abuse that you spoke of with your friends – had you suggested that he had done something in particular?” Emma answered “yes, that he had come into my room and touched me, but he didn’t”. She was very tearful and saying, despairingly, “I must be such a bad person...why would I do such a thing, why?” I replied by saying that I did not know the answer but that we could think about it together and see if it made any more sense.

There was a very painful atmosphere as Emma cried and at the same time a young child CAMHS patient in the waiting area outside screamed in a really high-pitched, disturbed way. Meanwhile Lily seemed to be distracted by the screaming and looked towards the door. Emma became a little more composed as Lily started getting restless and winged a little whilst on her lap. Emma suggested that Lily needed a feed and started preparing a bottle of milk, using the flask of water to warm the milk. She told me, as she did so, “these three things all happened around the same time”. Emma looked to be struggling, holding Lily under one arm and tipping the water and formula from containers. Water began to spill to the floor and she became upset about the mess. I told her not to worry about the spillage but also acknowledged that it was perhaps adding to a feeling that everything was feeling messy including her thoughts and emotions.

Emma mopped up some of the spillage with an already soggy tissue. The disturbing screams continued outside the room. Finally Emma sat back down and gave an increasingly fractious Lily her bottle. She looked wide-eyed and clutched the upper end of the bottle with both hands. She didn't seem quite able to take all the weight of the bottle and her mum lightly supported it at the base. Emma seemed to muster up some further courage as she took a deep breath and begun talking about "the second thing".

She spoke about telling staff at her school that she had started menstruating when she actually had not. She described being taken to the toilets by a female member of staff and then standing inside the cubicle thinking "how am I going to get out of this one" as the staff member asked from outside the cubicle whether she needed help. Emma told me that she answered "no, its fine, I can take care of this". I commented upon the question that had been asked by the female member of staff and said that I was wondering what Emma really needed help with at the time was an emotional problem as she had fabricated the start of her periods. Emma spoke of coming to a conclusion that there was no turning back at the time even if she was looking for emotional support, and maintained the idea that her periods had begun. Then she was told that "we'll have to tell your mum", and felt horrified. I spoke about Emma feeling as though she would be exposed, and then asked her if she had any thoughts about a possible motivation to announce that she was having her first period when she was not. She became tearful again as she said "I think you'll probably ask for Lily to be taken away from me". I asked "why would you think that?" She replied "because you must think I'm such a bad person".

Lily looked to be highly aware of her mum crying, slightly raising her head and looking upwards, with the bottle still in her mouth. I commented on the look of awareness from Lily and Emma gently stroked Lily's fine strands of hair. I told Emma that I was thinking she felt so negatively about herself that she had difficulty within herself believing she had produced a baby who was showing concern for her mummy. She responded "definitely, that's why I always think something bad will happen". Emma then asked me whether I really did think Lily was becoming more aware of her (Emma's) emotions. I said that I felt that Lily was increasingly observing and discovering things about her mummy. I

added that how important I felt the development of their mutual engagement had become, and I mentioned briefly the relevance of mirroring processes within the mother-baby relationship. Emma smiled at Lily and there were some moments of quiet reflection from Emma and then she cried further.

I then reflected something positive to Emma and commented upon an observation as Lily finished the bottle and was winded that her reflux events appeared to be decreasing. Emma nodded and again said “definitely....it gives me hope, seeing her get better”. Emma held Lily over her shoulder and she started to toy with her mum’s dangling earrings. Lily looked closely at her mummy’s earring and delicately touched it to make it swing to and fro. While Lily focused on the earring Emma told me that the “third thing” she wanted to tell me about involved another girlfriend from primary school. She described how they would play together regularly at each other’s homes over a two year period prior to joining secondary school. Emma spoke of them “often playing mums and dads and it often ending up with her [friend] on top pretending to have sex”. I spoke about it seeming like moments of high arousal but Emma quickly countered that by stressing to me that she was not aroused. She said “I just lay there underneath her while she was kissing and humping”.

I reflected for a moment and Emma appeared to be waiting on what I might say. I said that I felt she had brought me three things today which illustrated that she is worried about what kind of person she had developed into and that negative aspects from her childhood were going to be perpetuated. I then linked her perception of herself as bad news, for example, the way she has talked about herself throughout the therapy as flirtatious towards men (making her a bad person), to the three accounts that she had brought today. I suggested that for instance the poor sense of self-worth she had experienced after telling her friends that her dad had abused her resembled the poor self-image she has experienced following brief flirtations with men other than Steven.

Emma looked troubled by my comment and said that she felt she had acted badly in the past. Lily continued to toy with her mum’s earring. I commented on how close Lily seemed to want to be to her mummy and how she was able to playfully make use of her mummy’s jewellery. Emma had a pleased look on her

face and gave Lily an affectionate kiss. She told me "I've never spoken to anyone else about these things, not even Steven". I said "perhaps you were feeling that other people would find what you had to say about yourself unbearable?", and you are inclined to think that I will see you as so dreadfully bad that I would recommend Lily is removed from you". Emma said "well you must think I'm disgusting, you must be thinking what sort of child would say that about her dad". I said "perhaps a child who was confused and longing for a feeling of closeness?". I went on to talk about Emma aged 10 being on the brink of puberty and that developing sexual feelings got mixed up in a complex way with a longing to be close with a largely absent father. She nodded and told me with frustration in her voice "he was often down the pub, I don't think he realised how much I needed him, how much I loved him and wanted him to love me".

There was a pause of silence and then Emma seemed to divert a little. She told me that over the forthcoming weekend it will be Steven's birthday and she was worrying about the lunchtime celebration they will be having with friends at a pub. She continued by saying that she worries that with her it's either "angel or devil". I asked her whether she could define what each one is like. She explained that in her eyes the devil "equals feeling fat and horrible and when I feel like that I will try to compensate by flirting and drinking but then I feel disgusting; the next day I feel like a tramp". She continued "Angel equals feeling not so bad about myself, drinking less, in moderation, and not flirting". I spoke about it as Emma experiencing a conflict between good and bad going on inside her, and that it felt as black and white as that. I then asked Emma how she felt about her angel/devil split when Lily was so physically close to her. Emma answered "Lily helps me to feel more moderate, more angel than devil". I spoke about feeling moderate perhaps being something newer to her, and that Lily was helping her to feel that. Emma was gathering all her bits and pieces up as she had noticed herself that the room clock was showing that the session time was running out. She got up with Lily in her arms. She stopped opposite the mirror on the wall and looked at her reflection. She said "do I look a mess – oh don't' answer that". As she began to put Lily in the pushchair, she seemed to become very aware again of the boy screaming in the department. She said with a look and sound of concern "I hope that boy's going to be okay". I said

“you seem to be feeling anguish when you hear that child”. Emma replied “I just can’t stand hearing him so upset”. I mentioned that I thought she seemed to identify with him in some way.

Late August: First session after the summer break

Session 22

Emma came along to the first session after the break with her husband and Lily. I had received a message from the perinatal administrator notifying me that Emma had called to say they would arrive about 15 minutes late due to problems on the tube-line. Once they arrived it appeared that Emma was feeling stressed by the late arrival and this was evident in the regularity of her apologies and how she looked and sounded tense. Steven seemed to be more relaxed about the situation, and Lily seemed to negotiate her arrival back into the therapy room quite well, quickly re-aquainting herself with the toys put out for her on the couch and on the play-mat. Emma spoke of feeling very frustrated that there had been tube delays, and that consequently the length of the session was shortened. She also spoke about the tube train having slowed down and coming to halt in-between stations which she said had increased her anxiety levels. The couple then both made comments about wanting to mention to me the frustrations that they have been feeling in relation to “communication problems” that arose between them, especially during moments of conflict.

Emma appeared rather distant and unhappy during the meeting as she spoke about feeling frustrated with Steven primarily because she felt he had a tendency to “make mistakes”. She gave a recent example in relation to a prolonged mobile-phone contract issue being unresolved when Steven had promised her that he would resolve it. She gave the impression that she felt that she often had to be the one to resolve such issues, otherwise the problems would persist. After providing the example Emma spoke a little about her sense of frustration, but mostly Steven spoke about it, largely agreeing with his wife and saying that sometimes his mistake making (as Emma described it) was bound to invite his wife's angry criticisms and complaints. Emma and Steven both kept an eye on Lily as she explored the therapy room and all the various toys, room objects, and her number of excursions towards me, notably touching

my shoes as though making a connection with me again. Emma appeared to become more subdued, becoming rather quiet and seemingly pre-occupied with her thoughts. When I made an observation that I noticed her quieter state, she said that she felt less able to “talk things over” than Steven.

Emma appeared to be feeling down about the way she and Steven sometimes experience one another, and also down about herself in relation to the way she can feel angry and frustrated over his approach to dealing/not dealing with situations such as his mobile-phone contract issues. When Emma became tearful towards the end of the session when speaking about her tendency to become angry and frustrated with Steven, he was verbally supportive of his wife and put his arm around her consolingly. He then suggested that he could be more pro-active and more “on the ball” about certain matters such as the mobile-phone contract. When I referred to Steven appearing to be unsurprised by Emma’s response to something he had not sorted out, he pointed out that they can both feel disappointed in one another’s behaviours, and that perhaps this had become more so after having a baby, and all the pressures that can accompany that.

When I spoke of “buttons being pushed” in Emma which appear to bring about angry responses towards Steven and then towards herself for the way she has reacted, she said that she worried she would drive him away, and potentially drive Lily away from her, because she (Emma) would be experienced as a “horrible person”. As the session came towards its conclusion Emma and Steven jointly spoke about Emma’s propensity to feel that she will alienate herself from her family, and I added that I felt she was inclined to alienate from her own self. The couple talked about a need for Emma to feel less critical of herself when for instance she reacts with anger and frustration towards Steven.

I had noticed that no reference had been made to the fact that this was the first session following a four week break, and although there had been some frustration expressed by the patient/s regarding the tube delays, nothing had been mentioned about the break and how that might have been experienced. I questioned in my mind whether this was some form of avoidance on the part of Emma, and whether I had gone along with this to some extent. I thought to

myself that the fact that Steven had accompanied Emma and Lily had affected any such acknowledgement, and perhaps Emma's mood.

As the weeks progressed Emma regularly spoke about a long history of experiencing panic attacks and anxiety which had severely inhibited any sense of confidence. She reported that her mother had told her of having ambivalent feelings about Emma's conception, and questioned whether her relationship with her mother had contributed to her anxiety. Emma had experienced her mother as ambivalent towards her for as long as she could remember, and her father as typically feeling a sense of disappointment and failure in himself and about himself in relation to his wife and family. Emma continued to express thoughts that Lily would at some point turn towards Steven and his mother as the 'ideal couple' to look after her needs. Emma had a long history of feeling dissatisfied with herself and regularly looked at herself unfavourably in the mirror as she prepared to leave the therapy room with her baby in her arms at the end of sessions. Often she would check how badly her mascara had run due to her tears, and would say "what a mess". At the end of one session and wiping traces of mascara away Emma said "I kind of love these sessions and hate them at the same time". I commented that as such she would feel torn between wanting to come to them and not wanting to come to them. Emma turned and smiled and replied "you know I'm not very good with predicaments".

The focus of attention

In this session during the autumn Emma arrived feeling disappointed with herself.

Session 27

After arriving in the therapy room Emma lifted Lily who was sleeping, and placed her on the couch. It was apparent from Emma's facial expressions and quiet, serious mood that she was concerned about something. Firstly Emma grimaced and shook her head and then described herself as "hopeless". She expanded by saying that she considered herself to be hopeless in comparison to "other mothers" who she felt were able to not feel so worried about returning to work. Emma spoke about there being a financial necessity for her to return

to work, probably in the New Year, and although there was a need for her to go back to work, she acknowledged having a sense of guilt about it. Unsurprisingly Emma added that she had mixed feelings that Lily would be looked after by both of her grandmothers during the week. When I asked whether there were any triggers that had set off her gloomy state, she told me she had knocked Lily's leg while lifting her out of her high-chair in the morning, which had caused Lily to cry, and this had started her off the negativity she was feeling about herself as a mother today.

Emma described some of the difficulties she thought she would experience when leaving Lily in the care of others, which essentially amounted to other carers not really being fully aware of Lily's needs. Lily awoke at this point and quickly re-orientated herself with the therapy room and then rather burst into action, by trying to scramble herself off the couch and onto the play-mat to get to the toys. Emma spoke of Lily being like her "shadow", and that Lily was not able to "let me out of her sight". I reminded Emma of previous pockets of conversation that we had had about a central aspect of attachment theory and the work of John Bowlby in relation to separation anxiety, and how normal it was for both mother and baby to feel anxiety when separated. I had spoken about the fact that Lily's social world was opening up wider as she had become more mobile, and with that would come a developing realm of independence for both mother and baby, in comparison to the more dyadic aspects of the early months of the relationship between mother and baby.

Emma spoke about worrying that she had made Lily "too clingy". When I asked whether Steven was experiencing anything similar in terms of Lily being clingy towards him, Emma responded by saying with what I thought was tinged with self-satisfaction, "it doesn't happen so much with him.....she even comes to me when Steven comes in from work." I said that I was wondering what that felt like for her (Emma), and she told me with an air of reluctance "obviously I feel for him when she wants me more than him, but I suppose I do like being the one she looks for".

Lily became increasingly vocal in the therapy room and crawled towards me to tentatively touch my shoe. She looked hesitantly at me after touching it, and then when I smiled at her and talked to her about getting my attention, she

crawled back towards Emma and lifted herself up using her mother's legs to aid her. Emma said "see, this is the kind of thing she does with Steven". I referred to Lily's desire to explore and be curious but needing to return to "base camp" with her mummy being her secure base. We then spent some time talking about and observing Lily, looking at her and talking about what she was doing, especially in relation to the way she played with the toys and objects in the room. Emma then told me that there were moments when she felt they had a "bond" that was almost exclusive to them, but despite that she still felt threatened by the way Steven's mother would sometimes "take over", and Emma would then retreat into her "shell". She noticeably looked pleased when I told her that I thought Lily was an appealing baby with her very expressive, responsive, an easy temperament.

As the session progressed I noticed that Emma looked pre-occupied and seemed rather subdued. I commented on my observation, and Emma responded by making a remark about the weekend that had just passed. She had a worried expression and said "I had a really terrible weekend". She proceeded to tell me about having gone out on Friday evening with a group of girlfriends. Firstly they had gone to a restaurant for supper and then went on to a bar/club where people could also dance. Emma spoke in such a worried tone of voice which suggested that something terrible had happened. It transpired that Emma had gone out with three of Steven's work colleagues who she had met on previous occasions and they had invited her to join them for a night out.

A typical theme of how stupid and worthless Emma often felt about herself and her behaviour after being out in a social setting then re-emerged. Emma looked glum and apprehensive as described how a group of men had tried to buy them drinks towards the end of the night out. She referred to "two guys", one a similar age to Emma who told her that he had children – and another man who was around fifty years old who Emma noticed was wearing a wedding ring. She recalled how the older of the two men had persistently asked Emma if he could buy her a drink, and was trying to "chat me up". She spoke about wanting to tell him that he should not be trying to chat her up as he was clearly married, but also acknowledged that she did not want to hurt his feelings, and "felt bad" about declining his offer of a drink.

I drew attention to the fact that Emma had introduced for a second successive week an issue around the wearing of wedding rings. The previous week Emma arrived at the therapy session not wearing her wedding ring and also without Lily. Both the ring and Lily had been left at home. She said that she had forgotten to put her wedding ring on after taking it off, and felt very uncomfortable because she thought that men would notice her while travelling to the hospital, and think that she was “single”. Emma had also acknowledged during the previous session that she was experiencing some conflicting feelings about men who might see her as a single woman, in that, she liked the feeling that she was getting attention, e.g. in the way men were looking at her, and at the same time felt a sense of disloyalty to Steven. She told me that she thought it was her “Achilles” and would ultimately lead to her “downfall”. I reflected on the wedding ring theme further with Emma and asked whether she had been wearing hers when the man in the club was trying to buy her drinks. She smiled and said that she was wearing it, and had actually put it on again after getting home after last week’s session. I referred to how recently she had told me that her father still wore his wedding ring, and that it crossed my mind that the older man in the bar trying to chat her up could have potentially triggered some strange feelings for her.

Emma sat on the play mat with Lily who crawled over her lap whilst reaching out towards a group of toys on the other side of her mother. Emma seemed to notice the attention I was paying to Lily’s efforts to reach the toys and she said in a light-hearted tone that she was a “silly mummy” and lifted Lily to sit beside the toys. She started to speak about feeling that after she got home on Friday night that she fluctuated between feelings of intense anger towards herself to feelings of intense worry about her experience at the night club. She spoke about this fluctuation of feelings continuing into the next day and into Sunday, which she said made it difficult for her to look after Lily when she felt troubled by her emotional reactions. Emma had a very serious expression as she spoke of the older man encouraging her to go on “somewhere else with him”, while experiencing the younger man as someone she could relate to, able to “swap stories” about their children. She added that the older man “didn’t want to accept that she didn’t want a drink from him”, and raised the question for her

whether she had given him “a message”. I asked Emma what kind of message was she thinking of, and she answered “the wrong kind of signal”.

Emma then expressed how extremely worried she was that Steven’s female colleagues would tell him today (Monday) that she had given the men in the night club “the come on”, and the consequence would be that Steven would want to leave her. Her worries were being repeatedly vocalised in the session and in particular worries over what Steven’s work colleagues thought of her, and also what the married man thought of her, who Emma thought must have felt “rejected” by her.

I raised another question that was on my mind, which was, could it be that Emma had blown up Friday evening’s events out of proportion. She seemed to be very surprised that I had raised it as a possibility. I then commented upon the impression she gave me that she found it almost intolerable to not know what the others involved in Friday evenings events actually thought of her, and that she was also wondering what I thought of her. Emma responded by saying “I don’t think I want to know”, but quickly added by saying “I think you would say Emma is someone who tries her best but doesn’t get it right”. She counterbalanced that by telling me that she did not think I thought about her in such a “black and white way”, that it would not be a matter of getting it right or wrong. She went on to say that she constantly worries what people think of her, and it was the same in respect of me, but that she did not worry anymore about what Lily thought of her, because she knew that Lily would think “I’m trying to be a good mum and that I love her”.

In Emma’s case the sessions took place weekly on Mondays. It became evident that Emma often brought to the sessions worries and anxieties that were freshly triggered by weekend events, and typically linked to the way she had behaved and what others involved might have thought of her.

The psychotherapy moved towards Christmas and Emma spoke often about feeling that she needed to tone down her behaviour in social settings, feeling that in particular she sought attention when she had been drinking alcohol, especially attention from men (Session 34). She spoke about fearing that she could be prone to similar episodes of depression like her father, especially the

kind of episodes he experiences when he would mourn the life he once had. She told me that he had recently been telephoning late at night, having had too much to drink, when she and Steven had gone to bed, and he would be full of sorrow and regret, primarily over the breakdown of his marriage and consequently family life. He would ask about Lily, but clearly at an inappropriate time for Emma and Steven. She felt a lot of angst about these inappropriately late night phone calls from her father, as she had had to tell him in a firm way to stop calling late night and when drunk. She worried that setting boundaries might have a negative impact upon her father emotionally, but felt that she had to protect her family situation. Emma complained to me about her father's emotional demands and drunken habits but deeply identified with him. She admitted sadly 'I don't want to be like him, yet I feel it's wrong to turn my back on him'.

Emma also introduced some information about her father's aunt who apparently had committed suicide when Emma was a child. She talked about the paternal side of her family having a history of mental illness, citing her father and his aunt as the key figures, and worried that their mental health problems had increased the odds of her developing associated problems. Emma referred to her great aunt as "the scandalous one". She went on to talk about her great aunt having had a reputation for wanting to be the centre of attention. She spoke about being told things about this woman who ended up committing suicide, which Emma said happened after a love affair ended and she was left with a "broken heart". Emma had been told that the man involved in the affair had ended the relationship, not being prepared to leave his wife and children for her great aunt. In a slightly disparaging way said "yes, but she had lots of men.....when she was depressed she would strip off and have sex with men". Emma waved her arm outwards as though throwing off an imaginary garment of clothing. I commented on the apparent link Emma had stated between her great aunt's depressed mood and sexual activity. I speculated that perhaps her great aunt used sex as a means of compensation against her depressed mood. Emma responded by telling me that she had heard that her great aunt "just wanted to feel wanted and loved", but ended up feeling "sad and lonely". I talked with Emma about the possibility that her sometimes flirtatious behaviour in social settings had elements of her great aunt's sexualised behaviour when

she (great aunt) acted out to become the focus of attention in the pursuit of feeling wanted and loved. Emma said that she thought that she could be trying to “seek something” when she has been inclined to attract attention from other men, but hoped and felt that she was not as “extreme” as her great aunt.

New Year: Birthdays

The first time Emma was due to come back for a session following Christmas she called ahead of the appointment time to tell me that she did not think she could travel to the hospital as she Lily had gone for a sleep after lunch, and also Emma herself was feeling low and did not want to leave her home. She asked whether we could have a conversation over the telephone during her allotted session time which I agreed to. We spoke for approximately 20 minutes during which time she told me that she was feeling very let down by her father who had got drunk and consequently was effectively unavailable over Christmas. Emma spoke of the significance of it being Lily’s first Christmas, and her father not being able to “hold it together” for Lily.

In late January Steven joined Emma without Lily for an appointment (Session 36). They talked about how they were pleased overall with the way the psychotherapy sessions had developed, with Steven saying that he thought Emma was feeling more “secure” about herself as a mother. They both expressed some concerns and reservations about Emma returning to the workplace, especially as it would signal the end of the sessions. The couple said that Easter time would be the time Emma would be looking to be back in the workplace, and that they envisaged the perinatal sessions ending in March. Emma said with a degree of edginess “I’m not good with endings”. Emma reiterated her feeling of guilt about returning to work (4 days) and Steven told her that he thought she was being “too hard” on herself.

In February Emma had her 31st birthday and Lily had just had her 1st birthday. Emma arrived at a session directly following her birthday weekend and it was noticeable that she had a new hairstyle. Initially Lily stayed close to her mother, on her lap with her head against her mother’s chest. It looked as though she was feeling a bit sleepy, and Emma soon confirmed that Lily had fallen asleep on the way to the hospital. After a few minutes Lily became a little more alert

and started to take an interest in Emma's handbag beside them on the couch and she started to look inside it and take out a variety of items, including wet wipes. Emma told me that she and Steven had been away overnight at the weekend to celebrate her 31st Birthday. This was the first time since they had gone away without Lily. They left her with Emma's mother and sister. The couple had gone to stay at a country house for the weekend. She spoke about Steven having been more worried than she was about leaving Lily, and that he had been more inclined to get updates from Emma's Mother and sister on how Lily was managing. Emma told me that her mother and sister reported that there were no problems and that Lily settled well. Emma mentioned that she thought Steven had become somewhat "possessive" of Lily which she found irritating, and wished that he would "ease off a bit". She went on to say that when they arrived back from their stay to collect Lily she reacted quite indifferently which Emma found she had mixed feelings about. In one respect Emma felt pleased that Lily coped well with being left, and in another respect Emma felt she would have "liked a little reaction".

We spoke about the positive aspects of the separation that had taken place; in particular the way that it seemed Lily had felt secure enough to not feel anxious. We talked about the important factor of being reunited with Lily after a separation, and although Emma would have appreciated a more demonstrative response from Lily, she acknowledged the good feelings around being reconnected in both an emotional and physical sense. She asked me whether I thought that it would have been "more normal" for a child of Lily's age to become upset while they were parted, and I said that I thought it depended upon a number of factors, including whether her mother's home felt like a secure environment. I also mentioned that I felt that Emma and Steven have been facilitating Lily's development over the past year in a way that had enabled Lily to become a baby confident in seeking contact with others, and at the same able to feel that her parents were sensitive to her needs. Emma appeared to wipe away a tear, and also smiled.

Lily was using tissues from the tissue box to wipe cushions and other surfaces as though she was carrying out domestic chores. She seemed to be contented in removing a tissue, wiping various surfaces and then dropping the tissue into

the rubbish bin. Emma started telling me that prior to their weekend break, her father travelled from his home on the south coast to see Emma ahead of her birthday. Emma told me they had “chatted” about her coming for sessions at the hospital, and he asked Emma “if you don’t mind me asking, what kind of things do you talk about?” Emma said “I told him that the sessions were about my bond with Lily, but it’s also about other things, my bond with Lily is secure now”. According to Emma her father told her that he was pleased that she had an opportunity to speak with someone about her “concerns”. He went on to tell her that he had found it difficult to speak about his feelings and felt uncomfortable meeting “people in authority”. I asked Emma if she thought authority figures would include psychotherapists. She responded by saying that her father would view a hospital therapist as an authority figure, and that it resonated with her own experience of having inadequate feelings when meeting people in authority.

Emma spoke further about her father and told me that he had received treatment in a clinic when he was in his twenties for OCD type symptoms. She said that he had been obsessive about washing his hands. Emma spoke about her father being open with her during their “chat” and that she thought it was made more possible for him to be open because he had recognised that she was trying to make her “problems” better by coming to the hospital for the sessions. She described how she and her father had discussed the possible influence that his mother might have had on their emotional health. Apparently his mother was prone to depressive episodes, and Emma in particular recalled how her grandmother “gave up” after she was diagnosed with bowel cancer. Emma spoke of her grandmother “letting her depression take over, and not wanting to leave her house”. Lily stretched to climb up onto Emma’s lap. She then spent the next few minutes facing her mother and touching her face. When I commented upon Lily touching her in an affectionate way, Emma looked a bit surprised and said in an apologetic way to Lily “oh sorry, I wasn’t meaning to ignore you”. I commented on Lily seeming to have gained her mummy’s attention by very direct means but without having to scream or cry. Emma said that she thought Lily was able to communicate her feelings and needs better than she herself had ever managed and better than her father (Emma’s) also. As Emma hugged Lily she said in a mournful way that this was something that

she did not remember doing with her mother. I spoke with Emma about the pleasurable feelings she derived from cuddling Lily having the habit of evoking a feeling of sadness related to her relationship with her mother. She responded “sometimes I think I’m being irrational but I do feel it’s been unfair.....but at least it feels different with me and Lily”.

Over 12 months of therapy: April

Session 46

Emma and Lily came to the appointment following an Easter break around 15 minutes late. When I went to the reception area Lily was being sociable standing in the doorway of the office holding a stickle-brick, with the perinatal administrator talking to her in a light-hearted way. I immediately thought Emma looked very serious and edgy. We went into the therapy room with Lily leading the way and I commented on her knowing her way around the department.

Lily immediately went to investigate the toys that were already placed on the play mat. Emma continued to look serious and rather despondent. She sat on the couch and quickly reached for the tissues close by. She told me as she wiped away tears that she had thought about cancelling today’s session and had only changed her mind because she felt that she was being a “coward” not to come. When I asked whether being late was connected with her thoughts about not coming today she said it was and that it was a “last minute rush” after she thought to herself that she was being “stupid”. I noted vocally that there had been a Bank Holiday last week which meant the regular Monday session was not available, so I wondered what might encourage her to miss out on another session, especially when the end of the treatment was nearing with her return to work.

Emma wiped her eyes some more and Lily appeared to notice her mother’s tearfulness as she also pulled a tissue from the box and stood close to her mother, looking up towards her face. Emma said in a loving way to Lily that she should not be worried about her, that she was just being “a bit silly”. I commented on Lily being sensitive to Emma’s mood. Lily looked a little

concerned but then took the tissue with her and started dusting the little wooden table close to the door.

What came to light was another difficult weekend experience for Emma which revolved around a sense of disappointment in her behaviour within another social situation with friends. She told me that she was feeling “such a fool”, and that part of the reason she did not want to attend the session was because she thought “D will think he’s wasted his time with me”. She then spoke about having had a “bad time” after her father had contacted her and Steven by telephone last week. She explained that he had telephoned them again on consecutive nights, past midnight, after they had fallen asleep in bed. He was drunk on each occasion and it had caused a disruption between her and Steven. Emma was feeling very let down by her father and understood her husband’s criticism of her father but she was also feeling “sad” about him calling her to apologise for being a “failure”. I said that I was wondering whether it was worth thinking about whether there was a link between the feelings being expressed by Emma about wasting my time and her father’s feelings about being a failure. Emma told me that she thought that I must be disappointed with her and think why did I “bother” with her. Emma added that she knew her father felt he was a disappointment to her and his family.

When I asked Emma what it was that might make me feel so disappointed with her, she looked despondent and said “just about everything”. I noticed Lily take out a highlighter pen from the bag hanging from the pushchair, and then put it into her mouth. Emma continued to speak and began to tell me that the weekend just gone had been problematic for her and Steven. I felt that I needed to alert her to the highlighter pen in Lily’s mouth and I did so. Emma immediately asked Lily to give her the pen which she did willingly. Emma said “see, I’m neglecting her... this is what I was like on Saturday”. She became quiet briefly and looked forlornly out of the window. She then began to reflect upon her feeling of disappointment. She spoke about Saturday and being invited to watch the Grand National in the afternoon with friends at a friend’s home.

Emma spoke about initially not wanting to go to watch the Grand National, that she was feeling “horrible” about herself. I asked what she felt was so horrible

and she said “I was feeling fat and really bad about myself”. She spoke of Steven really wanting to go and him encouraging her. I asked Emma whether the invitation included children. She told me that it did but that Lily was the only one present and that Lily “charmed everyone”. I made a comment about it seeming as though Lily might have been the centre of attention as the only child at the social gathering. Emma described feeling a sense of “pleasure” that Lily was “popular”. I commented on the sociability, and self-assuredness that had developed within Lily.

Emma’s head dropped a little as though she was feeling dejected and described feeling that she was hopelessly bogged down by her contrastingly “bad feelings”, typified by her fat feeling, and not really able to appreciate at the time the interest that Lily was receiving. She described that she looked at herself in the mirror before leaving for the social event and when putting on lipstick thought the harder she tried, the more unattractive she looked. As we talked about the way she felt about herself in the mirror, Emma said that sometimes she felt “doomed”, and it did not matter whether anyone told her that her self-image was distorted, because ultimately she felt “stuck” with her appearance. Emma recalled feeling as though an unbearable sense of panic had been set off in her in relation to her appearance, that she could feel a state of anxiety growing inside her, and felt very alert to how the others at the social event might view her. When I spoke of there being little or no emotional assurance to draw upon when she had become preoccupied and anxious about the way she looked to herself and others, Emma told me that it was only when she had consumed some alcohol that she began to feel better about herself, and the sense of panic diminished. She went on to say that what she really wanted was for Steven to give her a hug, but that she realised that he was trying to help Lily with something, and then thought “I feel too fat to be hugged”.

Emma told me that they had all watched the horserace and “that was okay”, and then she had gone into the kitchen and asked whether she could put a pizza into the oven for Lily to eat. In the kitchen she got talking with “two friends”, and “had a couple of glasses of wine”. Once the pizza was ready, Steven “took over” with Lily and he fed her in the lounge while Emma stayed in the kitchen socialising. She spoke as though she had committed a crime, which I

commented upon, as she told me how much she had enjoyed talking with the friends and then afterwards that she had “felt rubbish” because she had “neglected Lily and Steven for about an hour”. When I asked whether the friends were female or male, she told me that they were both male. She said that after she, Lily and Steven had got home she couldn’t stop crying because she felt she had been so neglectful. I spoke about it being understandable at many levels that it was an opportunity for her as a fulltime mother to take a moment out when she knew Lily was in safe hands, to have some time out to socialise but that at another level it was perhaps significant that both the friends were male and it then made her feel disloyal. I noticed Lily turning to look at me with a serious expression and then turning to look at her mother, seemingly aware of the upset her mother was feeling, and then slowly returned her gaze to a book that she had been looking at.

Emma spoke about Steven telling her after they got home that he didn’t want to speak about her “problems” any more, that he was “finished” with speaking about her problems because he did not understand why she had become upset about her behaviour. She told me that she was feeling that Lily and Steven would be “better off” without her, but that she could not actually leave them, although she had had fleeting thoughts about committing suicide. I assessed Emma for level of intent and risk in relation to her suicidal thoughts, and concluded that she did not have suicidal intentions.

The session closed with Emma making some links with the history of her paternal aunt who had a reputation for being promiscuous, and who ended her own life after being disappointed romantically when an affair had ended. I made a link also to the fact that the therapy sessions were soon to end with Emma returning to work, and how the ending and loss of the therapy and might bring about a feeling of mourning. Emma responded by saying “I’m worried that things will fall backwards once it ends here, but I suppose it’s like letting children go and grow-up”. Her face reflected some anguish when she said “this has been one of the most intense experiences of my life”.

After the session I discussed suicidal risk factors with the team’s Consultant Psychiatrist to make her aware and to get her opinion. When I talked with Emma about her thoughts in a detailed manner I identified that she had no

actual plans to commit suicide. She had not thought of any methods, and that she was very clear that she could not actually leave Lily (especially), Steven or her parents, and siblings in such a way. It was more the fact that Emma felt such a “burden” to Lily and Steven which encouraged the concept within her to consider them better off without her, but not to a point whereby she would actually end her life as a result. Importantly from a clinical standpoint when making such a judgement I did not feel anxious in reaction to Emma’s suicide reference, and she never made me feel anxious in that sense, though I took very seriously her reference to it, particularly in light of the family history of suicide.

Summer: final month

Session 51

Into the final weeks of the treatment and Emma’s response to me in the waiting room suggested that she felt awkward for leaving Lily at home with her mother. As we walked into the therapy room she said “I hope that’s alright”. After getting into the room she told me that she felt it would have been difficult to have brought Lily today because she (Emma) had two appointments at the hospital, firstly with me and then with Dermatology at 2pm, which was her normal session time with me. Emma went on to say that it would have meant giving Lily her lunch “in here”, and that did not seem like a good idea. She looked at the play mat and toys and she commented upon the fact that I had prepared for Lily coming as normal.

After a few moments Emma sat further back in the couch and told me “I’m feeling a bit better, better in my own skin”. I acknowledged verbally that she seemed to be saying that she felt better than last week. However, things quickly seemed to then change, as she rubbed her eyes and said that she was feeling “disappointed” by recent events with Steven. She explained that an “email had gone round” last Tuesday from “two friends” who both were celebrating their birthdays on Friday inviting friends to join them on Friday evening for a drink at a pub. She spoke for a while about Steven arriving home from work on the Wednesday evening to tell her that he was going to “pop along for a couple of hours” on Friday. Emma explained that the two friends were

mutual friends and then her face had a tense expression as she vocally protested to me that it was a sudden decision by Steven to plan to join them, which he had not discussed with her.

Emma explained in an aggrieved way how Steven had said “I hope you don’t mind but I thought I’d pop in and see them for a couple of hours”. Emma added that this happened just when she has been telling Steven that she wanted them to do more together. She told me the friend’s invitation was “a prime opportunity” for them. She described how Steven then suggested that they try and organise a baby-sitter for Friday, but that she felt it was futile as it was “last minute”, and it felt to Emma that it was an afterthought. In a despondent way, she told me that a babysitter was unlikely to be found as her mother was going abroad and Steven’s mother would be working a late shift. Steven’s mother had said that she “needed more notice”. I commented on her seeming despondent when she spoke about Lily’s two grandmothers being unavailable. Emma shrugged her shoulders and said in a rather matter-of-fact way “they can’t always be there for us”. She then started to protest again about Steven being socially active, that his “diary is quite full”. She went on to say that he was about to go and see the comedian Ricky Gervais in concert and attend some other social events during May and June. I said to Emma that it looked as though she felt the emotional pain of feeling excluded. Emma acknowledged feeling excluded by Steven from his social calendar, and when I said that it was perhaps hard to manage the thought that her diary would soon be void of the perinatal sessions, Emma looked a little downcast and said that this had occurred to her and that, of course, it might mean that she was so anxious about this happening that she had been unable to think about it. She was able to acknowledge that feeling excluded and left out was a constant problem, and that she wanted to shield herself from feelings of loss at the end of the treatment. When I told Emma that I too would feel a sadness about the ending of the sessions, she looked moved and then said that she thought it was time that her appointment slot went to someone who needed it more than she did, because “there will be new mums who need you more than me.... .I feel much better than I did a year ago”. I said that perhaps the ending would bring feelings of ambivalence, with the thought of another patient filling her

appointment. It seemed to have a slightly emotionally detached tone as Emma said "I'm not complaining".

Emma looked a bit forlorn as she told me that she and Steven had gone to support a friend running in a local marathon race yesterday and had been joined by Steven's parents in the morning. Around lunchtime it was suggested by other friends that they go for a pub lunch, but Steven's parents had prior lunch arrangements elsewhere. There was a suggestion about finding a pub that was child-friendly, but Emma put it to Steven that maybe his parents could look after Lily for a short time. Apparently his parents had said "of course we'll have Lily for a couple of hours", but he was insistent that was not going to happen. I asked what would have made Steven so definite. Emma told me "he's become possessive of Lily. She went on to describe an example from Sunday when they were at the pub and Lily was feeling tired. "It was really nap time", she said "and she wanted me but when I went over to them he told me "she's fine with me". I said that I was wondering whether she (Emma) sometimes felt "out of favour, not the first choice". I carried on by suggesting that Emma might sometimes feel the experience of Steven and Lily being closely connected somewhat threatening and heightened her feeling of being excluded. She responded "a part of me can feel jealous". She spoke of their love for Lily as parents being "unconditional" but that as Steven's wife she could feel insecure when he "keeps possession of Lily". Emma went on to say "I worry that I will be left alone, and how I would survive".

A more aggrieved tone returned as she spoke about experiencing Steven as strict towards Lily. Emma said that she wants to "keep a united front" but can feel like disagreeing with his strictness. I asked whether she could provide an example and she did. She told me about how recently Lily was on their lounge sofa without her shoes and she walked up and down it excitedly with Emma herself in close attendance. From the kitchen Steven had said sternly "no Lily" and then told Emma that she was "too soft". Emma then said "he criticises me...he tells me I'm doing the housework wrong, and when I tell him that it makes me feel more unconfident he says "I'm just giving you some advice". She told me that when Steven is in critical mode it reminds her of her mother and how her mother can make her feel. We spoke about the feeling of being

criticised being deflating to her self-confidence. She then spoke of her fear of being a mother herself who could hurt and damage her child's self-confidence. Subsequently Emma said that she saw herself as using her negative experiences of feeling criticised to protect Lily, to be alert to the potential for Lily to be made to feel inadequate as she grows-up. Emma's mobile telephone rang in her bag. When she looked at the screen she asked if it was okay to answer. She did so and said to the caller "I'm with D right now; I'll call you back later". A few moments passed and I said "I wonder whether that could have been Steven calling". She said it was and that he had just started his "lunch break". I commented on it being a different therapy time today to accommodate her dermatology appointment. I then spoke a little about the possibility that he might have just felt a bit rejected or left out, "being told that she was busy". Admittedly he had attended some sessions with her and Lily but in the main he worked while Emma developed a personal space for herself and Lily.

She answered by saying that Steven has felt that the therapy sessions have made a positive difference. She told me "he says, Emma, you'd never have done the things you're doing now a year ago". I commented upon that sounding a positive reaction but questioned whether he still might have felt "a bit excluded". Emma said that she did not think Steven was sensitive to feeling excluded. When discussing Steven's needs, Emma seemed to oscillate between warmth and distance, between expressing concern for his needs and diminishing their importance.

As the sessions progressed towards their final conclusion Emma started to speak quite triumphantly, I felt, about how Steven had been made to choose between his mother and her when they developed a serious relationship. She told me that Steven was given an ultimatum by his mum, "it's either me or her" and in the end he chose Emma. She described Steven as his mum's blue-eyed boy, her oldest child and her best friend. I spoke of there being a theme about couples and that I wondered if sometimes it was difficult for her to adapt to anything more than a two-person relationship, and I referred to the sense of triumph that I thought she had conveyed. Emma was able to tell me that, while she was aware she could feel a degree of triumph, what was more important to her was that she relished being in the relationship with Steven. We then spoke

about Emma experiencing an ambivalent attitude towards anyone else getting involved in her close relationship pairings, feeling a third person as an intruder. I talked with Emma about within any group of three there being the potential of a couple emerging that can exclude the other person. She acknowledged that this can be an experience she is familiar with.

Final ending

Session 54

Emma reflected upon her experience of the therapy as it reached its ending. She described finding the listening and reflections I vocalised about the conflicts in her current life helpful but sometimes felt frustrated when I did not offer direct advice. She spoke about knowing that I was not “here” to give her advice, but at the same time felt frustrated by the fact that I did not do so. She expressed some frustration in relation to me not telling her what she felt she needed to know. However, during the penultimate session Emma told me that she had found a previous conversation that we had within a session prior to a job interview she was anxiously preparing for, had made a difference to her state of mind. She said “I’d remembered at the interview what you’d said to me at the end of the last session, that I had nothing to lose by being myself”. Emma smiled as though a sense of relief had been experienced. I said “I notice that you seem happy about that”. She said “well it just seemed to give me some confidence.....I guess they chose me on that basis”. That sense of relief seemed to dissipate within moments as Emma told me “of course now I’m thinking they’re going to see how useless I can be”.

I clarified with Emma that it was a PA post in an academic department of an internationally renowned London University. She told me “I was pleased to be offered it but immediately I’m thinking, oh my god, what if I make a mistake, what will they think of me, they’ll think why did we give it to her”. I commented “immediate self doubt”. She responded “yes, all the usual stuff and now I’m worrying that they’ll find out about me coming here, that they will find out about my postnatal anxieties”. I made a comment about this being a “classic response” from Emma, anticipating that she was going to be found out, and discovered to be fake. She said “yes, a fraud”. Emma told me “this time last

year I would never have been able to go to the interview”. I said that her comment was making me wonder whether this had for her both positive and negative connotations, that it might feel like a personal development but at the same time carry an element of sadness when looking back at the end of the therapy. She looked anxious and spoke anxiously saying “I know I really don’t know how all this is going to work out yet”

Emma became self-critical as she remembered her mistakes of the past in her previous job. She looked pained as she recalled sending a round robin email cancelling tickets for an event organised by the company she was employed by. She spoke of accidentally choosing the wrong option from a drop down menu on the computer and then had encountered an “avalanche” of telephone calls and emails from “angry customers”. She shook her head with despondency as she spoke of fearing that something similar could happen again in her new role. When I suggested that there often seemed to be a day of reckoning and judgement just around the corner within Emma’s mind, she told me that although she recognised this was the case, she was more able to forgive herself when she feels she has made a mistake.

The therapy ended with a degree of sadness for both patient and therapist that some well-established patterns of Emma’s behaviour which caused her unrest were still present, and yet there was also some real sense of optimism and sense of achievement in relation to Emma’s facilitation of Lily’s growth and Emma being successful in her job interview, with new beginnings ahead. Emma had also had a significant opportunity to acknowledge some of her most personal conflicts with someone she had grown to feel she could trust. She had also to some extent begun to recognise that although she was sometimes plagued by a sense of disappointment and failing over her relationship with her parents, she could see some positive distinctions within her relationship with Lily in her role as mother. She was also a little more able to allow herself some self-forgiveness.

4.2 Case study: Lucy

Referral

Lucy was referred to the Perinatal Service in early May by her health visitor, Helen. She reported that Lucy (aged 20) had been feeling highly anxious following the birth of her baby and had also expressed concerns about losing her temper with her four month old son, Jack, when he cried. Helen reported elements of Lucy's past in the referral, in particular noting that Lucy was hit as a child by her mother. She had attended anger management classes as a teenager and had self-harmed. She scored 20 on the EPDS.

Initial assessment appointment

Lucy told me that she had recently married Robbie (aged 20) who was a soldier in the Household Cavalry. They lived in Army accommodation (tower block) close to the regiment's London base. She told me that Robbie would be willing to attend some sessions but firmly believed that all her current emotional issues were self-inflicted and she was fearful that her postnatal emotional state would damage all her close relationships, especially her relationship with Jack and Robbie.

She told me that Robbie could be posted to Afghanistan at any time and that would result in a move from the London barracks to Berkshire and therefore a sudden departure. Lucy said that she and Robbie came from the North West of England.

In her strong regional accent Lucy told me that she had come close to cancelling the appointment because Jack had had a temperature the previous day. She quickly put his temperature down to him having "all his injections" and she told me that these had been "big ones" including "BCG" and she gently touched Jack's leg at the same time, indicating that the injection had gone in there. Lucy then added that she was feeling "knackered" because Jack had not slept well. While Lucy spoke about this she was feeding Jack a bottle of milk, with him in her arms. Jack appeared to be unsettled, he wriggled and griped when the teat popped out unintentionally and when his mother removed it. He

seemed restless often drawing his legs up. Lucy then jiggled him lightly over her shoulder and made soothing sounds.

I told Lucy that I was interested in how the referral came about and, although I had notes from the referrer, I wanted to know more from her perspective about the reasons for her referral to the Perinatal Service. Lucy's face immediately became sad. She then emphasised that she had never hurt Jack but she felt she needed "help" because as she put it "I don't want to hurt him but I can't stand it when he cries sometimes". I enquired whether there were particular episodes of crying that were worse than others for her. Lucy said "It's when I'm on my own with him". She continued by telling me that she was worried because she had "shouted at Jack and had to put him down and walk away". I noted verbally that she had recognised that she needed to walk away and she had also reached out for help by letting her Health Visitor know that her feelings of anger and frustration towards Jack were worrying her. Lucy described experiencing a straightforward pregnancy and birth, free of significant complications. However, she told me that a few weeks after birth she began to feel more irritated and found it difficult to remain calm, finding it hard to keep her feelings in proportion.

Lucy immediately expressed concern that I would direct all my attention to alerting Social Services and tell them that she was a "bad mother" and that Jack should be taken away from her. She emphasised that she wanted to be a "good mother" and added "I don't want Jack to go through what I went through". Lucy described her mother as a "bitch", having been unkind towards Lucy and her sister. She then told me that her mother was an "alcoholic" and "beat" her and her younger sister (Anna) from the time she (Lucy) was 7 years old. I asked Lucy if she thought there had been something specific that had sparked the beatings around that time. She told me that she remembered it being around the same time her father left the family home. I asked Lucy whether she felt her parent's separation had left her more exposed to her mother's punitive actions. She responded in a despondent way saying "He just pissed off and left us to it".

As the session developed Jack was sat upright on his mother's lap. He looked towards me with an uncertain expression – I thought it was as though he was not sure whether to smile or cry. When there was a hint of a smile, a stream of milky dribble fell down his chin. I thought Lucy looked pleased that I was paying Jack attention and that I had mentioned that he was a lovely baby. I established that Jack was the firstborn for both Lucy and her husband Robbie, but she told me in a regretful tone of voice that she had had a miscarriage a couple of years before having Jack. I asked how Jack's father was feeling about his baby son. Lucy said "dead proud". I then wondered if he had considered coming with them both for today's appointment. Lucy told me that he is being supportive of her getting help for her anger but she felt uncertain about inviting him. She told me that Robbie knew about her coming to the perinatal appointment but that it would also be difficult for him to get the time off because he was preparing for the "trooping the colour". I said that I had noticed from the referral details that they lived in barracks, and I asked about her experience of the army environment. Lucy enthusiastically said that she "loves the horses... and it feels safe in the barracks because it's secure". She then spoke further about Robbie forthcoming tour of duty in Afghanistan, departing in 3 months time. I commented on this being a worrying prospect for them. She nodded but said little more about it. I did notice her clutching Jack closer to her chest at this point, trying to soothe him with a dummy as he became sleepy, but I thought she looked tense in her demeanour – nervous and anxious. Lucy jiggled the drowsy Jack closely to her chest.

Lucy told me that she had met Robbie when they were both 16 and "hadn't imagined having a baby with him". In fact she had not really imagined having a baby. She told me that she had always considered herself to be a "tomboy", happiest when "hanging out with the lads playing football". Lucy and Robbie married last year and she told me that she "loved him to bits" and that he gave her "everything". Lucy looked serious and on the verge of tears when she told me that she "hated" herself because she sometimes hit Robbie when she got angry. She linked her aggression to her mother again by saying that her father "walked out" because he too was a victim of her mother's aggression. She made a point of underlining that she only hit Robbie sometimes, that it was not an everyday act of aggression. I then was able to ascertain that Lucy felt she

and Robbie were in a “loving” relationship and that he did not retaliate in aggressive ways. Lucy then got up from her seat and placed the sleepy Jack, who was startled by the movement, into his buggy.

Aged 16 when she met Robbie, Lucy wasn't expecting to settle down with him but things felt very different now, with her description of Robbie giving her everything. Lucy told me that she was at her “worst” at the time she met him. I asked what she meant by ‘worst’. She spoke about how she was cutting herself and at that time she had been seeing a “counsellor”. I clarified with her that she had seen the counsellor about her cutting. She confirmed that was the case. Lucy had an apprehensive expression as she spoke, but did so openly I thought, as she described cutting herself - arms and legs - with a razorblade in the main and often reopened her wounds, preventing healing. She spoke about cutting mainly between the ages of 14 to 16.

I asked whether she was still cutting (noticing that her bare arms looked cut-free). She told me that she rarely cut now. When I asked Lucy whether she had self-harmed in other ways she told me that in the past she had taken up to “32 co-codamol in a day”. She then claimed she was currently free of taking “pain killers”. I explored further her history of overdosing on pain killers.

I was interested in Lucy's experience of seeing a counsellor when she was younger and I asked her to say a bit more about that experience. She rocked the handle of the buggy gently as she told me that she “didn't like it” because she had to see two men, one being a trainee who “had to sit in”. I said on that basis it made me think she might have some negative feelings about seeing me, a male therapist. She said “You seem alright” and then she asked if I would be looking to bring in anyone else. I put forward the idea to Lucy that maybe what she really wanted was an individual space for herself with a clinician as she did not get that when she was younger, and then asked her how it might feel for her sharing a therapy space with her baby son. Lucy was definite in the way she responded telling me that what she wanted was to be a good mother to Jack and that she felt it would help them both if they “did this together”.

Lucy referred to the counsellor again, explaining that she would “never have gone” if it had not been for a friend at school noticing the wounds on her body while getting changed for a PE class. I was curious about how she had gone about concealing wounds until then. Lucy said that she used to get changed in a toilet cubicle but on that occasion her friend opened the door when she (Lucy) thought it was locked. I suggested to Lucy that maybe unconsciously at the time; leaving the cubicle door unlocked offered her help in the form of a concerned friend. Lucy looked reflective for a moment but then described her school friend as a “snitch”, going to a class teacher the next morning. I said maybe she was feeling worried about me being like the friend who snitched, someone who discovers something she wants to hide and runs to tell someone in authority. Lucy laughed nervously, shook her head as she did so, and said with an anxious undertone “I don’t think so”. I spoke about the potential for psychotherapy sessions to sometimes evoke uncomfortable feelings, often connected to earlier experiences. Lucy told me in response that she wanted to be able to share her “frustrations with someone” and added “I don’t want things to get out of control.”

Towards the completion of this initial session, the theme of confidentiality seemed to continue as Lucy spoke about her mother-in-law as an intrusive figure who regularly tried to come between her and Robbie. She told me that only recently a tax bill had arrived for Robbie but at his mother’s home. When the tax bill eventually reached Robbie, Lucy claimed that she was “horrified” to discover that it had already been opened. Lucy said in an aggrieved way “I can’t stand that woman”. Lucy proceeded to tell me that she and Robbie had previously lived with his parents after they met and Robbie’s mum once read her diary in which Lucy wrote about her cutting and the way she was feeling. We talked a little more about her experience of anger management/counselling and I told Lucy that I would like to see her for further sessions and agree on a treatment plan. She said “I would like to come back”. I said that I thought the best way forward would be weekly psychotherapy sessions. Lucy looked relieved and thanked me, then said “I want to try and sort things out”. The treatment plan was agreed and she quietly got ready to leave, with Jack asleep in his buggy.

The commencement of the treatment

The initial assessment uncovered that Lucy had struggled with low mood for several years. She had struggled with weight issues from her early teens and had a tendency to overeat. She complained about struggling to lose weight after having Jack and that she could not fit into clothes she wore prior to pregnancy. Lucy felt highly sensitive to any thoughts that Jack may/be overweight which, she told me, had recently been implied by a Health Visitor (not the referrer) at Lucy's local health centre. She expressed a sense of grievance towards the Health Visitor who suggested that Jack should be put on a diet. To me Jack did look stocky but not grossly overweight.

Lucy spoke about her parent's separation and described it as an acrimonious split. She talked about her father's departure as difficult to emotionally resolve for her and her younger sister. He remarried and he became a father again, having another daughter.

Lucy was sensitive to becoming both exasperated and humiliated when Jack had a tantrum in public places. From my initial observations of Lucy's responses to Jack it appeared that she worried about Jack having the capacity to show her up in a bad light.

As the sessions moved forward she seemed to express more and more that she felt hard done by. In particular she made rather malicious protests about her mother's lack of interest in her, Jack and Robbie, citing her mother as "not even bothering to send a text message". She also would complain about her mother-in-law, telling me that her mother-in-law found it difficult to refrain from intruding into their affairs. Lucy also complained to me about her mother-in-law treating her son and grandson as "mummy's boys", Lucy's feelings of resentment would fluctuate between her mother and mother-in-law. There appeared to be one other main target of Lucy's protests in sessions and that was another army wife friend named Karen.

The Summer Ball

Session 8

As I took my seat Jack looked unsteady sitting independently on the play mat. He looked to be in a dilemma about whether to laugh or cry as he looked at me. Lucy had sat down close to Jack and she stroked his head. I said hello to mother and baby and Lucy scooped Jack up and put him on her lap (facing me). He made a couple of cooing sounds as he looked at me. He looked down at his feet and touched a Velcro tab on one of his shoes. Lucy told me that Jack had not had his “morning sleep”. There was a moment of silence and I noticed a slight look of concern as Lucy said that the Summer Ball was approaching. Then she told me that it would be an opportunity for her and Robbie to celebrate his promotion to Lance Corporal.

Despite Lucy speaking about there being an opportunity for a celebration, her mood appeared to quickly become downhearted when she told me that they had recently had to pay a large credit card bill and combined with Robbie’s salary increase not activated yet, it made buying a “ball gown” difficult. Lucy said that over the coming weekend they would be going to Robbie’s parents’ in the North West and she was intending to go to the local “TK Max” to see if she could get a ball gown there, because it would be more affordable. She went on to say “I want to look my best but I can’t afford anything over £100”.

Lucy became more emotionally intense as she spoke about her friend Karen who lived in the same “tower block” and whose husband was also a Lance Corporal but more experienced than Robbie and was also gaining promotion. Lucy spoke of Karen already having got her dress for the ball, but “she wasn’t giving anything away about it”. I spoke about Lucy feeling that Karen was not revealing details about what she would be wearing and asked Lucy what she thought about that. Lucy had a moody facial expression as she said “I know she thinks I want to know what she’s bought – at one point I thought she was going to, but didn’t really”. I spoke of there may be something tantalising about Karen’s behaviour that was provoking Lucy. I spoke about certain information not being shared and there seeming to be an element of competition between Lucy and Karen within their friendship. As Jack stirred slightly on her lap Lucy nodded in a definite way, and said “I want to look good not just for Robbie but

because Karen's going too". I put it to Lucy that she wanted to outshine her friend. She agreed.

It then became clear that Lucy had got it into her mind that it was possible that Karen had also been referred to see me in the Perinatal Department. Lucy spoke in a concerned way when she said, "I know you are professional and things are confidential, but I've been thinking that you might see Karen because I know Helen (HV) has been seeing her". I acknowledged to Lucy that it was reasonable for her to think that I might be seeing her friend Karen, as they were now sharing the same Health Visitor. I asked Lucy how long she might have been having this in her mind, and whether the scenario she had visualised might have provoked jealous feelings. She told me it had been on her mind for a "couple of weeks". I said to Lucy that she had generated a provocative picture in her mind. I added that an image of me also being Karen's therapist would have been a difficult idea to have in her mind. She confirmed that it was, then told me that she had been wondering what Karen might have been saying about her, and that I might have a "bad impression" of her (Lucy) because I had found Karen not to be like the person she had described in sessions. Lucy said slowly "it's not quite jealousy, but it is weird – a weird feeling". She then added "it might sound stupid but I think of you as my therapist and you don't see anyone else, although I know you do". I spoke with Lucy about her being occupied by a feeling that had taken her by surprise and that it was hard to think that my time was also being shared with her friend. She said with a tinge of puzzlement, "I've never experienced this before". She then chuckled as she said "I'm not always good at sharing."

Lucy then broadened her curiosity and feelings about other patients that I might see when stating that sometimes when she left her sessions she felt "envious" of other patients in the waiting area, thinking that one of them might be about to start a session with me. She told me "I wonder what they might be coming for, what problems they have". I spoke with Lucy about whether she might have felt threatened by the other patients waiting for their sessions to begin, that somehow they might have bigger problems which could lead to her losing her sessions with me. She replied "I was thinking someone must need the sessions more than I do, and I wondered if they are more interesting than me". I asked

her whether the concerns she was telling me about had anything familiar about them. She initially said that she did not think so, but then added that she remembered feeling “pushed out” when her half-sister was born.

Lucy’s curiosity about other mothers and babies in the department’s waiting area prompted me into thinking about whether in a complex way Jack’s arrival had reawakened vulnerabilities around her needs, in the midst of having weighty responsibilities for her baby’s well-being. I mentioned my thoughts to Lucy and she responded by telling me “Having Jack I sometimes feel alone and not able to cope, but it’s not easy to tell anyone this is how I can feel”.

Summer Break

I was very aware that the timing of the summer ball coincided with a summer therapy break, which I had prepared Lucy for. Essentially at this stage in the therapy, central themes of rivalry and competition continued to emanate from Lucy's sessions. This was exemplified in how repeatedly antagonised she remained over Karen not giving her details about the dress she had chosen for the ball. Lucy was convinced that Karen would upstage her with a more expensive dress and that it would make her feel inadequate.

Sessions following the summer break

In November Jack (aged 9 months) had started pulling himself up to standing position and taking tentative steps, albeit unsteadily to begin with, and I spoke with Lucy about Jack becoming a little more independent and able to explore a little more. Lucy responded to this new development in a mixed way, at one level pleased that Jack was developing and that it was a milestone and at the same time aggravated that he was doing more to make her annoyed, for example touching more things that she did not want him to touch. It became very noticeable that Lucy would quickly stop Jack from touching things in the room like the desk telephone lead, and talk to him as though he had done something wrong or naughty. I would speak about Jack following his curiosity and it being normal for a more mobile baby to explore his surroundings and touch things. Lucy did not really seem to welcome the development and restated her point about Jack reaching out for things that he should not be touching.

During the month of November Lucy and Robbie attended with Jack (*Session 18*). He presented as a mild, quiet person who was thoughtful towards his wife and concerned for her well-being. He engaged well with Jack during the session in playful and caring ways, and Jack responded enthusiastically to his father's interaction and attention. Robbie confirmed that a likely posting to Afghanistan was worrying but also part of his role as a serving soldier. Overall the couple conveyed to me that all the problems associated with Lucy's referral to the perinatal service were about her. However, Robbie did comment during the session on feeling somewhat helpless when Lucy felt "unhappy", saying "I want to help but I'm not sure what to do for the best". I mentioned that sometimes fathers needed help also. I made it clear to them that the service actively welcomed the involvement of partners during the treatment period and that they could work out together the best time for Robbie to join Lucy again.

In Late November Lucy turned 21 years of age and she, Robbie and Jack had gone to Robbie's parents' home in the Northwest for her birthday weekend. After they returned to London, Lucy told me in the next session that Robbie had bought her a beautiful gift – "a diamond necklace". She spoke about the necklace with a sense of pleasure and yet at the same time there was an undercurrent of disappointment being generated by Lucy's physical demeanour and tone of voice.

Jack was taking unsteady steps while holding onto table edges, as he moved around the room. Lucy reacted quickly in clutching him and controlling what he could and could not touch. When he took an interest in the dolls' house and its contents he knocked a piece of dolls' house furniture to the floor and Lucy told him sternly that he should not do that to other people's things. Although I would protect toys and other items in the therapy room there was a quality of strictness in Lucy's manner that I was aware of. The strictness sparked a tension between mother and baby that grew during the session. Lucy said more about her 21st birthday and gradually revealed what the undercurrent of disappointment was about. She told me that Robbie had taken her out for a celebratory meal on the day of her birthday but that she had had to suggest the idea to him. Apparently, after returning to London, when Karen enquired about

her birthday weekend, Lucy made certain that she did not reveal to her that Robbie had not arranged to take her out for a meal unprompted.

There was a double disappointment aired when Lucy told me that there would not be any photographs to remember the occasion by because they had left their camera behind in the car. She said sharply to me “before you ask, it was parked too far away to go and get it and it was pouring with rain”. When I suggested that there still was a feeling of being let down leftover from the weekend, Lucy denied it by telling me “it’s nobody’s fault”. Immediately she then sounded saddened as she said regretfully “I had imagined lots of photographs to look back on”. Jack touched the telephone cord and Lucy called out in an admonishing way “Jack”. I noticed this to be another new development alongside Jack’s developing mobility, that his mum called out his name, often sternly, putting him on alert when she considered him to be about to do something naughty. He tested the situation by giving cheeky grins in response and sometimes Lucy melted and picked Jack up and hugged him and then switched when she rather firmly took him back on to her lap and told him “I’m not having it”.

This was a session full of conflicting reactions and as it neared its end another issue of conflict emerged. Lucy told me that the tower block in which they lived was going to be refurbished which meant that all the families would be moving out when the building works took place. Indeed from the way she spoke it sounded as though the move could be permanent. Lucy said that they had not been given a date but it was likely that it would happen sometime during the following 12 months and it would mean they would be moved to Berkshire. She spoke about the planned tower block refurbishment in mixed ways, that the housing was cramped and run down and that moving to Berkshire would mean more space and a garden for Jack to play in. She also spoke about it meaning that she would be losing the perinatal sessions as she did not imagine that it would be possible for me to see a patient no longer living in the catchment area for the perinatal service. Uncertainty was again problematic in this situation because there was no fixed date for the refurbishment but seemingly destined for the near future.

As Christmas approached

Lucy and Jack were due to attend as usual but I was told by the Perinatal administrator that Lucy had telephoned from the hospital's gynaecology unit to say that she wouldn't be able to attend. Lucy asked if I would be able to see her on the ward during the regular session time. I went to see her on the ward not knowing what the problem was. When I saw Lucy it was noticeable that she looked ashen in complexion and weary. She began to tell me the reason behind her admission. She told me that two days beforehand she had to be rushed to the hospital being in considerable lower abdominal pain which resulted in her undergoing emergency surgery for an ectopic pregnancy. Lucy recalled the physical pain that she had felt before making an appointment with her General Practitioner (GP) and then how quickly everything had moved from the discovery of the ectopic pregnancy to the removal of a fallopian tube. Lucy spoke about wanting another baby and was told by the obstetrician that she would still be able to get pregnant. Lucy offset the upsetting feelings she was experiencing by telling me that she and Robbie were lucky enough to have Jack when some couples go through infertility problems. She also acknowledged that it was a potentially life-threatening condition.

Before I left the ward and returned to the perinatal department, Lucy was keen for me to look out of the windows on the ward (3 floors up). She pointed out to me that I would be able to see where she lived from the window. Lucy made a comment about it being identifiable as the one that had "been condemned". However, when I showed interest in it and how visible it was from the window, I noticed that her tone became somewhat melancholic. Lucy seemed to engage with my visual and verbal recognition of the tower block as her home. I sensed that there was then an element of longing in Lucy as she looked out and said "in a funny way I do miss it". I spoke with Lucy about her experiencing a kind of homesickness when looking out of the window across to the tower block, and mentioned it being in the light of a sudden and unplanned hospitalization. I then spoke with her about the impact of the ectopic pregnancy and it also perhaps reactivating mournful feelings from her previous miscarriage experience. She told me that it had similarities. We both acknowledged that she was finding it difficult to be in hospital away from Robbie and Jack, and that

the suddenness of her surgery and hospitalisation was having a negative impact upon her mood.

New Year

Following the Christmas holiday period, Lucy returned to the therapy sessions with Jack (nearing 12 months). Lucy increasingly complained about a range of things that had upset her during the periods in-between her sessions. In this particular session (24) it appeared that Lucy had arrived in a prickly mood. As the session got underway I remarked upon how Jack had walked along the corridor independently. I added that he “looked lively and alert”.

Session 24

“oh good, I’m glad you think so because she [health visitor] is telling me that I can’t give him anything sweet – no juices, no chocolate, nothing... I don’t like her much, Helen has left and I’m gutted”. She quickly added “I can’t do that to him”. I spoke of the new health visitor’s advice making her feel that she would be denying Jack some of his favourite things. Lucy nodded then waved her arms (to signal everything being cut out) and said “she wants me to cut out all his favourite things”.

Four issues then dominated the session from this point which related to how Lucy was emotionally reacting: 1) the health visitor’s advice, 2) Robbie wanting to be sexually intimate following the ectopic pregnancy, 3) Jack’s growing independence and 4) Karen “turning her back” on Lucy. This was all in the context of this being the first session back following the Christmas break. When I mentioned that I had not seen them for a few weeks (they had left two weeks before Christmas for a trip back to Northwest), Lucy immediately said “yes, and I’ve noticed it over the last couple of weeks”. When I asked what she had noticed she answered despondently “it’s me and Robbie – we’ve been arguing and I’ve been saying some horrible things”. I noticed that Lucy became increasingly tense looking, as Jack dropped a couple of pieces of dolls house furniture to the floor. She said in a snappy tone “he’ll just keep on doing that and then sternly said “Jack”. He looked around at his mummy and then looked back at the dolls’ house with curiosity, but this time did not pull anything out.

Lucy continued to speak about arguing with Robbie, seeming agitated by intense feelings.

Lucy told Jack that he was “a naughty boy” for dropping things to the floor and then spoke of her argument with Robbie. She said that she had become fed-up with him for leaving his “dirty, muddy kit” spread over the lounge floor of their tower block apartment. Lucy revealed that during “two bad rows” she had said “horrible things” to him. She told me “I really do love him but I just want to hurt him when I’m feeling like that”. I said “feeling like what?” and she replied “mad with him”. I asked Lucy how Robbie reacted to her reaction and she told me that “he ended up crying”.

Meanwhile Jack had made his way unsteadily to the buggy and seemed to be searching for something that made the buggy begin to upend. Lucy called out sternly “Jack, don’t you dare”. Then she spoke in a softer, more comforting tone as she encouraged him to sit on the play-mat, as she got out a rice cake and a bottle of juice from the buggy. When I mentioned that perhaps it was food and drink that Jack had been searching for, Lucy smiled and said “yeah, I know, he knows where everything is”. Lucy spoke more about having made Robbie cry on another recent occasion. She described how she had turned away from Robbie in bed when he tried to put his arms around her and get intimate with her. She spoke about “tensing up” and that since the ectopic pregnancy she had lost her “sex drive”. She suggested that Robbie would not just want to be close, rather that he wanted sex and that currently she wanted a “cuddle” and no more than that. Apparently Robbie had said to her “do you know how horrible it is when your wife turns away from you?” We spoke for a few moments about Lucy knowing what it is like to feel rejected within other close relationships and I tried to explore with her the area of feelings involved when a loved one turns their back on you. I also acknowledged with Lucy that in the aftermath of having had an ectopic pregnancy a woman’s sex drive may diminish. Lucy described how she realised that she had made Robbie cry when she heard him sniffing. She commented “nobody snuffles in bed unless they’ve got a cold..... I thought he was crying but I didn’t want to think he was”. Lucy recognised that she did not like the fact that she had made her husband cry and

she also recognised that she did not like him crying because she associated his crying with that of a “softy”.

We spoke for a time during the session about her dislike of such vulnerability and I suggested that it was something that she tried to distance herself from. I suggested that at times her irritability and anger defended against any vulnerable feelings that would surface within her. Lucy responded by saying that she did not like “mummy’s boys” and that Jack would not grow up to be a mummy’s boy because she wouldn’t allow it to happen. I asked Lucy for her perspective on how a son develops into a mummy’s boy and she told me “when their mums don’t want to let them go”.

The theme of back turning continued through the session as Lucy spoke about a recent development involving her friend Karen. Lucy felt that Karen had recently ignored her, claiming that Karen had kept her back turned when Lucy was passing her, walking through “the park” pushing Jack in his buggy. Lucy said with an aggrieved tone “she blanked me, I was on the way home with Jack and I could see Karen with her new best friend, Zoe, and as we passed she had her back turned pretending to look at Zoe’s baby boy in the pushchair”. Lucy was highly charged in the way she spoke about what it was like for her to feel rejected. She counter-balanced her wounded experience of rejection by denying that she needed friends and family who did not show an interest in her and her family, all she needed was Robbie and Jack.

Towards the end of the session Lucy expressed how she felt annoyed and challenged by Jack when he had temper outbursts which, sometimes happened in public places which Lucy experienced as humiliating and embarrassing. She spoke forcefully about the way it sometimes left her feeling like she was not coping.

Jack 14 months

Although Lucy found Jack’s temper outbursts difficult to manage, I observed that she was also often able to keep relatively calm even when he would be at his most upset. Lucy spoke of being “offended” by Robbie’s mother when she had made a negative comment in response to Jack becoming angry when

visiting her home. The following vignette from the session in early Spring illustrates the sense of humiliation that Lucy was prone to experiencing when Jack had a tantrum.

Session 36

I went towards the waiting area but before I reached it Jack noticed me and started walking towards me. I said hello to Jack and then to Lucy, started pushing the buggy behind him. I walked along towards the therapy room just ahead of Jack. When I reached the room I held the door open waiting for them to enter. Jack peeked inside and grinned but waited at the threshold whilst his mummy waited behind Jack and encouraged him to go in. He turned his head and glanced further along the corridor as if he was curious to see what was beyond this room, and I commented on his curiosity. Lucy said impatiently "come on Jack". He then took a couple of steps away from the room. She then spoke as though she was on a short-fuse, saying "right, come on, I'm not having this" and put her hands around Jack from behind to lift him inside. Jack started kicking his legs and cried. Lucy somewhat plonked him down on the play-mat and went back out into the corridor to bring the buggy inside. I closed the door and went to my seat. Jack had got to his feet and was sobbing and looking towards his mum as she sat down. Momentarily Jack looked towards me as if he was contemplating coming to me for comfort. I said that it looked as though mummy was in a hurry to get into the room and Jack wanted to explore elsewhere. Lucy appeared to be tense and annoyed.

Jack went to his mum and placed his hands on her knees and she then gathered him up and sat him on her lap. He started to calm quickly. Lucy looked at me and told me "I'm not having him throwing a paddy". I listened while she spoke and told her that I thought she appeared to be on a short-fuse. Lucy was telling me that she "hated Jack getting into a paddy" and that she found it "embarrassing". I asked her what she felt was embarrassing about it. She answered briskly "I don't know – it just is". I gave Lucy a quizzical look. She then reacted by telling me "people will think I'm a young mum who can't cope". I spoke about her feeling 'shown-up' in front of people, including me, and not liking the feeling. Lucy said "I don't like it" and slightly shuffled in her seat, as though she was feeling uncomfortable. Meanwhile Jack, who sat

quietly seeming to be feeling calmer, looked towards me and looked to be listening to the conversation.

With an air of defiance Lucy commented, “anyway, I’m not having him going into paddies like that - laying down, throwing his legs around - no way!” I told Lucy that I was wondering what she found so difficult about Jack showing some interest in what was further along the corridor. I said that I had not noticed him throwing himself about on the floor at the doorway. She answered “well he’s been doing it a lot lately, and when he kicked off at Robbie’s mum’s she said, “I wonder where he gets that from” and turned and looked at me”. Lucy looked as though she was about to lose her temper – her face looked full of fury. She then said “stupid cow”. I commented on how angry she seemed, and that perhaps she felt like throwing a paddy in here. I then noticed Jack clambering off his mother’s lap and he went straight to the door. He was trying to turn the door handle just behind where his mum was sitting, but she seemed to be unaware. Lucy told me that she had not felt “angry” before coming in to the therapy room. I said that it looked as though something had aggravated her and I queried with her whether she might become aggravated after sessions are cancelled like last week’s. L told me “I do notice that I have more to say if I miss a week”. I nodded in acknowledgement.

During the session I attempted to understand from Lucy’s perspective how she experienced her mother-in-law’s comment “I wonder where he gets that from?” Lucy was again uncomplimentary about Robbie’s mother and said “obviously she was having a dig at me”. I spoke with Lucy about such a comment clearly being provocative but mentioned to her that she herself had often expressed concerns in the sessions that she may have passed on angry tendencies onto Jack. This was indeed hard for her to experience when I spoke about it but at the same time she said that she could identify with the way Jack was expressing anger and frustration. Noticeably his temper was riled on occasions when frustrated. I posed a question to Lucy in relation to what Robbie’s mum had asked, by asking when she (Lucy) felt infuriated where she thought it stemmed from. She was quick to respond by telling me that she was convinced that she had inherited “anger issues” from her mother, but was keen to deny that these were particularly relevant now as her own outbursts were

diminishing. I tried to gather from Lucy more about her mother's history but she did not appear to be forthcoming about this, which might have meant Lucy did not know much about it or that she did not want to talk about it.

Jack 16 months

Session 41

Lucy explained that she had had a row with her mother which centred on whether or not Lucy was prepared to post her mother an invitation to Jack's christening. Lucy's mother lived in the northwest of England with Lucy's younger sister Anna. Lucy told me that she and Robbie were cash strapped and that they were on a strict budget with the christening event making more demands of their finances. Lucy said that she did not feel it was necessary to buy a "first-class stamp" in order to send an invitation. Lucy felt that a verbal invitation was sufficient under the circumstances.

According to Lucy her mother had also asked for Anna to be godmother to Jack but Lucy had chosen her half-sister and a close friend for the role. Lucy told me that her mother had recently responded, sending a text message saying - 'no Anna as godmother, no invitation, no christening'. Lucy looked and spoke despondently as she told me that just a few days earlier her mother had been discussing with her what style of hat she should wear, but when she asked where her invitation was "it all kicked off". I said in an enquiring way "kicked off?" Lucy immediately spoke of how her mother became "jealous", suspecting that Robbie's mother had received her invitation by post. I drew attention to the mournful way she had relayed this episode to me but Lucy reacted by saying "I'm pleased she's not coming, I can relax – at least she won't be able to have a dig at Robbie's mum. I can't help feeling angry when she's being such a cow". Lucy snappily said that her mum had "blown it". I queried whether her mum would feel hurt by not being invited in the way she was hoping. I said that it might be unsurprising that her mum was feeling a sense of disappointment, as it seemed as though she was anticipating the event only days beforehand, discussing what style of hat to wear. Lucy did seem to mull thoughts over in her mind as she looked reflective. Then she referred to the recent telephone conversation by saying "I told her that she didn't suit a hat

Lucy expressed her conviction that her mother had spoiled things between them long ago. She spoke of not being sure that she loved her mother. She talked about her mother and Anna not taking an interest in the first year of Jack's life. Lucy said that they simply did not make enough effort to be interested. She added that her half-sister was the same age as Anna but she took an interest in Jack and made more regular contact through text messages. With an air of sadness, Lucy said, "I think my mother's side of the family's DNA is all wrong".

Lucy became exasperated with Jack who was grizzling, seeming to be over-tired and looking for some comfort. He was having a rummage around in the buggy which Lucy objected to and he began to cry. He looked to his mother and she said with frustration that she did not know what he wanted. When I said that I wondered whether he wanted his mummy, Lucy gathered him into her arms and he let out one or two snuffles and sighs as the crying subsided. She reached out to collect a carton of blackcurrant juice from the cover of the buggy. Lucy handed Jack the carton and he sat back against his mother, sucking from the straw looking content. I spoke with Lucy about moments when Jack wanted something from her that she sometimes acted as though his wants were unbearable. In a disheartened way, she said "I don't know what he wants". I put forward the idea that Jack sought moments like he was experiencing now, being on his mummy's lap sucking his drink, feeling contented. I explored with Lucy how to balance Jack's neediness and demands with the struggle experienced by many parents to manage the intense infantile feelings that can be stirred by the needs expressed by an infant.

I was not questioning that ultimately Lucy cared for Jack's needs because I consistently experienced her doing so, but at certain points she felt like abdicating the responsibility of looking after those needs. This all seemed to jettison Lucy into telling me that at the moment she was feeling "crapped on". She explained that everything was getting her down but especially as she had been on 'Face-book' a couple of days ago and discovered that Karen and other friends had arranged a trip to a holiday camp with their babies without including Lucy and Jack. She said "why does it always happen to me – I feel absolutely crapped on all the time". She spoke about not being able to talk with Robbie about how she was feeling excluded, as "he looks at me blank and thinks I'm

making something out of nothing”. I commented on the experience she had of feeling let down appearing again, and a sense of being left out by Karen and the other friends compounding a long-held feeling.

Lucy told me “I was dead pleased that we had a session today”. After a brief silence Lucy told me “no one listens to me apart from you”. Immediately after Lucy spoke, Jack kissed her on the cheek. I commented on their contact and Jack seemingly alert to his mummy’s emotions. Lucy squeezed him lovingly and rested her chin on Jack’s head. He looked up towards her face lovingly. Following further playful and loving exchanges between mother and baby, Lucy looked reflective and talked about having the therapy room every day if it were possible, adding “I’d be in it every day”. I spoke about the therapy room having some special qualities that Lucy appreciated. Lucy made further comments about the impact of the psychotherapy, telling me that she found it “weird” feeling able to talk to me (a man) about very personal issues for example that her periods were erratic following the ectopic pregnancy, and conversely found it more difficult to speak to her GP (also a man) about such issues. Then Lucy told me “what I really want is a friend, that’s all I ever want – not having a mum to turn to and everything...I want to go back home, they’re more genuine – I hate London”. The session ended with dialogue about Lucy feeling homesick.

The therapy at 12 months

Lucy had told me that she thought that it must be hard for me to focus on what she was telling me when Jack and I had moments of interaction. He was becoming increasingly interactive and would often stand in front of me, placing his hands on my knees, and have a cheeky grin on his face, as though he was doing something novel. Lucy conveyed conflicting feelings, uncertain whether she was happy or annoyed when Jack and I became interactive. She smiled when she witnessed Jack and I interacting but also felt that she could not be taken seriously if/when I gave my attention to Jack.

Session 46

Lucy told me that she had had an argument with Robbie over an issue of flirting. They had recently attended an annual cavalry event and during the day Robbie had apparently got talking to a “young blonde American tourist” and had ended

up taking the tourist's mobile telephone number. Lucy said that they had consumed some alcohol through the day and she put Robbie's flirting down to this. I was described a scene in which Robbie was chatting with the young American female tourist and Lucy was being "agony aunt" to one of Robbie's soldier friends who was having "girlfriend problems". She described again Robbie as having flirted and then suggested to me that perhaps she had been doing the same thing. It ended up in a "massive row" which she worried could lead to a "breakup". With a worried expression Lucy said "I've got something embarrassing to tell you". She looked to be struggling to speak but slowly she said quietly (hoping for Jack not to hear) "I cut myself". Lucy noticed me glance at her arms for any evidence and she tapped her leg, saying "I did it on my leg so no one would know". She said it was the first time in two years and associated it directly to the argument with Robbie. Lucy described how the following evening – with Jack asleep in his bed – that she began scratching her leg with her finger nails and made the wound bleed. She spoke of liking the feeling so much that she then got a knife from the kitchen to deepen the cut. Then "Robbie came in and took it away from me".

The theme of aggression continued during this session as Lucy spoke about sometimes feeling that Jack was like a "teenager" when he did not "get his own way", that he could be aggressive towards her and other children. She spoke about Jack having "bad behaviour". I acknowledged all the things that she was concerned about but for a moment wanted to acknowledge the fact that Robbie was due to have attended the appointment with Lucy and Jack but had not arrived with them. I said that it would have been helpful to get Robbie's perspective as husband and father on all that was going on. Lucy apologised for Robbie, saying that he had intended to come but Army commitments prevented it. During the session Lucy was inclined to stress to me that any aggression in Jack derived directly from her and not from Robbie. She told me that Robbie was "gentle" in nature and that she did not see him "as part of the equation". When I commented on the fact that he was an active soldier, Lucy was quick to tell me that his job did not reflect anything about aggression. Lucy told me that if Robbie ever got angry at home he would avoid direct conflict by leaving the room to make himself a cup of tea.

Lucy told me that on the way to the session she had been worrying about whether to tell me about her self-harming or not. She looked sorrowful and demoralised. She talked about feeling down after thinking that she had been “getting better”. The sense of failure expressed by Lucy felt profound as though everything was falling apart and that she was feeling efforts towards improvement had been wasted. That was the feeling I was being left with, especially when Lucy told me that she had been to see her GP about Jack’s behaviour. Lucy said that she had asked her GP to contact me to hear my view about Jack. I thought speaking with Lucy’s GP was good timing in light of Lucy’s recent self-harming incident and she was agreeable to me mentioning this to her GP. It was clear to me that Jack could react angrily to things not going his way but at the same time he was often frustrated when his mum thwarted his growing curiosity and mobility. Lucy was aware of my perspective. However, what was also noticeable was the continuing improvement in the way Lucy managed her emotions when Jack did become angry; she was dealing with it in a much calmer way.

When I asked Lucy about her GP’s response to her concerns over Jack’s behaviour it suddenly became clear that there was another pressing issue having emotional implications for Lucy. It was when she told me that her GP was going to look into the possibility of finding psychological support for them in the Berkshire area, that I realised something new had developed about moving from the London tower block. Lucy looked a little embarrassed when I suggested that leaving London seemed to have reappeared unexpectedly today. Lucy began to speak about all the positives of leaving the tower block and the advantages of moving to Berkshire. As she spoke Jack caught my attention and Lucy said in an irritated way “D are you listening to me?” I mentioned that perhaps it was hard to share the therapy space with Jack at times. She reacted “I just need you to listen”.

Jack had sat himself in a small chair in front of the doll’s house and was pushing two cars along the table top. He picked up a car in each hand, clashed their undersides against each other. Immediately Jack turned and looked towards his mother. She said to him “have they crashed?” Jack turned and then threw one to the floor. He looked towards Lucy again and she told him in a

firm voice “that’s naughty, Jack, they’re not your cars”. She spoke with Jack in a firm but non aggressive way, telling him that she wanted him to “respect things”. He put his arms out for a hug and she responded by hugging Jack.

After a few minutes had passed I speculated about her recent self-harming and whether a contributory factor was the news she had received from the army about leaving the tower block as soon as the following month. Lucy said that she had really felt it was all to do with the argument with Robbie over flirting, but appeared somewhat deflated and sad when she acknowledged the imminence of the move away. I told Lucy that I thought she looked sad. She then hung her head and looked down towards her lap. As Lucy gathered Jack up on to her lap she said “I was afraid you’d say something like that”. For the remainder of the session I tried to think more with Lucy about her recent self-harming. Lucy preferred to keep the discussion of it to a minimum as she did not want to talk about hurting herself in front of Jack.

One aspect she did refer to before the session ended was self-cruelty. She told me that she wanted to be “cruel” towards herself and when she made herself bleed it made things seem better. Lucy was very keen for me to know that this was a “one-off”.

The following day with Lucy’s permission I spoke with her GP about her self-harming, her depressed feelings and Jack’s behaviour, all in the context of a planned move away in the near future. Over the following weeks Lucy was certain that she did not want to be put on a course of anti-depressants by her GP or our team psychiatrist, and that the self-harming had been an isolated incident. Lucy did seem emotionally connected to the loss involved in leaving the tower block and that it meant also the end of the perinatal sessions. Lucy had spoken of her self-harming behaviour as an “old habit” and was determined not to reintroduce it as a way of dealing with her emotional state.

Ending of the therapy

No more news emerged about moving from the tower block until the autumn, but when the news did come it brought a sudden end to the psychotherapy. Lucy arrived for an appointment in September and announced that they had

received notification saying that a house in Berkshire was ready for them to move into. Immediately she spoke in a regretful way, saying that she was going to miss the barracks, and that there were “lots of memories” she had. This included their apartment having “all of Jack’s first things there” and her “knowing lots of people there”. She added “I don’t know, I’ll just miss it”.

Lucy still had concerns over Jack’s (20 months) behaviour, however, Lucy was noticeably agitated when she told me that she did not like the idea of “starting from scratch with someone else” (referring to seeing another therapist in Berkshire). I commented on Jack not being with her for the first time since she was referred. She explained that Robbie’s mother was visiting and she had offered to look after Jack.

Lucy’s fears about Jack becoming a “bully” were very active. She had again been to see her GP and had also spoken with the disliked health visitor. The health visitor apparently told her that Jack was a normal 20 month old, but Lucy complained to me “She wouldn’t listen”. She continued “I ended up telling the receptionist and she could see I was upset and gave me a hug – that’s what I wanted, a cuddle”. I spoke of her looking for someone to “soothe” her upset, and then spoke of the imminent move feeling “bittersweet news” and perhaps triggering a feeling of panic in her about getting further help. I then raised the idea that Lucy may feel I had not listened well enough to her fears about Jack or given her answers that she was looking for. Lucy defended against this by saying “I’ve been coming to see you for over a year, I don’t need help now; you sorted me out”. I asked Lucy what ‘sorted out’ meant for her. She replied “I’m a better person now and I’m able to appreciate my life more.”

I queried whether she was feeling that Jack was not sorted out. Lucy then spoke about her GP telling her that “behaviour can be genetic”. We spoke for a while about the relevance of what the GP said. I drew her attention to the worries she had had all along that she had inherited problems from her mother and that she (Lucy) worried she would pass these on to Jack. Lucy reacted “then it’s my fault”. It was a very difficult session and not easy for Lucy to focus on anything other than what her GP had said about behaviour. By the end of the session it seemed that she had taken on board again the fact that I had

always felt she had been courageous in coming to see a therapist following a negative experience as an adolescent and that she had shown great responsibility in trying to sort out her way of relating to Jack as a new mother.

Only two more sessions were able to be fitted in before the family left for Berkshire. Disappointingly both sessions were cut short as Jack appeared to find it unbearable to stay in the room. His cries could be heard throughout the department and on both occasions the sessions needed to stop prematurely as the level of Jack's distress was intense. Noticeably Lucy had hardly spoken about her relationship with her father throughout the therapeutic work, seeming as though he was off-limits, despite me raising it on occasions.

The final session (55) rather fell into a mood of unrest when Lucy stepped in to pick up a toy giraffe that Jack had dropped to the floor. He had been placing toy animals on the table and then dropping them to the floor in a playful way, not destructively. He became distraught once Lucy stepped in to hand him back the toy. From that point he did not want to stay in the room and made repeated attempts to get out. Unfortunately and sadly the session lasted only half its normal time as Lucy decided to take Jack home because of his distress. Whatever was behind Jack's reaction, it was a disappointing way to end. He appeared to experience his mother's offer of help as intrusive at that moment. The psychotherapy with Lucy and Jack ended there.

4.3 Case Study: Kate

Referral

30 year old Kate was referred suffering from episodes of Postnatal Depression and Anxiety. The referrer reported that Kate had not bonded with her baby - she felt anxious and panicky; she felt very low. Kate had a long, protracted labour following a premature rupture of the membranes; she was administered intravenous antibiotics. Kate suffered a 3rd degree tear which required treatment in theatre. There was a prolonged period of time before Kate could hold her baby daughter.

It was reported that Kate experienced upsetting flash-backs to the delivery, thinking her daughter was going to die. Delivery was complicated with forceps

extraction. The referrer noted that Kate could not 'get past the delivery'. The referrer reported that Kate felt tearful and low during her 2nd Trimester. She was conscious of her change in body shape and her change of life-style. There was apparently no previous history of mental health problems.

Kate was breastfeeding but was feeling numb and struggling to bond with her baby daughter. Kate felt ashamed and guilty because of her negative feelings; she said she could not bear to see other people happy with their babies. It was noted that there were days when Kate had stayed in bed all day and cried.

Kate's GP was keen for Kate to receive psychological support in order to talk through issues and her thoughts surrounding her traumatic delivery.

Kate's husband was said to be supportive. This was her first pregnancy.

Initial assessment appointment (early April, 5 weeks post-birth)

Kate and her husband Oliver arrived with their baby Ella for this initial appointment. Kate had scored 23 on the EPDS which is substantially high, indicating serious mental health problems. Once in the therapy room she immediately gave me the impression that she was in a shocked state. She looked lost and extremely worried. After some initial introductions she quickly told me that she was feeling "desperate and helpless". Her husband Oliver was clearly concerned for the well-being of his wife and encouraged her to let me know how she had been feeling. Kate described the trauma of the delivery and said she felt perplexed by her lack of emotional connection with Ella, and the depth of despair she had fallen into. She said that she felt disconnected from herself, as prior to becoming a mother she had felt capable, and in-control in her working role with a large media organisation. She spoke about finding it hard to get out of bed and attend to her baby's needs.

Both Kate and Oliver spoke further about Ella's delivery and the deterioration in mood that Kate had experienced subsequently. During this appointment Kate breastfed Ella but she appeared lost in her own thoughts and withdrawn from any emotional contact with her baby. Ella found it difficult to stay latched on the breast and became fractious. Kate spoke about feeding her baby daughter as a "bit mechanical". She did not feel that she could do anything worthwhile for Ella.

Kate told me with an air of despair that she did not know where to start to help herself. I suggested to her that she had made a start by being so open and honest about the way she was feeling, and by seeking professional help. Like many of the mothers referred to the perinatal service Kate was worried that she would be considered a bad mother and that a service such as ours would call for Ella to be permanently removed from her. I asked Kate whether she had ever experienced anything that felt similar to the way she had felt since Ella's birth. She looked a little surprised by my question, but after a few moments looking deep in thought she said "actually I can remember something similar", and went on to tell me that she experienced feeling helpless and scared as a little girl, particularly when her parent's marriage broke-up when she was aged seven.

Kate then seemed a little more inclined to speak about Ella's delivery and the fact that it had resulted in her experiencing a third degree tear. She spoke with distress when recalling her fears when Ella was taken to be resuscitated. Towards the end of the appointment Oliver urged his wife to tell me how dreadful she can feel. In response Kate said "Sometimes I feel I don't want to wake up" - this was immediately followed by her telling me that she knew she had to keep going for Ella. I made it clear to the couple that for Kate and Ella's well-being it was important for me to keep in close contact with her General Practitioner (GP) and Health Visitor. I said to the couple that a network of care needed to be linked and active. Kate nodded and said that it was helpful to think that people cared. A follow up perinatal appointment was made for a week later.

2nd assessment appointment

Oliver had returned to work on the day of the appointment. Kate and Ella attended together. Kate spoke of "reaching a turning point" after the previous session, feeling that she and Ella were "more settled". She felt that coming to see a therapist had helped her to realise how bad things had got.

Kate acknowledged that it was difficult with Oliver returning to work but that it had not left her feeling overwhelmed. As the session continued Ella became a little fractious and Kate told me that Ella needed feeding. Kate became anxious and tense as Ella regularly failed to stay latched on to the breast. Initially this

appeared unsatisfactory for mother and baby. Then Kate suddenly spoke rather irritably to me, telling me that she was not coming to Perinatal to “rake over past experiences”, saying that she wanted to focus on the present and not on the past. A few minutes later Kate spoke about feeling angry and resentful towards Ella when she cried. She told me that she had witnessed a lot of domestic violence as a child, with her father being violent towards her mother prior to the marital break-up. She spoke emotionally about feeling angry towards her father. I drew attention to the fact that Kate had linked these angry feelings together, those as a new mother towards Ella and those towards the violence she witnessed as a child. She emphasised that she would not actually hurt Ella but that something triggered inside her when Ella became needy of her. Kate felt puzzled as to why she had mentioned this at this point but we agreed that the anger she felt towards Ella resonated with issues from her childhood.

We agreed a treatment plan and arranged for Kate and Ella to come on a weekly basis for the following two months and that we would review their situation from there. As they were leaving the therapy room Kate asked me whether I thought she would “get better?”, and I replied yes I did, and that I was an optimistic psychotherapist.

Before the next appointment, I contacted again both Kate’s GP and Health Visitor to clarify that we were all united in our thoughts about the best way to care for this mother and her baby. I made the point to both professionals that I was worried about Kate’s capacity to bond with her baby and about her low mood.

Commencement of the treatment

I noticed Kate sitting in the waiting area 10 minutes ahead of the appointment time without Ella and with an angry expression. Her expression gave me the impression that there was something she was feeling angry about and that she was preparing to offload it on to me. Once we got into the therapy room I commented on it just being Kate today without Ella. Kate told me that she had left Ella at home today with her mother-in-law as she wanted to focus on speaking to me today. Kate said in a very straightforward way that she was feeling “affronted” by things that I had said in the previous session but mostly by

telling her GP and Health Visitor that I was concerned about her and Ella bonding. Apparently her Health Visitor had made contact with Kate soon after my telephone liaison call. Kate told me that I had made it seem as though she was a “bad mother”. She spent a large part of the session telling me that the opposite was true and that she and Ella had fully bonded, and that she was not even sure that they needed help from me or any service.

I sat in my seat feeling somewhat uncomfortable as Kate vented her dissatisfactions firmly at me, but at the same time I was thinking to myself that a spirit had got mobilised within her and I viewed it as a positive development.

I was able to highlight to Kate that she had arrived today in a very different state of mind, considerably less flat emotionally than I had witnessed previously. She then seemed to become calmer in mood and spoke about it feeling good that I had been able to see in her someone who was going to defend herself and her relationship with her baby. Kate and I spoke together about her now seeming less helpless. She became more reflective and then confirmed that she would continue with the treatment plan and that she would bring Ella to the following session.

Session 5

Kate arrived in the therapy room with Ella. Kate said “thanks for seeing me, I’m really glad we could come today”. Ella had been laid down on the play-mat while her mum removed her jacket, and put down bags, etc. Kate looked a little apprehensive, I felt, and I commented upon this look of apprehension. She said “I do feel a bit nervous, but I’m pleased we’re seeing you today”. She added shortly afterwards “But I don’t think I’ve got anything to say, I feel wrecked”. I said that I wondered why she might be feeling nervous and whether this had anything to do with her feeling wrecked. Kate explained that Ella had been unsettled through the night and she had got up to her several times. She then told me that she felt she should no longer be seen and that there must be someone “more deserving” who should be seen in her place. I said that I felt a little puzzled, that her comments had a contradictory quality, that she had said she was pleased to be seeing me today but then telling me that I should be seeing someone else. I added that maybe there was something she feared which contributed to a thought that she should give-up her therapy place to

someone else. Kate said with an abrupt tone "I'm not saying I'm giving-up, it's just that there are "other mums out there who are more deserving".

I then added an observation about the fact she cancelled last week's appointment and that maybe this was another factor. Kate said in response "I did think I might have blown it. She continued "actually when I arrive I feel that maybe I shouldn't be here, that I'm taking someone else's place". I asked whether she had any more thoughts about that "someone else" and she replied "someone more desperate".

Kate told me that she had told her GP that she did not feel "worthy" of being seen for perinatal sessions, but that her GP had "assured" her that she was "deserving". She continued, "The GP told me that I'm feeling depressed, but I told her that I'm fine most of the time". At this point, Kate decided to place Ella on the play-mat again. For a few minutes Ella looked comfortable and frequently looked towards her mum as she spoke. Then the sound of raised voices from a nearby therapy room appeared to disturb Kate and she picked her baby up again, placed her back on her lap and hugged her. I commented on the raised voices perhaps disturbing Kate. She looked somewhat blankly at me and said "I hate shouting". I commented on shouting being something she might have heard a lot when her parents were fighting. She replied "especially when I'd gone to bed".

I spoke about Ella seeming content to just sit on her mum's lap, sometimes listening and taking note of my voice. Kate looked lovingly at Ella as she said "she's so laid back". Kate looked reflective and said quietly "I just think something is damaging my confidence". I waited for a few moments before saying that I was wondering what the something might be. She looked lost for thoughts and words, as if she was bewildered. After a brief silence she said that at the weekend she and Oliver had met up with friends. She told me, "I looked at him on Saturday and he was talking to our friends being sociable and I just wanted to run back home". I mentioned to Kate that I was interested in the fact that she had spoken about something damaging and just how physically and emotionally damaged she had felt after Ella's birth. She nodded and told me more about the repercussions of the physical damage and then said in a

mournful way "I think I do feel damaged". She added "I get reminded of the damage every day" and spoke about experiencing incontinence. She then said that she had not felt inclined to wear anything "pretty" on Saturday as she was worried about "leaks", and added that she had to worry about her breasts leaking milk. I spoke of her feeling despair at not feeling in control of her body. Kate said "It's hideous".

As the session time came towards an end Kate said "I hope I can feel like I used to". I mentioned that she appeared to be grappling with many issues related to unexpected failings, and damage.

Weaning plans

During the following weeks Kate sometimes re-visited her traumatic experience of giving birth and when she did she still spoke with a degree of shock. It seemed that it was a fluctuating process for mother and baby to fully attune. Kate sometimes looked at and spoke to Ella in a rather flat way. This seemed to hamper the opportunity for Ella to respond in a lively or spontaneous way.

The treatment moved on beyond the 2 month review point and Kate told me she would like to continue as she felt that anxious feelings had replaced angry ones, and she did not understand why she was feeling vulnerable in the way that she remembered feeling as a child. She said she thought her anxiety was hindering her decision making around Ella, and that frequently she felt uneasy with what she did for Ella, for example, was it good enough? Prior to becoming a mother, Kate recognised herself as an organised and socially competent person but felt less so now.

Oliver Kate's husband attended a further two appointments and I observed that Ella, approaching four months, seemed to be more interactive in sessions when both parents were present.

A summer therapy break loomed and Kate raised the idea of stopping the perinatal sessions altogether, and taking anti-depressants instead as she was also preparing in her mind to wean Ella before she returned to work before Christmas. I suggested to Kate that she discuss this with her GP and/or our team Psychiatrist about taking medication, especially in the knowledge that at the current time she was breastfeeding. I mentioned to Kate that I was

interested in her timing planning to stop both the perinatal sessions and breastfeeding. Kate said that she thought that by vacating her sessions it would enable another woman to receive help, a woman who would be in greater need than she. I explored with Kate a feeling that I had that she was unconsciously testing me to say yes, absolutely you go now and let someone else replace you who is more deserving of my time. This I believe would have led, paradoxically, to Kate feeling that I had rejected her for someone else more deserving of a place. I gave Kate my perspective on this. I said that she seemed inclined to “abandon” the therapy, and this might feel safer than becoming attached to it. Kate smiled and said “you’re bound to get sick of me”. I responded by suggesting that a break in sessions for summer holidays might have been playing a part in her feeling this.

Not overtly linked, Kate told me that she felt frustrated and disappointed because her father did not remember details about her as a child, including not being sure about her birth weight. She also complained about him typically making lists of people to telephone and things to do, but he rarely spared time to call her and find out about how she, Oliver and Ella were doing. He knew that Kate had been unwell and attending perinatal sessions. Kate told me that she felt her father always made time for the daughters who were born subsequent to her, through another marriage. She also referred to not always experiencing her mother as being helpful and supportive because she regularly would seek attention for herself. We spoke about her being sensitive to feeling let down by significant others which had perhaps become more intense since becoming Ella’s mother.

After the summer break

Kate did return and told me with an air of certainty “I feel more comfortable as Ella’s mother now”. She spoke about needing to “aim” for an ending and after further discussion we agreed on planning for an ending date in November. We also arranged for sessions to change from weekly to fortnightly. Kate told me that she was pleased with this plan as it made her feel that she was becoming “more normal” again.

Kate missed a session due to Ella being unwell. She returned looking troubled as she waited for the session to begin.

Session 20

The first few minutes of the session were mainly taken up with Kate quietly speaking about “feeling awful” about missing her last appointment. I said that I wondered if the feeling had been compounded by today’s late start (Kate had not referred to the reason why). She then told me that it had “taken a while” to get herself and Ella ready and “out of the house”. Kate pushed the buggy very gently back and forth but I could see that Ella did not look like falling asleep; she seemed too involved in taking note of me to fall asleep. Kate mentioned that Ella would get grumpy if she didn’t fall asleep. I spoke about it being a possibility that Kate herself was actually concerned about feeling grumpy about something. She looked surprised by my comment and said “no way, I just know it’ll be tough later if she doesn’t sleep”

As the minutes passed Kate decided to get Ella out of the buggy and give her a feed. Kate adjusted herself and began breastfeeding Ella and I noticed she was using a nursing veil as cover. I did not comment on the fact that she had not used a veil in previous sessions as I already sensed that her mood was somewhat brittle. There was a noticeably quiet and uneasy atmosphere building in the session. Whilst winding Ella on her lap, Kate became tearful and upset. I asked Kate if she knew what was making her upset. She spoke with pain in her voice and etched across her face, as she said “There’s something I thought I had consigned to history”. Ella was placed back under the veil and I said to Kate that it had felt as though there had been an unidentified problem hanging around in the sessions and that perhaps she was about to bring it to light. She told me that she had not wanted to consider what she was about to tell me as relevant to the way she had been feeling about Ella and her delivery, but that recently she had linked it to the way she has felt. Kate described it as “a very personal issue”. She recalled being sexually abused at the age of 9 by a teenage boy who was a neighbour. She remembered going to his house with her younger brother and that when she got into bed with the teenage boy she knew something was wrong about it but was not sure what to think. She remembered the sexual abuse happened more than once, and had never shared it before with anyone else, apart from Oliver. Kate then described feeling psychologically cut off from a lot of what happened to her in relation to having experienced sexual abuse and the traumatic delivery of her baby.

Kate said "I can't believe how I'm reliving so much today". I asked whether there might be other things she was reliving. Kate replied "yes, I'm also reliving when I came here to give birth to Ella". She then spoke about how she had requested something to take away the pain, but was denied this for some time by the midwife. She described wanting the midwife to "hit the panic button" when feeling that Ella was in distress. She added that she had not envisaged how much it would affect her walking in through the "same doors and along the same corridor".

I asked Kate whether she thought there was something in particular today that had triggered her re-visiting traumatic experiences. She said that she was not sure but had not slept much thinking about "all of it". As the session came to an end Kate said "'I was too emotionally numb before to talk about it".

Ella 8 months old

The treatment continued into late autumn and Kate and Ella began to look more and more attuned. Ella had developed into an appropriately curious and interactive young child. Typically Ella would be placed on the play mat by Kate to play with the toys and intermittently Ella would look towards her mother as though checking that everything was all right. They both seemed to have developed a good balance between a need for proximity and close attachment and a need for Ella to be able to explore and play. Kate talked about feeling valued, personified for instance by the way Ella consistently would look towards her for soothing and comfort.

Session 24

The session began with Kate telling me that she was in the midst of organising a "baby shower party" for a friend. She spoke as though she was quite pleased with herself about this and made a comment about being pleased to do it for a friend, but it was not something that had happened for her. In an ironic tone of voice Kate said "can you imagine I'm now able host a party". When I then asked if she was hosting it at home she looked and sounded horrified. She told me "if it was at my home I'd be feeling a whole lot worse". She then spoke about the "lift not working and we're several floors up". I spoke of it sounding like a struggle to feel stranded in that way. She told me "anyway, I haven't wanted anybody in my flat since my friend Lizzie was so critical about our lounge

furniture resembling garden furniture". We then spoke for a few minutes about Kate being offended by Lizzie's comments but not feeling able to let Lizzie know that she was hurt by it. I said to Kate that I remembered her being able to let me know she felt offended by things I had said about her. Kate told me "that's different, you were being critical about me as a mother". When I queried the idea that I had been critical, Kate reacted by saying "yes you were, but that's in the past".

She moved the buggy so that Ella could fully see what was going on in the room. I spoke of Ella now really being a part of the session. Immediately Ella looked to be a little shy, especially when I vocally engaged with her. She pulled a material flap from the buggy partly over her face and she began peek-a-boo which she seemed to enjoy thoroughly. Kate looked on and appeared to be pleased that I was taking such an interest in Ella. I commented on Ella "wanting to play" and Kate seemed to glow with pride in response. She said with an air of pride "I think we're so blessed". I asked her about the relationship between Ella and her daddy. Kate told me "she lights up when he comes in and you can see that she wants him to pick her up.....she gets disappointed if he doesn't pick her up straight away". Kate looked slightly down at this point and I told her that I was noticing a sudden air of disappointment in her when she talked of Oliver not picking her up immediately. I asked Kate whether something "painful manifested" for her when she experienced Ella not being attended to by her daddy in those moments. She shrugged her shoulders and said "but he loves her to bits". The peek-a-boo continued for a few more moments. Then Ella appeared to become more restless and a little grizzly. Kate quickly lifted her out of the buggy.

Ella snuggled into her mum, clutching her around the neck and nestled her face into her mum's neck. Meanwhile Kate spoke about a "volatile argument" between her and her dad. I asked her what the "issue" had been between them. She replied "he's a critical man but doesn't have any solution". I instantly had a strong feeling about Kate's comment - it surged through me that the critical man comment also related to me. I asked her "what is he critical about?" She replied "just about everything at the moment". I said "of course you've got a man therapist and I wonder if sometimes you experience me as

critical and without solutions?” Kate smiled and chuckled and said “trust me I don’t have a problem with you, only in the early days”.

Kate looked very happy to have Ella clutching her closely and to have me notice it. A few minutes later Ella seemed to doze against her mum. She spoke in an aggrieved tone about her dad, saying “do you know he hardly ever calls”? She then pointed to her chest which Ella was sleeping against and said at the same time “he needs to take more of an interest in us”. I said “I noticed that you seemed aggrieved about him”. Soon after she told me “I think I’ve been feeling jealous, having to compete for his attention”. She continued “I would never have admitted that to anyone else, before coming to therapy”. I said that it seemed she wanted me to understand just how difficult it is to feel she is not her father’s “priority”. I then asked Kate whether she might unexpectedly feel that I was not making her enough of a priority as the end of the therapy was looming. She responded with a slight smile and said “I just think other women are more deserving of your time”.

A few minutes later Kate said “a light bulb has gone on in my head”. She added “therapy helps, I’m more aware of my feelings, I feel more secure but recognise I’m an insecure person”. She told me “I look forward to the sessions but I also feel I can do this by myself now”.

End of the therapy

As the therapy neared an end, she consulted with her GP and the perinatal team psychiatrist and between them a decision was made about medication and she was prescribed Sertraline to help her mood. Kate asked whether I would consider arranging a short tour of the labour ward and postnatal area of the hospital for her, Oliver and Ella. Kate thought that it might help her to make more sense of what had happened around Ella’s delivery, feeling that the experience was blurred and unclear in parts. I did arrange this and then Kate asked whether I would also join them. We did this prior to the final session. The treatment ended with Kate knowing that she could get back in touch should she experience any significant problems.

About 12 months later Kate was referred again by her GP as she was pregnant with her second baby. I saw her again up to the birth of her baby before she and the family moved away from the London area. During the second perinatal

treatment Kate was more emotionally secure than before and consequently I met with her less frequently than previously. Kate's need of me and the perinatal sessions as a safe haven was not as crucial as it was following the birth of Ella.

5. Commentaries

The following commentaries are grounded out of the material that emanated from each of the cases, my experience of the clinical work at the time, and an analysis of the material after the clinical work was completed. The analysis of the material and my own reflections on the treatment process with each patient has yielded particular themes that I felt were pertinent to each of the cases. The themes have been in effect collected under three main sub headings: 1. Anxieties from the patient's own early life. 2. Role of the transference in the treatment. 3. Mother and baby in the therapy room. The fundamental aim of these commentaries is to provide a reflective analysis of the patient's subjective world within the context of the psychoanalytic process as it unfolded. The case material led to the development of psychoanalytic interpretations as described in the commentaries that follow.

5.1 Emma: Anxieties from the patient's own early life

Unpredictability

Not exclusively, but to a large extent Emma identified her emotional problems as stemming from the time that her parents' marriage broke-up and her father left the family home. She described her father as someone who was also prone to self-deprecation, seeing himself as a failure. Emma spoke about her feeling that he would not have left had she been worth staying for.

Emma spoke about having had an ambivalent relationship with her mother, never really experiencing her mother as warm and affectionate towards her, and therefore unable to provide Emma with emotional containment for her fears and anxieties in childhood and growing-up. From Emma's account, something in their relationship was disturbed very early on, with Emma's birth being traumatic, an emergency Caesarian-Section, and her mother seemingly finding it difficult to be openly warm and loving towards her daughter thereafter. Emma recalled her mother telling her in the past that she was sure one of them was going to die during the birth. I was given the impression from Emma that as she was growing-up, on the surface her relationship with her mother was adequate, but actually Emma was painfully aware of an unsatisfactory parent-child relationship between them.

I remember that Emma regularly showed interest in and curiosity about the fact that I was wondering whether there may have been an association between her own birth, her mother's emotional reaction and the type of anxieties that Emma went on to develop from childhood into adulthood. For example the deep fears she had developed around travelling on tube trains and whether she would get out of them alive. This was exemplified during *session 13* when a number of agonizing thoughts and feelings were expressed by Emma, and they continued to be prominent as the therapy work neared the summer break. They included persistent issues around trust, fear of abandonment, fear of rejection, and unpredictability. In relation to unpredictability and the impact it could have upon Emma's mind, she frequently expressed worries about what might happen, and a very prominent theme developed when she spoke about "what if". This was exemplified in the worries she had over tube travel when attending sessions. She sometimes arrived and then reflected on a range of 'what ifs' that had been in her mind when the tube train came to a halt in-between stations, such as, what if we can't get out. During the same session Emma made her own link between the unpredictable aspects of her birth that her mother had described to her and her experience of being bullied at school.

*"I don't know, it was just something about mum thinking one of us was going to die and then with the bullying, how at school people were so unpredictable".....
"I think it's something to do with mum saying she felt she had been treated like a piece of meat {giving birth to Emma}.....and when I was at school I can remember never knowing how the other kids were going to be towards me".*

The question in my mind throughout the therapy and reflected upon during clinical and doctoral supervision was whether a traumatic birth experience involving unpredictability could have activated a traumatic depression in Emma's mother thus making it difficult to feel emotional warmth towards her baby (Emma). I regularly wondered whether the birth process that Emma's mother had described to her had distorted the way she and Emma were able to bond thereafter. In her paper, Tracey (2000) considers the impact of premature and traumatic birth experiences, when parent-baby connections are vulnerable to being disturbed, disrupted or fractured at this point.

Tracey considers the mother of the premature infant during the actual birth process and the period after birth, when her infant is cared for on a neonatal intensive care ward. Both Winnicott (1949) and Tustin (1983) have written that too sudden and too soon a birth can produce an extreme sense of paranoia in the infant. The author proposes that this paranoid "psychotic-like" state is also produced in the mother. A pattern of unexpected interference with basic "being" is imposed on infant and mother, and the autonomy of the mother–infant unit is ruptured. The birth of themselves as mothers to their newborn awakens a dead-mother/dead-infant dyad from their own infancy (Tracey, 2000).

Emma expressed much concern about being viewed as so stupid and flawed that inevitably I would confirm that she was indeed as flawed as she perceived herself to be, and her fears would be rubber-stamped. Over a range of sessions Emma reflected deeply on her sensitivity to feelings of rejection, a sensitivity that she began to reflect upon more and more during sessions. She spoke about having developed a persistent fear of rejection over *many years*. *I spoke to Emma about this persistent fear having had the potential to be an obstacle to forming close relationships past and present and she responded by telling me that she felt she constantly "looked for faults in relationships"*.

Emma frequently referred to unpredictability and inconsistency that accompanied her relationship with her father largely due to his alcoholism. Presumably this may have been a factor responsible for the parental divorce, and his alcoholism appeared to continue to penetrate the lives of Emma and her family after she became a mother. On a number of occasions Emma would report that her father had behaved in an unpredictable and chaotic way including when he telephoned late at night and was evidently drunk (*session 46*). Emma experienced these moments as temporary derailments in her relationship with her father and contributed to the sense of disappointment she felt about his behaviour.

I think Emma did feel defenceless at times against such moments of disappointment, for example, in her relationship with an unpredictable father. Consequently, she sought ways of counteracting such fragmenting experiences. I was left wondering whether Emma used flirtatious behaviour as a mechanism against the emotional wounds she had suffered. When she spoke about

incidents that had occurred during the weekends and between sessions that had left her feeling bad about herself, for instance, being chatted-up in a night club by an older man, it may have felt like an antidote to emotional wounds of the past and her feelings of inadequacy. It perhaps served to give her a temporary sense of potency and element of control within environments in which she could attract the attention of men. During session 27 she described her inclination to be flirtatious as her “*Achilles*”. This Achilles heel may have had a link to her pre-pubertal anxieties and the sexual arousal she had spoken about - being touched, humping, phantom periods at school. Her vulnerability to drinking too much in social settings tended to interconnect with her compulsively seeking to be validated and recognised as desirable.

In the face-to-face setting of the psychotherapy with attention to feeling states I felt that Emma found herself experiencing dependent and child-like feelings which were associated with unresolved maternal and paternal attachment issues, particularly related to feelings of abandonment and rejection. To enter into an affective connection with me in the therapy, meant she was drawn closer to the world of infantile feelings, revisiting the world of maternal and paternal attachments and what they represented. Oedipal issues around the dependability and trustworthiness of a parental type figure (therapist) are raised, as are such oedipal issues as how to connect and engage in a close relationship when one has a persistent fear of losing the other by being abandoned or rejected.

Emma’s tendency to feel that she was an inadequate mother often left me thinking it was linked to her child self feeling incompetent and powerless. Without wanting to pre-empt, and thereby potentially exacerbate Emma’s feeling of inadequacy I occasionally found it hard not to alert Emma to what Lily was seeking, for instance, the soft book in *session 21*. In that moment something was provoked in me around what Lily was craving and I brought it to Emma’s attention. Potentially I made Emma more vulnerable and exposed to a feeling of inadequacy as mother in her therapy setting, and it resulted in Emma telling me “*see, I’m a useless mum*”.

Role of the transference in the treatment

The patient's sexual anxieties

Emma worried that she had developed an unhealthy habit of flirting with other men after consuming alcohol and this subject began to regularly come to the fore during the psychotherapy sessions following weekends. Emma often fretted over how she had behaved over the weekend when socialising. She regularly expressed a worry that Steven would leave her as a result of her flirtatious behaviour. She wanted to make sense of her inclination to flirt, look sexy, and be the “centre of attention” when socialising. Emma spoke about her flirtatious behaviour towards other men when she had consumed alcohol, as being different to the way she would normally interact. She spoke about not typically seeking attention from men other than Steven, but that in a social situation which involved alcohol her attention-seeking behaviour was triggered. She told me that when in social situations with men present she liked to be viewed as sexually attractive. When she spoke about it usually being married men she would flirt with who were often part of Emma and Steven’s friendship circle, I highlighted the probability that the men were essentially unavailable. Emma typically felt disgusted with herself after flirtatious episodes with other men but began to show interest in the possibility that she looked for attention from men who were not available to her in a physical or sexual sense.

Perhaps there were times during the therapy when Emma may have felt that I was out of sync with what she was conveying to me about her weekend behaviour, seeking the interest of other men. At times she might have experienced the way I approached things in the sessions as not taking enough direct interest in the way she was acting out between sessions. I also thought that Emma was sometimes torn between whether to hold on to or let go of a connection to me, as she perceived me as someone who may facilitate a growth out of shameful behaviour and at the same time someone who may look upon her as though she was shameful and a disappointment. She worried that I might stop her therapy, finding her a waste of time, because she would arrive back to sessions reporting that she had messed up and was a terrible wife and mother. This was a challenging area in the work with Emma in a perinatal setting which centrally involved me as the therapist trying to cultivate a stable

therapeutic environment and a process in which Emma felt able to facilitate her baby's growth and development.

At this point in time I was going through my training as a child psychotherapist and still adjusting to the face-to-face perinatal work at the hospital with the adult being the index patient and not the child. Being fully attuned to all Emma was conveying about the realm of sexual flirtation was not always easy to adjust to in terms of technique. The growth of the transference was fundamental to the progress of this psychotherapy treatment and I felt that patient and therapist were emotionally sensitive to it. However, in the sessions I did not always feel able to work in the erotic transference within this mother-baby context. There were moments when I thought Emma wanted a physical as well as emotional proximity to me, as noted in session 13, when Emma sat on the rug which brought her close to where I sat and struggled to prevent her dress riding up. I sensed in moments such as this it reflected a particular vicissitude in the erotic transference that stemmed from an unfulfilled wish for closeness to a father who had effectively disappeared. It is reasonable to think of the therapy room as a setting in which this patient tested out what was permissible in the presence of a therapist seen as the paternal rescuer. Perhaps she experienced her husband as too safe and reliable and thus tended to test her powers of seductiveness through other relationships. These were challenging moments when trying to manage intense transference manifestations.

I did feel that the semiotic aspects of our dialogue provided me with a toolbox of clinical observations; not just what Emma said, but how she said things, how she sounded, looked, all of which were a connected chain of meaningful communications. Semiotics can be explained as a theory or study of signs and symbols, including those embedded in text and language (De Burgh-Woodman & Brace-Govan, 2008). In relation to the symbolic meanings within the psychotherapeutic process Salomonsson (2007) describes the semiotic value of the discourse and interaction between patient and therapist "If we view the analytic situation as a map of signs that we translate during our psychoanalytic work, we can proceed into defining containment as a semiotic process."

The nature of the communication between Emma, Lily, and myself was set within a therapeutic framework that I developed which I felt offered her and all

my perinatal patients a secure container in which to deposit and transmit subjective experiences past and present. Although I recognised the value of meaningful interpretation my focus was not always on making obvious interpretations, leaning more on creating a therapeutic environment which felt like a safe harbour for mother and baby to return to.

Winnicott (1971) noted that he somewhat used interpretations less and less:

[I]t is only in recent years that I have become able to wait and wait for the natural evolution of the transference arising out of the patient's growing trust in the psychoanalytic technique and setting, and to avoid breaking up this natural process by making interpretations (1971:253).

Making space for Emma being able to experience herself as facilitating Lily's overall development was something I was continually trying to work towards. There were occasions when Emma appeared to experience my absence painfully, sometimes physical absences that took place between appointments, over weekends, and during cancellations, and sometimes when holiday breaks arrived. In *session 22* following a summer therapy break, Emma and Lily were joined by Steven and no mention of the break in sessions was mentioned directly. Emma did arrive for that session in a complaining mood, particularly critical in relation to Steven making mistakes and not attending to tasks quickly enough, such as a problem with a mobile phone contract. The fact that Steven was present may have influenced me not taking up directly the fact that it was a first session back following a break, yet the emotional tone conveyed by Emma I think perfectly illustrated there was an underlying grievance. Having the couple and Lily together raised a question of technique, in that there was a lot which might typically be spoken or thought about with Emma that felt more off limits in the session with Steven present. What belonged in her relationship with me was perhaps compromised when trying to tailor to the needs of the couple. Lily did not really feature in this dilemma to any extent, since she was not old enough to understand what was being discussed, although she was able to respond to the emotional atmosphere.

Patients can feel abandoned by the therapist in-between sessions, cancellations and holidays and this can be conducive to disruptive acting out. It became clear during the therapy that Emma's acting out at weekends encouraged her to think that she was effectively inviting me to tell her that she

was unworthy of the sessions. Perhaps on an unconscious level she wanted me to walk away, thus repeating her father's behaviour. There was something Oedipal about Emma's relational way of being, flirting with married men but divided between a desire for secure love and the guilt provoking, clearly taboo nature of seeking a forbidden, unattainable object of desire. This relates to the unacceptable parts of herself she brought to me in *session 21* when she told me how bad she had been when potentially incriminating her father by suggesting to a friend that he had touched her inappropriately; a father whom she wanted to know how much she loved him and wanted him to love her in return. Indeed, a father who in many ways Emma had felt abandoned her.

Not surprisingly, throughout Emma's treatment, she expressed curiosity about my life, including wondering about my home, my family, where was I going on holiday. She was aware that I was married as my wedding ring made this evident. Interestingly wedding rings cropped-up as talking points more than once over the course of the therapy sessions. I wore two wedding rings, one on my left hand and one on my right. I remember this being discussed in clinical supervision in terms of what the patient might have fantasised, for instance, might I have been widowed. However, Emma did not directly ask me about this and I did not take it up despite Emma's references to wedding rings.

I think overall she held a conviction that my life was complete and happy, that I was surrounded by loving family and friends, something that was indicated during *session 19* when she told me that she pictured me holidaying in the South of France. I had a sense that she was expressing a feeling of being an onlooker, with secure connections being something she longed for but feared she was not worthy of. In the same session Emma in a somewhat teasing way, as though unconvinced, questioned whether the therapy relationship was a bonafide one. Her teasing and flirtatious aspects were also evident at the end of *session 21*, after she glanced in the mirror to check to what extent her mascara had run.

Emma was gathering all her bits and pieces up as she had noticed herself that the room clock was showing that the session time was running out. She got up with Lily in her arms. She stopped opposite the mirror on the wall and looked at her reflection. She said "do I look a mess – oh don't answer that".

Perhaps such moments and communications within the therapy, for instance, “do I look a mess – oh don’t answer that” acted as a channel through which sexual dynamics could be incorporated and withstood in a non-threatening manner within this mother-baby therapy environment. Through the sexual dynamics and way of communicating in this therapeutic relationship, Emma was able to convey important messages without feeling humiliated, for example, I’m going to miss you whilst you are away.

The angel and devil description of herself was imbued with symbolic connotations and I felt depicted conflicting aspects of Emma’s personality, and underlined aspects of her psychological and social worlds. Her maternal capabilities and her enactment of sexual impulses seemed to be split from one another, and yet mediated in the sense that her daughter helped make her feel more angel than devil.

Mother and baby in the therapy room

The psychotherapy process with Emma and Lily would at times evoke reactions in me that I might not have expected. These sometimes took me by surprise, and brought me into contact with feelings and thoughts that may have been dormant but came to life within this particular context and more widely in the clinical work within perinatal psychotherapy. On reflection, as I previously indicated I became prone to stepping-in when I noticed a mounting predicament or moment of helplessness in the room involving Lily. As a result there were occasions when Emma experienced me as impacting upon her already fragile sense of self-competence, for example in *session 46* when Lily had put a highlighter pen in her mouth and Emma experienced it as reinforcing her feeling that she was a neglectful mother. I think it is inevitable in this kind of psychotherapy work that the emotional world of the mother and baby interact with the intra-subjective world of the therapist. I suspect these were influenced by countertransference reactions stimulated by the fact that I was working with a patient who was highly sensitive to any hint of me reinforcing her worst fears.

Working in the realm of transference and countertransference is often complex and complicated when in the therapy room with a mother and baby who are at risk of emotional breakdown in their relationship. One particular facet of this

work which inevitably provokes reactions in the therapy room is the infantile projections of the mother when she is feeling especially vulnerable during the perinatal period. The following description from Swartz (2007) indicates the challenge for the therapist when strong feelings are evoked when working clinically in parent-infant psychotherapy and attachment is under threat.

Therapists remember the past, and hold hope for the future, but sit lightly to both memory and desire; they must be authentic in their exploration of their own subjectivity but self-effacing in their expression of it; they must own authority but refuse domination; and they must have the capacity to immerse themselves in the experience of their patients but also to recognise the ways in which their own subjectivity has constructed that experience” (Swartz, 2007:189).

Whatever the full extent of the emotional impact upon patient and therapist within psychotherapy, the interactional triangle between Emma, Lily and myself, left much to digest during and between sessions. This was as prevalent in the early months of the therapy as it was during the middle and the end of the therapy. Not least due to the lack of confidence Emma experienced in her caretaking functions when Lily was diagnosed with a gastro-reflux condition. Naturally there were high levels of distress when the baby cried and was irritable, due to her reflux condition especially at night. This left Emma feeling sleep deprived and exhausted. Understandably Emma was pre-occupied with Lily’s well-being and preservation, and also whether she was sufficiently a good-enough mother to nurse her during stressful reflux episodes. Feelings of guilt, irritation and helplessness were visibly at the fore, but also I sensed that there was an unspoken thought in Emma’s mind that Lily was rejecting her milk. Sometimes she was emotionally distraught by being unable to alleviate the cause of the reflux, and I felt worried that Lily had sucked-in something toxic from her and was impelled to expel these feelings. In terms of technique I felt that this was not an area to directly explore with a sleep deprived, vulnerable mother and I favoured trying to provide a steady, containing, empathic therapy structure within which Emma could deposit her fears and insecurities.

Fortunately, Emma did not have any major negative maternal reaction in relation to caring for an irritable baby during this time, despite it being hard to read her baby’s cues and communications when disturbed by acidic reflux. Coupled with the impact of sleep disturbance Lily’s reflux episodes challenged

the well-being of the parent couple, however, in *session 21* it becomes more evident that the reflux problems were decreasing and this represented a mark of parenting achievement. Emma commented “*it gives me hope, seeing her get better*”.

Lily increasingly began to become more responsive and attuned to her mummy’s emotional state. Although Emma was occupied with her own emotional struggles she became more able to see Lily and her as a couple who had survived the traumatic episodes of reflux, and who was separate from her past. Emma also became increasingly able to see that Lily was reaching significant milestones and that she and Steven were playing an important role in facilitating those developments. Emma managed to react to her baby with an increased awareness of her constantly shifting needs, demands, capabilities, and emotional condition. My view was that it was important for the development of the mother-baby relationship for me to signal to Emma that she was intrinsic in Lily’s development.

Emma conveyed the growing intensity of her relationship with Lily when she spoke in session 27 about her becoming “clingy” and seemed to take some pleasure in letting me know that others such as Steven or I could not modify the intensity of their mother-daughter bond. Although Lily was interacting with me in the session, she would return to her mummy after touching my shoe, and Emma appeared to be enjoy the experience of Lily returning to her for security. Paradoxically I think the term ‘clingy’ also suggested that Emma could feel that Lily was challenging any sense of separate individuality.

During the course of the psychotherapy treatment Emma became able to sooth Lily when she became upset, and mother and baby were able to engage in mutually fulfilling close contact, both needing each other for comfort at times. When opportunity allowed, I would comment on how much Lily enjoyed being close to her and how she became aware of her mummy’s face reflecting her mood. This was reflected in session 40 when Lily touched Emma’s face in an affectionate way. This was typically a difficult situation for Emma as she was persistently worried about Lily seeing her tearful and upset. This is a typical concern for all the mothers who are seen in the psychotherapy sessions with their babies. However, Lily like so many other babies within these sessions,

became over time highly sensitive to her mother's emotional states, and would be vigilant over what was happening to her mummy.

5.2 Lucy: Anxieties from the patient's own early life

By the time Lucy was referred to the perinatal service, she was in a state of despair. Her exterior presentation was one of extreme worry about whether I might decide that she was an unfit mother and alert social services to this. This was accompanied by an intense feeling that she was unable to cope with her baby (Jack) when he cried for prolonged periods and she was on her own with him. She was very clear that she did not want to hurt Jack but worried how overwhelmed she felt during these moments. Lucy let me know that she wanted help with anger issues which she felt stemmed from experiences in childhood and adolescence. She told me that she wanted to be the best mother that she possibly could be for Jack and hoped the therapy would help her achieve that.

She had been severely disappointed when seeking love and affection as a child from her parents and in particular from an alcoholic mother. An experience of emotional absence was further complicated by being the recipient of her mother's aggression. In a relational sense Lucy had an emotional need to feel loved and cared for by her mother but she had repeatedly experienced frustration in this respect with much disturbance in their relationship. By the time Lucy was referred for treatment to the perinatal service a long history of emotional disturbance challenged her ability to convey love and affection towards her baby. Lucy had internalised a model of parenting that was riddled with hostility, and which invaded her maternal state of mind. Lucy had felt let down in her relationship with her mother and she was fearful that she would damage her baby in similar ways. Lucy was earnest in her wish to parent in ways that she herself as a child had not experienced. In this way, she was desperate to prove to herself that she was not going to fail as a mother. However, she would often doubt that however much she tried to be a good mother it might never be enough to pacify her negative self-perceptions. She came to the perinatal service with a troubled past which was epitomised by her inclination to cut herself in her adolescence.

Intense feelings from the past transferred into new situations and there was an intensity of feeling often vented in the therapy sessions. Lucy revealed frequent mood swings and a high proportion of low phases. She worried about being judged as an incapable young mother by other people, in particular, when Jack would have a tantrum in a public place. She was prone to becoming both exasperated and humiliated when this took place, and rarely viewed it as an experience other mothers would understand.

Through this transitional passage into motherhood some of Lucy's emotional reactions to Jack bore the hallmarks of certain adolescent vulnerabilities. This was particularly the case when she experienced him as misbehaving, for example, a crying outburst. In relation to this I thought there was a vulnerability to feeling embarrassment, humiliation, self-consciousness, and negative self-perceptions. Lucy was acutely sensitive to feeling exposed by her baby, exemplified in *session 36* following Jack's growing curiosity of the spaces outside the therapy room in the perinatal department which prompted him to explore with his developing mobility. After she became angry and frustrated with him for not walking into the therapy room at the beginning of the session she angrily stated "I'm not having it". When I asked her about her reaction she told me that she did not want to be viewed as a young mother who could not cope. This was one of many examples of Lucy's vulnerability to feeling judged and contained elements of deflation when she felt an inability to measure up to an image of the mother ideal. Entrenched in this idealised mother image was her relationship to her own mother and all the related issues which came into play as Lucy stepped into this role. Unresolved conflicts threatened the mother ideal such as feeling she had not received good enough parenting and thus might never be good enough herself. In addition Lucy's own internal critics played on self doubts with deep roots. My experience of Lucy and many other patients alerted me in a clinical setting to the prohibitive functions of the superego. Freud's (1923) model of the superego with its potential to forcefully incite negative self-judgments about one's feelings and actions can be a dominant presence in shattering the mother ideal.

Frequently I experienced Lucy's responses towards Jack and indeed me as deeply reflective of unresolved grievance, which again I considered to be quite

adolescent. Clearly Lucy had experienced a crisis during her adolescence which manifested in the form of self-harm, and went on to take an overdose of painkillers. The feelings and thoughts at the root of self-harm are often complex, and difficult to define, not least for the clinician involved in the treatment of self-harming and suicidal inclinations. The therapeutic work with Lucy and Jack involved helping her to try and express in words what seemed to be so unbearable for so long and allowing the possibility of new development in the role of mother.

A psychoanalytic view of adolescence as a period of emotional turbulence and reorganisation is for me similar to the possibilities that arise within the perinatal period when women such as Lucy are trying to establish a maternal identity often in the midst of a reawakening of unresolved conflicts from childhood and adolescence. This is a time when many women are motivated to do their utmost in the best interests of their babies, hence a willingness to attend psychotherapy sessions, despite often fearing being judged a bad mother. Similarly in relation to the maternity period, adolescence is by nature a time of enormous biological, physical, social and psychological upheaval and significantly a time of psychosexual development. On reflection I wonder whether Lucy regarding herself as a “tomboy” in her adolescent years represented a temporary way of counteracting her sexual development as a young woman. I felt strongly that Lucy was a young woman who had developed a habit of symbolically acting out emotional pain in her cutting. An episode of cutting emerged during the therapy after she had a distressing exchange with Robbie, her husband. Lucy revealed that she felt emotionally aggrieved about having felt unprotected and badly treated as a child and adolescent. She spoke in aggrieved ways about her parents, in particular her experience of a hostile mother. As for her father, Lucy talked about him as emotionally out of touch with her, and there was an underlying air of resentment about him abandoning her to a hostile home environment. The way she spoke about her childhood environment indicated that she experienced it as a war zone at times, particularly when her mother had been drinking alcohol.

Role of the transference in the treatment

One of the observations I made about her husband Robbie was that on the surface at least, he appeared to be dependable, quiet and easier going than Lucy. It was difficult to explore the underlying emotional experience of this couple when essentially the importance of the mother-baby couple prevailed in this psychotherapeutic treatment. I thought that the underlying struggles for the couple that did arise in the therapy were around Lucy's angry reactions and Robbie's anticipated posting to Afghanistan and the obvious related dangers. In terms of their life as a couple in an army community, she appeared to appreciate some containing aspects of the barracks. However, in addition she experienced unsettling downsides, including having to move home and unreliable relationships with other army wives.

A dynamic I experienced whilst working with Lucy and Jack was the abrasive tone she often took towards anything she saw as a weakness, perfectly illustrated by the way she responded to anything she viewed as too soft about Robbie and/or Jack. She appeared to find it threatening when for instance her mother-in-law treated them like "mummies boys", as she put it. In the face of such threats, and threatening feelings of vulnerability, the first line of defence for Lucy was a tough offense. Hence people such as her mother-in-law were often out of favour with Lucy and she would frequently speak about her in deprecating terms. Perhaps Lucy's own history of aggression in the family home, being hit by her mother and feeling emotionally deprived made her hyper-vigilant to signs of weakness. With her anger management problems Lucy had an inclination to be unreflective and externalize her impulsive rage, however, I sensed that her don't mess with me exterior was a defensive response to experiencing emotional and physical abuse as a child. In addition this history made her prone to acting out, and highly sensitive to signs of disrespect and criticism,

I sensed that Lucy longed for a feeling of emotional closeness to someone who could be reciprocal and who could be genuinely interested in her, but it was hard for her to believe that anyone really might be. I thought that she found it difficult to really establish a personal engagement with a male therapist who might actually like her and see good things in her, even if secretly it was a

feeling she wished for. Lucy had seen male counsellor/s when she was younger and her recollection of these counsellor/s initially made me think that she might have a problem trusting me. It seemed that her previous experience had distorted her view of male therapists. I wondered to what extent Lucy experienced the intimate nature of the therapy as uncomfortably feminine on occasions, despite my being a male therapist.

I remember Lucy used to complain to me about having to catch a bus to the hospital, with the awkwardness of having to get Jack and his buggy on to the bus when often the buggy area was already occupied, and there was no room for her and Jack. She seemed convinced that I was the driver of an environmentally friendly car and thus I was exempt from paying the congestion charge. This seemed to get lodged against me when she arrived in an angry and frustrated mood and would then make a comment or two about things being alright for me but not her. There was often a sense that she felt deprived and that it was alright for others including me. Comments and questions concerning the kind of man I was emerged now and again, including was I the type of man who would offer my seat to a pregnant woman or mum with a baby on the bus. She complained to me about an older man on the bus “pretending to read his newspaper” and ignoring a pregnant woman who was standing. In terms of transference reaction by Lucy she questioned whether I was a man who would really look after her needs or was I really more likely to leave her feeling helpless and abandoned.

Lucy became rivalrous and apprehensive when she realised that she and her friend Karen shared the same health visitor. This led to a fear that I too might see Karen. Other related issues became increasingly prevalent for Lucy. She showed concern regarding the difficulties other perinatal patients were experiencing with parenting their babies, and how many of them were being seen by me (*session 8*). She worried about being replaced by patients who might be more interesting than her. At the heart of these reactions was for Lucy the issue of abandonment which presented itself with intensity, prompting a variety of reactions to and concerns over a premature termination of the sessions.

I often thought Lucy was suspicious of the motives of others and in a chronic way had long felt that she was unlovable. She faced some emotional adjustment within the experience of a patient-therapist relationship and its form of connectedness. She made it known in *session 41* that the connection felt weird, such as feeling able to tell me about her erratic periods following her ectopic pregnancy. I felt that Lucy developed trust in me and the therapy process once she felt safe, and in retrospect I think at times I explored significant issues metaphorically with Lucy as part of our therapeutic dialogue. This I felt was a medium for exploring the sense of loss that she felt, particularly at the time she suffered the ectopic pregnancy and was preparing to leave her tower block home. This was reflected when I went to see her on the hospital ward and she was understandably in a mournful almost melancholic state.

In respect of Freud's (1917) theory on persistent feelings of grief, there can be an intense focus on the lost object, with mourning and melancholia having comparisons in their symptomatology. In mourning the loved-object that no longer exists, the world becomes poor and empty (Dozois, 2000). There were undertones of emptiness in the way Lucy spoke about her mother and the dysfunctional aspects that she felt existed in their relationship, even when outwardly she reacted angrily. Despite having the tendency to react abrasively to the tensions in their relationship, for instance Jack's christening plan, Lucy mourned a mother she felt she could not turn to.

During the treatment there were a number of aspects related to loss that were explored within our dialogue, including the tower block being condemned, the ectopic pregnancy, homesickness and her previous miscarriage. It is worth noting the potential impact of miscarriage on the emotional well-being of women. It is not an uncommon complication in pregnancy and the emotional impact can be underestimated from my experience of working in the perinatal field. Research suggests that, even though a fetus may not legally qualify as a person, it is often attributed personhood and is invested in emotionally by parents (Tsartsara & Johnson, 2006).

Mother and baby in the therapy room

I was aware that our therapeutic connection sometimes reawakened old emotional wounds for Lucy. However, I felt that she had not had much experience of being listened to especially when she was distressed. This was a reasonably ordinary and yet transformative experience for Lucy. I wanted to co-create with Lucy and Jack an opportunity for change and for her to feel that it was not predetermined that she would become the bad mother she dreaded. This was very important to Lucy in the context that she wanted to improve her personal life story at a significant time of transition into motherhood.

Lucy was able to vent her discontent in sessions with an understanding that my intention was not to judge her. Many worries unfolded regarding her concern that she had passed on aggressive aspects of her own to Jack. It was very difficult for her to hold onto a view of herself as a capable young mother when she felt Jack had the habit of exposing her to awkward situations. Over the course of the therapy Lucy's reactions to Jack quickly switched between delivering reprimand and offering care and comfort. For instance, as documented in *session 24*:

Jack had made his way unsteadily to the buggy and seemed to be searching for something that made the buggy begin to upend. Lucy called out sternly "Jack, don't you dare". Then she spoke in a softer, more comforting tone as she encouraged him to sit on the play-mat.

Looking back on the sessions, I think that Lucy did experience the time when Jack became more mobile as a major development, but at the same bemoaned the explorations he made as a result. Sadly this pattern of mother-baby interaction became firmly entrenched as the therapy progressed. She began to feel more and more that she had to rein in Jack as his curiosity developed. I tried to help her with thoughts about the positiveness of curiosity and how this state of mind would help Jack develop in a positive way.

She worried that Jack had inherited aspects of her destructiveness and hated it when either professionals or family members such as her mother-in-law

implied that Jack had inherited negative traits from Lucy (*session 36*), “*I wonder where he gets that from*”. This all served to feed her already well established persecutory anxieties. Waska (2001) suggests patients who experience such tormenting anxiety, suffer profound feelings of aloneness, fearing the destructive potential of their impulses to damage their close relationships.

It appeared that Lucy had conflicted feelings about sharing the therapy space with Jack. Occasionally she would have some resentment about the fact that there was somebody else I gave my attention to. Lucy told me that she thought it must be hard for me to focus on what she was telling me when Jack and I had moments of interaction. He became socially interactive and would often stand in front of me, placing his hands on my knees, and have a cheeky grin on his face, as though he was doing something audacious. On occasions Lucy looked to be in conflict with herself, unsure whether she was happy or annoyed when Jack and I interacted. She sometimes expressed annoyance when Jack took my attention away from her as illustrated in *session 46* when she asked “D are you listening to me?”

I was aware that it was not always easy in sessions to foster a triangular relationship. The potential to share was frequently tested and I felt that sometimes when I engaged with Jack it was bittersweet for Lucy. She liked the fact that I took notice of him but did not like it compromising the attention I was able to give her. There was a sense that she wanted me exclusively. Not only were other perinatal patients and her friend Karen experienced as competition but sometimes Jack as well -

“It might sound stupid but I think of you as my therapist”.

There were moments when I conveyed that I thought Jack’s play and curiosity was normal, however, it was often difficult for Lucy to recognise it in this way, indeed she often experienced this as Jack being naughty and disobedient. She found it a challenge to allow Jack to use the therapy room as a space to explore and the toys as objects to play with, and was often inclined to intervene. Looking at it retrospectively, perhaps Lucy found Jack’s play and desire to explore unbearable as it reactivated familiar and dreaded tensions, hence Lucy

projected unwanted feelings on to Jack. In those moments she could be identified with her child and feared she would be reprimanded by her internal mother if she showed signs of adventurousness and curiosity.

At the end of the treatment Lucy gave me a thank you card. She had written inside that I had helped to make her a better person but I was left feeling that she thought I had been more limited in helping Jack. She left the therapy worried that he had bullying tendencies, which she was concerned were connected to her.

5.3 Kate: Anxieties from the patient's own early life

Unpredictability

I found it difficult trying to attune myself to the way Kate presented in the early phase of the therapy. Initially I experienced a realm of psychic trauma in Kate that somewhat created an obstacle to establishing an understanding between us. I was aware that my perceptions of Kate's post trauma presentation were only tentative and I thought could not be considered fully accurate until a therapeutic dynamic grew. Clearly she had suffered physically and mentally in delivering her baby and there were elements of the damage that had resulted. She experienced this damage as cruel and grotesque. The post traumatic stress that Kate suffered also left her feeling alienated from her expectations of motherhood and this was exacerbated by suffering from feelings of helplessness and exhaustion.

Fortunately Kate's husband was a helpful hands-on father in the early period post-birth when she was essentially not coping, finding it difficult to do essential things and feeling unmotivated to get out of bed. Oliver played a massively important role at this point when his calm presence helped to counterbalance Kate's traumatic reaction. Without this support it is possible that a lot more could have gone wrong.

Kate felt guilty for not feeling able to connect with Ella in the initial phase, post birth. She initially felt a distance between herself and Ella as a result of the

difficult birth process. I think probably Oliver understandably compensated by being very hands-on, which at times left Kate feeling that Ella would be better off just being cared for by him. She lacked confidence in her maternal ability largely because she thought that she had failed her baby so badly at the beginning of their relationship.

A life threatening situation such as, a severe perineal tear, can impact strongly on women's perceptions of their birth experience. This has the potential to impact profoundly on the way women adjust to motherhood (Beck, 2004b) and the mother–infant relationship (Ayers et al, 2006). Negative feelings about birth or a traumatic birth experience can be distressing for women (Waldenstrom et al, 2004) and can arise when women's birth experiences are short of their expectations; thus provoking feelings of disappointment, anger, loss of control and inadequacy. The crucial impact of birth trauma in parent-baby psychotherapy is addressed by Reid (2011):

Many women speak of feeling that they have failed when their delivery is traumatic. Recent research shows that trauma associated with childbirth can result in post-traumatic stress and high levels of anxiety. Those working with women during the postnatal period have as a result been encouraged to ask questions about the birth and the mother's state of mind. Furthermore it is important to be aware that traumatic delivery can result in the woman losing a sense of connection between her pregnancy and her live baby. This can affect her capacity to mother. (Reid, 2011:120)

In Kate's case it was difficult for her to see other people happy with their babies when she was feeling so wretched emotionally and physically. Without there being a holding and containing approach from the therapist and an attitude of trying to understand the impact of the damage Kate felt, we might not have had the opportunity to persevere with the process of therapeutic change in the relationship between mother and baby. I had to help Kate manage the risk of a re-traumatisation if the therapeutic process became too intensive and felt too intrusive. One of the main difficulties in the early stages of the psychotherapeutic process was that she was adamant that she was not going to attend sessions to reactivate old emotional wounds. She told me clearly in the second session that she was not interested in "raking over past experiences",

despite the fact that she had linked her childhood experience of witnessing domestic violence with the hostility she was feeling towards her baby.

In a pivotal way I believe that she had begun the process of identifying that trauma from other historical aspects of her development resonated with the present and the traumatic birth events. This began the gradual process of Kate becoming able to see Ella's birth and her feeling of numbness in a fresh light. Indeed the traumatic birth had its own independent reality but the trauma was also being complicated by previous trauma that it seemed Kate had wanted to bury.

Kate recalled her experience of giving birth to Ella and told me about its unpredictable aspects and the feeling of no longer being in control of what was happening to her body and what was going on around her in the delivery room. She told me that she was begging a midwife for pain relief and found that it was denied for a prolonged period. Kate described a situation in which she felt there was little she could depend on. During psychotherapy she would re-visit the birth trauma and on one occasion rather demonised the midwife whom she said denied her the pain relief, describing her as "the devil incarnate". She also talked about her experience in childhood of her father's alcoholism and violent outbursts towards her mother.

During the course of the treatment I learned that she had hidden as a child during episodes when her father was fuelled with alcohol and had become angry. Typically she hid under her duvet in bed and sometimes in other places. It appeared that aggressive and volatile feelings were often acted out in the family home. The violence and changeability that accompanied home life was rarely if ever acknowledged by her parents, according to Kate. In the sessions she spoke about her mother far less than she did her father, but essentially described her as someone she could not depend upon for support, and experienced her mother to be an attention seeker. Kate's anticipation of other people to being undependable and her environment as unstable, appeared to exacerbate her mental health difficulties.

Role of the transference in the treatment

In a resigned manner Kate spoke about her father not meeting her needs and expressed disappointment regularly about him prioritising the needs of his daughters (Kate's half-sisters) born through his subsequent marriage. There was a strong feeling in Kate that he did not keep her in mind in the way she expected, which she felt was epitomised by him not really knowing her weight at birth. In relation to his aggression within the family home, during the treatment, she did imply that she thought her father's behaviour was his way of dealing with her mother's "over-demanding nature".

Perhaps because I am a male therapist it did evoke paternal transferences that related to men who had left her and who would be fantasised to leave her at any minute. Oliver was a highly supportive husband who showed concern for Kate and demonstrated great patience, especially through the early days postpartum. Kate's anger was frequently directed toward her father more than toward her mother, and perhaps this was because her mother had been the parent who had not left her. Kate was also conscious of her anger toward Ella following the birth and the needs that her baby naturally expressed. Despite her anger being frozen by her experience of the birth when she first came into treatment, I thought that a state of perpetual doubt existed about whether this mother would find her way to falling in love with her baby. I believed this doubt existed in Oliver's mind too.

This patient resented the demands she felt had been placed upon her by motherhood and that she felt unable to meet them when she felt emotionally blank at times. She accused me of being critical of her as a mother and indeed made it abundantly clear that she felt "affronted" and decided not to bring Ella to the session when she wanted to confront me. As noted in the case study this appeared to mobilise something far more active in Kate. In retrospect I would suggest that the idea that I had been critical about her reactivated more of a narcissistic equilibrium within Kate and diminished the frozen quality she had presented with. I would further suggest that as one of my first perinatal patients to work with in my training I experienced Kate as frequently able to threaten my self-confidence as a therapist and my ability to relate to her without feeling

defensive. In terms of narcissistic injuries that can occur within the therapeutic relationship, Ivey (1995) comments:

This focus on the needs of the other makes it difficult to acknowledge the extent to which we unconsciously require patients to meet our own narcissistic needs by affirming us as wise, insightful, caring, and possessed of healing powers. Narcissism is thus not what distinguishes patient and therapist, and countertransference difficulties can be traced as readily to narcissistic injuries and defences as transference responses. (1995:17)

I suggest that as a psychotherapist in often intense emotional dialogue with patients such as Kate my sense of professional maturity and/or a susceptibility to narcissistic injury was frequently under threat. I propose that the narcissistic elements that operated within Kate characteristically functioned as a defensive mechanism, typically against a feeling of devaluation. On reflection my work with Kate has brought to mind Rosenfeld's (1987) description of "thin-skinned" narcissism. Rosenfeld refers to narcissistic patients who have experienced in childhood persistent and excessive inferiority, vulnerability and dismissal by everybody. An important feature of the "thin-skinned" narcissistic patient is that over time they tend to cover up their underlying fragility by tending to present a highly superior self image as a way of gaining a sense of triumph and revenge against the parents or siblings that caused feelings of belittlement and humiliation. Rosenfeld points to the precariousness of such a narcissistic personality structure. I think though it is also important to keep in mind the point Alvarez (1992) makes, that defences can be regarded as developmental processes, such as grandiosity and narcissism, functioning to keep alive the patient's sense of self.

There was an underlying bittersweet conflict to Kate's relationship with the psychotherapy sessions. She made comments about finding the sessions helpful and would sometimes counteract this by saying that she thought the treatment should stop as there must be another woman who needed my help more and therefore should take her place. To some extent Kate was saying to me that I could be getting on with more important things, and this appeared to be a replaying of her relationship with her father: a patient/daughter wanting a deeper, closer relationship but who could feel neglected and left to suffer by a therapist/father with other priorities.

I interpreted that Kate did not really know what to expect from an ending to her treatment, for instance, she was unsure whether the end might feel as though she was being let down again. Although she spoke with emotion at the times she suggested ending, it was difficult for Kate to fully put into words why she wanted to break free of the therapy prematurely. Perhaps it was considerably influenced by her wanting to come out of a connection with me which might have felt too close and intimate. Instead she favoured the feeling of her emotional position moving towards one of independence. On the surface she did not panic about her capacity to cope without her therapist being available to her. She did go on to re-activate her connection to me when she became pregnant for the second time and began seeing me again at the hospital.

Mother and baby in the therapy room: Reawakening past traumas

It seemed that at times Kate's experience of returning to the hospital where she gave birth to Ella reawakened historical trauma, including the birth itself and an older trauma of sexual abuse. I had not bargained for the psychological impact that being back in the hospital with her baby would have on Kate. At the time I was a trainee child psychotherapist and I think, I underestimated how traumatic experiences could be reawakened; especially when the patient was returning to the place where a major trauma had occurred. It appeared to lead Kate in to revealing conflicts which had preceded the birth trauma and yet were interconnected.

The advantage of working with the parent and infant together in the therapy room is that feelings and fantasies that are active in the dyad can come to the fore and indeed in the patient-therapist dyad too. It is also a clinical situation where the past and present come together and that which has structured the patient's disturbances and anxieties can re-emerge in this setting. I remember in the early phase of the therapy with Kate when she was feeling very low in mood, she mentioned in a session with Ella that she had screamed at her because she would not stop crying. Kate recalled how she had angrily told her baby to "shut up" and then rather pleaded to her when saying "have I not had enough to deal with?" To some extent perhaps this was an indication of the

disturbance and abuse she had suffered as a child and carried around for many years.

It was a gradual process for Kate to feel able to speak with me about the sexual abuse that she had suffered. Their relationship took time to cement and I remember feeling aware that something other than the traumatic birth had affected the mother-baby dyad. It was through remaining observant of and attuned to the reactions and nuances of the mother-baby interactions and patient-therapist interactions as well as the atmosphere in the sessions, that I felt there was another emotional disturbance in the picture. My response to feeling that something serious was not being spoken about was to allow Kate at times to withdraw into her shell. I remained present and attuned, thinking that there could be more to be discovered when/if she felt able to make more of a connection with me. It is important in the role of psychotherapeutic practice to be able to tolerate something unknown. Something that felt active yet cast an obscuring shadow over the mother-baby relationship.

Bit by bit our psychotherapeutic relationship appeared to establish a foundation of trust, enough for Kate to be able to voice and discuss the sexual abuse which she had never talked about with anyone other than her husband. This helped to integrate past and present trauma and allow Kate to adjust to the role of mother in her adult skin. She realised that there were things about the abuse that had affected her for years but which she had cut off from. When she was nine years old her teenage neighbour told her it would be fun to 'fool around'. Towards the end of the treatment she spoke about it happening repeatedly until she was about eleven. She told me that it had impacted on her life in ways she did not understand and probably had affected her relationships with men.

Working with patients such as Kate has alerted me to the often terrifying nature of flashbacks and re-emergence of trauma for women navigating the process of pregnancy, labour and childbirth. Medical examinations can resonate with the physical intrusions that women have suffered during sexual assaults as children, and can involve loss of control over one's own body. The experience of being helpless in the hands of another person recalls their powerlessness during abusive events (Weinstein & Thomas, 2004).

There was marked contrast between the way Kate related to Ella at the beginning and end of the therapeutic process, when she really began to engage with her maternal responsibilities. It was rewarding to witness Kate steadily regaining control over her physical and mental self and getting emotionally in touch with an inner essence of motherhood. Perhaps the “light bulb” moment she spoke about in session 24 related to her realising the progressive potential of re-creating her identity through the experience of motherhood. This was aided greatly during the most difficult postpartum period by Ella being responsive, reasonably easy to satisfy, having good self-regulation and a fairly relaxed temperament. In addition Oliver played a vital role, supporting mother and baby when they entered into the psychotherapeutic relationship. He was sensitive and non-intrusive in his manner, when he was feeling so worried himself about his wife’s state of mind and attachment to their baby. That state of mind had already been affected by feelings of aloneness and powerlessness during her childhood, the numbness she felt when hearing and witnessing her father’s rage and when sexually abused by her neighbour. Through the course of the therapy with Kate and Ella it became apparent that an interrelationship existed between all Kate’s experiences of trauma and contributed in a clear way to the anxiety and depression she struggled with in becoming mother.

Within each of the clinical examples is the technical approach of the therapist trying to remain open to the patient's struggle in a diligent way, when attempting as a trainee to understand complex transference issues, combined with symbolic communications. A willingness to be open to the pervasive insecurities and unconscious representations that presented within each case was extremely challenging whilst trying to maintain some centrality to the mother-baby relationship. The coupling of paternal and maternal function in the psychotherapeutic technique was an attempt to pull together pieces of the parental couple to provide a holding experience for the vulnerable new mothers and their babies.

6. The Three Cases

The following commentary on the three cases derives each patient narrative related to profound feelings of inadequacy. This is my reflection on particular similarities and differences between each patient, based upon my experience of them in the therapy room and their own unique accounts. In trying to establish meaning and understanding from the thematic frames that grew out of the psychotherapies with Emma, Lucy and Kate, I have formed the four following sub headings that significantly associated to those frames: 1. The Family Environment as a Pathway of Transmission. 2. Paternal Absence. 3. The Paternal Function. 4. Working with the Mother-Baby Configuration. The commentary includes psychoanalytic theory to highlight different facets of each patient's experience.

From my experience of working with these patients in the perinatal service, they came into the sessions fearing that once they revealed something that they perceived as bad about themselves, I might look at them disapprovingly in a judgemental way and want nothing more to do with them. This was a fear that was the crux of many of the problems that the patients brought to their psychotherapy sessions when they felt that they had exposed some intrinsic flaws about themselves. These were also in relation to fearing criticisms and doubts from family members, friends and the outside world over their maternal abilities with the arrival of their babies into their worlds. These patients, epitomised by Emma and Lucy, almost sought confirmation from me to tell them that they were as dreadful as they feared, and yet at the same time despaired at the thought of their psychotherapist confirming their worst fears. Very contradictory and confusing feelings were often operating within these patients. These feelings indicated the conflict that these patients struggled with, though Kate similarly to Emma and Lucy did not wish to be viewed as a bad mother, she was the one who reacted in the most spirited way and defended herself when she told me that she felt affronted by me casting any doubt over whether she would bond with baby Ella. Despite Kate feeling affronted she was also aware of a conflict of feelings between the mother she wanted to be and the mother she perceived herself as being. That is cut off, and essentially experiencing a division or battle within herself.

Within this context, women such as Kate, Emma and Lucy experienced dilemmas about openly expressing their difficulties adjusting to motherhood and their negative or ambivalent emotions. They feared being judged as bad mothers, having their babies taken away or being admitted to a Mother and Baby Unit. The women in this study also feared that their complex emotional states would harm their babies. Thus self-blame tended to surface in relation to their perceived faults and sense of failure, and weighed heavily with each of them feeling as though they were a burden to their husbands. To a large extent the self-recrimination these women spoke of during their sessions was characteristic of the way many women have presented with anxiety and depression in perinatal psychotherapy. All three women worried that their own experiences of being parented had played a role in the difficulties they had adjusting to motherhood and the interconnected feelings of inadequacy. All three women depicted issues from their relationships with their parents when they had felt let-down, and certainly in the case of Emma and Lucy they worried about the impact of their family legacies upon their own caregiving qualities and as individuals. They shared common threads of rather negative appraisals of their childhoods. An underlying theme was their inability to recall anything much that was positive about their childhoods.

6.1 The Family Environment as a Pathway of Transmission

Factors such as the parent–child interactions and family environment that all three women experienced in their past may explain, at least to some extent, the internalizing and externalizing problems they exhibited during their transition into motherhood. The interpersonal relationships within their family systems possibly played a mediating function in their psychological problems. Early experiences of relationships can have a bearing upon a later propensity towards mental health issues, and in each of these cases, the patient had struggled to internalise a containing parental figure, probably complicated by the parental issues in their external reality.

To achieve a well-attuned internal image of mother, father and the parental couple it is necessary for the child to have been able to introject a good identification (Frisch, 2010). For Britton (1989, p. 86): “The acknowledgement by the child of the parents' relationship with each other unites his psychic world,

limiting it to one world shared with his two parents". But the path towards this goal very often requires a good deal of psychoanalytic elaboration.

Under the impact of strong persecutory anxiety Lucy sometimes seemed to be urged to behave in a somewhat punitive way towards Jack and this alerted me to the shadow of the punitive nature of her own childhood experience. On many occasions she referred to her past experiences of her mother being critical and cruel. Lucy had memories of her mother punishing her physically for not doing things well enough, for example the washing-up. She claimed that her mother was usually fuelled by alcohol when she hit her. This would have hampered her ability to develop an internal image of a stable and emotionally containing mother.

Parental mental health problems may have also affected the amount of support parents were able to give to their daughters. For instance, Emma spoke in great depth during sessions about her father's mental health problems and his issues with alcoholism. Parents struggling with such issues are less likely to be emotionally available to their child and less likely to provide parental nurturance. Both she and Lucy spoke of the way their parents found it difficult to express love and warmth. An important factor that could explain the relationship between having experienced a difficult family environment and problems adjusting to motherhood could be family conflict, for instance Kate's experience of domestic violence in the family home. All three women experienced parental divorce. Taking their narratives into account I am hypothesising that for all three patients the experiences of conflict in childhood had negatively affected their maternal psychological functioning.

It was apparent that during their transitions from childhood into adolescence they had to negotiate stressful experiences that may have contributed to the development of emotional problems in young adulthood. In the case of Kate she was left having to manage long-term negative consequences of sexual abuse by a neighbour. Added to which having witnessed domestic violence between her parents, her own traumatic delivery with the birth of her first baby Ella evoked memories of trauma. It was not until several months of therapy that Kate disclosed to me that she had suffered sexual abuse as a child. I was not completely surprised by Kate's disclosure, as in my counter transference I felt there was something that could not be said within sessions. For instance, in

retrospect I probably retreated from some of the more harrowing aspects of her traumatic delivery, feeling a little inhibited by the fact I was a male therapist. It felt appropriate not to encroach too much. When reflecting on the transference-countertransference interplay the patients unresolved antecedents were likely to arise through the course of the psychotherapy and the ghosts of the past reacted to in the transference. This links with Fraiberg's (1975) account of 'ghosts in the nurse' and the relevance of how ghostly trauma can resonate through the transference relationship between patient and therapist.

In the case of Emma her narrative during sessions alerted me to potential consequences of transgenerational traumatic birth experience, however, during the progress of her therapy she said that she could identify with her mother's experience especially in relation to feeling a loss of control and helpless. All three patients reported being the recipients of traumatic experiences. They showed desire to repair emotionally, with the goal of protecting their babies from trauma, which was a powerful motivator for change.

6.2 Paternal Absence

Kate, Emma and Lucy all spoke about feeling their fathers were unable to provide them with the father-daughter relationship that they sought.

They all had varying degrees of contact with their fathers. Lack of contact, inconsistency and quality time spent together, strongly influenced and shaped the relationships the daughters had with their fathers. Emotional dialogue and a sense of paternal care were lacking from these relationships as particularly illustrated by Lucy when she described her father leaving the family home, stating "he just pissed off and left us to it". Although she had some understanding of why he had decided to leave the relationship with her mother she also felt resentful that he no longer spent time with her and her younger sister.

Emma revealed that her father had moved to the south coast after leaving the family home. It appeared that she had relatively more frequent contact with her father than Kate and Lucy, but she longed for more contact with a father who was sober and more able to provide consistent, solid support. She often did not experience the contacts they had as satisfactory, illustrated by the

feelings of sadness she felt when he telephoned to apologise for being a “failure”.

Kate expressed a desire to establish a closer bond with her father however; she felt her father was not sufficiently interested in her and her family, as he was more focussed on his daughters from his second marriage. She described feeling hurt that her father did not initiate contact and communication with her frequently enough and did not make it a priority. She resented being part of his “things to do list”.

These daughters felt that their fathers did not make an adequate effort in maintaining supportive contact and in establishing the quality relationship they sought. This created a feeling that the fathers did not care and/or were not interested in their daughters and their lives.

The findings of this study illuminate an aspect of women’s perinatal mental health that is perhaps understated despite the fact that many children and young people are directly affected by parental relationship breakdown. The majority of these children and young people will experience some degree of paternal absence. My case studies suggest that paternal absence can disrupt the development of a satisfying relationship between daughters and their fathers. The experiences of the women in this study highlight the distress that this can cause. These daughters wish to be cared for in a loving way by their fathers extended from childhood into adolescence and adulthood. Their narratives were characterised by feelings of abandonment, hurt, resentment, anger, feeling unloved and a pervading sense of disappointment around the father-daughter relationship within each of the case studies.

6.3 The Paternal Function

Paternal absence could be defined as any situation where the father is emotionally disconnected from his children, whether or not he is currently living in the same home. When looking at the father-daughter related dynamics of these case narratives it appeared the emotional developments of these three patients were affected by an emotional absence, as much as or if not more than by a physical absence. Even though in each case the father was living at home during the early stages of their daughter’s development, they each experienced the departures of their fathers at critical developmental landmarks around the

time of transition into adolescence. Experiencing the father as an inner presence to draw a source of strength from is a significant aspect attached to the paternal functions necessary for the successful negotiation of critical developmental times for the child, adolescent and young adult. I felt through the course of these psychotherapies that Kate, Emma and Lucy frequently made use of my paternal qualities in a therapeutic sense. I felt that in quite an ordinary way the steady, unwavering and reliable approach that I took, which included being an emotional buffer during times of acute insecurity and uncertainty, helped them when they needed nurturance. I further suggest that I offered qualities associated more with the maternal function and indeed psychotherapists are characteristically able to offer both functions within this intimate environment. Davies (2014) writes:

Turning to the metaphorical nature of 'the father', Winnicott put a lot of emphasis on the person of the actual mother but over time his theory of the 'good enough mother' has come to be understood as metaphorical, referring not so much to a real mother but rather to an environment which is sufficiently consistent but also provides opportunity for development through manageable failures. In the same way 'the father' is also a metaphor for other aspects of the environment, in particular those aspects historically carried out by the father, different from the aspects encapsulated in the maternal metaphor, and which are necessary for psychic development. (Davies, 2014:21).

Various elements of the psychotherapeutic process with patients are instilled with characteristics that may resonate as paternal or maternal. As Winnicott (1958a) exhibited throughout his work, early maternal care allows human beings to develop a fundamental trust in life processes, represented in his concept of the good-enough mother. I attempted with all three patients to be the good-enough psychotherapist, to be sensitive enough for each patient to be able to absorb aspects of the maternal and paternal function. I would suggest the case studies illustrate that in the therapeutic relationship with Kate, Emma and Lucy I emerged as a paternal figure they respected, who they regularly brought their most intimate thoughts and feelings to, their self-discredits and emotional enactments and feared that I would look badly upon them. What they absorbed and recognised as the sessions developed was that although it was the same paternal figure they worried might make unforgiving judgements I actually paid close attention to their state of mind to gently confront their

anxieties and propensity to breakdown as new mothers. In this way I formed a psychotherapeutic framework in which the patients responded to a sense of safety in the paternal transference and a sense of being nurtured in the maternal transference.

Perhaps a feeling of protectiveness was felt by the female patients within this therapeutic gender dynamic and the interactional style we formed. Another important factor that was highly relevant to the gender difference was that these women knew that I would not be able to relate to their experiences of gynaecologically related issues and therefore unable to judge them on that basis. Indeed a number of perinatal patients that I have seen subsequently, including those who experienced traumatic deliveries, have reported that they have valued this aspect. A patient who had undergone an emergency Caesarian-Section, which resulted in her having to recover from a wound infection stated that she would have been more concerned about being judged by a female therapist, as she might have had a similar experience and secretly thought the patient was being pathetic. It is important to acknowledge that there can be helpful and unhelpful reactions to the gender dynamic in the psychotherapy with perinatal patients. However, I think the role I played as a male psychotherapist in the mother-baby sessions with Emma, Kate and Lucy functioned as a resilient conduit for them to project some of the unacceptable impulses they felt towards their significant others. All these various aspects of gender difference appeared to seep into the transference relationship.

In all three scenarios my role as a male psychotherapist became an important part of the material they brought to their sessions. However, in each situation I felt the baby pivotally enhanced the mental health of the mother through the women gradually absorbing the fact they had facilitated their physical, social, cognitive and emotional growth. The influence of the motherhood constellation (Stern, 1995) in respect of the transformational aspect of learning from the baby should not be underestimated, with all the mutuality and reciprocal nature of the mother-baby dyad. Furthermore, it has been argued that family relations become more relevant as the coexistence of different generations becomes more evident and salient during pregnancy (Raphael-Leff, 2001). In all three cases these women had moments when they became deeply critical of their

own mothers and it is worth noting that this might have contributed to them feeling unable to value things their mothers were able to offer.

From the evidence of the sessions with these three patients I hypothesise that the absence of their fathers contributed to their partner choice. Oliver, Robbie and Steven appeared in general to provide gentle, committed and loving qualities to the respective relationships as husbands and fathers. Perhaps in some way due to the troubled relationships the women had endured with their fathers they held deep concerns that they had the potential to drive their husbands away.

6.4 Working with the Mother-Baby Configuration

I found that seeing these patients with their babies in the therapy room offered helpful insights into the ambivalence and emotional complexities they experienced about being the baby's primary caretaker. In each case I found when they began their treatment that there was a strong degree of ambivalence about functioning as the main carer. It took several sessions in each case before it became evident whether their tendencies to feel not good enough was stronger or weaker than their wishes to become the mother they wanted to be. They each expressed how difficult it felt to be responsible for the physical and emotional well-being of their baby. It was a daunting prospect to step into the role of primary caretaker, to feel everything rested on their shoulders. Regardless of the support their husbands provided the three women experienced an overwhelming sense of responsibility. I remember one session with Kate when tearful and upset she told me "the buck stops with me" and just how overwhelming that felt for her. This was particularly problematic when she somewhat doubted her experience of being parented as a good enough working model for the early formative months of Ella's life.

These patients were in each case prone in their vulnerable states of mind to project unwanted aspects of their own emotional pasts on to their infants. At different points of the psychotherapeutic process they all encountered struggles in being able to fully translate the way they were feeling into words and give voice to thoughts and feelings that they felt were stigmatic. One of my tasks during those sessions was to understand not only their conscious and

unconscious communication but to develop an understanding of their working models of internal dynamics and relational representations operating within them. Lucy was more insecure than the other two patients about being able to make her emotional state understood through words. This I suggest was pertinent to her self-harming actions during adolescence and which reappeared briefly during the perinatal treatment. Lucy spoke to me about a sense of release when she cut herself and if she was not able to cut she occasionally regurgitated her food without others knowing during her adolescent years. Jackson (1996) likens the hidden and mechanical aspects of the stomach to the Unconscious, and refers to it as place of holding and turning things over. She writes:

If what has been taken in is poisonous or otherwise unacceptable, can't after all be stomached, it will be forcefully ejected, rejected, thrown back the way it came. (1996:107)

Working therapeutically with patients such as Lucy with histories of self-harm led me to think that when they had felt sick to the stomach with emotional pain they had tendencies to expel what they had taken-in through physical-emotional mechanisms such as cutting and vomiting. The potential to project indigestible emotions on to the baby of course worried Lucy and indeed Kate and Emma. Freud (1915) noted that the intense accumulation of stimulus could result in the patient's excessive discharge of internal tensions. In relation to my patients I thought there was a significant feeling of relief when complex thoughts and negative feelings that had built up were able to be translated into a conscious picture of themselves as mothers. I thought in the therapist role I operated as a conduit for the derivatives of past and present traumas to be expressed and tolerated. I suggest that these three patients ultimately knowing that I was not there to judge them or hold them to account, gradually made their most unpleasant thoughts and feelings more tolerable. Helping these patients through a different relationship to digest experiences which had persistently felt indigestible created the potential for emotional growth, particularly in the form of a more tolerable state of mind. Bion (1962) highlighted the important function of maternal receptiveness to helping the infant manage pleasant and unpleasant sensations through providing a containing and modifying apparatus. This decreases the need to impulsively despatch any intolerably provoking sensations. In ways this too relates to the developmental process of growing

into the depressive position (Klein 1946) and the maternal receptivity required in making the developmental step possible.

Developmental steps in the treatment processes with these three patients I think was integrally helped by the dyadic interactions between mother and baby and also through the dynamic processes between mother, baby and therapist in a triadic configuration. For instance, in quite an ordinary way I alerted the mother to the mirroring that would occur within their mother-baby interaction but which, initially at least, the mother appeared to be emotionally tepid about. Potentially the perinatal therapist can function as a mediating element in what at first glance looks like a purely dyadic configuration, not unlike the important potential function of the father at home.

I remember some of the loving looks baby and mother would give each other and yet the mother would sometimes be rather indifferent about the way her baby was looking at her lovingly; as though she did not see it. Perhaps, my countertransference responses were at play during those moments when I was gently helping her to become aware of her baby's delight and reactivity and her own reactions in return. It was a challenge in the therapist role to sometimes experience lifeless reactions of the mother towards her baby when the baby would attempt to induce a reaction. This was evident in the case of Kate following her traumatic experience of birth and the aftershock she experienced. Initially it was sometimes difficult for her to lovingly relate to her baby in a traumatised state with the impact of physical and emotional damage.

Within this form of psychotherapy with the mother and her baby there was frequent reflecting and thinking together, as we searched for a balance between emotional connection, protection, and individual growth of mother and baby. In all three cases as the dyadic and triadic aspects of the psychotherapy grew, the stigmatic reactions the women associated with their problems appeared to diminish and they appeared to feel less fearful of their contact with me as a mental health clinician. All three women expressed concerns about how and when the therapy would end, and wondered how their problems compared to other patients. Kate tried to bring the therapy to an end herself as part of this anxiety. At various stages they indicated that someone else must feel more

desperate and need me more, inviting my rejection. Naturally it was always important for me to keep the needs of the baby firmly in mind, and not discard the baby prematurely from the therapy process.

It appeared to me that the emotional developments of these three patients were affected by internalised relationships that were experienced as or deemed to be inadequate. As a result of such early losses, Emma, Lucy and Kate were predisposed to recurrent anxieties and bouts of acting out which created difficulties in their most intimate relationships. However charged their feelings could become inside the therapy room and in relation to their therapist, I felt that their transitions into motherhood ultimately served as a potential release from long established internal despair and through the building of an intimate, trusting therapeutic relationship, nurturing qualities were helped and given time to evolve.

7. Conclusion

The data presented in this study illustrate how each participant was grappling with persistent, negative, self-critical thoughts. They may have been predisposed to worries ordinarily but what is apparent here is that the participants were suffering from anxieties which could become exaggerated and inclined to become catastrophic during their transition into motherhood. In each case the woman's exposure to maternal anxiety was exacerbated by the level of responsibility and expectation involved in caring for her baby. During one of her sessions, "the buck stops with me" comment that Kate made in a moment of severe distress encapsulated the weight of responsibility she felt rested on her shoulders. All three case studies underline that these patients were weighed down with a constant barrage of unpalatable feelings and induced worries in them that their internal conflicts would drive their husbands away. Indeed their way of feeling and being during those early stages postpartum was what they feared had the potential to drive them away. These were women who were at risk of breaking down due to mental distress, and the perinatal sessions functioned as a preventative mechanism as much as an intervention.

The in-depth individual narratives demonstrated the underlying doubts and fears that anxiety brought to the patient's situation. They were each faced with trying to cope with physical and psychological distress that had old and new complexities attached to the process of becoming a mother. Themes of abandonment, disappointment, rejection and insecurity emerged repeatedly. In the early periods of the psychotherapeutic treatment they appeared to be engulfed by feelings of social and psychological isolation that felt difficult to bear. Although difficult for them to acknowledge, there were times each woman felt alone and trapped by unwanted feelings and severe doubts about being able to manage the social, physical and emotional demands of being the primary caretaker.

Each of the clinical situations was different and at the same time had similarities in the ways the mothers presented. The consistent structure of therapy offered the patients something to hold on to - a containing space knowing that the weekly sessions offered potential release from the overwhelming feelings that antagonised them moment to moment. Finding a therapeutic space to be able

to deposit and share deep seated antagonisms and doubts helped to lessen feelings of psychological solitude when feeling the weight of the world. The sessions offered beads of hope in relation to the patient being able to make an emotional connection of a new kind which was designed to contain the unwanted thoughts and feelings deposited. This corresponds with the psychotherapeutic process Ruzczynski (2010) has described:

A necessary aspect of our clinical role is to allow patients to use our minds and bodies to deposit that which they fear, whilst they watch and observe how we process and manage that (2010:23).

From my analysis of the case studies it appears that the psychotherapeutic setting attained a special quality and importance for the patients. It provided a holding area in which to deposit toxic thoughts and feelings that had built-up between sessions and that could be re-visited if so wished and thought to be useful. The special quality also included the character of the communication between patient and therapist. In each case the uniqueness and reactive disposition of the patient helped develop the more evident and the more abstract communications in the transference relationship.

The patient-therapist psychodynamics were illustrated within the case studies developing from one session to the next, building from the initial stages to the final stages of therapy, showing particular styles of relating to the therapist in each patient. It is not easy for patients impaired by trauma and internal conflicts to be able to develop a symbolic dialogue and reflectiveness, however, as an emotionally damaged patient recovers the capacity for communicating subjective experiences through the symbolic use of language can grow. I feel that each case narrative often revealed a translation of inner, subjective feelings into language and generated a dialogue between patient and therapist that was sometimes symbolic in the way it transpired.

As the case studies reveal, the participants had to develop a level of trust in the therapist when they were each feeling frantic with worry about being labelled a bad mother and feared that the baby would be removed from their care. In addition the patient had to acquire a level of trust in the therapist being able to withstand being the recipient of their potent and toxic feelings. The relevance of basic trust was an important component to emerge from the cases and it

became clear that the psychotherapeutic work could arouse a conflict between trusting and mistrusting the therapist. When participants established a sense that they were in an emotional dialogue with a person invested in trying to understand them, they then felt that they were involved in a dialogue that had an authentic quality. This helped in relation to developing an emotional connection to help shore-up the fragmented sense of self in the mothers and help them develop a different perspective about relating to their babies.

It became apparent from the patient narratives, that factors which had contributed to maternal anxiety had psychological residues in relation to the experience each had of being parented. It is evident that there were reactions to feelings of loss, disappointment and deprivation in relation to their own childhoods. One particular variable to emerge from each case study in relation to emotional disturbance that had origins in childhood was the experience of having an alcoholic parent. Such emotional disturbance meant that there were pre-existing problems before becoming mothers which had never been adequately processed. Being able to rely on an alcoholic parent for physical and emotional security would not be easy.

The patients in this study wrestled with various self-doubts in sessions and from time to time questioned the specialness of the relationship with me and whether indeed it did qualify as a relationship, exemplified by Emma. I believe this was a transference yearning to feel exclusively cared for and was a powerful unconscious factor in the erotic transference. This transference yearning was connected to painful internal conflicts of the patient's oedipal period and an elusive paternal caretaker. This too was associated with all three patients' fear of being abandoned. There were moments when these patients presented with such infantile anxieties it was as though they had retreated regressively. This can be understood when there was an internal absence of feeling held emotionally. I think this is highly relevant at a time when these patients were experiencing so much emotional upheaval in the perinatal period and they each had a history of feeling abandoned and deprived by parents.

I thought there were times when in each of these three cases the triadic elements of the mother-baby, therapist dynamic gave rise to triangular complications, for instance, when the mother experienced her baby as a rival for my attention. The parental couple intermittently came together for sessions but

in the main husbands appeared to be unavailable or kept out to some extent. It often seemed to me that the mothers were longing for a separate space in which to deposit troubling thoughts and feelings that they might not otherwise have felt able to do. This was an area that perhaps I should have taken-up and interpreted more. Clearly if the parents had attended together more often it would have altered the dynamics in the therapy room. My colleagues working in couple psychotherapy might view the absence of the baby's father in the sessions as a disadvantage to the treatment. Aznar-Martínez, et al (2016) endorse the value of treatment involving the couple:

The couple works and grows together, and this has an enormous benefit in their real lives as both members learn and advance in understanding as a shared project (2016:16).

In each of the cases featured in this study, the baby's father was caring and supportive. However, I suggest the patients were relieved that a professional had been accessed who could play a central role in attempting to contain the primitive fear of abandonment the women were affected by. The psychotherapeutic process acted as an intermediary agent in the time period from initial assessment to the end of the treatment. It functioned as an intermediary holding bay for the raw anxieties that provoked psychological unrest in the patient's early postnatal period whilst maternal connections solidified and the adult self became re-organised. The challenge of womanhood is release from the inhibiting childhood identification without loss of the inner maternal presence which is both a treasured emotional bond and a vital source of self (Vivona, 2000). An important dimension to emerge from the case studies was how the mothers increasingly absorbed the development of their babies with occasional prompts from me and in turn their identity as mothers appeared to strengthen. This was another feature of the triadic aspect of this kind of psychotherapeutic work with mother and baby.

Through the course of their psychotherapies separateness and union constituted a difficult process to navigate in the transition to motherhood. Their maternal identities grew as they began to recognise the range of attributes they had as mothers and adult women. Each patient became more aware of her internal world and the historical conflicts as the months progressed and all three felt impelled to be the best mother possible. The fact that the treatments were

able to span a considerable period and were consistent in regularity was potentially significant. Perhaps the same outcomes would be possible in shorter-term treatment, however, as the case studies show trust and understanding can take time to establish when engulfed by maternal anxiety. I do not doubt the contribution to maternal anxiety that hormonal factors play and other variables such as sleep deprivation and these were considered as relevant during the course of the treatments.

I would conclude that a key facet to come out of all three case studies was the sense that the whole stratum of pregnancy and childbirth triggered internal panic. This inner panic was aggravated by chronic emotional wounds and vulnerabilities that engendered irrational thoughts. There was an absence of a containing internal object to stem some of the insecure feelings and troubling thoughts. It appeared that the psychotherapeutic space and relationship offered the patients an opportunity to convey uncomfortable thoughts and feelings without being judged, despite concerns that the therapist could actually be another critical figure to absorb. The session notes illustrate that at times patients are not always aware of the flavour of their words and actions but the therapy sessions allow for pauses in which the therapist can help bring about more awareness. We can all appreciate that old habits die hard, and in this regard the psychotherapeutic relationship facilitated the patient in noticing habitual tendencies. Under the stable and regular conditions of the sessions the psychotherapeutic interpretations and attention to detail steadily challenges the rigid framework of old habits. Consequently a potential to be unchained from habitual ways of being develops over time and the mother can begin to embrace her maternal role.

To mourn what feels a catastrophic loss, for instance the absence of the paternal function, was never far away from the surface in the work with these patients. As Groarke (2010) points out in relation to Winnicott's clinical thinking, life is never too far away from its roots, no matter how calamitous the sense of beginning. Becoming a mother was a root source of psychological calamity for Kate, Emma and Lucy because they each felt threatened by what had gone before in their lives and which then threatened the potential for a recreation of identity.

To reflect on what I thought helped these patients, I believe the case studies highlight that it was probably multi-layered. However I understand there to be two key elements that supported the process of recovery. Firstly, the patients in their most vulnerable states, felt able within the atmosphere of their psychotherapy sessions to use an opportunity for making reparations to some of the things that had prevented them from having positive feelings about themselves. Secondly, and interconnected, each female patient in the transference relationship with me made use of the paradoxical elements of the therapist's capacity to function as a resilient paternal rescuer and a capacity to offer maternal resilience and benevolence. I acknowledge that characteristics of gender can be viewed as social and cultural constructs, nonetheless, characteristics of gender in the transference played a role in helping these women get back on their feet emotionally. This combination assisted them to feel secure enough to reveal intimate and upsetting things about themselves to a male psychotherapist with their babies present.

Transference dynamics.

The patients featured in this study were all hugely worried that they might be unable to meet their own internal and external expectations within their social contexts, or to satisfy their own longings for closeness with their babies. Commonly they had all experienced unstable attachments in childhood, which intensified needs to form primary attachments as new mothers, and/or to heal preexisting conflicts. Long established anguish can manifest in the patients relationship with the psychotherapist; the relational void can mirror in the therapeutic relationship, and previous environmental failure feel as though it is being repeated within the therapy. I felt that within each of the treatments it was for the psychotherapeutic process to represent the realm of potential, to illuminate what was possible, not only to mirror what was present or past.

Perinatal psychotherapy can play the role of a bridge, a transitional place, for processing the old and the new. I believe the development of a transference relationship offers a mental connection between old and new feelings, which in itself may be experienced as strange and unfamiliar by the patient. Nonetheless a space where potentially the patient via the psychodynamic interchanges might be able to entertain alternative perspectives to those rooted in the past.

If the patient's relational blueprint has been typified by emotional instability and unavailability and internalised as such, her established view of others, including the therapist might tend to mirror her relational blueprint. I would suggest the importance of receptive listening for many patients plagued by unsatisfactory relationships and connections arose in a moments within sessions, including session 46 of Lucy's psychotherapy when she felt I was being distracted from what she was telling me. Questioning whether I was listening to what she was saying might well have related to memories of not being listened to in the past by significant others. Lucy could be hyper-sensitive to a feeling that others, including her mother and her husband did not understand what she wanted or needed from them, and sometimes her therapist too. During the passage of Lucy's time in the psychotherapy there were moments when I believe she began to yearn for our therapeutic relationship to be more emotionally exclusive which made her sometimes resent the distracting presence of her baby boy.

In terms of psychotherapeutic technique, the treatment of the mother-baby couple can be considerably different than that of individual psychotherapy. The cases illustrated the importance of the therapist being open and flexible in shifting between dyadic and triadic conceptualisation of the transference process.

When a strong, meaningful, consistent therapeutic relationship is interrupted by holiday breaks, missed sessions or cancellations it might feel to the patient that she has little to hold onto. It is probable that the reason for the absence of sessions will play a significant part in the emotional reactions of the patient. It is important to be mindful of the undercurrents which can emerge following the resumption of treatment and may play a significant role in how the transference then gets played out in the following sessions. Session 36 exemplified how Lucy felt about not having her regular session, and typified an emotional reaction from a patient when in this case she projected anger and frustration onto others, especially Jack. Her short-fuse did not outwardly direct it's way on to me, who for whatever reason was unavailable to her the previous week, although she as able to acknowledge that she had "more to say" if a session did not take place as planned.

Emma appeared to fear that love and emotional fulfillment were for others, that there was something fundamentally flawed within her, and that what she desperately yearned for could prove to be unreachable for her. Her wish for meaningful attachment was strongly linked to a self-anticipation that she would be found out as flawed and undeserving. Thus, for Emma, seeking intimacy and mutual pleasure frequently brought about feelings of anxiety.

In relation to working with adult patients within the realm of perinatal, a patient such as Emma, who sometimes expressed herself in sexually flirtatious ways within the therapy room, often felt like an uncharted and daring area for a trainee male psychotherapist to become too embroiled in. Perhaps the sessions and the therapeutic repertoire we built-up did enable Emma to translate enough painful feelings into more pleasurable ones through sexual flirtations and yet still remain focused enough upon the development of the mother-baby dyad.

It did feel as though there were moments when she sought more concrete expressions of my interest and attentiveness towards her and might have felt despairing or disappointing when this failed to happen. Interwoven into this was the moment in session 21 after she had stood up and looked in the mirror to check how badly her mascara had run, asking me *“do I look a mess – oh don’t answer that”*. Emma did not insist in wanting me to answer direct questions about what I thought about her, for instance did I find her attractive, likable, but I am sure she often wondered about it.

I came to suspect that the attempts Emma sometimes made for me to make concrete criticisms of her sexual flirtations with other men reflected an underlying anxiety about feeling close to me. She did, in essence, up the ante with her narratives about liking male attention, inviting criticism to step away from what she feared to be the inevitable, that closeness brings disappointment. I suspected that Emma must have felt a sense of potency when making men turn their attentions on to her and any sense of gratification, however short-lived, helped reverse her feeling of having been a vulnerable, powerless child and anxious adult.

Dilemmas always existed in how much erotic transference that I should pick-up in the sessions with Emma, but in the context of a perinatal psychotherapy, it felt to me that the style of relatedness we developed was an appropriate way of regulating the transference temperature.

Limitations and future research

The data collected were from case studies of three patients who fitted the study's inclusion criteria. Whilst there may be some similarities between these three patients and other patients who attend the perinatal service but were not included in this study, it is important to recognise that the case study method of investigation does not enable statistical generalisations to be made from the findings. However, this was not the intention here. Rather the aim of this study was to carry out an in-depth exploration - which the case study method facilitates - of the experiences of maternal anxiety disorder in patients and the role of psychoanalytic psychotherapy as a form of treatment. Given the individual characteristics of the three patients, it is possible that the data upon which the findings are based may have varied, for example amongst patients of different cultural and ethnic backgrounds.

Future research might explore maternal anxiety disorder in relation to the role that different social and cultural factors may play in the experience of maternal anxiety disorders. Future studies of particular personal interest might explore reflux in babies where the mother experiences maternal anxiety; and the place of semiotics in the patient-therapist transference relationship. Given that NHS treatment for women during the perinatal period often constitutes a multi-disciplinary approach, future research might also focus on psychoanalytic psychotherapy and psychiatry working alongside in the clinical setting.

In returning to the aspects the study set out to explore from the beginning it is important to acknowledge that patients can eventually improve or even recover deriving from a multiplicity of factors. However, from my experience as the psychotherapist involved in each of the three case examples and my analysis of the qualitative data I feel the following factors that I describe were significant factors in the eventual outcomes in each case.

This study I believe shows that there were particular factors within the psychotherapeutic process that fundamentally helped the repair to the emotional functioning of the three women hampered as new mothers by anxiety disorders. I understand there to be two key elements that supported the process of recovery. Firstly, the patients in their most vulnerable states, felt able within the atmosphere of their psychotherapy sessions to use an opportunity for making reparations to some of the things that had prevented them from having positive feelings about themselves. Secondly, and interconnected, each female patient in the transference relationship with me made use of the paradoxical elements of the therapist's capacity to function as a resilient paternal rescuer and a capacity to offer maternal resilience and benevolence. I acknowledge that characteristics of gender can be viewed as social and cultural constructs; nonetheless, characteristics of gender in the transference played a role in helping these women get back on their feet emotionally. This combination assisted them to feel secure enough to reveal intimate and upsetting things about themselves to a male psychotherapist with their babies present.

Ultimately, when deeply analysing the data I think the patients came to understand that they were provided with a reliable time and space to feel a sense of containment. Through the psychodynamic and evolving process of the therapy relationship they were more able to see that whilst the internal damage experienced through their childhoods was integral in the present, those feelings of damage were no longer defining them in the same way. Fears of rejection and abandonment pervaded each of the psychotherapy treatments but I felt intense connections formed towards a male psychotherapist as a paternal rescuer helped the mourning process brought about by memories and actual experiences of rejections and abandonments. I am left wondering how Emma, Lucy and Kate, with their levels of insecurities, would have fared working with a female psychotherapist. My experience of these and many perinatal patients subsequently is that they can fear in their vulnerable psyches the possibility that a female psychotherapist already has the answers to mothering, which might threaten the possibility of an engagement. In the therapy with me, Emma, Lucy and Kate might have wanted to impress me at times but I did not experience them as feeling a powerful drive to compete with me.

I recognise that of course same sex patient-therapist relationships have potential advantages and disadvantages like any psychotherapeutic permutation, undoubtedly the personal characteristics and lived experiences of both patient and therapist play a role in whether there is a connection or not. Nonetheless, perhaps the psychodynamics of the female patient-male psychotherapist relationship within the perinatal context is something I can explore further in future papers.

Final comment.

As I moved towards the final year of my training at the Tavistock I knew that I wanted my thesis to be focussed on perinatal patients and the kind of disorders that were presenting in the hospital clinic. My original thoughts around writing this paper were gathering around themes of internal damage. The internal damage themes that were building in my mind were growing out of the deep seated unrest that appeared to lurk in many of the patients that I was seeing in the department. They often appeared to have an air of despondency and restlessness that many times obliquely pointed towards something deep rooted and concealed that was dragging them down. When I began working with these patients in this busy NHS department I felt that the art of thinking with patients about what might be hidden and needing time to emerge through reflexive thinking and developing a level of trust was highly valued. I have felt that gradually through different levels of changing structures within an NHS service that the climate and atmosphere has changed somewhat. The patients' space for thinking still exists but it has faced pressures and threats to its survival, perhaps somewhat from the constant drive for evidence based practice.

I recognise the fact that NHS psychotherapy treatments need to yield evidence through the gathering of quantitative and qualitative data to show outcomes. However, I feel strongly that perinatal patients who are typically highly vulnerable and overwhelmed by internal and external conflicts need to have a thinking space kept intact within NHS mental health departments. Perhaps psychotherapists working in the NHS had taken their eye off the ball to some extent in terms of producing adequate data when working within multi-disciplinary settings, although it is important to acknowledge the relevance of practice based evidence which has been produced by psychotherapists

consistently. I tend to think though that maybe an intolerance or frustration towards the psychotherapeutic model has firmly set in, often from other disciplines within our multi-disciplinary contexts. To a large extent psychotherapy treatments appear to be viewed today as not good value for money, which consequently leaves our patients at risk of losing the thinking space that they often seem to value so highly, not least the women frantic with worries over their ability be receptive enough to bond with their babies.

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Appendix 1: Coding

The themes coded below reflect what emerged in the Emma case study, but are typical of what happens during therapy treatments and the process within. For instance, Emma would come in to sessions on a Monday and she would talk about her recent experiences of the weekend, yet so much of her narrative had connotations to her past and her own deep rooted anxieties which could be linked to entrenched internal conflicts and experiences. The example of coded text given below is from sessions 27 and 46. The text that is highlighted in the sessions relates to the sub categories and sub-sub categories of main themes 1 and 2 only.

Main theme 1: Anxieties from the patient's own early life & anxieties

Sub categories:

- Sad about her father apologising for being a failure
- Therapist questioning whether Emma talking about wasting his time and her father's feelings about being failure
- How the others at the social event might view her
- Sense of panic

Main theme 2: Role of the transference in the treatment

Sub category: Transference

Sub-sub categories:

- Older man wanting Emma to go somewhere else with him
- Younger man able to relate to / swap stories
- Wrong kind of signal, had she given older man wrong signal
- Kind of things Lily does with Steven
- Therapist questioning whether Emma talking about wasting his time and her father's feelings about being failure were connected
- Therapist alerting Emma to Lily putting highlighter pen in her mouth (counter transference - therapist)
- Felt too fat to be hugged – wanted Steven to hug her – realised he was trying to help Lily with something
- Emma spoke about Steven telling her after they got home that he didn't want to speak about her "problems" any more, that he was "finished" with speaking about her problems

- Emma making some links with the history of her paternal aunt who had a reputation for being promiscuous, and who ended her own life after being disappointed romantically when an affair had ended.

Sub category: The patient's sexual anxieties

Sub-sub categories:

- Night out men buying drinks
- Wedding ring
- Being seen as a single woman
- Chatted up by older man
- Wrong kind of signal, had she given older man wrong signal
- Feeling rubbish about having socialised with two men in the kitchen
- Emma making some links with the history of her paternal aunt who had a reputation for being promiscuous, and who ended her own life after being disappointed romantically when an affair had ended.

Main theme 3: Mother and baby in the therapy room

Sub categories:

- Silly mummy
- Lily's efforts to get the toys
- Lily noticing her mother's tearfulness and looking up towards her face
- Feeling Hopeless
- Knocked baby's leg - guilt
- Negativity about herself as a mother
- Lily looking at therapist with serious expression then turning to look at her mother, seemingly aware of the upset her mother was feeling

Main theme 4: The Family Environment as a Pathway of Transmission

Sub categories:

- Bad time – her father contacted her and Steven by telephone
- Father drunk on each occasion
- Only when she consumed alcohol did she feel better about herself

- Emma being worried that things would fall backwards once the therapy ends

Main theme 5: Paternal Issues

Sub category: Absence

Sub-sub categories:

- Declining offer of a drink, older men
- Father still wearing wedding ring
- Bank holiday weekend missed session
- No emotional assurance to draw upon
- Felt too fat to be hugged
- 'This has been one of the most intense experiences of my life'

Sub category: The Paternal Function

Sub-sub categories:

- Wanting to know what therapist thought of her
- Not thinking about her in a 'black and white way'
- D will think he's wasting his time
- Emma spoke about Steven telling her after they got home that he didn't want to speak about her "problems" any more, that he was "finished" with speaking about her problems
- 'This has been one of the most intense experiences of my life'

Main theme 6: Working with the Mother-Baby Configuration

Sub categories:

- Lily 'charmed everyone' – centre of attention at the weekend
- realised Steven was trying to help Lily with something (dilemma for her as a mother)
- That Lily and Steven would be better off without her
- Emma being worried that things would fall backwards once the therapy ends 'but I suppose it's like letting children go and grow up'

Session 27 Emma

After arriving in the therapy room Emma lifted Lily who was sleeping, and placed her on the couch. It was apparent from Emma's facial expressions and quiet, serious mood that she was concerned about something. Firstly Emma grimaced and shook her head and then described herself as "hopeless". She expanded by saying that she considered herself to be hopeless in comparison to "other mothers" who she felt were able to not feel so worried about returning to work. Emma spoke about there being a financial necessity for her to return to work, probably in the New Year, and although there was a need for her to go back to work, she acknowledged having a sense of guilt about it. Unsurprisingly Emma added that she had mixed feelings that Lily would be looked after by both of her grandmothers during the week. When I asked whether there were any triggers that had set off her gloomy state, she told me she had knocked Lily's leg while lifting her out of her high-chair in the morning, which had caused Lily to cry, and this had started her off the negativity she was feeling about herself as a mother today.

Emma described some of the difficulties she thought she would experience when leaving Lily in the care of others, which essentially amounted to other carers not really being fully aware of Lily's needs. Lily awoke at this point and quickly re-orientated herself with the therapy room and then rather burst into action, by trying to scramble herself off the couch and onto the play-mat to get to the toys. Emma spoke of Lily being like her "shadow", and that Lily was not able to "let me out of her sight". I reminded Emma of previous pockets of conversation that we had had about a central aspect of attachment theory and the work of John Bowlby in relation to separation anxiety, and how normal it was for both mother and baby to feel anxiety when separated. I had spoken about the fact that Lily's social world was opening up wider as she had become more mobile, and with that would come a developing realm of independence for both mother and baby, in comparison to the more dyadic aspects of the early months of the relationship between mother and baby.

Emma spoke about worrying that she had made Lily "too clingy". When I asked whether Steven was experiencing anything similar in terms of Lily being clingy towards him, Emma responded by saying with what I thought was tinged with self-satisfaction, "it doesn't happen so much with him.....she even comes to me when Steven comes in from work." I said that I was wondering what that felt like for her (Emma), and she told me with an air of reluctance "obviously I feel for him when she wants me more than him, but I suppose I do like being the one she looks for".

Lily became increasingly vocal in the therapy room and crawled towards me to tentatively touch my shoe. She looked hesitantly at me after touching it, and then when I smiled at her and talked to her about getting my attention, she crawled back towards Emma and lifted herself up using her mother's legs to aid her. Emma said "see, this is the kind of thing she does with Steven". I referred

to Lily's desire to explore and be curious but needing to return to "base camp" with her mummy being her secure base. We then spent some time talking about and observing Lily, looking at her and talking about what she was doing, especially in relation to the way she played with the toys and objects in the room. Emma then told me that there were moments when she felt they had a "bond" that was almost exclusive to them, but despite that she still felt threatened by the way Steven's mother would sometimes "take over", and Emma would then retreat into her "shell". She noticeably looked pleased when I told her that I thought Lily was an appealing baby with her very expressive, responsive, an easy temperament.

As the session progressed I noticed that Emma looked pre-occupied and seemed rather subdued. I commented on my observation, and Emma responded by making a remark about the weekend that had just passed. She had a worried expression and said "I had a really terrible weekend". She proceeded to tell me about having gone out on Friday evening with a group of girlfriends. Firstly they had gone to a restaurant for supper and then went on to a bar/club where people could also dance. Emma spoke in such a worried tone of voice which suggested that something terrible had happened. It transpired that Emma had gone out with three of Steven's work colleagues who she had met on previous occasions and they had invited her to join them for a night out.

A typical theme of how stupid and worthless Emma often felt about herself and her behaviour after being out in a social setting then re-emerged. Emma looked glum and apprehensive as described how a group of men had tried to buy them drinks towards the end of the night out. She referred to "two guys", one a similar age to Emma who told her that he had children – and another man who was around fifty years old who Emma noticed was wearing a wedding ring. She recalled how the older of the two men had persistently asked Emma if he could buy her a drink, and was trying to "chat me up". She spoke about wanting to tell him that he should not be trying to chat her up as he was clearly married, but also acknowledged that she did not want to hurt his feelings, and "felt bad" about declining his offer of a drink.

I drew attention to the fact that Emma had introduced for a second successive week an issue around the wearing of wedding rings. The previous week Emma arrived at the therapy session not wearing her wedding ring and also without Lily. Both the ring and Lily had been left at home. She said that she had forgotten to put her wedding ring on after taking it off, and felt very uncomfortable because she thought that men would notice her while travelling to the hospital, and think that she was "single". Emma had also acknowledged during the previous session that she was experiencing some conflicting feelings about men who might see her as a single woman, in that, she liked the feeling that she was getting attention, e.g. in the way men were looking at her, and at the same time felt a sense of disloyalty to Steven. She told me that she thought it was her "Achilles" and would ultimately lead to her "downfall". I reflected on

the **wedding ring** theme further with Emma and asked whether she had been wearing hers when the man in the club was trying to buy her drinks. She smiled and said that she was wearing it, and had actually put it on again after getting home after last week's session. I referred to how recently she had told me that her father still wore his **wedding ring**, and that it crossed my mind that **the older man in the bar trying to chat her up** could have potentially triggered some strange feelings for her.

Emma sat on the play mat with Lily who crawled over her lap whilst reaching out towards a group of toys on the other side of her mother. Emma seemed to notice the attention I was paying to Lily's efforts to reach the toys and she said in a light-hearted tone that she was a "silly mummy" and lifted Lily to sit beside the toys. She started to speak about feeling that after she got home on Friday night that she fluctuated between feelings of intense anger towards herself to feelings of intense worry about her experience at the night club. She spoke about this fluctuation of feelings continuing into the next day and into Sunday, which she said made it difficult for her to look after Lily when she felt troubled by her emotional reactions. Emma had a very serious expression as **she spoke of the older man encouraging her to go on "somewhere else with him", while experiencing the younger man as someone she could relate to, able to "swap stories" about their children.** She added that the older man "didn't want to accept that she didn't want a drink from him", and raised the question for her whether she had given him "a message". I asked Emma what kind of message was she thinking of, and she answered "**the wrong kind of signal**".

Emma then expressed how extremely worried she was that Steven's female colleagues would tell him today (Monday) that she had given the men in the night club "the come on", and the consequence would be that Steven would want to leave her. Her worries were being repeatedly vocalised in the session and in particular worries over what Steven's work colleagues thought of her, and also what the married man thought of her, who Emma thought must have felt "rejected" by her.

I raised another question that was on my mind, which was, could it be that Emma had blown up Friday evening's events out of proportion. She seemed to be very surprised that I had raised it as a possibility. I then commented upon the impression she gave me that she found it almost intolerable to not know what the others involved in Friday evenings events actually thought of her, and that she was also wondering what I thought of her. Emma responded by saying "I don't think I want to know", but quickly added by saying "I think you would say Emma is someone who tries her best but doesn't get it right". She counterbalanced that by telling me that she did not think I thought about her in such a "black and white way", that it would not be a matter of getting it right or wrong. She went on to say that she constantly worries what people think of her, and it was the same in respect of me, but that she did not worry anymore about

what Lily thought of her, because she knew that Lily would think “I’m trying to be a good mum and that I love her”.

In Emma’s case the sessions took place weekly on Mondays. It became evident that Emma often brought to the sessions worries and anxieties that were freshly triggered by weekend events, and typically linked to the way she had behaved and what others involved might have thought of her.

Session 46 Emma

Emma and Lily came to the appointment following an Easter break around 15 minutes late. When I went to the reception area Lily was being sociable standing in the doorway of the office holding a stickle-brick, with the perinatal administrator talking to her in a light-hearted way. I immediately thought Emma looked very serious and edgy. We went into the therapy room with Lily leading the way and I commented on her knowing her way around the department.

Lily immediately went to investigate the toys that were already placed on the play mat. Emma continued to look serious and rather despondent. She sat on the couch and quickly reached for the tissues close by. She told me as she wiped away tears that she had thought about cancelling today’s session and had only changed her mind because she felt that she was being a “coward” not to come. When I asked whether being late was connected with her thoughts about not coming today she said it was and that it was a “last minute rush” after she thought to herself that she was being “stupid”. I noted vocally that there had been a Bank Holiday last week which meant the regular Monday session was not available, so I wondered what might encourage her to miss out on another session, especially when the end of the treatment was nearing with her return to work.

Emma wiped her eyes some more and Lily appeared to notice her mother’s tearfulness as she also pulled a tissue from the box and stood close to her mother, looking up towards her face. Emma said in a loving way to Lily that she should not be worried about her, that she was just being “a bit silly”. I commented on Lily being sensitive to Emma’s mood. Lily looked a little concerned but then took the tissue with her and started dusting the little wooden table close to the door.

What came to light was another difficult weekend experience for Emma which revolved around a sense of disappointment in her behaviour within another social situation with friends. She told me that she was feeling “such a fool”, and that part of the reason she did not want to attend the session was because she thought “D will think he’s wasted his time with me”. She then spoke about having had a “bad time” after her father had contacted her and Steven by telephone last week. She explained that he had telephoned them again on consecutive nights, past midnight, after they had fallen asleep in bed. He was

drunk on each occasion and it had caused a disruption between her and Steven. Emma was feeling very let down by her father and understood her husband's criticism of her father but she was also feeling "sad" about him calling her to apologise for being a "failure". I said that I was wondering whether it was worth thinking about whether there was a link between the feelings being expressed by Emma about wasting my time and her father's feelings about being a failure. Emma told me that she thought that I must be disappointed with her and think why did I "bother" with her. Emma added that she knew her father felt he was a disappointment to her and his family.

When I asked Emma what it was that might make me feel so disappointed with her, she looked despondent and said "just about everything". I noticed Lily take out a highlighter pen from the bag hanging from the pushchair, and then put it into her mouth. Emma continued to speak and began to tell me that the weekend just gone had been problematic for her and Steven. I felt that I needed to alert her to the highlighter pen in Lily's mouth and I did so. Emma immediately asked Lily to give her the pen which she did willingly. Emma said "see, I'm neglecting her... this is what I was like on Saturday". She became quiet briefly and looked forlornly out of the window. She then began to reflect upon her feeling of disappointment. She spoke about Saturday and being invited to watch the Grand National in the afternoon with friends at a friend's home.

Emma spoke about initially not wanting to go to watch the Grand National, that she was feeling "horrible" about herself. I asked what she felt was so horrible and she said "I was feeling fat and really bad about myself". She spoke of Steven really wanting to go and him encouraging her. I asked Emma whether the invitation included children. She told me that it did but that Lily was the only one present and that Lily "charmed everyone". I made a comment about it seeming as though Lily might have been the centre of attention as the only child at the social gathering. Emma described feeling a sense of "pleasure" that Lily was "popular". I commented on the sociability, and self-assuredness that had developed within Lily.

Emma's head dropped a little as though she was feeling dejected and described feeling that she was hopelessly bogged down by her contrastingly "bad feelings", typified by her fat feeling, and not really able to appreciate at the time the interest that Lily was receiving. She described that she looked at herself in the mirror before leaving for the social event and when putting on lipstick thought the harder she tried, the more unattractive she looked. As we talked about the way she felt about herself in the mirror, Emma said that sometimes she felt "doomed", and it did not matter whether anyone told her that her self-image was distorted, because ultimately she felt "stuck" with her appearance. Emma recalled feeling as though an unbearable sense of panic had been set off in her in relation to her appearance, that she could feel a state of anxiety growing inside her, and felt very alert to how the others at the social event might

view her. When I spoke of there being little or no emotional assurance to draw upon when she had become preoccupied and anxious about the way she looked to herself and others, Emma told me that it was only when she had consumed some alcohol that she began to feel better about herself, and the **sense of panic** diminished. She went on to say that **what she really wanted was for Steven to give her a hug, but that she realised that he was trying to help Lily with something, and then thought “I feel too fat to be hugged”.**

Emma told me that they had all watched the horserace and “that was okay”, and then she had gone into the kitchen and asked whether she could put a pizza into the oven for Lily to eat. In the kitchen she got talking with “two friends”, and “had a couple of glasses of wine”. Once the pizza was ready, Steven “took over” with Lily and he fed her in the lounge while **Emma stayed in the kitchen socialising.** She spoke as though she had committed a crime, which I commented upon, as she told me how much she had enjoyed talking with the friends and **then afterwards that she had “felt rubbish” because she had “neglected Lily and Steven for about an hour”.** When I asked whether the friends were female or male, she told me that they were both male. She said that after she, Lily and Steven had got home she couldn’t stop crying because she felt she had been so neglectful. I spoke about it being understandable at many levels that it was an opportunity for her as a fulltime mother to take a moment out when she knew Lily was in safe hands, to have some time out to socialise but that at another level it was perhaps significant that both the friends were male and it then made her feel disloyal. I noticed Lily turning to look at me with a serious expression and then turning to look at her mother, seemingly aware of the upset her mother was feeling, and then slowly returned her gaze to a book that she had been looking at.

Emma spoke about Steven telling her after they got home that he didn’t want to speak about her “problems” any more, that he was “finished” with speaking about her problems because he did not understand why she had become upset about her behaviour. She told me that **she was feeling that Lily and Steven would be “better off” without her,** but that she could not actually leave them, although she had had fleeting thoughts about committing suicide. I assessed Emma for level of intent and risk in relation to her suicidal thoughts, and concluded that she did not have suicidal intentions.

The session closed with Emma making some links with the history of **her paternal aunt who had a reputation for being promiscuous, and who ended her own life after being disappointed romantically when an affair had ended.** I made a link also to the fact that the therapy sessions were soon to end with Emma returning to work, and how the ending and loss of the therapy and might bring about a feeling of mourning. Emma responded by saying “I’m worried that things will fall backwards once it ends here, but I suppose it’s like letting children go and grow-up”. Her face reflected some anguish when she said “this has been one of the most intense experiences of my life”.

Appendix 2 - Glossary

- BCG – (Bacille Calmette-Guerin – Tuberculous injection)
- BMC - British Medical Council
- CAMHS - Child and Adolescent Mental Health Services
- CBT – Cognitive Behavioural Therapy
- DNA – Deoxyribonucleic Acid
- EPDS - Edinburgh Postnatal Depression Scale
- GP – General Practitioner
- NCH - National Children Homes
- NCSS – National Council of Social Service
- NHS – National Health Service
- NICE - National Institute for Health and Clinical Excellence
- OCD – Obsessive Compulsive Disorder
- PIMH – Perinatal and Infant Mental Health
- PTSD – Post Traumatic Stress Disorder
- SANE – (Australian mental health organisation)
- SES - Socio-Economic Status
- UK – United Kingdom
- WHO – World Health Organisation

