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Maternity and Madness

A psychodynamic view of perinatal mental health

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Summary by Frank Kelley

Katrina's entry into public service was as a nurse in 1974, in Glasgow. Since then she has also worked as a midwife and psychoanalytic psychotherapist. In 2024 Katrina will have reached 50 years of service in the NHS, during which time the topic of *maternal madness* has surfaced on and off both in clinical practice and familial settings and has been discussed from various different perspectives and in different contexts.

Over 10 years ago, in 2013, The Guardian newspaper identified mental illness as *one of the biggest health risks in pregnancy.* One in ten mothers suffer from it, either before or after the birth. As counsellors and psychotherapists, we know that untreated psychological distress and mental ill-health can have devastating and far-reaching implications. With serious illness the outcomes can be suicide and infanticide. The rest of the mother's life may be affected, as can the life of her child and the lives of future generations of the family.

For an overview see the reports of the HSC Public Health Agency confidential enquiry into maternal deaths. Saving Mothers Lives

Ten years on from that Guardian article Katrina provided an overview of what has sometimes been called *maternal madness* and offered fascinating insights from a psychodynamic perspective.

The process of birth itself can be traumatic. Mothers can experience birth as a near death experience. For example clothes being ripped off during an emergency caesarian and the fairly common experience of auditory hallucinations. In the face of these traumatising experiences it is hard to hold onto the integrity of mind, body and spirit.

Part of these changes can be the helpful experience Donald Winnicott described as primary maternal preoccupation. According to Winnicott immediately after giving birth the mother becomes fixated with the infant to the point where everything and everyone else plays a secondary role. This makes her even more sensitive to the infant's needs. How well this

works will be a personal quality of the mother and is not something that ca be taught, it is a process of being not doing. It also needs others to support the mother in this preoccupation. Winnicott also had the important and reassuring notion of the good enough mother. With psychosis a vulnerable baby is depending on a mother who is not capable of being good enough and whose preoccupations are dangerous to mother and baby rather than meeting the baby's needs.

According to Ronald Fairbairn the ego is split. We have an unconscious drive to repeat a decaying process. There are projections from the mother's own birth experiences and other destructive projections. Hallucinations and nightmares are not uncommon. These strong regressive feelings can quickly spiral out of control and contribute to a wish for death. The mother can express these feelings by shouting and screaming at her baby, and threatening or attempting harm. One example is of a mother imagining killing her baby by putting her fingers in the babies fontanelle.

This delusional thinking is an insight into the mother's internal world. Psychosis is not gibberish, it does have meaning. For a therapist it is better to get in the internal world of the mother in the earlier prodromal phase.

A transitional phenomena of child birth is a belief that the mother and/or baby cannot survive the process of birth. Midwives are quite often good at holding these anxieties, although professionals too will be caught up in these profound feelings.

A book Katrina found helpful is *The language of Psychosis* by Bent Rosenbaum and Harly Sonne. New York University Press, 1986.

To use our members words from the day, **thank you to Katrina Ashton** for a beautiful flowing talk and her wealth of experience.